# E Health sector overview

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| Attachment tables |
| Attachment tables are identified in references throughout this sector overview by an ‘EA’ prefix (for example, table EA.1). A full list of attachment tables is provided at the end of this sector overview, and the attachment tables are available from the Review website at www.pc.gov.au/gsp. |
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## E.1 Introduction

This sector overview provides an introduction to the Public hospitals (chapter 10), Primary and community health (chapter 11), and Mental health management (chapter 12) chapters of this Report. It provides an overview of the health sector, presenting both contextual information and high level performance information.

Major improvements in reporting in health this year are identified in each of the service-specific health chapters.

Health services are concerned with promoting, restoring and maintaining a healthy society. They involve illness prevention, health promotion, the detection and treatment of illness and injury, and the rehabilitation and palliative care of individuals who experience illness and injury. The health system also includes a range of activities that raise awareness of health issues, thereby reducing the risk and onset of illness and injury.

### Policy context

All levels of government in Australia fund, deliver and regulate health services, with most of the activity performed by the Australian, State and Territory governments. The Australian Government’s health services activities include:

* funding State and Territory governments to assist with the cost of providing public hospital services in line with the National Health Reform Agreement and the National Healthcare Agreement (NHA)
* providing rebates to patients and regulating medical services provided by General Practitioners (GPs) and specialists, practice nurses, and some services provided by allied health professionals (such as Medicare), and delivering public health programs
* funding and regulating the Pharmaceutical Benefits Scheme (PBS)
* funding and regulating private health insurance rebates
* funding improved access to primary health care, including Indigenous‑specific primary health, specialist services and infrastructure for rural and remote communities
* promulgating and coordinating health regulations
* undertaking health policy research and policy coordination across the Australian, State and Territory governments
* funding hospital services and the provision of other services through the Department of Veterans’ Affairs
* funding hearing services for eligible Australians through the Australian Government Hearing Services Program
* funding the Medicare Safety Net.

State and Territory governments contribute funding for, and deliver, a range of health care services (including services specifically for Indigenous Australians) such as:

* community health services
* mental health programs
* specialist palliative care
* public hospital services

1. public dental services
2. patient transport
3. health policy research and policy development
4. public health (such as health promotion programs and disease prevention)
5. the regulation, inspection, licensing and monitoring of premises, institutions and personnel.

Local governments are generally involved in environmental control and a range of community‑based and home care services, although the exact nature of their involvement varies across jurisdictions. The non‑government sector plays a significant role in the health system, delivering general practice and specialist medical and surgical services, dental services, a range of other allied health services (such as optometry and physiotherapy) and private hospitals.

### Sector scope

Health services in Australia are delivered by a variety of government and non‑government providers in a range of service settings. This Report primarily concentrates on the performance of public hospitals (chapter 10), primary and community health services (including general practice) (chapter 11) and mental health management (chapter 12). These services are selected for reporting as they:

* make an important contribution to the health of the community
* reflect government priorities, for example, they fall within the National Health Priority Areas
* represent significant components of government expenditure on healthcare
* have common objectives across jurisdictions.

High level residential aged care services and patient transport (ambulance) services are not covered in the health chapters in this Report, but are reported separately in chapter 13 (‘Aged care services’) and chapter 9 (‘Fire, road rescue and ambulance’).

Other major areas of government involvement in health provision not covered in the health chapters, or elsewhere in the Report, include:

* public health programs, other than those for mental health
* funding for specialist medical practitioners.

### Profile of health sector

Detailed profiles for the services within the health sector are reported in chapters 10, 11 and 12, and cover health service funding and expenditure as well as the size and scope of the individual service types.

#### Descriptive statistics

Descriptive statistics for the health sector are included in this section. Additional descriptive data for each jurisdiction are presented in tables EA.5–EA.6.

Total expenditure (recurrent and capital) on health care services in Australia was estimated to be $140.2 billion in 2011-12 (figure E.1). This total was estimated to account for 9.5 per cent of gross domestic product in 2011-12, an increase of 1.7 percentage points from the 7.8 per cent of GDP in 2002‑03 (AIHW 2013a).

Figure E.1 Total health expenditure, by source of funds (2011‑12 dollars)**a,** **b,** **c,** **d**

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| Figure E.1 Total health expenditure, by source of funds  More details can be found within the text surrounding this image. |

a Includes recurrent and capital expenditure. b Includes expenditure on ambulance services (reported in chapter 9). c Expenditure by Australian Government and non‑government sources has been adjusted for tax expenditure in relation to private health incentives claimed through the taxation system. d ‘Non-government’ includes expenditure by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurers.

*Source*: AIHW 2013, *Health Expenditure Australia 2011-12*, Health and Welfare Expenditure Series no. 50. Cat. no. HWE 59, Canberra; Table EA.1.

In 2011-12, the health expenditure of the Australian, State and Territory, and local governments was $97.8 billion, which represented 69.7 per cent of total health expenditure within Australia. The Australian Government accounted for the largest proportion of health care expenditure — $59.5 billion or 42.4 per cent of the total in 2011-12. State and Territory, and local governments contributed $38.3 billion or 27.3 per cent of total health expenditure in that year (AIHW 2013a). The remainder was paid by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurance providers (tables EA.1 to EA.7).

Between 2002‑03 and 2011‑12, the average annual rate of growth in real expenditure was 4.9 per cent for the Australian Government, 6.8 per cent for State, Territory and local governments, and 5.0 per cent for non‑government sources (table EA.1).[[1]](#footnote-1)

The Health chapters (Part E) provide performance information on Australian, State and Territory, and local governments health services that account for $77.4 billion of total recurrent health expenditure (or 84.3 per cent of all government recurrent expenditure on health in 2011‑12) (table EA.4). The services covered are:

* public hospitals (chapter 10)
* primary and community health (chapter 11) — medical services (including payments to general practitioners [GPs] and other specialist practitioners), community and public health, medications and public dental services
* specialist mental health services (chapter 12) — recurrent expenditure estimated to be around $7.0 billion in 2011‑12 (table 12A.4).

Health expenditure per person in each jurisdiction is affected by different policy initiatives and socioeconomic and demographic characteristics. Nationally, total health expenditure per person in Australia increased from $4474 in 2002-03 to $6230 in 2011‑12 (expressed in 2011‑12 dollars) (table EA.5). Government real recurrent health expenditure per person in Australia increased from $2985 in 2002‑03 to $4079 in 2011‑12 (expressed in 2011‑12 dollars). Non‑government recurrent expenditure per person in Australia rose from $1259 in 2002-03 to $1802 in 2011‑12 (expressed in 2011‑12 dollars) (figure E.2 and table EA.6).

In 2010-11, Australian, State and Territory government total expenditure on health for Indigenous Australians was $4.2 billion (AIHW 2013b; table E.1). Health expenditure by area of expenditure in 2010-11 is presented for Indigenous and non‑Indigenous Australians in table E.2.

Figure E.2 Recurrent health expenditure per person, by source of funds, 2011‑12 **a,** **b,** **c**

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| Figure E.2 Recurrent health expenditure per person, by source of funds, 2011-12  More details can be found within the text surrounding this image. |

a Includes expenditure on ambulance services (reported in chapter 9). b Government expenditure includes expenditure by the Australian, State, Territory and local governments. c ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditure for NSW residents, and the ACT population is not the appropriate denominator. d Excludes expenditure on high level residential aged care.

*Source*: AIHW 2013, *Health Expenditure Australia 2011-12*, Health and Welfare Expenditure Series no. 50. Cat. no. HWE 59, Canberra; Table EA.6.

Table E.1 **Health funding for Indigenous and non-Indigenous Australians by source of funding, 2010-11**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Source of funding | *Amount ($ million)* | | |  |
|  | Indigenous | Non-Indigenous | Total | Indigenous share (%) |
| State and Territory governments | 2 119.2 | 28 172.0 | 30 291.2 | 7.0 |
| Australian Government | 2 040.7 | 52 967.2 | 55 007.8 | 3.7 |
| Direct Australian Government | 1 245.0 | 33 078.3 | 34 323.3 | 3.6 |
| Indirect through Australian State/Territory governments | 746.1 | 13 493.9 | 14 240.0 | 5.2 |
| Indirect through non-governmenta | 49.6 | 6 394.9 | 6 444.5 | 0.8 |
| *All governments* | 4 159.9 | 81 139.2 | 85 299.0 | 4.9 |
| Non-government | 392.1 | 37 964.9 | 38 357.1 | 1.0 |
| **Total health** | **4 552.0** | **119 104.1** | **123 656.1** | **3.7** |

a Includes private health insurance rebates for all Australians. Also includes Specific Purpose Payments covering highly specialised drugs in private hospitals and other payments.

*Source*: AIHW 2013, *Expenditure on health for Aboriginal and Torres Strait Islander people 2010–11,* Health and Welfare Expenditure Series no. 48. Cat. no. HWE 57, Canberra.

Table E.2 Expenditure on health services for Indigenous and non‑Indigenous Australians, 2010-11

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Area of expenditure | Expenditure ($ million) | | |  | Expenditure per person ($) | |  |
| Indigenous | Non-Indigenous | Total | Indigenous share (%) | Indigenous | Non-Indigenous | Ratio |
| Total hospital services | 2 178.0 | 47 527.6 | 49 705.7 | 4.4 | 3 825.6 | 2 169.4 | 1.8 |
| Public  hospitalsa | 2 067.4 | 36 870.4 | 38 937.8 | 5.3 | 3 631.3 | 1 683.0 | 2.2 |
| Admitted patientsb | 1 748.7 | 31 106.6 | 32 855.4 | 5.3 | 3 071.6 | 1 419.9 | 2.2 |
| Non- admitted patients | 333.0 | 5 749.4 | 6 082.4 | 5.5 | 584.9 | 262.4 | 2.2 |
| Private  hospitalsc | 110.7 | 10 657.3 | 10 767.9 | 1.0 | 194.4 | 486.5 | 0.4 |
| Patient transport | 183.4 | 2 601.4 | 2 784.7 | 6.6 | 322.1 | 118.7 | 2.7 |
| Medical | 376.3 | 22 148.2 | 22 524.5 | 1.7 | 660.9 | 1 011.0 | 0.7 |
| Medicare | 286.0 | 17 380.7 | 17 666.8 | 1.6 | 502.4 | 793.3 | 0.6 |
| Other | 90.2 | 4 767.5 | 4 857.7 | 1.9 | 158.5 | 217.6 | 0.7 |
| Dental | 84.8 | 7 780.8 | 7 865.5 | 1.1 | 148.9 | 355.2 | 0.4 |
| Community healthd | 1 119.6 | 5 172.0 | 6 291.6 | 17.8 | 1 966.5 | 236.1 | 8.3 |
| Other professional | 43.8 | 4 053.4 | 4 097.2 | 1.1 | 77.0 | 185.0 | 0.4 |
| Public health | 185.7 | 1 810.3 | 1 996.1 | 9.3 | 326.2 | 82.6 | 4.0 |
| Medications | 209.9 | 18 215.2 | 18 425.0 | 1.1 | 368.7 | 831.4 | 0.4 |
| Aids and appliances | 15.2 | 3 616.6 | 3 631.8 | 0.4 | 26.7 | 165.1 | 0.2 |
| Research | 124.2 | 4 158.5 | 4 282.7 | 2.9 | 218.2 | 189.8 | 1.2 |
| Health administration | 31.1 | 2 020.1 | 2 051.2 | 1.5 | 54.6 | 92.2 | 0.6 |
| **Total health** | **4 552.0** | **119 104.1** | **123 656.1** | **3.7** | **7 995.4** | **5 436.5** | **1.5** |

a Excludes dental services, patient transport services, community health services, public health and health research undertaken by the hospital. b Admitted patient expenditure estimates are adjusted for Aboriginal and Torres Strait Islander under-identification. c Includes State/Territory governments’ expenditure for services provided for public patients in private hospitals. The estimates are not comparable to previous estimates due to improved methodology. d Includes other recurrent expenditure on health not elsewhere classified, such as family planning previously reported under ‘Other health services (n.e.c.)’. State and Territory expenditure on Closing the Gap initiatives have been allocated to this category for the first time.

*Source*: AIHW 2013, *Expenditure on health for Aboriginal and Torres Strait Islander people 2010-11,* Health and Welfare Expenditure Series no. 48. Cat. no. HWE 57, Canberra.

### Factors affecting demand for services

Health status is linked to demand for health services and is associated with a range of demographic and socioeconomic factors. Financial, educational, geographic and cultural barriers can reduce access to health services and contribute to poorer health outcomes.

#### Social and economic factors

It has been well documented that people who experience social and economic disadvantage are at risk of negative health outcomes. Compared with those who have social and economic advantages, disadvantaged Australians are more likely to have shorter lives (AIHW 2012). Those who are disadvantaged tend to have greater health risks such as smoking more and higher rates of obesity (SCRGSP 2012). Burden‑of‑disease studies indicate greater burden among people who are relatively disadvantaged in society (Begg et al. 2007). Those who are disadvantaged are more likely to report their health as fair or poor than those that do not suffer the same disadvantage as measured by the Socio Economic Indexes for Areas (SEIFA).

Higher income and wealth are associated with better health. People with higher income are better able to access health services in a timely manner, and are also able to access goods and services that have health benefits such as better housing, food and other healthy pursuits (AIHW 2012). People with higher education levels, which are also associated with higher incomes and better access to health care, are likely to have better health (AIHW 2012).

#### Geographic location

Geographic distance to health services, particularly in remote and very remote areas, can contribute to poor health. People living in rural and remote areas tend to have higher levels of disease risk factors and illness than those in major cities (AIHW 2012). Those in remote areas are more likely to report their health as fair or poor and less likely to report their health as excellent, very good or good than those in major cities.

Nationally, 2.3 per cent of the population lived in remote and very remote areas in 2012 (table 2A.12). Those living in remote and very remote areas made up less than 7 per cent of the population in each State and Territory except the NT, where the figure was 43.9 per cent — 20.8 per cent in remote and 23.1 per cent in very remote areas.

#### Indigenous status

Indigenous Australians are generally less healthy than other Australians, die at much younger ages, and have more disability and a lower quality of   
life (AIHW 2012; tables EA.35 and EA.37). Many Indigenous Australians live   
in conditions of social and economic disadvantage — a recent study found socioeconomic disadvantage to be the leading health risk for Indigenous Australians in the NT, accounting for 42 to 54 per cent of the life expectancy gap between Indigenous and non-Indigenous Australians (Zhao *et al*. 2013). Indigenous Australians have low employment and income levels when compared to non‑Indigenous Australians (see chapter 2 Statistical context p. 2.2; tables 2A.23–2A.25; tables 2A.34–2A.36; SCRGSP 2011). Indigenous Australians have relatively high rates for many health risk factors and are more likely to smoke and to consume alcohol at risky levels (ABS 2013a; SCRGSP 2011; Zhao *et al*. 2013). Indigenous Australians are more likely to live in inadequate and overcrowded housing (SCRGSP 2011) and in remote areas with more limited access to health services.   
In 2006, 51 992 Indigenous Australians were living in discrete Indigenous communities that were 100 kilometres or more from the nearest hospital (ABS 2007).

Nationally, 3.0 per cent of the total population identified as Indigenous in 2011. Those identifying as Indigenous made up less than 5 per cent of the population   
in each State and Territory except the NT, where the figure was 29.8 per cent (tables 2A.1 and 2A.15).

### Service-sector objectives

Government involvement in health services is predicated on the desire to improve the health of all Australians and to ensure equity of access and the sustainability of the Australian health system. Box E.1 presents the overall objectives of the health system as summarised for this Report, which are consistent with the objectives outlined in the National Healthcare Agreement (MCFFR 2012). Governments provide a variety of services in different settings to fulfil these objectives.

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| Box E.1 Overall objectives of the health system |
| Government involvement in the health system is aimed at efficiently and effectively improving health outcomes for all Australians and ensuring the sustainability of the Australian health system, achieving the following outcomes:   * Australians are born and remain healthy * Australians receive appropriate high quality and affordable primary and community health services * Australians receive appropriate high quality and affordable hospital and hospital related care * Australians have positive health care experiences which take account of individual circumstances and care needs * Australians have a health system that promotes social inclusion and reduces disadvantage, especially for Indigenous Australians * Australians have a sustainable health system. |
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Measuring the equity, effectiveness and efficiency of Australia’s health system is a complex task. It must account for the performance of a range of services (such as prevention and medical intervention) and service providers (such as community health centres, GPs and public hospitals), and account for the overall outcomes generated by the health system. The appropriate mix of services — including the prevention of illness and injury, and medical treatment (prevention versus medical intervention) — and the appropriate mix of service delivery mechanisms (community‑based versus hospital‑based) plays an important role in determining outcomes. Other relevant factors are external to the health system, such as the socioeconomic and demographic characteristics of the population, available infrastructure and the environment.

## E.2 Sector performance indicator framework

This sector overview is based on a sector performance indicator framework (figure E.3). This framework is made up of the following elements:

* Sector objectives — three sector objectives are a précis of the key objectives of the health system and reflect the outcomes in the NHA (box E.1).
* Sector-wide indicators — seven sector-wide indicators relate to the overarching service sector objectives identified in the NHA.
* Information from the service-specific performance indicator frameworks that relate to health services. Discussed in more detail in chapters 10, 11 and 12, the service-specific frameworks provide comprehensive information on the equity, effectiveness and efficiency of these services.

This sector overview provides an overview of relevant performance information. Chapters 10, 11 and 12 and their associated attachment tables provide more detailed information.

Figure E.3 Health services sector performance indicator framework

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| Figure E.3 Health services sector performance indicator framework  More details can be found within the text surrounding this image. |

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.

### Sector-wide performance indicators

This section includes high level indicators of health outcomes. Many factors are likely to influence outcomes — not solely the performance of government services. However, these outcomes inform the development of appropriate policies and delivery of government services.

#### Babies born of low birth weight

‘Babies born of low birth weight’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.2). The birth weight of a baby is an important indicator of its health status and future wellbeing. Low birth weight babies have a greater risk of poor health and dying, require a longer period of hospitalisation after birth, and are more likely to develop significant disabilities (Goldenberg & Culhane 2007).

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| Box E.2 Low birth weight of babies |
| Babies’ birth weight is defined as low if they weigh less than 2500 grams, very low if they weigh less than 1500 grams and extremely low if they weigh less than 1000 grams (AIHW and Li et al. 2013).  A low or decreasing number of low birth weight babies is desirable.  Factors external to the health system also have a strong influence on the birth weight of babies. Some factors contributing to low birth weight include socioeconomic status, size of parents, age of mother, number of babies previously born, mother’s nutritional status, smoking and alcohol intake, and illness during pregnancy (Li et al. 2011).  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 2011 data are available for all jurisdictions.   Data quality Information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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In 2011, 93.7 per cent of liveborn babies in Australia weighed 2500 grams or over (AIHW and Li et al. 2013). The average birth weight for all live births was 3367 grams in 2011 (table EA.8). In 2011, 6.3 per cent of all liveborn babies in Australia weighed less than 2500 grams. This included 1.0 per cent of babies with a very low birth weight — less than 1500 grams (table EA.8).

Nationally, rates of low birth weight babies increased with remoteness, from 4.6 per cent in major cities, rising to 5.3 per cent in outer regional areas, and 9.3 per cent in very remote areas in 2011 (table EA.11).

Nationally, the average birth weight for liveborn babies of Indigenous mothers was 3187 grams in 2011 (table EA.9). Among live-born singleton babies born to Indigenous mothers in 2011, the proportion with low birth weight was twice that of those born to non‑Indigenous mothers (figure E.4).

Figure E.4 Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status, 2011**a,** **b,** **c,** **d, e**

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| Figure E.4 Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status, 2011  More details can be found within the text surrounding this image. |

a Low birth weight is defined as less than 2500 grams. b Disaggregation by State/Territory is by place of usual residence of the mother. c Data excludes Australian non-residents, residents of external territories and where State/Territory of residence was not stated. d Excludes stillbirths and multiple births. Births were included if they were at least 20 weeks gestation or at least 400 grams birth weight. e Birth weight data on babies born to Indigenous mothers residing in the ACT and Tasmania should be viewed with caution as they are based on small numbers of births.

*Source*: AIHW (unpublished) National Perinatal Data Collection; table EA.10.

#### Prevalence of risk factors to the health of Australians

‘Prevalence of risk factors to the health of Australians’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.3).

A number of behaviours create risks to health outcomes; for example, lack of exercise, smoking, excessive alcohol consumption, sun exposure and unhealthy dietary habits. Health services are concerned with promoting, restoring and maintaining a healthy society. An important part of this activity is reducing health risk factors through activities that raise awareness of health issues to reduce the risk and onset of illness and injury.

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| Box E.3 Prevalence of risk factors to the health of Australians |
| ‘Prevalence of risk factors to the health of Australians’ is defined by the following measures:   * Prevalence of overweight and obesity — the number of people with a Body Mass Index (BMI) in the categories of either overweight or obese, as a percentage of the population. BMI is calculated as weight (kg) divided by the square of height (m). BMI values are grouped according to World Health Organization and National Health and Medical Research Council guidelines.   Among adults, a BMI of 25 to less than 30 is considered overweight and a BMI of 30 and over is considered to be obese (WHO 2000; NHMRC 2013).  Children are defined as people aged 5–17 years. For children, obesity is defined as BMI (appropriate for age and sex) that is likely to be 30 or more at age 18 years.   * Rates of current daily smokers — number of people aged 18 years or over who smoke tobacco every day as a percentage of the population aged 18 years or over. * Risk of alcohol related harm over a lifetime — people aged 18 years or over assessed as having an alcohol consumption pattern that puts them at risk of long‑term alcohol related harm, as a percentage of the population aged 18 years or over.   ‘Lifetime risk of alcohol related harm’ is defined according to the 2009 National Health and Medical Research Council guidelines: for males and females, no more than two standard drinks on any day. This has been operationalised as: for both males and females, an average of more than 2 standard drinks per day in the last week.  Rates for all three measures are age standardised.  A low or decreasing rate is desirable for each health risk factor.  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  2011–2013 data are available for all jurisdictions.   Data quality Information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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##### Prevalence of overweight and obesity

Being overweight or obese increases the risk of an individual developing, among other things, heart disease, stroke and Type 2 diabetes. In 2011-12, over a third of Australians’ measured BMI was in the overweight range and over a quarter were obese (figure E.5; table EA.12).

The percentage of adults who were overweight or obese tended to be higher in remote (70.1 per cent) and outer regional areas (67.8 per cent), than in major cities (60.9 per cent) in 2011-12 (table EA.13). The percentage of people who were overweight or obese increased from 2007-08 in all areas of Australia (table EA.13).

Figure E.5 Proportion of adults in BMI categories, 2011-12**a, b, c, d, e, f**

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| Figure E.5 Proportion of adults in BMI categories, 2011-12  More details can be found within the text surrounding this image. |

a Adults are defined as people aged 18 years and over. b Obesity for adults is defined as BMI equal to or greater than 30. c Measured people only. d Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population. e Data have been revised and may differ from data published in the 2013 Report. f 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* (2011-12 Core component); table EA.12.

The percentage of people who were overweight or obese tended to be higher in older age groups, peaking at age 70–74 for males and females (83.8 per cent and 74.0 per cent respectively) in 2011-12. Overall, the percentage of males and females that were overweight or obese increased from 2007-08 (by 2.1 percentage points for males and 0.9 percentage points for females) although the change varied by age category (table EA.15).

Nationally, the rate of overweight and obesity was higher for Indigenous adults (71.4 per cent) than for non‑Indigenous adults (62.6 per cent) in 2011–13 (table EA.16). Data for the rate of overweight and obesity for children by Indigenous status are reported in table EA.18.

##### Rates of current daily smokers

Smoking is an important risk factor for heart disease, stroke and lung cancer. These were the three leading causes of death in Australia in 2011 (ABS 2013b). Smoking is responsible for around 80 per cent of all lung cancer deaths and 20 per cent of all cancer deaths (HealthInsite 2011).

The proportion of adult daily smokers aged 18 years and over accounted for 16.3 per cent of the population in 2011-12, a decrease of 2.8 percentage points from 2007‑08 (figure E.6 and table EA.19).

Nationally, people from more disadvantaged socioeconomic backgrounds have a higher propensity to smoke (age standardised). In 2011-12, 24.3 per cent of adults   
living in areas from the first quintile of the SEIFA — the areas of greatest relative disadvantage — were daily smokers, compared with 9.0 per cent from the fifth quintile — the areas of least relative disadvantage — (figure E.6 and table EA.20).

Adults from more remote locations also had a higher propensity to smoke (age standardised). In 2011-12, daily smokers accounted for 26.1 per cent of the population in remote geographical areas, gradually decreasing as remoteness of residence decreases, accounting for 22.6 per cent of the population in outer regional areas, 19.5 per cent in inner regional areas and 14.7 per cent in major cities (table EA.19).

Nationally, Indigenous Australians had higher age‑standardised rates of daily smoking (41.2 per cent) than non‑Indigenous Australians (16.0 per cent) in 2011–13 (table EA.21).

Figure E.6 Proportion of adults who are daily smokers, by State and Territory**a, b, c, d, e, f**

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| Figure E.6 Proportion of adults who are daily smokers, by State and Territory  More details can be found within the text surrounding this image. |

a Rates for total are age‑standardised by State and Territory to the 2001 Estimated Resident Population (5 year ranges from 18 years). b A lower SEIFA quintile indicates relatively greater disadvantage and a lack of advantage in general. A higher SEIFA quintile indicates a relative lack of disadvantage and greater advantage in general. c Total includes persons for whom an Index of disadvantage of residence score was not known. d 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. e Data for 2011-12 have been revised and differ from data published in the 2013 Report. f 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* (2011-12 Core component)*;* ABS (unpublished) *National Health Survey 2007-08*; table EA.19.

##### Levels of risky alcohol consumption

The National Health and Medical Research Council (NHMRC) reports that excessive long term alcohol consumption increases the risk of heart disease, diabetes, liver cirrhosis and some types of cancers. It can contribute to injury and death through accidents, violence, suicide and homicide, and also to financial problems, family breakdown, and child abuse and neglect (NHMRC 2009).

Rates are based on the 2009 NHMRC guidelines for reducing risks from drinking alcohol (NHMRC 2009). Across Australia, 19.4 per cent of adults were at risk of alcohol related harm over a lifetime in 2011-12, although the age standardised rates varied among jurisdictions (table EA.22). Adults who are at risk of alcohol related harm over a lifetime gradually decreased as remoteness of residence decreased in 2011‑12 (figure E.7). There is no statistically significant difference between socioeconomic categories of the proportion of Australians at risk of alcohol related harm over a lifetime (table EA.23).

Figure E.7 Proportion of adults at risk of alcohol related harm over a lifetime, by remoteness, 2011-12a, b, c, d, e

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| Figure E.7 Proportion of adults at risk of alcohol related harm over a lifetime, by remoteness, 2011-12  More details can be found within the text surrounding this image. |

a Rates are based on the 2009 NHMRC guidelines and can be used for the purposes of comparisons over time. b Rates are age standardised by State and Territory to the 2001 Estimated Resident Population (5 year ranges from 18 years). 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. d Very remote data were not collected. e 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* (2011-12 (National Health Survey (NHS) component); ABS (unpublished) *National Health Survey 2007-08*; table EA.22.

Nationally, the age standardised proportion of adults at risk of alcohol related harm over a lifetime (2009 NHMRC guidelines) was similar for Indigenous Australians (19.2 per cent) and non‑Indigenous Australians (19.5 per cent) in 2011–13, although results varied across jurisdictions (table  EA.24).

#### Selected potentially preventable diseases

‘Selected potentially preventable diseases’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.4).

Selected potentially preventable diseases are diseases that can potentially be prevented through reducing health risk factors such as obesity, smoking and harmful drinking. Note that a similarly named indicator ‘selected potentially preventable hospitalisations’ is reported in chapter 11 Primary and community health. Selected potentially preventable *hospitalisations* are hospital admissions that could potentially be reduced by more effective management of illness and injury in the primary and community healthcare sector.

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| Box E.4 Selected potentially preventable diseases |
| ‘Selected potentially preventable diseases’ is defined by the following measures:   * Incidence of selected cancers — incidence of selected cancers of public health importance. * For melanoma, lung and bowel cancer, the measure is defined as the number of new cases in the reported year expressed as a directly age standardised rate. * For breast and cervical cancer in females, the measure is defined as the number of new cases in women in the reported year expressed as a directly age standardised rate. * Data reported for this measure are: * comparable (subject to caveats) across jurisdictions and over time except for NSW and the ACT, for which 2010 data are estimated * incomplete for the current reporting period. Data for 2010 were not available for NSW or the ACT and estimates are reported for these jurisdictions. * Incidence of heart attacks — the number of deaths recorded as acute coronary heart disease deaths plus the number of non-fatal hospitalisations for acute myocardial infarction or unstable angina not ending in a transfer to another acute hospital, expressed as a directly age-standardised rate. * Data reported for this measure are: * comparable (subject to caveats) over time at the national level * incomplete for the current reporting period. Data are not currently available by State and Territory. * Prevalence of type 2 diabetes — the number of people recorded as having Type 2 diabetes as a percentage of the total population aged 18 years or over. * Data reported for this measure are: * comparable across jurisdictions except for the NT where people in very remote areas, for which data are not available, comprise around 23 per cent of the population (see caveats in attachment tables) but are not comparable over time * complete for the current reporting period except for the NT. All required 2011–13 data are reported for all jurisdictions except the NT.   A low or decreasing rate is desirable for each incidence/prevalence rate.  Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.  Prevalence is defined as the proportion of the population suffering from a disorder.  Data quality Information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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As well as addressing health risk factors, well-planned disease prevention and early intervention programs help prevent a number of diseases (or more successfully treat diseases through early identification). A number of programs form an important element of preventing disease and improving the health of Australians (NPHT 2009), such as:

* immunisation
* cancer screening and early treatment
* early detection and intervention
* individual disease risk assessments and early intervention for biomedical risk factors such as: high blood pressure, high blood cholesterol, or impaired glucose tolerance
* childhood infectious diseases control
* sexually transmitted infections control.

##### Incidence of selected cancers

Health service efforts to control cancer involve (AIHW 2013c):

* *public health programs* — programs to reduce the major risk factors; tobacco consumption, poor diet, insufficient physical activity, being overweight or obese, unsafe alcohol use, infectious diseases and exposure to ultraviolet radiation
* *early detection* — screening programs for cancers in Australia have contributed to substantial declines in associated mortality. Screening can also help prevent the development of cancer if changes can be found before they become cancer
* *research support* — such as provided through the National Health and Medical Research Council.

Nationally, the age standardised rate of lung cancer was 42.8 new cases per 100 000 people in 2010. Bowel cancer, which has been linked to diet, occurred at a rate of 61.8 new cases per 100 000 people in 2010 (table EA.24). Other cancers such as melanoma are also preventable. The incidence of these cancers for 2010, along with breast and cervical cancer, are reported in figure E.8. Tables EA.26–28 report the incidence of the selected cancers by remoteness, SEIFA IRSD quintiles and Indigenous status.

Figure E.8 Incidence of selected cancers, per 100 000 people, 2010**a, b, c**

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| Figure E.8 Incidence of selected cancers, per 100 000 people, 2010  More details can be found within the text surrounding this image. |

a Age‑standardised to the Australian population as at 30 June 2001 using five-year age groups to 84 years, and expressed per 100 000 persons (per 100 000 females for female breast cancer and cervical cancer).   
b Due to the low incidence of cancers in some jurisdictions, comparisons across time and between jurisdictions should be made with caution. c Data for NSW and the ACT are based on projections rather than actual cancer incidence and are not comparable with data for other jurisdictions.

*Source*: AIHW (unpublished) Australian Cancer Database; ABS (unpublished) Estimated Resident Population, 30 June 2010; table EA.25.

##### Incidence of heart attacks

Cardiovascular disease is the largest cause of premature death in Australia. Although death rates for cardiovascular disease have declined considerably in recent decades, it continues to be one of the biggest health problems requiring attention in Australia (AIHW 2013c).

The major, preventable risk factors for cardiovascular disease are: tobacco smoking; high blood pressure; high blood cholesterol; insufficient physical activity; overweight and obesity; poor nutrition; and diabetes.

Nationally, the rate of heart attacks was 427 new cases per 100 000 people in 2011 (table EA.30). The incidence of heart attacks was greater for Indigenous Australians (table EA.29). Caution should be taken in interpreting these data as they have been estimated using an algorithm that is under AIHW development. It should be considered an interim measure until current validation work is complete.

##### Prevalence of type 2 diabetes

Diabetes mellitus is a chronic condition in which the body makes too little of the hormone insulin or cannot use it properly. Type 2 diabetes is the most common form of diabetes, occurring mostly in people aged 50 years and over, and accounting for 85-90 per cent of all cases of diabetes mellitus (AIHW 2013c).

Diabetes mellitus and its complications contribute significantly to ill health, disability, poor quality of life and premature death. It also increases the risk of a variety of complications including end-stage kidney disease, coronary heart disease, stroke and other vascular diseases. Type 2 diabetes is more common in people who do insufficient physical activity and are overweight or obese. It is strongly associated with high blood pressure, high cholesterol and excess weight carried around the waist (Better Health Channel 2013). Thus, early intervention and treatment programs have the potential to reduce the cases and severity of the disease.

Prevalence of type 2 diabetes is derived using a combination of fasting blood glucose and self-reported information on diabetes diagnosis and medication use. Data include all newly diagnosed diabetes cases as the vast majority can be assumed to be type 2 diabetes. See DQI for further detail.

Nationally, an estimated 4.3 per cent of people aged 18 years or over had type 2 diabetes in 2011‑12 (table EA.31).

#### Potentially avoidable deaths

‘Potentially avoidable deaths’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.5). Avoidable deaths reflect the effectiveness of current and past preventative health activities.

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| Box E.5 Potentially avoidable deaths |
| ‘Potentially avoidable deaths’ is defined as potentially preventable deaths (deaths amenable to screening and primary prevention, such as immunisation) and deaths from potentially treatable conditions (deaths amenable to therapeutic interventions) for those aged less than 75 years per 100 000 people aged less than 75 years.  A low or decreasing potentially avoidable death rate is desirable.  Most components of the health system can influence potentially avoidable death rates, although there can be decades between the action and the effect. Factors external to the health system also have a strong influence on potentially avoidable death rates.  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  2007–2011 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Indigenous Australians had significantly higher death rates from potentially avoidable deaths (preventable and treatable) over the period 2007–2011, comprising higher potentially preventable deaths per 100 000 people and higher treatable deaths per 100 000 people (figure E.9 and table EA.33). Single year data for all Australians are presented in table EA.32.

Figure E.9 Age standardised mortality rates of potentially avoidable deaths, under 75 years, 2007–2011**a,** **b,** **c,** **d,** **e,** **f, g, h, i, j**

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| Legend to Figure E.9  More details can be found within the text surrounding this image.  Figure E.9 Age standardised mortality rates of potentially avoidable deaths, under 75 years, 2007–2011, by Indigenous status - potentially preventable deaths  More details can be found within the text surrounding this image.Figure E.9 Age standardised mortality rates of potentially avoidable deaths, under 75 years, 2007–2011, by Indigenous status - potentially treatable deaths  More details can be found within the text surrounding this image.Figure E.9 Age standardised mortality rates of potentially avoidable deaths, under 75 years, 2007–2011, by Indigenous status - all potentially avoidable deaths  More details can be found within the text surrounding this image. |

a Standardised death rates calculated using the direct method, age-standardised by 5 year age groups to less than 75 years. b Excludes deaths where Indigenous status was not provided. c Avoidable mortality is defined as mortality before the age of 75 years, from conditions which are potentially avoidable within the existing health system. d Data based on year of registration. See DQI for more information. e Data are reported by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. Only these five states and territories have evidence of a sufficient level of Indigenous identification and sufficient numbers of Indigenous deaths to support mortality analysis. f Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See DQI for more information. g For WA, Indigenous deaths data for 2007, 2008 and 2009 have been revised. See DQI for more information. h Total includes data for NSW, Queensland, WA, SA and the NT only. i Preventable deaths are those which are amenable to screening and primary prevention such as immunisation, and reflect the effectiveness of the current preventative health activities of the health sector. j Deaths from potentially treatable conditions are those which are amenable to therapeutic interventions, and reflect the safety and quality of the current treatment system.

*Source*: ABS (unpublished) *Causes of Deaths, Australia, 2011*, Cat. no. 3303.0; table EA.33.

#### The mortality and life expectancy of Australians

‘The mortality and life expectancy of Australians’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.6).

Comparing mortality and life expectancy data across populations, including cause, age, sex, population group and geographical distribution, provide important insights into the overall health of Australians (AIHW 2013d). Trends over time in mortality and life expectancy data can signal changes in the health status of the population, as well as provide a baseline indicator for the effectiveness of the health system.

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| Box E.6 The mortality and life expectancy of Australians |
| ‘The mortality and life expectancy of Australians’ is defined by the following measures:   * ‘Life expectancy’ — the average number of additional years a person of a given age and sex might expect to live if the age-specific death rates of the given period continued throughout his/her lifetime.   A high or increasing life expectancy is desirable.   * ‘Median age at death’ — the age at which exactly half the deaths registered (or occurring) in a given time period were deaths of people above that age and half were deaths below that age.   A high or increasing median age at death is desirable.   * ‘Mortality rates’ — the number of registered deaths compared to the total population (expressed as a rate). Rates are provided for: * Australian mortality rate — age standardised mortality per 1000 people * infant and child mortality rates — the number of deaths of children under one year of age in a calendar year per 1000 live births in the same year (infant mortality rate) and the number of deaths of children between one and four years of age in a calendar year per 100 000 children (child mortality rate) * mortality rates by major cause of death — age standardised deaths, by cause of death compared to the total population (expressed as a rate).   A low or decreasing mortality rate is desirable.  Most components of the health system can influence the mortality and life expectancy of Australians, although there can be decades between the action and the effect. Factors external to the health system also have a strong influence.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time except for median age at death * complete (subject to caveats) for the current reporting period. All required  2010–2012 data for life expectancy, 2012 data for median age at death and  2012 data for mortality rates are available for all jurisdictions.   Data quality Information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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##### Life expectancy

The life expectancy of Australians improved dramatically during the twentieth century and so far during the twenty‑first century. The average life expectancy at birth in the period 1901–1910 was 55.2 years for males and 58.8 years for females (ABS 2013c). It has risen steadily in each decade since, reaching 79.9 years for males and 84.3 years for females in 2010–2012 (figure E.10).

Figure E.10 All Australians average life expectancy at birth, 2010–2012**a**

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| Figure E.10 All Australians average life expectancy at birth, 2010–2012  More details can be found within the text surrounding this image. |

a Data for Australia include 'other territories'.

*Source*: ABS (2013) *Deaths, Australia,*2010-2012, Cat. no. 3302, Canberra; table EA.34.

The life expectancies of Indigenous Australians are considerably lower than those of non‑Indigenous Australians. ABS estimates indicate a life expectancy at birth of 69.1 years for Indigenous males and 73.7 years for Indigenous females born from 2010 to 2012. In the same time period, life expectancy at birth for non-Indigenous males was 79.7 years and for non‑Indigenous females was 83.1 years (table EA.35). Life expectancy at birth by Indigenous status and sex for NSW, Queensland, WA and the NT are presented in figure E.11.

Figure E.11 Estimated life expectancies at birth, by Indigenous status and sex, 2010–2012 (years)**a,** **b**

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| Figure E.11 Estimated life expectancies at birth, by Indigenous status and sex, 2010–2012   More details can be found within the text surrounding this image. |

a Indigenous estimates of life expectancy are not available for Victoria, SA, Tasmania or the ACT due to the small number of Indigenous deaths in these jurisdictions. b Life tables are constructed separately for Males and Females.

*Source*: ABS (2013) *Life Tables for Aboriginal and Torres Strait Islander Australians 2010–2012*,   
Cat. no. 3302, Canberra; table EA.35.

##### Median age at death

The median age at death in 2012 was 78.9 years of age for Australian males and 84.7 years of age for Australian females (table EA.36).

Comparisons of the median age at death for Indigenous and non‑Indigenous Australians are affected by different age structures in the populations and by differences in the extent of identification of Indigenous deaths across jurisdictions and across age groups. Identification of Indigenous status for infant deaths is high, but falls significantly in older age groups. The median age of death for Indigenous Australians is, therefore, likely to be an underestimate.

Caution should be taken when comparing median age at death between Indigenous and non-Indigenous populations. Coory and Baade (2003) note that:

* the relationship between a change in median age at death and a change in death rate depends upon the baseline death rate. So comparison of trends in median age at death for Indigenous and non-Indigenous Australians is difficult to interpret
* changes in the median age at death of public health importance might be difficult to distinguish from statistical noise.

In the jurisdictions for which data were available for Indigenous Australians, the median age at death for male Indigenous Australians was 55.0 years of age. The median age at death for female Indigenous Australians was 61.3 years of age (figure E.12 and table EA.37).

Figure E.12 Median age at death, by sex and Indigenous status, 2012**a, b**

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| Figure E.12 Median age at death, by sex and Indigenous status, 2012  More details can be found within the text surrounding this image. |

a Victoria, Tasmania and the ACT are excluded due to small numbers of registered Indigenous deaths. b The accuracy of Indigenous mortality data is variable as a result of varying rates of coverage across jurisdictions and age groups, and of changes in the estimated Indigenous population caused by changing rates of identification in the Census and births data.

*Source*: ABS (2013) *Deaths, Australia, 2012*, Cat. no. 3302.0, Canberra; table EA.37.

##### Mortalityrates

There were 147 098 deaths in Australia in 2012 (ABS 2013c), which translated into an age standardised mortality rate of 553.6 deaths per 100 000 people (figure E.13). Death rates over the last 20 years have declined for all states and territories (ABS 2013c).

##### Mortality rates — Infant and child

The annual infant mortality rate in Australia declined from an average of 4.8 deaths per 1000 live births in 2003 to 3.3 deaths per 1000 live births in 2012 (table EA.42 and figure E.14).

The Australian infant and child combined mortality rate was 91.5 deaths per 100 000 population in 2010–2012 (children aged 0 to 4 years). Of the total deaths for this age group, 84.5 per cent were infant deaths (table EA.43).

Figure E.13 Mortality rates, age standardiseda, b, c, d

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| Figure E.13 Mortality rates, age standardised   More details can be found within the text surrounding this image. |

a Deaths are based on year of registration of death. b Deaths per 100 000 standard population. Standardised death rates use total people in the 2001 Australian population as the standard population. c Rates may differ from previous reports as they have been revised using ERPs based on the 2011 Census. Rates are not comparable with rates for Indigenous and non-Indigenous Australians which use ERPs based on the 2006 Census.d Australian totals includes all states and territories.

*Source*: ABS (2013) *Deaths, Australia, 2012*, Cat. no. 3302.0, AusInfo, Canberra; table EA.38.

Figure E.14 Infant mortality rate**a,** **b**

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| Figure E.14 Infant mortality rate  More details can be found within the text surrounding this image. |

a Infant deaths per 1000 live births. b Data for Australia include all states and territories.

*Source*: ABS (2013) *Deaths, Australia, 2012,* Cat. no. 3302.0, Canberra; table EA.41.

##### Mortality rates — by remoteness

Mortality indicators showed that very remote areas of Australia have had consistently higher mortality rates than have other remoteness areas. In 2012, the age standardised mortality rates were highest in very remote areas (8.4 deaths per 1000 people), while major cities had the lowest mortality rates (5.5 deaths per 1000 people) (ABS 2013c).

##### Mortality rates — Indigenous Australians

Data on Indigenous mortality are collected through State and Territory death registrations. The completeness of identification of Indigenous Australians in these collections varies significantly across states and territories so care is required when making comparisons.

For the period 2008–2012, NSW, Queensland, WA, SA and the NT have been assessed as having adequate identification and number of Indigenous deaths for mortality analysis. For these five jurisdictions combined, the overall mortality rate for Indigenous Australians was 1143.4 per 100 000 people, nearly twice as high as for non‑Indigenous Australians (589.7 per 100 000 people) (figure E.15 and table EA.39). Due to identification completeness issues, mortality rates presented here are likely to be underestimates of the true mortality of Indigenous Australians (ABS and AIHW 2008).

Data on longer-term trends for WA, SA and the NT suggest that the mortality rate for Indigenous infants decreased by 62 per cent between 1991 and 2010 (AHMAC 2012). While this is a significant improvement, infant mortality rates for Indigenous children are still markedly higher than for non-Indigenous children in Australia.

For the period 2008–2012, the average infant mortality rate for Indigenous infants (less than one year) was higher than for non-Indigenous infants in the jurisdictions (NSW, Queensland, WA, SA and the NT) for which there were data available (table EA.44). For the same period, the average child mortality rate for Indigenous children (1–4 years) was also higher for these jurisdictions (table EA.44). The combined infant and child average mortality rate for Indigenous infants and children (0–4 years) was 203.3 deaths per 100 000 of the infant and child population in NSW, Queensland, WA, SA and NT. This compared with 91.4 deaths per 100 000 of the infant and child population for non‑Indigenous infants and children (table EA.44).

Figure E.15 Mortality rates, age standardised, by Indigenous status, five year average, 2008–2012**a, b, c, d, e**

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| Figure E.15 Mortality rates, age standardised, by Indigenous status, five year average, 2008–2012  More details can be found within the text surrounding this image. |

a Deaths are based on year of registration. b Mortality rates are age-standardised to the 2001 Australian standard population. c Calculations of rates for the Indigenous population are based on *ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians 1991 to 2009* (ABS Cat. no. 3238.0, low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for comparison with the Indigenous population are derived by subtracting Indigenous population projections from total Estimated Resident Population (ERP) and should be used with care, as these data include deaths and population units for which Indigenous status were not stated. ERP used in calculations are final ERP based on 2006 Census. d Total includes NSW, Queensland, SA, WA, and NT combined, based on State or Territory of usual residence. Victoria, Tasmania and the ACT are excluded due to small numbers of registered Indigenous deaths. e Error bars represent the 95 per cent variability band associated with each point estimate. See the DQI for more information.

*Source*: ABS (unpublished), *Deaths, Australia, 2012*; table EA.39.

##### Mortality rates — by major cause of death

The most common causes of death among Australians in 2011 were cancers, diseases of the circulatory system (including heart disease, heart attack and stroke), and diseases of the respiratory system (including influenza, pneumonia and chronic lower respiratory diseases) (tables E.3 and EA.45).

In the jurisdictions for which age standardised death rates are available by Indigenous status (NSW, Queensland, WA, SA and the NT), death rates were significantly higher for Indigenous Australians than for non‑Indigenous Australians in 2007–11. For these jurisdictions the leading age-standardised cause of death for Indigenous Australians was circulatory diseases followed by neoplasms (cancer) (tables E.4 and EA.46).

Table E.3 Age standardised mortality rates by major cause of death (deaths per 100 000 people), 2011**a, b**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
| Certain infectious and parasitic diseases | 11.6 | 8.5 | 8.5 | 6.3 | 8.9 | 6.8 | 8.5 | np | 9.4 |
| Neoplasms | 177.7 | 173.3 | 175.1 | 166.6 | 170.6 | 189.5 | 146.5 | 220.3 | 174.5 |
| Diseases of the bloodc | 1.9 | 1.8 | 1.8 | 1.6 | 2.2 | np | np | – | 1.8 |
| Endocrine, nutritional and metabolic diseases | 20.9 | 24.8 | 23.7 | 23.4 | 24.8 | 34.1 | 20.0 | 60.1 | 23.5 |
| Mental and behavioural disorders | 27.9 | 27.3 | 27.3 | 23.7 | 30.4 | 40.6 | 26.5 | 51.6 | 27.9 |
| Diseases of the: |  |  |  |  |  |  |  |  |  |
| * nervous system | 23.8 | 27.8 | 23.3 | 30.5 | 28.4 | 29.5 | 32.2 | 30.9 | 26.0 |
| * eye and adnexa | np | np | np | np | – | – | – | – | np |
| * ear and mastoid process | np | np | np | np | np | – | – | – | np |
| * circulatory system | 177.5 | 161.8 | 180.3 | 153.1 | 171.3 | 190.4 | 151.5 | 201.4 | 171.6 |
| * respiratory system | 49.5 | 46.3 | 49.9 | 42.1 | 45.9 | 53.3 | 42.8 | 83.5 | 48.0 |
| * digestive system | 20.2 | 19.9 | 20.3 | 19.8 | 19.5 | 21.9 | 19.4 | 37.0 | 20.2 |
| * skin and subcutaneous tissue | 2.1 | 1.4 | 1.4 | 1.3 | 1.6 | np | np | np | 1.6 |
| * musculoskeletal system and connective tissue | 4.7 | 4.4 | 4.8 | 3.7 | 3.3 | 5.4 | np | np | 4.4 |
| * genitourinary system | 12.9 | 14.1 | 12.1 | 11.2 | 13.2 | 13.1 | 14.5 | np | 13.0 |
| Pregnancy, childbirth and the puerperium | np | np | np | – | np | – | – | – | np |
| Certain conditions originating in the perinatal period | 3.0 | 2.5 | 3.3 | 2.0 | 1.9 | np | np | np | 2.8 |
| Congenital conditionsd | 2.5 | 2.3 | 2.7 | 1.9 | 2.4 | np | np | np | 2.4 |
| Abnormal findings nece | 5.9 | 3.3 | 3.7 | 4.2 | 4.3 | np | 7.7 | np | 4.6 |
| External causes of morbidity and mortality | 34.1 | 36.0 | 42.7 | 44.2 | 37.6 | 45.5 | 31.5 | 60.5 | 38.1 |
| **Total** | **576.4** | **555.8** | **581.0** | **535.6** | **566.6** | **642.4** | **513.1** | **795.0** | **570.0** |

a Age standardised to the Australian population as at 30 June 2001. b Australian total includes 'Other territories'. c Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism. d Congenital malformations, deformations and chromosomal abnormalities. e Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified. – Nil or rounded to zero. **np** Not published.

*Source*: ABS (unpublished) *Causes of Death Australia, 2011* Cat. no. 3301.0; table EA.45.

Compared to non‑Indigenous Australians, Indigenous Australians died at higher rates from ‘endocrine, metabolic and nutritional disorders’, ‘kidney diseases’, ‘digestive diseases’, and ‘respiratory diseases’ (tables E.4 and EA.46).

Table E.4 Age standardised Indigenous mortality rate (deaths per 100 000 people) compared to non‑Indigenous rate, by major cause of death, 2007–2011**a, b, c**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Rate difference — Indigenous rate less non‑Indigenous rate | | | | | | | |  | Rate ratio — Indigenous rate divided by non‑Indigenous rate | | | | | |
|  | NSW | | | Qld | WA | SA | NT | Total |  | NSW | Qld | WA | SA | NT | Total |
| Circulatory diseases | 130.0 | | | 122.7 | 238.3 | 128.3 | 192.9 | 147.0 |  | 1.6 | 1.6 | 2.4 | 1.6 | 2.2 | 1.7 |
| Cancer | 60.5 | | | 76.6 | 87.9 | 26.2 | 114.4 | 76.3 |  | 1.3 | 1.4 | 1.5 | 1.1 | 1.6 | 1.4 |
| External causes | | 27.2 | | 28.4 | 90.3 | 65.7 | 57.7 | 48.1 |  | 1.8 | 1.7 | 3.2 | 2.8 | 1.9 | 2.3 |
| Endocrine and other disorders**d** | | 48.2 | | 103.9 | 140.5 | 42.9 | 167.9 | 94.9 |  | 3.3 | 5.6 | 6.9 | 2.7 | 6.4 | 5.3 |
| Respiratory diseases | 59.0 | | | 48.9 | 71.0 | 62.9 | 98.5 | 64.0 |  | 2.2 | 2.0 | 2.6 | 2.3 | 2.8 | 2.3 |
| Digestive diseases | 19.9 | | | 33.8 | 56.3 | 38.3 | 57.6 | 36.5 |  | 2.0 | 2.7 | 3.8 | 2.9 | 3.2 | 2.8 |
| Kidney Diseases | 11.7 | | | 20.6 | 39.9 | np | 57.6 | 24.8 |  | 2.0 | 3.0 | 4.9 | np | 6.5 | 3.2 |
| Conditions originating in the perinatal period | | 2.0 | | 2.9 | 3.3 | np | 6.6 | 3.2 |  | 1.7 | 2.0 | 3.1 | np | 3.3 | 2.2 |
| Infectious and parasitic diseases | | | 8.4 | 16.2 | 17.7 | np | 31.6 | 15.6 |  | 1.8 | 3.3 | 3.5 | np | 3.4 | 2.8 |
| Nervous system diseases | | - 1.3 | | - 2.7 | 16.2 | 5.7 | 3.8 | 2.1 |  | 0.9 | 0.9 | 1.5 | 1.2 | 1.2 | 1.1 |
| Other causes | 30.0 | | | 28.8 | 73.8 | 33.2 | 75.9 | 42.7 |  | 1.6 | 1.7 | 2.8 | 1.7 | 2.5 | 2.0 |
| **All causes** | **395.7** | | | **480.2** | **835.1** | **439.1** | **864.6** | **555.5** |  | **1.7** | **1.8** | **2.5** | **1.7** | **2.4** | **1.9** |

a All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2006 (final) 2007 (final), 2008 (final), 2009 (revised), 2010 (preliminary). See Cause of Death, Australia, 2010 (cat. no. 3303.0) Explanatory Notes 35-39 and Technical Notes, Causes of Death Revisions, 2006 and Causes of Death Revisions, 2008 and 2009. b Age standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 100 000 persons. SDRs in this table have been calculated using the direct method, age standardised by 5 year age group to 75 years and over. Rates calculated using the direct method are not comparable to rates calculated using the indirect method. c Data are reported by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. Only these five states and territories have evidence of a sufficient level of Indigenous identification and sufficient numbers of Indigenous deaths to support mortality analysis. d Endocrine, metabolic and nutritional disorders. **np** not published

*Source*: ABS (unpublished) *Causes of Death Australia, 2011* Cat. no. 3301.0; table EA.46.

#### Profile of employed health workforce

‘Profile of employed health workforce’ is an indicator of governments’ objective that Australians have a sustainable health system (box E.7).

|  |
| --- |
| Box E.7 Profile of employed health workforce |
| ‘Profile of employed health workforce’ is defined by three measures:   * the full time equivalent employed health workforce divided by the population * the proportion of the full time equivalent employed health workforce under the age of 45 years * the net growth in the full time equivalent employed health workforce.   High or increasing rates in the health workforce measures can give an indication of the sustainability of the health system and its ability to respond and adapt to future needs.  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.   Information about data quality for this indicator/measure is at www.pc.gov.au/gsp/reports/rogs/2014. |
|  |
|  |

In 2012, the majority of employed medical practitioners (commonly referred to as doctors) that were employed in medicine were clinicians (94.5 per cent), of whom 34.5 per cent were general practitioners, 35.0 per cent were specialists, 15.3 per cent were specialists-in-training, 12.7 per cent were hospital non-specialists and 2.5 per cent were other clinicians. The proportion of women increased from 34.9 per cent in 2008 to 37.9 per cent in 2012 (AIHW 2014). The number of full time equivalent (FTE) practitioners per 100 000 people by jurisdiction is illustrated in figure E.16.

In 2012, the number of nurses and midwives registered in Australia was 334 078. In 2012, the number of nurses and midwives registered and employed in Australia was 290 144, or 1279 per 100 000 population (table EA.48). The majority of employed nurses and midwives were clinicians (80.1 per cent). The principal area of the main job of employed registered and enrolled nurses and midwives was aged care (14.2 per cent) followed by medical (9.0 per cent) and surgical (8.0) roles. The average age of employed nurses and midwives changed little between 2008 (44.1 years) and 2012 (44.6 years). The proportion of employed nurses and midwives aged 50 or older increased from 35.1 per cent to 39.1 per cent over this period (AIHW 2013e). The number of FTE nurses and midwives per 100 000 people by jurisdiction is illustrated in figure E.17.

Figure E.16 Full time equivalent employed medical practitioners**a,** **b,** **c, d, e, f, g**

|  |
| --- |
| Figure E.16 Full time equivalent employed medical practitioners  More details can be found within the text surrounding this image. |

a FTE rate (FTE per 100 000 people) is based on a standard full-time working week of 40 hours. b Excludes employed medical practitioners on extended leave. c Care must be taken when interpreting the ACT’s data as the ACT’s medical practitioners provide a large number of services to NSW residents. This rate used the ACT resident population as the denominator, hence a high rate for the ACT. The rate will reduce if the NSW population within the catchment area of Southern NSW is included in the denominator.d From 2010, health workforce labour surveys are conducted at the national level and survey questions are consistent across jurisdictions. For 2009 and previous years, surveys were managed by each jurisdiction’s health authority and there were some differences in survey questions between jurisdictions and within jurisdictions over time. This has little impact on the data reported here. However, caution should be used in comparing data between jurisdictions and over time (see DQI for further details). e 2010 data exclude Queensland and WA due to closure of the registration period after the national registration deadline. f Caution should be used in comparing data for the NT with other jurisdictions from 2010 as this was the first year of changed doctors’ registration requirements (in particular, doctors providing fly in fly out services are no longer required to register in the NT where they are registered nationally). g From 2011, State and Territory is derived from State and Territory of main job where available; otherwise State and Territory of principal practice is used as a proxy. If principal practice details are also unavailable, State and Territory of residence is used. Records with no information on all three locations are coded to ‘Not stated’.

*Source*: AIHW (unpublished) National Health Workforce Data Set: medical practitioners; AIHW (unpublished) Medical Labour Force Survey; ABS (unpublished) Estimated Resident Population (based on 2011 ABS Census of Population and Housing); table EA.47.

Figure E.17 Full time equivalent employed nurses and midwives**a,** **b,** **c, d,** **e**

|  |
| --- |
| Figure E.17 Full time equivalent employed nurses and midwives  More details can be found within the text surrounding this image. |

a FTE nurse rate (per 100 000 people) based on a 38‑hour week. b Excludes nurses on extended leave. c Data are not available for 2010. d From 2011, health workforce labour surveys are conducted at the national level and survey questions are consistent across jurisdictions. For 2009 and previous years, surveys were managed by each jurisdiction’s health authority and there were some differences in survey questions between jurisdictions and within jurisdictions over time. This has little impact on the data reported here. However, caution should be used in comparing data between jurisdictions and over time (see DQI for further details). e  From 2011, State and Territory is derived from State and Territory of main job where available; otherwise State and Territory of principal practice is used as a proxy. If principal practice details are also unavailable, State and Territory of residence is used. Records with no information on all three locations are coded to ‘Not stated’.

*Source*: AIHW (unpublished) National Health Workforce Data Set and AIHW 2011; table EA.48.

At the national level, 50.9 per cent of employed medical practitioners were under the age of 45 in 2012 (table EA.47). The medical practitioner workforce grew at an average annual rate of 3.8 per cent from 2008 to 2012 (figure E.18). The nursing and midwifery workforce grew at an average rate of 1.8 per cent annually from 2008 to 2012 (figure E.18), and 47.0 per cent of employed nurses were under the age of 45 in 2011 (table EA.48).

Nationally, 0.8 per cent of the nursing and midwifery workforce were Indigenous in 2012 (table EA.50). Of people employed in health-related occupations in 2011, 1.6 per cent were Indigenous. Within health related occupations in 2011, the occupations with the highest percentage of Indigenous Australians were health and welfare support officers, which includes the occupation Indigenous Health Workers   
(tables EA.51–EA.53).

Figure E.18 Annual average growth in selected workforces,   
2008–2012**a,** **b, c, d, e, f**

|  |
| --- |
| Figure E.18 Annual average growth in selected workforces,  2008–2012  More details can be found within the text surrounding this image. |

a Net growth measures the change in the FTE number in the workforce in the reference year compared to the year prior to the reference year. b FTEs calculated based on a 40-hour standard working week for medical practitioners and a 38-hour week for nurses/midwives. c From 2010, health workforce labour surveys are conducted at the national level and survey questions are consistent across jurisdictions. For 2009 and previous years, surveys were managed by each jurisdiction’s health authority and there were some differences in survey questions between jurisdictions and within jurisdictions over time. This has little impact on the data reported here. However, caution should be used in comparing data between jurisdictions and over time (see DQI for further details) d From 2011, state and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to ‘Not stated’. e Data for 2007, 2008 and 2009 are for the workforce (i.e. including those employed, on extended leave and looking for work in the workforce). Data from 2010 are only for those employed in the workforce. f Caution should be used in comparing medical workforce data for the NT with other jurisdictions from 2010 as this was the first year of changed doctors’ registration requirements (in particular, doctors providing fly in fly out services are no longer required to register in the NT where they are registered nationally).

*Source*: AIHW (unpublished) National Health Workforce Data Set; ABS (unpublished) Estimated Resident Population (based on the 2011 ABS Census of Population and Housing); table EA.49.

#### Access to services compared to need by type of service

‘Access to services compared to need by type of service’ is an indicator of governments’ objective that Indigenous Australians and those living in rural and remote areas or on low incomes achieve health outcomes comparable to the broader population (box E.8).

Results from the 2011‑12 Australian Health Survey indicate that the majority of Australians (85.6 per cent) aged 15 years or over reported their health as either good, very good or excellent (ABS 2012). In the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, 75 per cent of Indigenous Australians reported their health as either good, very good or excellent (ABS 2013a).

|  |
| --- |
| Box E.8 Access to services compared to need by type of service |
| ‘Access to services compared to need by type of service’ is defined as the number of people aged 15 years or over who accessed a particular health service in the past 12 months (for hospital admissions), 3 months (for dental services) or 2 weeks (for other health services) divided by the population aged 15 years or over, expressed as a percentage. Rates are age standardised and calculated separately for each type of service and by categories of self‑assessed health status. Service types are: admitted hospitalisations, casualty/outpatients, GP and/or specialist doctor consultations, consultations with other health professional and dental consultation. Self-assessed health status is categorised as excellent/very good/good and fair/poor. Data are reported for all Australians by remoteness and by Socio Economic Indexes for Areas (SEIFA) and for Indigenous Australians.  High or increasing rates of ‘access to services compared to need by type of service’ are desirable, as are rates for those in disadvantaged groups being close to the rates for those who are not disadvantaged.  Data reported for this indicator are   * comparable (subject to caveats) across jurisdictions but not over time * complete (subject to caveats) for the current reporting period. All required  2011‑12 data are available for all jurisdictions   Data quality information for this indicator is under development. |
|  |
|  |

The latest available data for self-assessed health status are from the 2012-13 National Aboriginal and Torres Strait Islander Health Survey for Indigenous Australians (ABS 2013a) and from the 2011‑12 National Health Survey for non‑Indigenous Australians (ABS 2012). Indigenous Australians were less likely than non-Indigenous Australians to report very good or excellent health. Taking into account differences in age structure between the populations, Indigenous Australians overall were more than twice as likely to report their health as fair or poor than non‑Indigenous Australians in 2011–13 (ABS 2013a).

Data from the surveys show that 27.1 per cent of Australians who reported their health status as being excellent/very good/good accessed health services in   
2011‑12, while health services were accessed by 48.5 per cent of people who reported their health status as being fair/poor (table EA.54).

Data for Indigenous Australians are not comparable with data for non-Indigenous Australians due to a slightly different methodology. Nationally, the proportion of Indigenous Australians who accessed services varied significantly by self-assessed health status for hospital admissions and doctor consultations, but not consultations with other health professionals (figure E.19). Data for people accessing health services by Indigenous status in 2004-05 are reported in table EA.57.

Data on the proportion of people who accessed health services by remoteness and SEIFA and data on the types of health services people accessed are reported for 2004-05 and 2011‑12 in tables EA.58–EA.61.

Figure E.19 Proportion of Indigenous Australians who accessed health services by health status, 2011‑12**a,** **b,** **c,** **d,** **e, f, g**

|  |
| --- |
| Legend to Figure E.19   More details can be foudn within the text surrounding this image. Figure E.19 Proportion of Indigenous Australians who accessed health services by health status, 2011 12 - admitted to hospital  More details can be found within the text surrounding this image.Figure E.19 Proportion of Indigenous Australians who accessed health services by health status, 2011 12 - consulted a doctor  More details can be found within the text surrounding this image.Figure E.19 Proportion of Indigenous Australians who accessed health services by health status, 2011 12 - consulted other health professional  More details can be found within the text surrounding this image. |

a Rates are age standardised by State/Territory to the 2001 estimated resident population. b Data are not comparable with data for all Australians due to differences in methodology. c People aged 15 years or over who consulted a doctor or another health professional in the last 2 weeks, or were admitted to hospital in the last 12 months. d Error bars represent the 95 per cent confidence intervals associated with each estimate.

*Source*: ABS (unpublished) *National Aboriginal and Torres Strait Islander Health Survey, 2012-13*, Cat. no. 4727.0.55.001; table EA.56.

### Service-specific performance indicator frameworks

The health service specific frameworks in chapters 10, 11 and 12 reflect both the general Report framework and the National Health Performance Framework.[[2]](#footnote-2) They differ from the general Report framework (see chapter 1) in two respects. First, they include three subdimensions of quality — safety, responsiveness and continuity — and, second, they include an extra dimension of efficiency — sustainability. These additions are intended to address the following key performance dimensions of the health system in the National Health Performance Framework that were not explicitly covered in the general Report framework:

* *safety*: the avoidance, or reduction to acceptable levels, of actual or potential harm from health care services, management or environments, and the prevention or minimisation of adverse events associated with health care delivery
* *responsiveness*: the provision of services that are client oriented and respectful of clients’ dignity, autonomy, confidentiality, amenity, choices, and social and cultural needs
* *continuity*: the provision of uninterrupted, timely, coordinated healthcare interventions and actions across programs, practitioners and organisations
* *sustainability*: the capacity to provide infrastructure (such as workforce, facilities and equipment), be innovative and respond to emerging needs (NHPC 2009).

Other aspects of the Steering Committee’s framework of performance indicators are defined in chapter 1.

This section summarises information from the following specific indicator frameworks:

* public hospitals (see chapter 10 for more detail)
* maternity services (see chapter 10 for more detail)
* primary and community health (see chapter 11 for more detail)
* mental health management (see chapter 12 for more detail).

Additional information is available to assist the interpretation of these results:

* indicator interpretation boxes, which define the measures used and indicate any significant conceptual or methodological issues with the reported information (chapters 10, 11 and 12)
* caveats and footnotes to the reported data (chapters 10, 11 and 12 and Attachments 10A, 11A and 12A)
* additional measures and further disaggregation of reported measures (for example, by Indigenous status, remoteness, disability, language background, sex) (chapters 10, 11 and 12 and Attachments 10A, 11A and 12A)
* data quality information for many indicators, based on the ABS Data Quality Framework (chapters 10, 11 and 12 Data quality information).

A full list of attachment tables and available data quality information is provided at the end of chapters 10, 11 and 12.

#### Public hospitals

The performance indicator framework for public hospitals is presented in figure E.20. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of public hospitals.

Figure E.20 Public hospitals performance indicator framework

|  |
| --- |
| Figure E.20 Public hospitals performance indicator framework  More details can be found within the text surrounding this image. |

An overview of the public hospital performance indicator results are presented in table E.5. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 10 and the footnotes in attachment 10A.

Table E.5 Performance indicators for public hospitalsa

|  | | | | NSW | | Vic | Qld | WA | | SA | | Tas | | ACT | | | NT | | | Aust | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Effectiveness — Access indicators** | | | | | | | | | | | | | | | | | | | | | |
| Emergency department waiting times, 2012-13 Most recent data for this indicator are complete but not directly comparable (chapter 10) | | | | | | | | | | | | | | | | | | | | | |
| Proportion of patients seen on time (per cent) | | | | | | | | | | | | | | | | | | | | | |
|  | | Resuscitation | | 100 | | 100 | 100 | 100 | | 100 | | 100 | | 100 | | | 100 | | | 100 | |
|  | | Emergency | | 83 | | 84 | 84 | 81 | | 75 | | 83 | | 74 | | | 66 | | | 82 | |
|  | | Urgent | | 73 | | 72 | 68 | 52 | | 66 | | 65 | | 43 | | | 52 | | | 68 | |
|  | | Semi-urgent | | 77 | | 68 | 74 | 67 | | 78 | | 70 | | 46 | | | 52 | | | 72 | |
|  | | Non-urgent | | 92 | | 87 | 92 | 93 | | 92 | | 90 | | 79 | | | 89 | | | 91 | |
|  | | Total | | 78 | | 73 | 74 | 66 | | 75 | | 71 | | 51 | | | 57 | | | 73 | |
| Waiting times for admitted patient services | | | | | | | | | | | | | | | | | | | | | |
| Elective surgery waiting times: Number of days waited, 2012-13  Most recent data for this measure are complete but not directly comparable (chapter 10) | | | | | | | | | | | | | | | | | | | | | |
|  | | 50th percentile | | 50 | | 36 | 27 | 30 | | 34 | | 41 | | 51 | | | 40 | | | 36 | |
|  | | 90th percentile | | 335 | | 223 | 163 | 159 | | 182 | | 406 | | 277 | | | 196 | | | 265 | |
| Elective surgery waiting times: Proportion who waited more than 365 days, 2012-13  Most recent data for this measure are complete but not directly comparable (chapter 10) | | | | | | | | | | | | | | | | | | | | | |
|  | | % | | 2.8 | | 3.3 | 2.5 | 1.5 | | 1.0 | | 11.5 | | 4.1 | | | 3.3 | | | 2.7 | |
| Proportion of presentations to emergency departments with a length of stay of 4 hours or less   ending in admission, public hospitals (per cent), 2012-13  Most recent data for this measure are complete but not directly comparable (chapter 10) | | | | | | | | | | | | | | | | | | | | | |
|  | | Resuscitation | | 44 | | 56 | 54 | 59 | | 55 | | 56 | | 62 | | | 48 | | | 52 | |
|  | | Emergency | | 32 | | 44 | 40 | 52 | | 41 | | 32 | | 40 | | | 23 | | | 39 | |
|  | | Urgent | | 27 | | 36 | 39 | 43 | | 38 | | 22 | | 24 | | | 23 | | | 34 | |
|  | | Semi-urgent | | 30 | | 36 | 45 | 45 | | 43 | | 24 | | 28 | | | 24 | | | 35 | |
|  | | Non-urgent | | 53 | | 53 | 62 | 55 | | 61 | | 47 | | 40 | | | 50 | | | 54 | |
|  | | Total | | 30 | | 38 | 41 | 46 | | 41 | | 25 | | 29 | | | 24 | | | 36 | |
| Source: tables 10A.17, 10A.22 and 10A.44. | | | | | | | | | | | | | | | | | | | | | |
| **Effectiveness — Appropriateness indicators** | | | | | | | | | | | | | | | | | | | | | |
| Separation rates for selected procedures, public hospitals, per 1000 people (age‑standardised), 2011-12 Most recent data for this indicator are complete and comparable (chapter 10) | | | | | | | | | | | | | | | | | | | | | |
|  | | Cataract extraction | | 2.6 | | 3.1 | 1.6 | 4.3 | | 3.5 | | 1.3 | | | | 3.5 | | | 5.1 | 2.7 | |
|  | | Cholecystectomy | | 1.4 | | 1.4 | 1.2 | 1.1 | | 1.4 | | 1.4 | | | | 1.4 | | | 1.2 | 1.3 | |
|  | | Coronary angioplasty | | 0.9 | | 0.8 | 0.8 | 0.9 | | 1.0 | | 1.0 | | | | 1.9 | | | .. | 0.9 | |
|  | | Coronary artery bypass graft | | 0.3 | | 0.3 | 0.3 | 0.2 | | 0.3 | | 0.4 | | | | 0.6 | | | .. | 0.3 | |
|  | | Cystoscopy | | 1.6 | | 2.8 | 2.0 | 3.0 | | 2.6 | | 1.5 | | | | 2.4 | | | 1.7 | 2.2 | |
|  | | Haemorrhoidectomy | | 1.0 | | 0.8 | 0.4 | 0.5 | | 0.5 | | 0.7 | | | | 0.4 | | | 0.9 | 0.7 | |
|  | | Hip replacement | | 0.7 | | 0.7 | 0.5 | 0.8 | | 0.7 | | 0.6 | | | | 1.0 | | | 0.6 | 0.6 | |
|  | | Hysterectomy | | 1.0 | | 1.1 | 1.0 | 1.1 | | 1.3 | | 1.1 | | | | 0.7 | | | 0.8 | 1.0 | |
|  | | Inguinal herniorrhaphy | | | 1.0 | 1.0 | 0.8 | 0.9 | | 1.0 | | 1.1 | | | | 0.9 | | | 0.9 | 1.0 | |
|  | Knee replacement | | 0.7 | | | 0.5 | 0.5 | | 0.7 | | 0.6 | | 0.3 | | 0.9 | | | 0.4 | | | 0.6 |
|  | Myringotomy | | 0.5 | | | 0.8 | 0.7 | | 0.7 | | 1.3 | | 0.6 | | 0.8 | | | 0.6 | | | 0.7 |
|  | Prostatectomy | | 0.9 | | | 1.1 | 0.8 | | 0.8 | | 1.0 | | 0.8 | | 0.9 | | | 1.0 | | | 0.9 |

(Continued next page)

Table E.5 (continued)

|  | | | | | NSW | | | | Vic | | Qld | WA | SA | Tas | | ACT | NT | Aust | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Septoplasty | | | | | 0.3 | | | 0.5 | | 0.2 | 0.2 | 0.4 | 0.1 | | 0.4 | 0.1 | 0.3 | |
|  | Tonsillectomy | | | | | 0.9 | | | 1.2 | | 0.9 | 1.0 | 1.3 | 0.8 | | 1.0 | 0.7 | 1.0 | |
|  | Varicose veins, stripping and ligation | | | | | 0.2 | | | 0.3 | | 0.1 | 0.1 | 0.3 | 0.1 | | 0.6 | 0.2 | 0.2 | |
| Source: table 10A.45. | | | | | | | | | | | | | | | | | | | |
| **Effectiveness — Quality — Safety indicators** | | | | | | | | | | | | | | | | | | |
| Unplanned hospital readmissions within 28 days of selected surgical admissions, 2011-12  Most recent data for this indicator are complete but not directly comparable (chapter 10) | | | | | | | | | | | | | | | | | | |
| Surgical, procedure prior to separation, rate per 1000 separations | | | | | | | | | | | | | | | | | | |
|  | Knee replacement | | | | 18.5 | | | | 19.1 | | 26.9 | 17.4 | 17.7 | np | | np | np | 20.0 |
|  | Hip replacement | | | | 17.7 | | | | 17.4 | | 14.2 | 22.5 | 23.7 | np | | np | np | 17.7 |
|  | Tonsillectomy and adenoidectomy | | | | 24.8 | | | | 23.7 | | 32.6 | 33.3 | 33.7 | 60.6 | | 18.3 | np | 27.8 |
|  | Hysterectomy | | | | 27.9 | | | | 32.4 | | 33.2 | 31.5 | 28.1 | 28.1 | | np | np | 30.9 |
|  | Prostatectomy | | | | 22.7 | | | | 26.4 | | 36.3 | 50.3 | 25.9 | np | | np | np | 27.2 |
|  | Cataract surgery | | | | 2.8 | | | | 3.2 | | 4.0 | 2.6 | 3.3 | 7.2 | | – | np | 3.2 |
|  | Appendicectomy | | | | 23.5 | | | | 24.5 | | 20.4 | 31.3 | 36.0 | 29.8 | | 26.3 | 49.6 | 24.7 |
| Accreditation, proportion of accredited beds, public hospitals 2011-12 Most recent data for this measure are complete and comparable (chapter 10) | | | | | | | | | | | | | | | | | | |
|  | % | | | | 97 | | | | 100 | | 100 | 100 | 100 | 87 | | 100 | 100 | 99 |
| Adverse events in public hospitals | | | | | | | | | | | | | | | | | | |
| Healthcare associated infections in acute care hospitals per 10 000 patient days, 2012-13  Data for this measure not complete or not directly comparable (chapter 10) | | | | | | | | | | | | | | | | | | |
|  |  | | | | 1.0 | | | | 0.9 | | 1.0 | 0.8 | 0.8 | 1.0 | | 1.3 | 0.7 | 0.9 |
| Separations with an adverse event, public hospitals: Events per 100 separations, 2011-12  Data for this indicator not complete or not directly comparable (chapter 10) | | | | | | | | | | | | | | | | | | |
|  | Total | | | | 6.3 | | | | 6.1 | | 6.0 | 6.0 | 6.7 | 7.7 | | 6.3 | 3.2 | 6.1 |
| Source: tables 10A.47–10A.51. | | | | | | | | | | | | | | | | | | |
| **Efficiency sustainability indicators** | | | | | | | | | | | | | | | | | | |
| Workforce sustainability Most recent data for this indicator are complete and comparable (chapter 10) | | | | | | | | | | | | | | | | | | |
| Nursing workforce by age group (per cent), 2012 | | | | | | | | | | | | | | | | | | |
|  | <30 | | 13.8 | | | | 17.0 | | | | 14.7 | 16.0 | 14.1 | 12.0 | | 15.4 | 17.9 | na | |
|  | 30-39 | | 20.1 | | | | 21.3 | | | | 20.7 | 20.1 | 18.9 | 15.5 | | 21.7 | 25.6 | na | |
|  | 40-49 | | 24.5 | | | | 25.9 | | | | 27.8 | 26.7 | 26.7 | 27.7 | | 25.6 | 22.8 | na | |
|  | 50-59 | | 30.3 | | | | 26.3 | | | | 26.7 | 26.8 | 31.0 | 34.2 | | 28.3 | 25.3 | na | |
|  | 60+ | | 11.2 | | | | 9.5 | | | | 10.0 | 10.4 | 9.3 | 10.6 | | 9.0 | 8.4 | na | |
| Medical practitioner workforce by age group (per cent), 2012 | | | | | | | | | | | | | | | | | | | |
|  | | <30 | | 7.7 | | | | 10.3 | | 9.5 | | 11.7 | 10.0 | 8.6 | 7.0 | | 9.6 | na | |
|  | | 30-39 | | 26.7 | | | | 28.1 | | 29.6 | | 27.9 | 27.4 | 23.9 | 28.1 | | 35.6 | na | |
|  | | 40-49 | | 24.5 | | | | 24.1 | | 25.7 | | 25.4 | 24.9 | 26.4 | 26.6 | | 24.4 | na | |
|  | | 50-59 | | 21.8 | | | | 21.0 | | 20.7 | | 20.4 | 20.5 | 23.8 | 23.3 | | 17.6 | na | |
|  | | 60+ | | 19.3 | | | | 16.4 | | 14.4 | | 14.6 | 17.2 | 17.3 | 14.9 | | 12.7 | na | |
| Source: tables 10A.52–10A.55. | | | | | | | | | | | | | | | | | | | |

(Continued next page)

Table E.5 **(continued)**

|  | | | | | NSW | | | Vic | | | Qld | | WA | | SA | | Tas | | | ACT | | NT | | Aust |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Medical practitioner workforce by age group, 2012 | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | <30 | 7.7 | | | 10.3 | | | 9.5 | | | | 11.7 | | 10.0 | | 8.6 | 7.0 | | | | 9.6 | | na |
|  | | 30-39 | 26.7 | | | 28.1 | | | 29.6 | | | | 27.9 | | 27.4 | | 23.9 | 28.1 | | | | 35.6 | | na |
|  | | 40-49 | 24.5 | | | 24.1 | | | 25.7 | | | | 25.4 | | 24.9 | | 26.4 | 26.6 | | | | 24.4 | | na |
|  | | 50-59 | 21.8 | | | 21.0 | | | 20.7 | | | | 20.4 | | 20.5 | | 23.8 | 23.3 | | | | 17.6 | | na |
|  | | 60+ | 19.3 | | | 16.4 | | | 14.4 | | | | 14.6 | | 17.2 | | 17.3 | 14.9 | | | | 12.7 | | na |
| Source: tables 10A.52–10A.55. | | | | | | | | | | | | | | | | | | | | | | | | |
| **Efficiency indicators** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recurrent cost per casemix adjusted separation, dollars, 2011-12 Most recent data for this indicator are complete but not directly comparable (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Total recurrent | | | 5 280 | | | 4 693 | | | 5 246 | | 5 733 | | 5 251 | | 6 033 | | | 6 384 | | 6 017 | | 5 204 | | |
|  | Capital | | | 475 | | | 804 | | | 424 | | 542 | | 395 | | 427 | | | 556 | | 693 | | 493 | | |
| Relative stay index, 2011-12 Most recent data for this indicator are complete and comparable (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Total | | | 1.05 | | | 0.91 | | | 0.89 | | 0.98 | | 1.02 | | 1.04 | | | 1.00 | | 1.16 | | 0.98 | | |
| Recurrent cost per non-admitted occasion of service, 2011-12 Most recent data for this indicator not complete or not directly comparable (chapter 10). Data are available in tables 10A.61–10A.65. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Source: tables 10A.56–10A.68. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Outcome indicators** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient satisfaction, 2012-13 Most recent data for this indicator are complete and comparable (chapter 10). | | | | | | | | | | | | | | | | | | | | | | | | | |
| Proportion (%) of persons who went to an *emergency department* in the last 12 months reporting: | | | | | | | | | | | | | | | | | | | | | | | | | |
| ED doctors, specialists or nurses always or often listened carefully to them | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Doctors/specialists | | | 85.0 | | | 83.4 | | | 84.0 | | 84.7 | | 83.4 | | 81.3 | | | 82.5 | | 87.6 | | 84.2 | | |
|  | Nurses | | | 87.6 | | | 89.8 | | | 90.1 | | 90.9 | | 87.4 | | 89.6 | | | 83.5 | | 90.5 | | 89.1 | | |
| ED doctors, specialists or nurses always or often showed respect to them | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Doctors/specialists | | | 86.4 | | | 84.7 | | | 85.5 | | 87.2 | | 84.8 | | 83.3 | | | 82.6 | | 88.4 | | 85.7 | | |
|  | Nurses | | | 88.5 | | | 91.1 | | | 90.2 | | 92.4 | | 89.6 | | 90.3 | | | 86.7 | | 90.2 | | 90.1 | | |
| ED doctors, specialists or nurses always or often spent enough time with them | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Doctors/specialists | | | 81.0 | | | 79.9 | | | 80.7 | | 83.1 | | 79.5 | | 74.9 | | | 75.3 | | 85.0 | | 80.7 | | |
|  | Nurses | | | 85.2 | | | 85.6 | | | 87.5 | | 90.4 | | 86.6 | | 84.3 | | | 80.8 | | 89.5 | | 86.4 | | |
| Proportion (%) of persons who were admitted to hospital in the last 12 months reporting: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hospital doctors, specialists or nurses always or often listened carefully to them | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Doctors/specialists | | | 91.3 | | | 89.5 | | | 87.1 | | 90.8 | | 89.5 | | 85.9 | | | 89.3 | | 81.5 | | 89.5 | | |
|  | Nurses | | | 90.5 | | | 92.1 | | | 91.8 | | 92.0 | | 90.8 | | 89.9 | | | 89.8 | | 86.9 | | 91.2 | | |
| hospital doctors, specialists or nurses always or often showed respect to them | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Doctors/specialists | | | 91.5 | | | 89.3 | | | 88.4 | | 92.6 | | 90.2 | | 86.2 | | | 91.2 | | 81.3 | | 90.2 | | |
|  | Nurses | | | 92.2 | | | 91.1 | | | 91.4 | | 93.0 | | 91.7 | | 88.4 | | | 90.6 | | 87.6 | | 91.5 | | |
| hospital doctors, specialists or nurses always or often spent enough time with them | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Doctors/specialists | | | 87.5 | | | 85.6 | | | 85.8 | | 87.2 | | 84.0 | | 84.7 | | | 85.4 | | 80.3 | | 86.2 | | |
|  | Nurses | | | 88.5 | | | 89.0 | | | 89.2 | | 91.8 | | 87.7 | | 86.5 | | | 85.3 | | 85.8 | | 88.9 | | |
| Source: tables 10A.69–10A.76. | | | | | | | | | | | | | | | | | | | | | | | | | |

(Continued next page)

Table E.5 **(continued)**

|  |
| --- |
| Sentinel events, 2011-12 Most recent data for this indicator are complete but not directly comparable (chapter 10).  Data are available in tables 10A.77–10A.93. |

a Caveats for these data are available in chapter 10 and attachment 10A. Refer to the indicator interpretation boxes in chapter 12 for information to assist with the interpretation of data presented in this table. – Nil or rounded to zero. **na** Not available. **np** Not published.

#### Maternity services

The performance indicator framework for maternity services is presented in figure E.21. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of maternity services.

Figure E.21 Maternity services performance indicator framework

|  |
| --- |
| Figure E.21 Maternity services performance indicator framework   More details can be found within the text surrounding this image. |

An overview of the maternity services performance indicator results are presented in table E.6. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 10 and the footnotes in attachment 10A.

Table E.6 Performance indicators for maternity servicesa

|  | | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | | Aust |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Effectiveness — Appropriateness indicators** | | | | | | | | | | | |
| Caesareans for selected primiparae — Proportion (%) of births that were caesareans, 2012 Most recent data for this indicator not complete or not directly comparable (chapter 10) | | | | | | | | | | | |
|  | Public hospitals | 23.8 | 23.2 | 22.9 | 24.7 | 20.2 | na | 21.3 | 28.6 | 23.3 | |
|  | Private hospitals | 30.9 | 30.6 | 36.5 | 33.4 | 29.3 | na | 36.3 | np | 32.9 | |
| Inductions for selected primiparae — Proportion (%) of births that were induced, rate, 2012 Most recent data for this indicator not complete or not directly comparable (chapter 10) | | | | | | | | | | | |
|  | Public hospitals | 36.3 | 31.7 | 29.4 | 36.3 | 38.3 | na | 23.5 | 36.0 | 33.7 | |
|  | Private hospitals | 35.5 | 34.5 | 33.8 | 42.3 | 44.3 | na | 25.9 | np | 36.4 | |
| Instrumental vaginal births, 2011 Most recent data for this indicator not complete but are comparable (chapter 10) | | | | | | | | | | | |
|  | % | 23.2 | 27.6 | 21.2 | 29.9 | 24.0 | 29.2 | 26.6 | 18.9 | 24.8 | |
| Vaginal birth following a previous caesarean, 2011 Most recent data for this indicator are complete and comparable (chapter 10) | | | | | | | | | | | |
|  | Non-instrumental | 12.9 | 12.3 | 12.2 | 9.5 | 13.1 | 13.9 | 11.5 | 18.3 | 12.3 | |
|  | Instrumental | 3.6 | 3.9 | 2.6 | 3.7 | 4.2 | 4.0 | 4.8 | 3.0 | 3.5 | |
| Source: tables 10A.97–10A.107. | | | | | | | | | | | |
| **Effectiveness — Quality — Safety indicators** | | | | | | | | | | | |
| Perineal status after vaginal birth — Mothers with third or fourth degree lacerations after vaginal births, 2011Most recent data for this indicator are complete and comparable (chapter 10) | | | | | | | | | | | |
|  | % | 2.0 | 1.9 | 1.8 | 2.1 | 2.2 | 1.7 | 3.6 | 2.9 | 2.0 | |
| Source: table 10A.108. | | | | | | | | | | | |
| **Efficiency indicators** | | | | | | | | | | | |
| Cost per maternity separation, without complications, dollars, 2010-11,  Most recent data for this indicator are complete but not directly comparable (chapter 10) | | | | | | | | | | | |
|  | Vaginal delivery | 5 304 | 4 359 | 5 096 | 5 669 | 4 495 | 5 829 | 6 919 | 5 137 | 4 998 | |
|  | Caesarean | 8 689 | 8 947 | – | 13 196 | 9 917 | 12 010 | 12 328 | 11 257 | 9 681 | |
| Mother’s average length of stay, days, 2011-12 Most recent data for this indicator are complete and comparable (chapter 10) | | | | | | | | | | | |
|  | Vaginal delivery | 1.8 | 1.8 | 1.6 | 1.9 | 1.8 | 2 | 1.4 | 2 | 1.8 | |
|  | Caesarean | 3.9 | 3.8 | 3.4 | 3.8 | 4.1 | 3.8 | 3.9 | 4.6 | 3.8 | |
| Source: table 10A.109–10A.110. | | | | | | | | | | | |

(Continued next page)

Table E.6 (continued)

|  | | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | | Aust |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Outcome indicators** | | | | | | | | | | | | Apgar score at 5 minutes, 2012 Most recent data for this indicator are not complete and are not directly comparable (chapter 10) | | | | | | | | | | | | Percentage of live births with an Apgar score of 3 or lower by birthweight | | | | | | | | | | | |  | <1500g | 17.7 | 17.5 | 17.0 | 4.1 | 12.7 | na | 12.4 | np | na | |  | 1500g–1999g | 1.3 | 1.1 | 2.2 | 1.3 | 0.8 | na | – | np | na | |  | 2000g–2499g | 0.7 | 0.6 | 0.6 | 0.5 | 0.1 | na | 0.5 | np | na | |  | 2500g+ | 0.2 | 0.2 | 0.2 | 0.2 | 0.1 | na | 0.2 | 0.3 | na |   Perinatal death rates — deaths per ‘000 total births, 2011 Most recent data for this indicator are not complete but are comparable (chapter 10) | | | | | | | | | | | |
|  | Fetal deaths | 5.2 | 5.6 | 5.9 | 7.8 | 4.5 | 7.4 | 5.4 | 8.5 | 5.8 | |
|  | Neonatal deaths | 3.0 | 2.6 | 3.1 | 2.0 | 1.5 | 2.7 | 1.8 | 4.3 | 2.7 | |
|  | Perinatal deaths | 8.1 | 8.1 | 9.1 | 9.7 | 6.0 | 10.1 | 7.2 | 12.8 | 8.4 | |
| Source: tables 10A.111–10A.116. | | | | | | | | | | | |

a Caveats for these data are available in chapter 10 and attachment 10A. Refer to the indicator interpretation boxes in chapter 12 for information to assist with the interpretation of data presented in this table. – Nil or rounded to zero. **na** Not available.

#### Primary and community health

The performance indicator framework for primary and community health is presented in figure E.22. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of primary and community health.

Figure E.22 Primary and community health performance indicator framework

|  |
| --- |
| Figure E.22 Primary and community health performance indicator framework  More details can be found within the text surrounding this image. |

An overview of the primary and community health performance indicator results are presented in table E.7. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 11 and the footnotes in attachment 11A.

Table E.7 Performance indicators for Primary and community healtha, b

|  | | | NSW | Vic | | | Qld | | | WA | | | SA | | Tas | | ACT | | NT | | | | Aust |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Availability of PBS medicines — PBS prescriptions filled at concessional rate (per cent), 2012‑13 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Proportion of total | 88.2 | 88.5 | | | 87.6 | | | 83.9 | | | 89.5 | | 91.0 | | 76.3 | | 77.7 | | 87.8 | | |
| Equity of access to GPs, 2012‑13 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | |
| Full time workload equivalent GPs by remoteness area per 100 000 people | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Major cities, rate | 106.7 | 99.1 | | | 102.7 | | | 71.5 | | | 104.8 | | .. | | 72.6 | | .. | | 98.9 | | |
|  | | Outer regional, rate | 79.2 | 93.5 | | | 93.8 | | | 83.9 | | | 87.5 | | 76.1 | | .. | | 74.4 | | 86.5 | | |
| Availability of female GPs per 100 000 females | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Rate | 68.1 | 62.1 | | | 65.6 | | | 44.5 | | | 57.4 | | 63.0 | | 57.9 | | 58.4 | | 62.4 | | |
| Availability of public dentists — per 100 000 people, 2012 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | |
|  | Proportion of total | | 5.1 | | 4.2 | | | 6.0 | | | 5.6 | | | 5.7 | | 3.8 | | 6.9 | | 8.1 | | 5.2 | |
| Early detection and early treatment for Indigenous Australians — Proportion of Older Indigenous Australians who received a health assessment, 2012‑13 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Proportion | 29.8 | 17.9 | | | 37.0 | | | 30.2 | | | 21.0 | | 19.1 | | 26.1 | | 35.1 | | 30.3 | | |
| Children receiving a fourth year developmental health check, 2012‑13 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Proportion | 61.4 | 29.3 | | | 72.1 | | | 45.3 | | | 48.1 | | 57.3 | | 35.3 | | 65.0 | | 52.8 | | |
| Source: tables 11A.11–11A.31. | | | | | | | | | | | | | | | | | | | | | | | |
| **Effectiveness — Access indicators** | | | | | | | | | | | | | | | | | | | | | | | |
| Effectiveness of access to GPs  Most recent data for this indicator are comparable and complete (subject to caveats) for some but not all measures (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | |
| Bulk billing rates for non-referred patients, 2012-13 | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Proportion (%) | 86.8 | 82.1 | | | 81.7 | | | 73.0 | | | 81.4 | | 76.4 | | 55.0 | | 78.2 | | 82.3 | | |
| GP waiting times for urgent appointment, 2011-12 — less than 4 hours | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Proportion (%) | 64.3 | 63.4 | | | 66.8 | | | 62.0 | | | 66.2 | | 54.1 | | 61.2 | | 49.5 | | 64.1 | | |
| People deferring treatment due to cost, 2012-13 — deferring visits to GPs | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Proportion (%) | 4.8 | 5.2 | | | 6.3 | | | 8.0 | | | 6.1 | | 7.7 | | 8.8 | | 5.0 | | 5.8 | | |
| Selected potentially avoidable GP-type presentations to emergency departments, 2012-13 | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | ‘000 | 682.3 | | | 574.5 | | | 383.8 | | | 282.1 | | 105.9 | | 61.6 | | 46.6 | | 39.8 | | 2176.6 | | |
| (Continued next page) | | | | | | | | | | | | | | | | | | | | | | | |

Table E.7 (continued)

|  | | | | NSW | | | Vic | | | Qld | | | WA | | | SA | | | Tas | | | ACT | | | | NT | | | | Aust |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Financial barriers to PBS medicines | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| People deferring treatment due to cost, 2012-13 — deferring purchase of medicines  Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Proportion (%) | | | 7.9 | | | 8.6 | | | 9.9 | 7.1 | | | 9.1 | | | 9.8 | | 6.7 | | | | 8.9 | | | | 8.5 | | |
| Public dentistry waiting times, 2012-13 — less than 1 month Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | | 34.2 | | | 28.5 | | | 28.3 | | | 37.4 | | 15.1 | | | 32.5 | | | | 36.3 | | | | 40.4 | | 30.5 | | | |
| Source: tables 11A.32–11A.45. | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |
| **Effectiveness — Appropriateness indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GPs with vocational registration, 2012-13 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | | | 91.3 | | | 86.9 | | | 88.4 | | | 90.7 | | | 90.7 | | | 92.2 | | | 93.0 | | | | 72.1 | | | 89.4 | |
| General practices with accreditation, at 30 June 2011 Most recent available data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | | | 61.1 | | | 69.2 | | | 75.8 | | | 73.3 | | | 69.1 | | | 75.3 | | | 70.2 | | | | 45.7 | | | 67.4 | |
| Management of upper respiratory tract infections Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prescriptions for oral antibiotics used to treat upper respiratory tract infections  per 1000 people, 2012-13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Rate | | | 318.5 | | | 311.4 | | | 311.1 | | | 191.1 | | | 320.2 | | | 331.6 | | | 176.8 | | | | 88.0 | | | 297.1 | |
| Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, April 2008 to March 2013 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | | | 35.7 | | | 29.9 | | | 34.1 | | | 25.9 | | | 28.6 | | | 26.5 | | | 28.0 | | | | 21.4 | | | 32.5 | |
| Management of chronic disease Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| People with diabetes mellitus who have received an annual cycle of care within general practice, *2012-13* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | | | 25.1 | | | 26.2 | | | 25.5 | | | 20.5 | | | 29.1 | | | 31.9 | | | 15.4 | | | | 19.2 | | | 25.0 | |
| People with asthma who have a written asthma action plan, *2011-12* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | | | 26.6 | | | 25.3 | | | 18.4 | | | 24.5 | | | 29.3 | | | 22.6 | | | 24.3 | | | | 33.7 | | | 24.6 | |
| Pathology tests and diagnostic imaging — Medicare benefits for pathology tests, 2012-13 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | $ per person | | | 63.8 | | | 59.4 | | | 67.0 | | | 55.1 | | | 59.3 | | | 55.7 | | | 58.7 | | | | 66.0 | | | 61.8 | |
| Source: tables 11A.46–11A.66. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Effectiveness — Quality — Safety indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Electronic health information systems — general practices using electronic systems, May 2013 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | | | 69.4 | | | 76.2 | | | 74.2 | | | 68.4 | | | 72.7 | | | 75.6 | | | 80.0 | | | | 48.2 | | | 72.2 | | |
| Source: tables 11A.67–11A.69. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Continued next page) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Table E.7 (continued)

|  | | | NSW | | | Vic | | | Qld | | | | WA | | | | | | SA | | | | Tas | | | | ACT | | | NT | | | | Aust | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Effectiveness — Quality — Responsiveness indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient satisfaction, 2012-13 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Proportion (%) of people who saw a practitioner in the previous 12 months where the practitioner always or often: listened carefully to them | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | GP | | | 90.1 | | | 89.4 | | | 88.7 | | | | 88.3 | | | | | 88.2 | | | | 89.7 | | | | 89.5 | | | | 87.2 | | 89.3 | | | |
|  | Dental practitioner | | | 95.8 | | | 94.2 | | | 94.0 | | | | 95.5 | | | | | 94.4 | | | | 94.1 | | | | 94.8 | | | | 91.9 | | 94.8 | | | |
| Source: tables 11A.70–11A.74. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Effectiveness — Quality — Continuity indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Health assessments for older people — proportion of older people assessed, 2012-13 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Proportion (%) | | | 29.4 | | | 27.1 | | | | 33.4 | | | | 27.5 | | | | 27.2 | | | | 34.3 | | | | 22.0 | | | 26.5 | | | | 29.2 |
| Source: table 11A.75. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Efficiency indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cost to government of general practice per person — fee-for-service expenditure, 2012-13 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | $ per person | | | 303.1 | | | 288.0 | | | | 299.9 | | | | 224.7 | | 285.0 | | | | 265.1 | | | | 225.1 | | | 223.1 | | | 286.1 | | | |
| Source: table 11A.2. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Outcome indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child immunisation coverage — Children aged 60 to 63 months fully immunised, 2012‑13 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Proportion (%) | | | 91.6 | | | 92.6 | | | 91.5 | | | | | 89.4 | | 90.9 | | | | 92.9 | | | | 92.3 | | | 90.7 | | | 91.5 | | | |
| Notifications of selected childhood diseases —notifications per 100 000 children, 2012‑13 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Measles | | | 6.1 | | | np | | | np | | | | | 0.6 | | np | | | | – | | | | – | | | np | | | 2.2 | | | |
| Participation rates for women in breast cancer screening — Ages 50–69, 1 January 2011 to 31 December 2012 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Rate | | | 50.4 | | | 54.3 | | | 57.1 | | | | | 57.8 | | 58.8 | | | | 57.8 | | | | 53.5 | | | 41.6 | | | 54.5 | | | |
| Participation rates for women in cervical screening — Ages 20–69 (ASR), 1 January 2011 to 31 December 2012 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Rate | | | 56.8 | | | 61.1 | | | 55.8 | | | | | 55.9 | | 59.4 | | | | 56.6 | | | | 57.2 | | | 53.8 | | | 57.7 | | | |
| Influenza vaccination coverage for older people — 65 years or over, 2009 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Rate | | | 72.7 | | | 75.0 | | | 74.6 | | | | 72.9 | | 81.3 | | | | 77.5 | | | | 78.0 | | | | 69.3 | | | 74.6 | | | |
| (Continued next page) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Table E.7 (continued)

|  | | NSW | | | Vic | | Qld | | WA | | | SA | | Tas | | ACT | | NT | | Aust |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Separations for selected potentially preventable hospitalisations, 2011-12, per 1000 people Most recent data for the indicator are comparable and complete (subject to caveats) except for the measure potentially preventable hospitalisations for diabetes (chapter 11) | | | | | | | | | | | | | | | | | | | | |
|  | Vaccine-preventable | | | 0.8 | | 0.8 | | 0.9 | | 0.8 | 0.9 | | 0.5 | | 0.7 | | 3.1 | | 0.8 | |
|  | Acute conditions *excluding dehydration and gastroenteritis* | | | | | | | | | | | | | | | | | | | |
|  |  | | 10.9 | | | 12.0 | | 12.7 | | 13.6 | 12.8 | | 8.5 | | 9.5 | | 19.8 | | 12.0 | |
|  | Chronic conditions *excluding additional diagnoses of diabetes complications* | | | | | | | | | | | | | | | | | | | |
|  |  | | 10.4 | | | 11.9 | | 12.5 | | 10.7 | 11.4 | | 9.1 | | 8.5 | | 21.0 | | 11.3 | |
| Source: tables 11A.76–11A.93. | | | | | | | | | | | | | | | | | | | | |

a Caveats for these data are available in Chapter 11 and Attachment 11A. Refer to the indicator interpretation boxes in chapter 11 for information to assist with the interpretation of data presented in this table. b Some data are derived from detailed data in Chapter 11 and Attachment 11A. – Nil or rounded to zero. **na** Not available. **np** Not published.

Source: Chapter 11 and Attachment 11A.

#### Mental health management

The performance indicator framework for mental health management is presented in figure E.23. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of mental health management.

Figure E.23 Mental health management performance indicator framework

|  |
| --- |
| **Figure E.23 Mental health management performance indicator framework  More details can be found within the text surrounding this image.** |

An overview of the mental health management performance indicator results are presented in table E.8. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 12 and the footnotes in attachment 12A.

Table E.8 Performance indicators for Mental health managementa

|  | | | | NSW | | | Vic | | Qld | | WA | | SA | | Tas | | ACT | | NT | | | Aust |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Equity — Access indicators** | | | | | | | | | | | | | | | | | | | | | | |
| *New client index*  Most recent data for this measure are not directly comparable nor complete (chapter 12) | | | | | | | | | | | | | | | | | | | | | | |
| Proportion of clients under the care of State or Territory specialised public mental health services who were new clients, 2011-12 | | | | | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | | | 39.8 | | | na | | 45.5 | | 41.6 | | 42.7 | | 21.9 | | 42.2 | | 49.6 | | | 41.5 |
| Mental health service use by selected community groups | | | | | | | | | | | | | | | | | | | | | | |
| Proportion (%) of the Indigenous population using State and Territory mental health services, compared with the proportion for non-Indigenous population, 2011-12  Most recent data for this measure are comparable (subject to caveats), but not complete (chapter 12) | | | | | | | | | | | | | | | | | | | | | | |
| Indigenous | | | | 5.4 | | | na | | 4.8 | | 5.4 | | 6.9 | | 1.2 | | 7.9 | | 3.8 | | | na |
| Non-Indigenous | | | | 1.2 | | | na | | 1.7 | | 1.8 | | 1.7 | | 0.8 | | 1.9 | | 2.3 | | | na |
| Proportion (%) of the Indigenous population using MBS and DVA funded mental health services, compared with the proportion for non-Indigenous population, 2011-12  Most recent data for this measure are comparable and complete (chapter 12) | | | | | | | | | | | | | | | | | | | | | | |
| Indigenous | | | | 10.7 | | | 12.5 | | 6.7 | | 4.0 | | 8.2 | | 8.4 | | 12.5 | | 1.5 | | | 7.4 |
| Non-Indigenous | | | | 7.0 | | | 7.8 | | 6.7 | | 5.5 | | 7.0 | | 6.2 | | 5.6 | | 3.6 | | | 6.9 |
| Source: tables 12A.25–26. | | | | | | | | | | | | | | | | | | | | | | |
| **Effectiveness — Access indicators** | | | | | | | | | | | | | | | | | | | | | | |
| *Mental health service use by total population*  Most recent data for this indicator are comparable, but not complete (chapter 12) | | | | | | | | | | | | | | | | | | | | | | |
| Proportion (%) of the population in a State and Territory using a specialised public mental health service or a MBS-subsidised service, 2011-12 | | | | | | | | | | | | | | | | | | | | | | |
| Specialised public mental health | | | | | | 1.6 | | na | | 1.8 | | 2.0 | | 2.1 | | 1.6 | | 2.2 | | 2.7 | | 1.4 |
| MBS and DVA subsidised service | | | | | | 7.3 | | 8.0 | | 7.0 | | 5.5 | | 7.2 | | 6.3 | | 5.7 | | 3.0 | | 7.1 |
| *Primary mental health care for children and young people* Most recent data for this indicator are comparable, but not complete (chapter 12) | | | | | | | | | | | | | | | | | | | | | | |
| Proportion of young people aged under 25 years who had contact with primary mental health care services subsidised through the MBS*,* 2012-13 | | | | | | | | | | | | | | | | | | | | | | |
| Proportion (%) | | | | 5.3 | | | 6.1 | | 5.0 | | 3.9 | | 5.5 | | 5.2 | | 4.6 | | 1.8 | | | 5.2 |
| Source: tables 12A.30 and 12A.33. | | | | | | | | | | | | | | | | | | | | | | |
| **Effectiveness — Appropriateness indicators** | | | | | | | | | | | | | | | | | | | | | | |
| Services reviewed against national standards Most recent data for this indicator are complete, but not complete (chapter 12) | | | | | | | | | | | | | | | | | | | | | | |
| Proportion of specialised public mental health services that had completed an external review against national standards and were assessed as meeting ‘all Standards’ (level 1), June 2012 | | | | | | | | | | | | | | | | | | | | | | |
|  | | Proportion (%) | | 72.9 | | | 63.4 | | 99.7 | | 62.9 | | 41.7 | | – | | 100.0 | | 100.0 | | 71.5 | |
| Services provided in the appropriate setting Most recent data for this measure are comparable and complete (chapter 12) | | | | | | | | | | | | | | | | | | | | | | |
| Recurrent expenditure on community-based services as a proportion of total expenditure on mental health services, 2011-12 | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Proportion (%) | | 43.5 | | 64.2 | | 56.3 | | 53.4 | | 58.8 | | 56.8 | | 74.4 | | 63.9 | | 54.2 | |
| (Continued next page) | | | | | | | | | | | | | | | | | | | | | | |

Table E.9 (Continued)

|  | | | NSW | | Vic | | Qld | | WA | | SA | | Tas | | ACT | | NT | | Aust |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Collection of information on consumers outcomes  Most recent data for this measure are comparable, but not complete (chapter 12) | | | | | | | | | | | | | | | | | | | |
| Proportion of episodes with completed consumer outcomes measures collected for people in specialised public mental health services — ongoing community care, 2011-12 | | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | | 21.1 | | na | | 34.1 | | 29.1 | | 34.8 | | 23.3 | | 7.8 | | 19.7 | | 26.5 |
| Source: tables 12A.34–36. | | | | | | | | | | | | | | | | | | | |
| **Effectiveness — Quality — Safety indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of seclusion ― acute inpatient units  Most recent data for this indicator are comparable and complete (chapter 12) | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Number of seclusion events per 1000 patient days in specialised public mental health acute inpatient units, 2012-13 | | | | | | | | | | | |  | no. | 8.5 | 10.9 | 12.7 | 6.0 | 9.1 | 19.7 | 0.9 | 15.8 | 9.6 |   Source: table 12A.37. | | | | | | | | | | | | | | | | | | | |
| **Effectiveness — Quality — Responsiveness indicators** | | | | | | | | | | | | | | | | | | | |
| Consumer and carer involvement in decision making Most recent data for this measure are comparable and complete (chapter 12) | | | | | | | | | | | | | | | | | | | |
| Paid consumer workers (FTE) per 1000 paid direct care, consumer and carer staff (FTE), 2011-12 | | | | | | | | | | | | | | | | | | | |
|  | no. | | 3.0 | | 3.2 | | 3.9 | | 0.7 | | 4.0 | | 2.3 | | – | | – | | 2.9 |
| Source: table 12A.38. | | | | | | | | | | | | | | | | | | | |
| **Effectiveness — Quality — Continuity indicators** | | | | | | | | | | | | | | | | | | | |
| Community follow up for people within the first 7 days of discharge from hospital Most recent data for this indicator are not comparable nor complete (chapter 12) | | | | | | | | | | | | | | | | | | | |
| Proportion of overnight separations from psychiatric inpatient acute services with a community mental health service contact recorded in the 7 days following separation, 2011-12 | | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | | 52.4 | | na | | 64.4 | | 50.7 | | 50.5 | | 27.4 | | 77.7 | | 44.1 | | 54.6 |
| Readmissions to hospital within 28 days of discharge Most recent data for this indicator are complete, but not comparable (chapter 12) | | | | | | | | | | | | | | | | | | | |
| Proportion of overnight separations from psychiatric inpatient acute services that were followed by a readmission to a psychiatric inpatient service within 28 days of discharge, 2011-12 | | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | | 15.7 | | 14.3 | | 15.1 | | 13.7 | | 9.3 | | 14.1 | | 12.6 | | 9.8 | | 14.4 |
| Source: tables 12A.39 and 12A.41. | | | | | | | | | | | | | | | | | | | |
| **Efficiency indicators** | | | | | | | | | | | | | | | | | | | |
| Cost of inpatient care Most recent data for this indicator are comparable and complete (chapter 12) | | | | | | | | | | | | | | | | | | | |
| Cost per inpatient bed day, 2011-12 | | | | | | | | | | | | | | | | | | | |
| General mental health services (acute units) | | | | | | | | | | | | | | | | | | | |
|  | $ per bed day | 949 | | 800 | | 859 | | 1 123 | | 865 | | 931 | | 910 | | 1 526 | | 921 | |
| Public acute hospital with a psychiatric unit or ward (acute units) | | | | | | | | | | | | | | | | | | | |
|  | $ per bed day | 944 | | 802 | | 891 | | 1 104 | | 871 | | 1 036 | | 839 | | 1 526 | | 918 | |
| (Continued next page) | | | | | | | | | | | | | | | | | | | |

Table E.10 (Continued)

|  | | | NSW | | Vic | | Qld | | WA | | SA | | Tas | | ACT | | NT | Aust |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Average recurrent cost per patient day for community residential services Most recent data for this indicator are comparable and complete (chapter 12) | | | | | | | | | | | | | | | | | | |
| General adult units — 24-hour staffed units, 2011-12 | | | | | | | | | | | | | | | | | | |
|  | $ per patient day | 225 | | 488 | | .. | | 368 | | 484 | | 490 | | 650 | | 308 | | 447 |
| Average cost of ambulatory care  Most recent data for this indicator are comparable, but not complete (chapter 12)  Average cost per treatment day of ambulatory care, 2011-12 | | | | | | | | | | | | | | | | | | |
|  | $ per episode | 245 | | na | | 424 | | 431 | | 324 | | 467 | | 249 | | 543 | | 326 |
| Source: tables 12A.43, 12A.45–47. | | | | | | | | | | | | | | | | | | |
| **Outcome indicators** | | | | | | | | | | | | | | | | | | |
| Rates of licit and illicit drug use Most recent data for this indicator are comparable and complete (chapter 12) | | | | | | | | | | | | | | | | | | |
| Proportion of people aged 14 years or over who used any illicit drug in the preceding 12 months, 2010 | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | 11.4 | | 11.0 | | 12.3 | | 15.4 | | 12.7 | | 9.6 | | 11.4 | | 18.8 | | 12.0 |
| Prevalence of mental illness Most recent data for this indicator are comparable and complete (chapter 12) | | | | | | | | | | | | | | | | | | |
| Proportion of people with a lifetime mental disorders among adults aged 16–85 years, 2007 | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | 20.1 ± 2.2 | | 20.7 ± 2.3 | | 19.2 ± 2.6 | | 21.4 ± 4.1 | | 19.1 ± 3.4 | | 14.1 ± 5.4 | | np | | np | | 20.0 ± 1.1 |
| Mortality due to suicide  Most recent data for this indicator are comparable and complete (chapter 12)  Suicide rate per 100 000 people, 2007–2011 | | | | | | | | | | | | | | | | | | |
|  | Rate | 8.6 | | 9.5 | | 12.7 | | 13.0 | | 12.0 | | 14.1 | | 9.9 | | 20.1 | | 10.6 |
| *Social and economic inclusion of people with a mental illness* Most recent data for this indicator are comparable and complete (chapter 12) | | | | | | | | | | | | | | | | | | |
| Proportion of people aged 16–64 years with mental or behavioural problems who are employed, 2011-12 | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | 65.2 ± 7.7 | | 59.4 ± 6.4 | | 57.7 ± 6.7 | | 65.0 ± 5.9 | | 61.2 ± 7.2 | | 51.6 ± 8.7 | | 72.5 ± 8.2 | | 63.2 ± 10.3 | | 61.7 ± 3.1 |
| *Mental health outcomes of consumers of specialised public mental health services* Most recent data for this indicator are not comparable nor complete (chapter 12) | | | | | | | | | | | | | | | | | | |
| Proportion of people discharged from a State or Territory public hospital psychiatric inpatient unit who had a significant improvement in their clinical mental health outcomes, 2011-12 | | | | | | | | | | | | | | | | | | |
|  | Proportion (%) | 68.1 | | na | | 73.4 | | 72.1 | | 71.3 | | 73.0 | | np | | 77.6 | | 70.8 |
| Source: tables 12A.49, 12A.56, 12A.61, 12A.65 and 12A.72. | | | | | | | | | | | | | | | | | | |

a Caveats for these data are available in chapter 12 and attachment 12A. Refer to the indicator interpretation boxes in chapter 12 for information to assist with the interpretation of data presented in this table.   
– Nil or rounded to zero. .. Not applicable. **np** Not published.

## E.3 Cross cutting and interface issues

Many determinants affect Australian’s health (AIHW 2012). They include the delivery of an efficient, effective and equitable health service, but also factors such as individuals’ and communities’ social and economic conditions and background.

Major improvements in health outcomes therefore depend on strong partnerships between components of the health system and relationships between the health sector and other government services:

* *Early childhood, education and training services* play an important role in shaping a child’s development, which has consequences for overall health and wellbeing in later life (AIHW 2011).

Good health is critical to a child’s educational development. Impaired hearing, malnutrition, poor general health, including poor eyesight, anaemia, skin diseases, and sleep deprivation have been identified as having adverse effects on the educational attainment of Indigenous children (AMA 2001).

* *Justice services* have a critical role in providing a safe and secure society, free from violence. They also enforce laws designed to improve public health such as to prevent road traffic accidents and the use of illicit drugs.

A person’s health can also be a critical factor in a person’s interaction with the justice system. Research shows that prisoners have significantly worse health, with generally higher levels of diseases, mental illness and illicit drug use than Australians overall (AIHW 2012).

* *Emergency management services* have an important role in the preparation and response to emergency events providing emergency first aid, protection and shelter. Ambulance services are an integral part of a jurisdiction’s health service providing emergency as well as non‑emergency patient care and transport.
* *Community services* and health services interact at many levels. People with disability are more likely than others to have poor physical and mental health, and higher rates of risk factors such as smoking and obesity (AIHW 2012). Aged care services can keep people living independently and healthily, without undue call on the health sector. Child protection services act to protect children and ensure their good health (while medical professionals are the source of many child protection notifications).
* *Housing and homelessness services* play an important role in ensuring the health of Australians. Living conditions (particularly poor housing and infrastructure) are a major contributor to health and well being. People with unmet housing needs tend to experience higher death rates, poor health, and are more likely to have serious chronic illnesses (Garner 2006).

## E.4 Future directions in performance reporting

This health sector overview will continue to be developed in future reports.

It is anticipated that work undertaken to achieve the COAG aspirations will lead to improvements in performance reporting for the health sector. There are several important national initiatives currently underway. COAG has agreed to the National Health Reform Agreement (COAG 2011). The Agreement includes a commitment to introduce clear and transparent performance reporting against the new Performance and Accountability Framework that will include:

* a subset of the national performance indicators already agreed by COAG through the NHA
* reference to national clinical quality and safety standards developed by the Australian Commission on Safety and Quality in Health Care
* design principles for the new Hospital Performance Reports and Healthy Communities Reports.

Performance reporting will be through the establishment of the National Health Performance Authority. The Authority will:

* provide clear and transparent quarterly public reporting of the performance of every Local Hospital Network, private hospital and Medicare Local
* monitor the performance of Local Hospital Networks, Medicare Locals and hospitals
* develop additional performance indicators as appropriate
* maintain the MyHospitals website.

The COAG Reform Council will continue its role of reviewing the national performance indicators at a State and Territory level. It will report on the performance of the Australian and State and Territory governments in achieving the jurisdictional level outcomes and performance benchmarks included in the NHA.

The Public hospitals, Primary and community health and Mental health management chapters contain a service‑specific section on future directions in performance reporting.

## E.5 Jurisdictions’ comments

This section provides comments from each jurisdiction on the services covered in this sector overview.

|  |  |  |
| --- | --- | --- |
| **“** | New South Wales Government comments  During 2012-13 significant progress was made on our reform journey.  Partnerships between NSW Health organisations continue to mature, and we can report strong achievements against the targets in NSW 2021- A Plan to Make NSW Number One.  NSW Health performed well against the key performance targets under Goals 11 and 12.  Key achievements in Keeping people healthy and out of hospital (Goal 11) include:   * Enrolled 4446 adults in the Get Healthy Information and Coaching Service * Commenced the NSW Healthy Children’s Initiative 2013–2017 and the Healthy Worker Initiative 2013–2017 to promote healthy weight, healthy eating and physical activity. The rate of overweight and obesity has stabilised for children and adults * Implemented the NSW Tobacco Strategy 2012–17 to reduce smoking and decrease associated chronic diseases. The rate of smoking has declined since 2002 in both Indigenous and non-Indigenous adults aged 16 years or over * Amended the Smoke-free Environment Act 2000 to reduce exposure to second hand smoke in a range of public places, with the first major changes taking effect in January 2013 with smoking restricted in outdoor public places which are most commonly visited by families and children * Launched a range of evidence-based public education programs to reduce smoking and risky drinking, including two programs targeting people whose alcohol consumption poses a lifetime risk to health * A significant decrease in Aboriginal infant mortality over the last 10 years. The gap between Aboriginal and non-Aboriginal infant mortality has also reduced significantly * Significant effort has been made to promote the benefits of timely complete immunisation. The rate for children who are fully immunised at one year of age remains high. * Key achievements in Providing world class clinical services with timely access and effective infrastructure (Goal 12) include: * Meeting waiting time targets for booked surgery in all categories for the National Elective Surgery Targets (NEST) under the National Health Reform Agreement with the Federal Government * Meeting or exceeding national performance targets in providing timely care for people presenting to our Emergency Departments in four out of five triage categories. | **”** |
| **“** | Victorian Government comments  In 2012-13, healthcare services in Victoria have been navigating through the challenges of a slower Australian economy, a growing and ageing population, and more complex healthcare needs. National Health Reform has been challenging as new national agencies have become established. Against this backdrop, in partnership with a range of healthcare providers, the Victorian government continues to build and maintain high quality health, mental health and aged care services for Victorians.  Health spending in 2012-13 totalled $13.67 billion, which will increase to $14.34 billion in 2013-14. Increased investment in 2012-13 included $818 million over four years for growth in hospital services, including additional State funding for elective surgery in the context of lapsing Commonwealth funding for these services. A range of initiatives to support the rural maternity workforce and improve maternity service sustainability were also implemented in 2012-13. Investment in the Victorian health system is continuing in 2013-14 with an additional $1.47 billion committed over 4 years for growth in hospital services.  The Victorian Government is also committed to ensuring state-funded mental health services are a more integral and connected part of Victoria’s broader health and human services system, with community-based recovery-oriented treatment and care at the centre of reform. Investment of $1.14 billion was allocated in 2012-13, including additional funding for community-based mental health services, new and redeveloped acute and sub-acute mental health beds, and new specialist services. Funding for mental health services will increase to over $1.2 billion in 2013-14 with new funding for more hospital beds for people with a mental illness, improved access to services for vulnerable Victorians and more support for mental health and alcohol and drug sector workers.  Investment in State-funded primary health care in Victoria in 2012-13 included $61.8 million over four years to improve health outcomes for Aboriginal Victorians, including assistance to increase access to both Aboriginal community-controlled and mainstream health services. Further State funding has been allocated in 2013-14 to improve health outcomes associated with cardiovascular disease and stroke, with improved access initiatives for Victorians living in rural and regional areas.  Victoria’s clinical networks continue to provide leadership and support for collaboration between clinicians. Improved consumer information about the maternity and neonatal service system has also been published, including a statewide parenting kit for Victorian families that develops health literacy and facilitates better health outcomes for children.  The Victorian Government is confident that Victoria’s health system is well placed to address major challenges ahead, continues to perform to a high standard, and is sustainable and responsive to people’s needs. | **”** |
| **“** | Queensland Government comments  The 2013-2014 Queensland State budget will see a record $12.3 billion invested in the Queensland healthcare system, an increase of 4.5 per cent on the 2012‑2013 estimated actual budget. However, meeting healthcare needs sustainably also requires a continuing commitment to innovation and reform with a focus on measuring outputs and outcomes rather than just inputs.  In 2013-2014, 83.7 per cent of the total Queensland Health budget will be channelled directly to independent Hospital and Health Services (HHS), empowering local management and better responsiveness of healthcare services. The Queensland Government is committed to a robust performance management and reporting framework to hold HHSs accountable for their performance. Open hospital performance reporting allows healthcare consumers to more easily track and compare local health services. Services continue to be delivered within budget — an overall surplus that was recorded by the HHSs in 2012‑2013 is being reinvested in additional health services, including extra elective surgery activity to reduce waiting times across the state.  The recently published Blueprint for better healthcare in Queensland outlines structural and cultural improvements that need to occur in coming years to establish Queensland as the leader in Australian healthcare. For instance, it sets a target for the cost of healthcare delivery to equal or better national benchmarks by mid 2014. Improvements have already been achieved since 2009-2010, with further significant improvements expected in 2013-2014.  Significant investment is being made to implement a range of clinical redesign projects. There are many positive indicators of performance with continued reductions in waiting times for emergency department and elective surgery, as well as decreasing average length of stay in our public hospitals. Increased partnerships with the private and not-for-profit sectors in providing innovative, effective and efficient public service delivery models are being explored.  Investment in Queensland’s healthcare infrastructure continued apace in 2013 with the opening of the Gold Coast University Hospital and further progress on the new Queensland Children’s Hospital and the Sunshine Coast Public University Hospital (SCPUH).  Queensland has the most decentralised population of any Australian jurisdiction. The recently announced expansion of the Rural Telehealth Service will help support equity of access to healthcare across the State. Improving Indigenous health toward ‘closing the gap’ is an ongoing priority with several initiatives this year including a new Brisbane-based Centre of Excellence in Indigenous Health.  The Queensland Mental Health Commission was also established from 1 July 2013 to drive and lead cultural change in the way mental health, drug and alcohol services are planned and delivered. Other important developments include the launch of a new Queensland HIV Strategy to reduce infection rates, increased funding to clear cochlear implant waiting lists and the ‘Mums and Bubs’ package of enhanced Maternal and Child Health Services. | **”** |
| **“** | Western Australian Government comments  In 2012-13, WA Health continued to provide a high quality service for the Western Australian community, despite increasing demand for its services from the State’s growing population. The solid performance was underpinned by long‑term planning, regular and ongoing monitoring and review, innovative reform and a professional workforce. The year began with restructuring public health system governance through appointing five high-level governing councils. In addition, health system efforts were focused through the four pillars of the WA Health Strategic Intent 2010–2015:   * Caring for individuals and the community The Western Australian community benefits from effective public health programs, responsive health services and hospitals which meet high standards of safety and quality. The commitment to safety and quality was strengthened in 2012-13 by adopting new national safety and quality service standards. A range of public health initiatives aimed at preventing chronic disease and injury were delivered, including those designed to better protect the community from vaccine-preventable diseases and ongoing initiatives to reduce smoking. * Caring for those who need it most In 2012-13, WA Health hospitals performed strongly against the National Emergency Access Target, with measures implemented to ensure timely access to appropriate care. Community care initiatives were established to enhance services for people with a disability or chronic health condition. New subacute care programs commenced and existing ones were expanded. WA Health has made a significant contribution under the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, including 98 Aboriginal specific programs delivered in country Western Australia that improved health outcomes for Aboriginal people. * Making the best use of funds and resources Statewide capital programs have progressed well, with several health building projects completed in 2012-13. Construction continued on other major developments including the Fiona Stanley and new children’s hospitals. Of WA Health services, 76 per cent are now funded under the Activity-Based Funding model with an aim to improve efficiency in service delivery. Implementation of an Emergency Telehealth Service in selected rural areas has delivered significant benefits to areas in need. * Supporting our team  WA Health has seen more doctors and nurses recruited to meet challenging health workforce demands, particularly in the country areas. Recognised as key to improving the health of Aboriginal people, WA Health also embarked on a range of initiatives to increase the number of Aboriginal people working in the health system. | **”** |
| **“** | South Australian Government comments  In 2012-13, the Department for Health and Ageing experienced significant reform designed to support the department’s achievement of goals set out in the SA Health Care Plan 2007–16.  Significant legislative reform was achieved during 2012-13. The *Advance Care Directives Bill 2013*, which will simplify existing arrangements for advance care directives, passed both houses of the Parliament of South Australia and is likely to commence mid-2014. The *South Australian Public Health Act 2011* became fully operational, providing the basis for developing a state Public Health Plan and local planning by local councils.  SA Health continued to excel in the provision of Emergency Department and elective surgery services, bettering the national average in a number of key areas of hospital performance. By the end of 2012-13, there were no patients overdue for elective surgery in the South Australian public health system.  The department progressed work on major capital developments during 2012-13 and investment in medical research and innovation continued, with the opening of the $5 million Australian Cancer Research Foundation’s Cancer Genomics Facility at the SA Pathology site. Work on the new Royal Adelaide Hospital site reached several significant milestones and the $163 million Flinders Medical Centre redevelopment was opened. A new $12 million Rehabilitation and Allied Health Building at The Queen Elizabeth Hospital was opened and construction on the final phase of the $17.4 million Modbury Hospital Emergency Department redevelopment began. Young patients with chronic illnesses are now being treated in a new ward at the Women’s and Children’s Hospital, following the opening of the $5.4 million 20-bed Cassia Ward, and SA Ambulance Service launched its first MedSTAR Kids neonatal and paediatric ambulance.  Investment continued in major eHealth initiatives. The largest, the Enterprise Patient Administration System (EPAS), continued to progress during 2012-13. EPAS will provide the foundations for the delivery of an SA Health wide electronic health record and will help improve care by enabling clinicians to spend less time on paperwork and more time with patients at the bedside.  The Northern Community Mental Health Centre was opened, furthering SA Health’s efforts to provide high-quality mental health services. This is the third  of six being built across Adelaide as part of a $34 million state government initiative.  Redevelopment works at Country Health SA sites progressed well in 2012‑13, including the $39.2 million Port Lincoln and $36 million Riverland hospitals. Redevelopment and upgrade works of the Emergency Departments at Cummins Hospital and the South Coast District Hospital in Victor Harbor were completed.  SA Health’s efforts to reduce the prevalence of smoking continues to deliver good results. Data from the 2012 South Australian Health Omnibus Survey showed that the key target in the South Australian Tobacco Control Strategy 2011–16, to reduce the percentage of young smokers (15 to 29 years) to 16 per cent by 2016, is on track. | **”** |
| **“** | Tasmanian Government comments  During 2012-13 the Department of Health and Human Services has continued to deliver high quality health services to the population of Tasmania.  This year marked the first year of operation of the three Tasmanian Health Organisations, and the first year in which service agreements were required in accordance with the *Tasmanian Health Organisation Act 2011*.  In 2012-2013, Ambulance Tasmania reduced its statewide median emergency response times despite the number of call-outs increasing by more than  12 per cent, and BreastScreen Tasmania continued to out-perform the national target, with almost 93 per cent of clients assessed within the recommended timeframe.  Another significant milestone was the passing of the new *Mental Health Act 2013* through the Tasmanian Parliament, which comes into effect from 1 January 2014 to ensure there is a human rights approach taken to helping clients suffering from mental illness.  Preventative health remains a core focus and this year the five-yearly *State of Public Health Report* was released, accompanied by the *Health Indicators Tasmania Report*. It shows that the life-expectancy of Tasmanians is improving and self-reported health is generally good. However, Tasmania’s health challenges continue to be towards encouraging Tasmanians to maintain healthy lifestyles and to reduce the prevalence of smoking and chronic disease caused by obesity. Tasmania also has a generally older and more dispersed population than other states, creating particular challenges for our health system.  To meet these and other challenges, the Tasmanian Lead Clinicians Group (TLCG) is leading work to update Tasmania’s Health Plan. They are consulting widely with clinicians and stakeholders to ensure the vision for health services into the future remains flexible and relevant.  The TLCG released *Tasmania’s Health Planning Framework* in August 2013 as the first step in developing a new health plan. Following this, a discussion paper on Clinical Advisory Groups (CAGs) was released seeking feedback on the proposed strategy for implementing the planning framework through the development of CAGs.  Work is currently underway to establish a number of these high level CAGs. Each CAG will provide advice to the TLCG, and lead work in a range of specific areas, including access to and integration of services; quality and safety of care; clinical governance and engagement; efficient resource utilisation; and, statewide service planning.  The TLCG have also identified a number of priority areas for action over the next twelve months as we move forward in building an efficient, safe and sustainable health system for all Tasmanians. | **”** |
| **“** | **Australian Capital Territory Government comments**  The ACT Government, through ACT Health, plans, manages and delivers public sector health services to both ACT residents and residents in the NSW surrounding region. The total catchment population (the Australian Capital Region) was 617 071 persons as at June 2012. Canberra is the major health referral centre for the Greater Southern Region of NSW.  As a result of the requirements under the current national health reform agenda, the ACT has established a Local Hospital Network comprising of Canberra Hospital and Health Services, Calvary Hospital, Clare Holland House, and Queen Elizabeth II Family Centre. The network provides a comprehensive range of acute, sub‑ and non‑acute, emergency, non-admitted, and community based health services in the ACT.  In 2012-13, the ACT exceeded its target for the number of people removed from the elective surgery waiting list — the highest on record for the ACT — and continues to reduce the quantum of patients waiting longer than clinically recommended times. The high quality of service that patients receive in ACT public hospitals was reflected in the quality of theatre and post operative care, the effective treatment of people who received hospital healthcare through our hospital and community based services, and the low number of people who acquired a bacteraemial infection during their hospital stay.  The ACT, through the Australian Council on Healthcare Standards, met  all accreditation criteria — with 28 marked achievements, 18 extensive achievements, and one outstanding achievement — to retain its full accreditation status for another four years.  The needs of the Canberra community are changing and the ACT Government is embarking on a program of investment in health infrastructure to meet the challenges of a growing and ageing population in the ACT and surrounding region.  The Health Infrastructure Program began with a careful examination of the current health system and a comprehensive review of the future needs of the community. Since the program was first announced in 2008, it has delivered a range of community based projects and many enhancements to services and facilities at our hospitals.  New building projects completed in 2013 include the Belconnen Community Health Centre; the Centenary Hospital for Women and Children; and an extension to the emergency department/intensive care unit at Canberra Hospital, while an expansion and refurbishment of the Tuggeranong Community Health Centre and the Canberra Region Cancer Centre will be completed in 2014. Planning continues on further hospital and community health infrastructures and associated workforce and e-Health services.  The ACT continues to work with the Commonwealth and the health reform bodies on matters relating to the *National Health Reform Agreement*. | **”** |
| **“** | * **Northern Territory Government comments** * During 2012-13, Northern Territory Department of Health services provided care in a range of settings, including remote health centres and our five hospitals. * Northern Territory statistics reflect the challenges of geography and a population widely distributed across remote and very remote areas. This contributes to significant socioeconomic disadvantage for some sectors of the population which often results in limited life and health choices and poorer wellbeing. We continue to address these challenges through service delivery approaches that respond to local needs and conditions. * The Northern Territory Government’s New Service Framework for Health and Hospital Services (the NSF) was announced in November 2012. The NSF’s key objective is to redesign our organisation and health services in order to: * deliver improved patient and client access to better integrated services * increase local decision making across our services * ensure a regional focus and regional input into service provision in communities * provide a Territory-wide performance and accountability framework * provide a Territory-wide safety and quality system. * The NSF also implements national health reforms. Operational services will be delivered by two organisations: the Top End and Central Australia Health Services. A more streamlined contemporary Department of Health will be established as the overall health system manager, with responsibility for: planning and managing the Northern Territory public health system; setting Territory-wide policy and frameworks, and monitoring the performance of  health services. The Department will also continue to deliver a number of Territory‑wide services and provide corporate services for the whole public health system. * Other major initiatives in 2012-13 included: * improving performance against national targets for Emergency Departments and elective surgery waiting times * implementing Alcohol Mandatory Treatment (on 1 July 2013) * enhancing police watch house and prisoner health services * reviewing the Patient Assistance Travel Scheme (PATS) * commencing a scoping study for a Palmerston hospital * opening the New Alice Springs Hospital Emergency Department and Medical Imaging Department * enhancing cardiac and cardiac outreach services * commencing secure care services in Alice Springs. | **”** |
| **“** | **Australian Government comments**  Australia’s health system is world class, supporting universal and affordable access to high quality medical, pharmaceutical and hospital services, while helping people to stay healthy through health promotion and disease prevention activities.  Compared to similar countries, Australia has an efficient health system. The most recent Global Burden of Disease Study found that Australia achieves strong health outcomes with lower than average spending on health per capita.  Effective and efficient health policy takes into consideration the effects of an ageing population on demand for health care, increasing risks to the overall health of Australians through poor lifestyle choices and the impact of advancing technology and new drugs. Australia’s health system faces significant challenges from illness, poor health behaviours and health outcome disparities. About one-third of Australia’s burden of disease is due to ‘lifestyle’ health risks such as smoking, obesity, dietary risks, physical inactivity, and alcohol misuse. Significant gains have been made with lower smoking rates across the population. Obesity is being tackled through work to develop dietary guidelines and a front of pack labelling system to provide consumers with the information they need to make healthy eating choices.  Medicare provides all Australians with free treatment as a public patient in public hospitals. Over 80 per cent of general practitioner services are bulk billed at no cost to the patient. Medicare also provides subsidised access to specialists, optometrical services and certain allied health services. The Pharmaceutical Benefits Scheme (PBS) allows Australians to access medications at affordable prices. The PBS subsidises around 750 medicines available in more than 1970 forms.  Australia’s comprehensive immunisation program protects people against harmful diseases. Compared to most other countries, Australia provides a greater range of vaccines free to its citizens. In 2012-13, immunisation coverage for five year olds exceeded 90 per cent. | **”** |

## E.6 List of attachment tables

Attachment tables are identified in references throughout this appendix by an ‘EA’ prefix (for example, table EA.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

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## E.7 References

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1. There was a break in series due to differences in definitions of public hospital and public hospital services between 2002‑03 and 2003‑04. [↑](#footnote-ref-1)
2. The former National Health Performance Committee developed the National Health Performance Framework to guide the reporting and measurement of health service performance in Australia. The National Health Performance Framework was reviewed by the National Health Performance Committee and a revised framework was agreed by the National Health Information Standards and Statistics Committee in 2009. A number of groups involved in health performance indicator development have adopted this framework for use within specific project areas and in publications. [↑](#footnote-ref-2)