# 10 Primary and community health

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This chapter reports on the performance of primary and community health services which include general practice, pharmaceutical services, dentistry, allied health services, maternal and child health, alcohol and other drug treatment and other services. This chapter does not include:

* public hospital emergency departments and outpatient services (reported in chapter 12, ‘Public hospitals’)
* community mental health services (reported in chapter 13, ‘Mental health management’)
* Home and Community Care program services (reported in chapter 14, ‘Aged care’ and chapter 15, ‘Services for people with disability’).

All abbreviations used in this Report are available in a complete list in volume A: Approach to performance reporting.

## 10.1 Profile of primary and community health

### Roles and responsibilities

The primary and community health sector is the most frequently used part of Australia’s healthcare system. Primary and community healthcare services are delivered by a range of health and allied health professionals in various private, not‑for‑profit and government service settings. Definitions for common health terms are provided in section 10.4.

#### General practice

General practice is a major provider of primary healthcare in Australia. General Practice services include preventative care and the diagnosis and treatment of illness and injury, through direct service provision and/or referral to acute (hospital) or other healthcare services, as appropriate.

The Australian Government provides the majority of general practice income, through DHS Medicare — mainly as fee‑for‑service payments via the Medicare Benefits Schedule (MBS) — and the Department of Veterans Affairs (DVA). Additional Australian Government funding is provided to influence the supply, regional distribution and quality of general practice services, through initiatives such as the Practice Incentives Program (PIP) and Primary Health Networks (PHNs) (Australian Government DHS 2015). State and Territory governments also provide some funding for such programs, particularly in relation to regional distribution of general practices (to influence the availability of GPs in rural and remote areas). The remainder comes mainly from insurance schemes and patient contributions.

#### Pharmaceutical services

The Australian Government funded Pharmaceutical Benefits Scheme (PBS) aims to provide affordable, reliable and timely access to prescription medicines for all Australians. Around 80 per cent of prescription medicines are subsidised through the PBS (Department of Health 2010). Users make a co‑payment and the Australian Government pays the remaining cost of medicines eligible for the subsidy (Department of Health 2016). Co‑payments are subject to a safety net threshold.

The Repatriation Pharmaceutical Benefits Scheme (RPBS) provides subsidised pharmaceutical medicines, dressings and other items to war veterans and war widows. The RPBS is administered by the DVA.

#### Dental services

Australia has a mixed system of public and private dental healthcare. State and Territory governments have the main responsibility for funding and delivery of major public dental programs, with public dental services primarily available to children and disadvantaged adults. The private sector receives funding to provide some public dental services, from the Australian Government through the DVA and the Dental Benefits Schedule, and from State and Territory governments through dental voucher systems. The Australian Government also supports private dental services through the private health insurance rebate.

#### Allied health services

Allied health services include, but are not limited to, physiotherapy, psychology, occupational therapy, audiology, podiatry and osteopathy. They are delivered mainly in the private sector. Some government funding of private allied health services is provided through insurance schemes and the private health insurance rebate. The Australian Government makes some allied health services available under the MBS to patients with particular needs — for example, people with chronic conditions and complex care needs. Employment data for occupational therapists and psychologists working in the public sector are presented in table 10A.26.

#### Community health services

Community health services generally comprise multidisciplinary teams of health and allied health professionals and aim to protect the health of people who experience barriers that impede access to private sector primary and community health services. Governments (including local governments) provide services directly or indirectly through funding of service provision by a local health service or community organisation. There is no national strategy for community health services and there is considerable variation in the services provided across jurisdictions.

State and Territory governments are responsible for most community health services. Those serving Aboriginal and Torres Strait Islander communities are mainly the responsibility of the Australian Government (State and Territory governments provide some funding).

#### Maternal and child health

Maternal and child health services are funded by State and Territory governments. They provide services including: parenting support (including antenatal and postnatal programs); early childhood nursing programs; disease prevention programs (including childhood immunisations); and early intervention and treatment programs related to child development and health. Some jurisdictions also provide specialist programs through child health services, including hearing screening programs, and mothers and babies residential programs.

#### Alcohol and other drug treatment

Alcohol and other drug treatment activities range from a brief intervention to   
long‑term residential treatment. Types of treatment include detoxification, pharmacological treatment, counselling and rehabilitation.

### Funding

In 2014‑15, government recurrent expenditure on primary and community health services (excluding public health) was $29.9 billion, of which State, Territory and local governments provided 23.9 per cent and the Australian Government 76.1 per cent (table 10.1).

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| Table 10.1 Estimated funding on primary healthcare, 2014‑15 ($ million)**a, b** |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | Australian Government | | | | State, Territory and local government | Total government | Non‑ government | Total government and non‑ government | |  | DVA | Department of Health  and other | Premium rebates | Total | | Unreferred medical services | 840 | 8 376 | .. | 9 216 | .. | 9 216 | 1 814 | 11 031 | | Dental services | 96 | 788 | 681 | 1 565 | 713 | 2 279 | 7 285 | 9 564 | | Other health practitioners | 235 | 1 355 | 317 | 1 907 | 8 | 1 915 | 3 638 | 5 552 | | Community health and other | 1 | 1 242 | – | 1 243 | 6 419 | 7 662 | 469 | 8 131 | | Benefit‑paid medications | 363 | 7 899 | .. | 8 262 | .. | 8 262 | 1 513 | 9 775 | | All other medications | .. | 566 | 19 | 585 | .. | 585 | 9 459 | 10 044 | | **Total** | **1 535** | **20 226** | **1 017** | **22 778** | **7 140** | **29 919** | **24 178** | **54 097** | |  |  | |
| a See table 10A.1 for detailed footnotes and caveats. b Totals may not add due to rounding.  – Nil or rounded to zero. .. Not applicable. |
| *Source*: AIHW (Australian Institute of Health and Welfare) (2016), *Health Expenditure Australia 2014‑15*, Cat. no. HWE 67; table 10A.1. |
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#### General practice

Australian Government total expenditure on general practice in 2015‑16 was $8.7 billion, or $365 per person (table 10A.2), of which 93.4 per cent was fee‑for‑service expenditure through DHS Medicare and the DVA.

State and Territory governments contribute funding to general practice mainly through support programs such as assistance with housing and relocation, education programs and employment assistance for spouses and family members of doctors in rural areas. Non‑government sources also contribute through insurance schemes (such as, workers compensation and third party insurance) and private individuals.

#### Pharmaceutical services

Australian Government expenditure through the PBS and RPBS on prescription medicines filled at pharmacies was around $8.3 billion in 2015‑16 (tables 10A.3-4) – 96.2 per cent through the PBS. PBS expenditure per person was $332, representing a continued decrease from the 10-year peak in 2009‑10 (table 10A.3). The proportion of PBS expenditure that is concessional fell from 80.4 to 76.0 per cent in the period 2006‑07 to 2015‑16 (table 10A.3).

The Australian Government separately funds the supply of PBS medicines to Aboriginal and Torres Strait Islander primary healthcare services in remote and very remote areas. In 2015‑16, this was $27.9 million down from $30.1 million in 2014‑15 (table 10A.5).

#### Dental services

Australian Government expenditure on dental services was $1.6 billion in 2014‑15, of which 56.5 per cent was through DVA and the Department of Health, and 43.5 per cent through private health insurance premium rebates (tables 10.1 and 10A.1). State, Territory and local government expenditure on dental services was $713 million in 2014‑15. Dental expenditure data by State and Territory are provided in table 10A.6.

#### Community health services

In 2014‑15, government expenditure on community health services was $7.6 billion, of which State, Territory and local governments provided 83.8 per cent and the Australian Government 16.2 per cent (tables 10.1 and 10A.1). Australian Government expenditure on Aboriginal and Torres Strait Islander primary health care services was $603.4 million in 2015‑16 (table 10A.7).

### Size and scope

#### General practice

There were 34 605 GPs — 23 170 on a Full Service Equivalent (FSE) basis — billing Medicare Australia for around 153.5 million services, in 2015‑16 (Department of Health and DVA unpublished; see section 10.4 for a definition of FSE). This equated to 96.8 FSE GPs per 100 000 people delivering around 6416 services per 1000 population. Nationally, rates have increased from 2011‑12 to 2015‑16, for GP availability and services provided (figures 10.1 and 10.2).

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| Figure 10.1 Availability of GPs**a** |
| Figure 10.1 Availability of GPs  More details can be found within the text surrounding this image. |
| a See table 10A.8 for detailed footnotes and caveats. |
| *Source*: Department of Health (unpublished) MBS Statistics; table 10A.8. |
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| Figure 10.2 GP type service use**a** |
| |  | | --- | | Figure 10.2 GP type service use  More details can be found within the text surrounding this image. | |
| a See table 10A.9 for detailed footnotes and caveats. |
| *Source*: Department of Health (unpublished) MBS Statistics; DVA (unpublished) DVA data collection; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 10A.9. |
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#### Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Around 208 million services — 91.7 per cent of which were concessional — were provided under the PBS in 2015‑16, equating to 8.7 per person (tables 10A.10-11). A further 10.5 million services were provided under the RPBS in the same period.

#### Public dental services

Nationally, 97.8 per 1000 people accessed public dental services in 2013. Of these, around 23 per cent accessed emergency services (AIHW, unpublished).

#### Community health services

There is no national data collection for community health services other than Aboriginal and Torres Strait Islander primary health care services. In 2014-15, there were 203 Aboriginal and Torres Strait Islander primary healthcare services with 45.8 per cent located in remote or very remote areas (table 10A.14). Of the 3.5 million episodes of healthcare provided, 45.6 per cent were provided in remote or very remote areas (table 10A.14). Staffing numbers are reported in table 10A.17.

#### Alcohol and other drug treatment services

Data for a total of 843 alcohol and other drug treatment agencies were reported for 2014‑15, with 41.8 per cent identified as government providers (table 10A.12). There were 170 367 reported closed treatment episodes in 2014‑15 (table 10A.12) (see section 10.4 for a definition of a closed treatment episode).

## 10.2 Framework of performance indicators

The performance indicator framework is based on common objectives for primary and community health (box 10.1).

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| Box 10.1 Objectives for primary and community health |
| Primary and community health services aim to promote health and prevent illness, and to manage illness and injury effectively in the community, by providing universal access to primary healthcare that is:   * timely, affordable and accessible * appropriate and responsive to meet the needs of individuals throughout their lifespan and communities * high quality and safe * well co-ordinated to ensure continuity of care where more than one service type, and/or ongoing service provision is required * sustainable in terms of workforce, infrastructure, innovation and capacity to respond to emerging needs.   Governments aim for primary and community health services to meet these objectives in an equitable and efficient manner. |
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The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of primary and community health services (figure 10.3). The performance indicator framework shows which data are complete and comparable in the 2017 Report.

For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability, data completeness and information on data quality from a Report wide perspective.

In addition to section 10.1, the Report’s statistical context chapter (chapter 2) contains data that may assist in interpreting the performance indicators in this chapter.

Improvements to performance reporting for Primary and Community Health are ongoing and will include identifying indicators to fill gaps in reporting against key objectives, improving the comparability and completeness of data and reviewing proxy indicators to see if more direct measures can be developed.

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| Figure 10.3 Primary and community health performance indicator framework |
| Figure 10.3 Primary and community health performance indicator framework  More details can be found within the text surrounding this image. |
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## 10.3 Key performance indicator results

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

### Outputs

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

### Equity

#### Access — Availability of PBS medicines

‘Availability of PBS medicines’ is an indicator of governments’ objective to provide access to PBS medicines in an equitable manner (box 10.2).

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| Box 10.2 Availability of PBS medicines |
| ‘Availability of PBS medicines’ is defined by three measures:   * Access to PBS medicines by region, defined as the ABS census population divided by the number of approved providers of PBS medicines, by Pharmacy Access/Remoteness Index of Australia (PhARIA) area * PBS expenditure per person by region, defined as expenditure on PBS medicines, divided by the ABS estimated resident population (ERP), in urban and rural regions * Proportion of PBS prescriptions filled at a concessional rate, defined as the number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled.   Care should be taken in interpreting results. For all three measures, a low or decreasing proportion may indicate improved availability of PBS medicines/prescriptions filled. It is also important that there are not large discrepancies by region in these measures.  This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions for 2016 for the Access to PBS medicines by region measure and for 2015‑16 for the other two measures. |
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Across Australia in the period 2012 to 2016, the number of people per pharmacy decreased in urban areas (from 4082 to 3884) and rural areas (from 4148 to 3615) (table 10A.19). Taking into account the 19 medical practitioners and 162 Aboriginal and Torres Strait Islander primary health care services also approved to provide PBS medicines to the community in remote/very remote areas, there were 3065 people per PBS approved provider in rural areas in 2016 (figure 10.4 and table 10A.18). Nationally, PBS expenditure per person was highest in inner regional areas and lowest in remote/very remote areas (table 10A.20).

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| Figure 10.4 People per approved PBS provider, 2016**a, b** |
| |  | | --- | | Figure 10.4 People per approved PBS provider, 2016  More details can be found within the text surrounding this image. | |
| a See box 10.2 and table 10A.18 for detailed definitions, footnotes and caveats. b The ACT has no rural areas under the classification used. |
| *Source*: Department of Health (unpublished) derived from DHS Medicare, ABS (unpublished) *2011 Census of Population and Housing* and the University of Adelaide’s Australian Population and Migration Research Centre; table 10A.18. |
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#### Access — Equity of access to GPs

‘Equity of access to GPs’ is an indicator of governments’ objective to provide access to primary healthcare services in an equitable manner (box 10.3).

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| Box 10.3 Equity of access to GPs |
| Equity of access to GPs’ is defined by two measures:   * Availability of GPs by region, defined as the number of FSE GPs per 100 000 people, by region * Availability of GPs by sex, defined as the number of FSE GPs per 100 000 population, by sex.   High or increasing availability of GPs can indicate improved access to GP services. Low availability of GPs by region can be associated with an increase in distance travelled and waiting times to see a GP, and increased difficulty in booking long consultations. Reduced competition for patients can also reduce bulk billing rates.  High or increasing availability of GPs of each sex means it is more likely that patients who prefer to visit GPs of their own sex will have their preference met. Low availability of GPs of each sex can be associated with increased waiting times to see a GP, for patients who prefer to visit GPs of their own sex.  This indicator does not provide information on whether people are accessing GP services or whether the services are appropriate for the needs of the people receiving them.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time for both measures, but a break in time series means that data from 2012‑13 onwards are not comparable to data for the ‘Availability of GPs by region’ measure * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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In most jurisdictions in 2015‑16, there were more FSE GPs per 100 000 people available in major cities and inner regional areas than in outer regional, remote and very remote areas (figure 10.5). The bulk‑billed proportion of non‑referred attendances was higher in very remote areas than in major cities, where the proportion was in turn higher than in all other areas (table 10A.32).

In 2015‑16, 36.2 per cent of Australia’s FSE GPs were female (table 10A.22). There were 69.6 FSE female GPs per 100 000 females and 124.3 FSE male GPs per 100 000 males in 2015‑16 (figure 10.6).

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| Figure 10.5 Availability of GPs by region, 2015‑16**a, b** |
| |  | | --- | | Figure 10.5 Availability of GPs by region, 2015-16  More details can be found within the text surrounding this image. | |
| a See box 10.3 and table 10A.21 for detailed definitions, footnotes and caveats. b There are no major cities in Tasmania; no outer regional or remote areas in the ACT; no major cities or inner regional areas in the NT. Major cities and inner regional areas are combined for the ACT. |
| *Source*: Department of Health (unpublished) MBS Statistics; table 10A.21. |
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| Figure 10.6 Availability of GPs by sex, 2015‑16**a, b** |
| |  | | --- | | Figure 10.6 Availability of GPs by sex, 2015-16  More details can be found within the text surrounding this image. | |
| a See box 10.3 and tables 10A.22 and 10A.23 for detailed definitions, footnotes and caveats. b There are no major cities in Tasmania; no outer regional or remote areas in the ACT; no major cities or inner regional areas in the NT. Major cities and inner regional areas are combined for the ACT. |
| *Source*: Department of Health (unpublished) MBS Statistics; tables 10A.22 and 10A.23. |
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#### Access – Availability of public dentists

‘Availability of public dentists’ is an indicator of governments’ objective to provide access to dental services in an equitable manner (box 10.4).

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| Box 10.4 Availability of public dentists |
| ‘Availability of public dentists’ is defined as the number of full time equivalent (FTE) public dentists per 100 000 people by region, based on clinical hours worked in the public sector.  High or increasing availability of public dentists can indicate improved access to public dental services. The availability of public dentists by region may affect people’s access to public dental services, particularly in rural and remote areas. Low availability can result in increased travel distance to a dentist and increased waiting times to see a dentist.  This indicator does not provide information on whether people are accessing the service or whether the services are appropriate for the needs of the people receiving them.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data for 2014 are not comparable to data for 2013 and previous years * complete (subject to caveats) for the current reporting period. All required 2014 data are available for all jurisdictions. |
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Nationally in 2014, there were 6.6 FTE public dentists per 100 000 people (figure 10.7). Data for FTE dental hygienists and dental therapists are presented in table 10A.25.

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| Figure 10.7 Availability of public dentists, 2014**a, b** |
| |  | | --- | | Figure 10.7 Availability of public dentists, 2014  More details can be found within the text surrounding this image. | |
| a See box 10.4 and table 10A.24 for detailed definitions, footnotes and caveats. b There were no public dentists in remote or very remote areas in Victoria. Tasmania has no major cities. The ACT has no outer regional, remote or very remote areas. The NT has no major cities or inner regional areas. |
| *Source*: AIHW (unpublished) National Health Workforce Data Set; table 10A.24. |
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#### Access – Early detection and early treatment for Aboriginal and Torres Strait Islander Australians

‘Early detection and early treatment for Aboriginal and Torres Strait Islander Australians’ is an indicator of governments’ objective to provide access to primary and community healthcare in an equitable manner (box 10.5).

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| Box 10.5 Early detection and early treatment for Aboriginal and Torres Strait Islander Australians |
| Three measures of early detection and early treatment for Aboriginal and Torres Strait Islander Australians are reported:   * Proportion of older people who received a health assessment under DHS Medicare by Indigenous status * older people are defined as Aboriginal and Torres Strait Islander Australians aged 55 years or over and other Australians aged 75 years or over, excluding hospital inpatients and people living in aged care facilities * health assessments are MBS items that allow comprehensive examinations of patient health, including physical, psychological and social functioning * Proportion of older Aboriginal and Torres Strait Islander Australians who received a health assessment under DHS Medicare in successive years of a five‑year period * Proportion of Aboriginal and Torres Strait Islander Australians who received a health assessment or check under DHS Medicare by age group — health assessment/checks are available for Aboriginal and Torres Strait Islander children (0–14 years), adults (15–54 years) and older people (55 years or over).   A low or decreasing gap between the proportion of Aboriginal and Torres Strait Islander and other Australians who received a health assessment can indicate more equitable access to early detection and early treatment services for Aboriginal and Torres Strait Islander Australians. An increase over time in the proportion of older Aboriginal and Torres Strait Islander Australians who received a health assessment is desirable as it indicates improved access to these services. A low or decreasing gap between the proportion of Aboriginal and Torres Strait Islander Australians in different age groups who received a health assessment/check can indicate more equitable access to early detection and treatment services within the Aboriginal and Torres Strait Islander population.  This indicator provides no information about health assessments provided outside DHS Medicare (predominantly used by Aboriginal and Torres Strait Islander people in remote and very remote areas). Accordingly, this indicator understates the proportion of Aboriginal and Torres Strait Islander people who received early detection and early treatment services.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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Nationally in 2015‑16, the proportion of older people receiving a health assessment was 35.5 per cent for Aboriginal and Torres Strait Islander people and 31.9 per cent for other Australians (figure 10.8).

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| Figure 10.8 Older people who received a health assessment by Indigenous status, 2015‑16**a** |
| |  | | --- | | Figure 10.8 Older people who received a health assessment by Indigenous status, 2015-16  More details can be found within the text surrounding this image. | |
| a See box 10.5 and table 10A.27 for detailed definitions, footnotes and caveats. |
| *Source*: Derived from Department of Health (unpublished) MBS Statistics, ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; ABS (various years) *Australian demographic statistics*,Cat. no. 3101.0; table 10A.27. |
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Nationally, over the five years to 2015‑16, the proportion of older Aboriginal and Torres Strait Islander people who received an annual health assessment increased by 13.5 percentage points to 35.5 per cent, compared to an increase of 4.4 percentage points to 32 per cent for all older Australians (albeit from a lower base) (table 10A.27). Time series data for Aboriginal and Torres Strait Islander people are presented in table 10A.28 and for all Australians in table 10A.30.

The proportion of the eligible Aboriginal and Torres Strait Islander population who received a health assessment or check in 2015‑16 was highest for older people in all jurisdictions, and lowest for children aged 0–14 years in most jurisdictions (table 10A.29).

#### Access – Developmental health checks

‘Developmental health checks’ is an indicator of governments’ objective to provide access to early detection and intervention services for children in an equitable manner (box 10.6).

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| Box 10.6 Developmental health checks |
| ‘Developmental health checks’ is defined as the proportion of children who received a fourth year developmental health assessment under DHS Medicare, by health assessment type.  A high or increasing proportion of children receiving a fourth year developmental health assessment is desirable as it suggests improved access to these services.  The ‘Healthy Kids Check’ MBS health assessment item is available to all children aged 3 or 4 years, while the ‘Aboriginal and Torres Strait Islander Peoples Health Assessment’ item is available to Aboriginal and Torres Strait Islander people of all ages. The proportion of Aboriginal and Torres Strait Islander children aged 3 to 5 years who received the Aboriginal and Torres Strait Islander Peoples Health Assessment is reported as a proxy for the proportion of Aboriginal and Torres Strait Islander children who received a fourth year developmental health assessment. The proportion of other children who received either a Healthy Kids Check (at the age of 3 or 4 years), or a Health assessment at the age of 5 years, is reported as a proxy for the proportion of other children who received a fourth year developmental health assessment. Children are counted once only.  Fourth year developmental health assessments are intended to assess children’s physical health, general wellbeing and development. Early identification provides the opportunity for timely prevention and intervention measures that can ensure children are healthy, fit and ready to learn when they start schooling.  This indicator provides no information about developmental health checks for children that are provided outside DHS Medicare, as comparable data for such services are not available for all jurisdictions. Accordingly, this indicator understates the proportion of children who receive a fourth year developmental health check.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data from 2012‑13 onwards are not comparable to data for previous years * not available for the current reporting period. |
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Updated data were not available for the 2017 Report. The Healthy Kids Check service was removed from the MBS, effective from 1 November 2015. Historic data are reported in table 10A.31.

### Effectiveness

#### Access – Effectiveness of access to GPs

‘Effectiveness of access to GPs’ is an indicator of governments’ objective to provide timely, affordable and accessible primary healthcare services (box 10.7).

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| Box 10.7 Effectiveness of access to GPs |
| Four measures of effectiveness of access to GPs are reported:   * Bulk billing rates, defined as the proportion of non‑referred attendances by GPs and practice nurses that were bulk billed. * People deferring visits to GPs due to cost, defined as the proportion of people who delayed seeing or did not see a GP at any time in the previous 12 months due to cost. * GP waiting times, defined as the proportion of people who, in the previous 12 months, saw a GP for urgent medical care within specified times from making the appointment. Specified waiting time categories are: less than 4 hours; 4 to less than 24 hours; 24 hours or more. * Potentially avoidable presentations to emergency departments (interim measure), defined as the number of selected ‘GP‑type presentations’ to emergency departments, where selected GP‑type presentations are emergency presentations: * allocated to triage category 4 (semi‑urgent) or 5 (non‑urgent) * not arriving by ambulance, with police or corrections * not admitted or referred to another hospital * who did not die.   For the first three measures above:   * A high or increasing bulk billing rate can indicate more affordable access to GP services. This measure does not provide information on whether the services are appropriate for the needs of the people receiving them. * A low or decreasing proportion of people deferring visits to GPs due to financial barriers indicates more widely affordable access to GPs. * A high or increasing proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs.   Data reported for these three measures are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions.   The Patient Experience Survey does not include people living in discrete Indigenous communities, which affects the comparability of the NT results for the measures people deferring visits to GPs due to financial barriers and GP waiting times.  Potentially avoidable presentations to emergency departments (fourth measure) are presentations for conditions that could be appropriately managed in the primary and community health sector. In some cases, this can be determined only retrospectively and presentation to an emergency department is appropriate. A low or decreasing proportion of potentially avoidable presentations to emergency departments can indicate better access to primary and community health care.  Data reported for this measure are:   * comparable (subject to caveats) within some jurisdictions over time but not comparable within other jurisdictions over time or across jurisdictions (see caveats in attachment tables for specific jurisdictions) * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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##### Effectiveness of access to GPs — bulk billing rates

Where bulk billing is used, patients incur no out‑of‑pocket expense and, for most GP services, the GP receives the full Schedule fee from DHS Medicare. Nationally in 2015‑16, 85.4 per cent of non‑referred attendances were bulk billed, with the proportion highest in very remote areas and lowest in inner regional, outer regional and remote areas (table 10A.32). Non‑referred attendances for children under 16 years and older people were bulk billed at higher rates than people aged 16 to 64 years in 2015‑16 (table 10A.33) For most states and territories, the proportion increased from 2011‑12 to 2015‑16 (figure 10.9).

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| Figure 10.9 GP visits that were bulk billed**a** |
| |  | | --- | | Figure 10.9 GP visits that were bulk billed  More details can be found within the text surrounding this image. | |
| a See box 10.7 and table 10A.33 for detailed definitions, footnotes and caveats. |
| *Source*: Department of Health (unpublished) MBS Statistics; table 10A.33. |
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##### Effectiveness of access to GPs — people deferring visits to GPs due to financial barriers

Nationally in 2015‑16, 4.1 per cent of the population reported that they delayed or did not visit a GP in the previous 12 months because of cost (figure 10.10). Data for Aboriginal and Torres Strait Islander Australians are sourced from a different data collection to the data for the general population and are not directly comparable (table 10A.35).

| Figure 10.10 People deferring visits to GPs due to cost**a, b** |
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| | Figure 10.10 People deferring visits to GPs due to cost  More details can be found within the text surrounding this image. | | --- | |
| a See box 10.7 and table 10A.34 for detailed definitions, footnotes and caveats. b Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) Patient Experience Survey (various years), Cat. no. 4839.0; table 10A.34. |
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##### Effectiveness of access to GPs — GP waiting times

Nationally in 2015‑16, for people who saw a GP for urgent care:

* 63.6 per cent waited less than 4 hours
* 11.9 per cent waited from 4 to less than 24 hours
* 24.5 per cent waited for 24 hours or more (table 10A.36).

Overall, 18.9 per cent of people who saw a GP for any reason waited longer than they felt was acceptable to get an appointment (table 10A.37).

##### Effectiveness of access to GPs — GP‑type presentations to emergency departments

Factors contributing to GP‑type presentations at emergency departments include perceived or actual lack of access to GP services, the proximity of emergency departments and trust in emergency department staff. Nationally, there were around 2.8 million GP‑type presentations to public hospital emergency departments in 2015‑16 (table 10A.38).

#### Access – Financial barriers to PBS medicines

‘Financial barriers to PBS medicines’ is an indicator of governments’ objective to ensure access to prescribed medicines is affordable and accessible (box 10.8).

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| Box 10.8 Financial barriers to PBS medicines |
| ‘Financial barriers to PBS medicines’ is defined as the proportion of people who delayed getting or did not get a prescription filled at any time in the previous 12 months due to cost.  A low or decreasing proportion of people deferring treatment due to financial barriers indicates more widely affordable access to medications.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions.   The PExS does not include people living in discrete Aboriginal and Torres Strait Islander communities, which affects the comparability of the NT results. Data for Aboriginal and Torres Strait Islander Australians are sourced from a different data collection to the data for the general population and are not directly comparable. |
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Nationally in 2015‑16, 7.6 per cent of respondents delayed or did not purchase prescribed medicines due to cost in the previous 12 month period (figure 10.11). Data for Aboriginal and Torres Strait Islander Australians are presented in table 10A.40. These data are sourced from a different data collection to the data for the general population and are not directly comparable.

| Figure 10.11 People deferring buying prescribed medicines due to cost**a, b** |
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| | Figure 10.11 People deferring buying prescribed medicines due to cost  More details can be found within the text surrounding this image. | | --- | |
| a See box 10.8 and table 10A.39 for detailed definitions, footnotes and caveats. b Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) Patient Experience Survey (various years), Cat. no. 4839.0; table 10A.39. |
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#### Access – Public dentistry waiting times

‘Public dentistry waiting times’ is an indicator of governments’ objective to ensure timely access to public dental services for eligible people (box 10.9).

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| Box 10.9 Public dentistry waiting times |
| ‘Public dentistry waiting times’ is defined as the median time waited between being placed on  a public dentistry waiting list and receiving dental care (or, if data not available, being offered dental care).  A shorter median time waited to see a dental professional indicates more timely access to public dental services.  Data reported for this indicator are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * incomplete for the current reporting period. All required 2015‑16 data were not available for NSW and the NT. |
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Data for the median time waited by people on a public dental waiting list are presented for states and territories in tables 10A.41–48.

#### Appropriateness – Chronic disease management

‘Chronic disease management’ is an indicator of governments’ objective to ensure that management of chronic disease is appropriate and responsive to individual needs (box 10.10).

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| Box 10.10 Chronic disease management |
| ‘Chronic disease management’ is defined by three measures:   * Management of diabetes — PIP diabetes incentive, defined as the proportion of general practices enrolled in the PIP that are registered for the PIP diabetes incentive * Management of diabetes — HbA1c, defined as the proportion of people with diabetes with HbA1c (glycosolated haemoglobin) below 7 per cent (the number of people with diabetes with HbA1c below 7 per cent, divided by the estimated number of people with diabetes) * Management of asthma, defined as the proportion of people with asthma who have a written asthma action plan   A high or increasing proportion for each measure is desirable.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions for: management of diabetes — PIP diabetes incentive (2016); management of diabetes — HbA1c (2011‑12); and, management of asthma (2014‑15).   The total and non‑Indigenous components of the Australian Health Survey 2011–13 did not include people living in discrete Aboriginal and Torres Strait Islander communities or very remote areas, which affects the comparability of the NT results for the measures management of diabetes — HbA1c and management of asthma. |
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##### Chronic disease management — diabetes

Type 2 diabetes is the most common form of diabetes and is largely preventable. The PIP diabetes incentive provides incentives to eligible practices to improve management of patients with diabetes. In order to register for the PIP Diabetes incentive, general practices are required to maintain an active patient register and recall and reminder system for all known patients with diabetes mellitus, and to agree to implement an annual cycle of care for patients with diabetes mellitus. The annual cycle of care is generally based on the RACGP’s clinical guidelines for the management of Type 2 diabetes in general practice, which represent the minimum required level of care.

Nationally, the proportion of PIP practices registered for the PIP diabetes incentive increased from 51.5 per cent in May 2015 to 55.8 per cent in May 2016, with similar increases in all states and territories (figure 10.12).

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| Figure 10.12 PIP practices registered for the PIP diabetes incentive**a** |
| |  | | --- | | Figure 10.12 PIP practices registered for the PIP diabetes incentive  More details can be found within the text surrounding this image. | |
| a See box 10.10 and table 10A.53 for detailed definitions, footnotes and caveats. |
| *Source*: Department of Health (unpublished) MBS and PIP data collections; table 10A.53. |
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| HbA1c provides a measure of the average blood glucose level for the preceding three months. A HbA1c level at or below 7 per cent indicates appropriate management. Nationally, 77.5 per cent of people with known diabetes in 2011‑12 had a HbA1c test in the previous 12 months (table 10A.54) and 50.5 per cent of people with known diabetes had a HbA1c level at or below 7 per cent (figure 10.13). |

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| Figure 10.13 People with known diabetes with HbA1c level 7 per cent or less, 2011‑12**a, b** |
| |  | | --- | | Figure 10.13 People with known diabetes with HbA1c level 7 per cent or less, 2011-12  More details can be found within the text surrounding this image. | |
| a See box 10.10 and table 10A.55 for detailed definitions, footnotes and caveats. b Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) Australian Health Survey, 2011–13 (2011‑12 National Health Measures Survey component), Cat. No. 4364.0; table 10A.55. |
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##### Chronic disease management — asthma

Written asthma action plans enable people with asthma to recognise and respond quickly and appropriately to deteriorating asthma symptoms, thereby preventing or reducing the severity of acute asthma episodes (ACAM 2008).

Nationally, the age standardised proportion of people with asthma reporting that they have a written asthma action plan was 28.4 per cent for people of all ages in 2014‑15, compared to 22.9 per cent in 2004‑05 (figure 10.14). In all jurisdictions, the proportion was higher for children aged 0–14 years than for other age groups (table 10A.56).

Nationally in 2011-13, the proportion of Aboriginal and Torres Strait Islander people with asthma reporting that they have a written asthma action plan was 29.4 per cent for people of all ages and 50.9 per cent for children aged 0–14 years (table 10A.57). Data for people of all ages are reported by Indigenous status for 2004‑05 and 2011–13 in table 10A.58.

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| Figure 10.14 People with asthma who have a written asthma action plan**a, b, c** |
| |  | | --- | | Figure 10.14 People with asthma who have a written asthma action plan  More details can be found within the text surrounding this image. | |
| a See box 10.10 and table 10A.56 for detailed definitions, footnotes and caveats. b NT data not published for 2004-05. c Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) Australian Health Survey, 2011–2013 (2011‑12 NHS component)*,* Cat. No. 4364.0; ABS (unpublished) National Health Survey, 2014-15, 2007‑08, 2004‑05, Cat. No. 4364.0; table 10A.56. |
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#### Appropriateness ‑ Use of pathology tests and diagnostic imaging

‘Use of pathology tests and diagnostic imaging’ is an indicator of governments’ objective to ensure that primary healthcare services are appropriate (box 10.11).

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| Box 10.11 Use of pathology tests and diagnostic imaging |
| ‘Use of pathology tests and diagnostic imaging’ is defined by four measures:   * MBS items rebated through DHS Medicare for pathology tests requested by vocationally registered GPs and OMPs, per person * Diagnostic imaging services provided on referral from vocationally registered GPs and OMPs and rebated through DHS Medicare, per person * DHS Medicare benefits paid per person for pathology tests * DHS Medicare benefits paid per person for diagnostic imaging. |
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| Box 10.11 (continued) |
| This indicator needs to be interpreted with care as appropriate levels of use of pathology tests and diagnostic imaging cannot be determined. A high or increasing level of use can reflect overreliance on tools to support the diagnostic process. A low or decreasing level of use can contribute to misdiagnosis of disease and to relatively poor treatment decisions. Pathology tests and diagnostic imaging are important tools used by GPs in the diagnosis of many diseases, and in monitoring response to treatment. Pathology and diagnostic imaging services performed at the request of vocationally registered GPs and OMPs and rebated through DHS Medicare is used as a proxy in reporting against this indicator.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012‑13 onwards are not comparable to data for previous years * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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Available data from DHS Medicare reflect only those services provided and rebated. For example, rebates are provided for a maximum of three MBS pathology items — any additional pathology tests are excluded from the data because rebates are not provided.

Nationally in 2015‑16:

* there were 92.4 million rebated MBS items for pathology tests requested by GPs and eligible nurse practitioners, costing $1.7 billion (table 10A.60). This translated to 3.9 MBS items per person at a cost of $70 per person (table 10A.60 and figure 10.15)
* there were 15.2 million rebated MBS items for diagnostic imaging performed on referral from GPs and eligible nurse practitioners, costing $1.8 billion (table 10A.61). This translated to 0.7 MBS items per person at a cost of around $74 per person (table 10A.61 and figure 10.15).

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| Figure 10.15 Benefits paid for GP‑referred pathology tests and diagnostic imaging rebated through DHS Medicare**a** |
| |  | | --- | | Figure 10.15 Benefits paid for GP-referred pathology tests and diagnostic imaging rebated through DHS Medicare, Pathology tests  More details can be found within the text surrounding this image.Figure 10.15 Benefits paid for GP-referred pathology tests and diagnostic imaging rebated through DHS Medicare, Diagnostic imaging  More details can be found within the text surrounding this image. | |
| a See box 10A.11 and tables 10A.60-61 for detailed definitions, footnotes and caveats. |
| *Source*: Department of Health (unpublished) MBS and DVA data collections; tables 10A.60-61 |
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#### Quality — Safety — GPs with vocational registration

‘GPs with vocational registration’ is an indicator of governments’ objective to ensure the GP workforce has the capability to deliver high quality and safe services (box 10.12).

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| Box 10.12 GPs with vocational registration |
| ‘GPs with vocational registration’ is defined as the proportion of FSE GPs with vocational registration. Vocationally registered GPs are considered to have the values, skills and knowledge necessary for competent unsupervised general practice within Australia (RACGP 2014).  A high or increasing proportion of FSE GPs with vocational registration can indicate an improvement in the capability of the GP workforce to deliver high quality services. Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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Nationally in 2015-16, the proportion of FSE GPs with vocational registration was 80.1 per cent, with the proportion highest in major cities and lowest in outer regional and remote areas (table 10A.49). From 2013-14 to 2015-16, the proportion decreased from 82.5 to 80.1 per cent (figure 10.16).

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| Figure 10.16 FSE GPs with vocational registration**a** |
| |  | | --- | | Figure 10.16 FSE GPs with vocational registration  More details can be found within the text surrounding this image. | |
| a See box 10.12 and table 10A.50 for detailed definitions, footnotes and caveats. |
| *Source*: Department of Health (unpublished) MBS Statistics; table 10A.50. |
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#### General practices with accreditation

‘General practices with accreditation’ is an indicator of governments’ objective to ensure the GP workforce has the capability to provide high quality and safe services (box 10.13).

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| Box 10.13 General practices with accreditation |
| ‘General practices with accreditation’ is defined as the proportion of general practices in Australia that are accredited. Accreditation is a voluntary process of independent third‑party peer review that assesses general practices against a set of standards developed by the RACGP.  A high or increasing proportion of practices with accreditation can indicate an improvement in the capability of general practice to deliver high quality services. However, general practices without accreditation may deliver services of equally high quality. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * not available for the current reporting period as data for the number of general practices are not available. |
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Data for the number of accredited practices and the available historical data for the proportion of practices with accreditation are reported in table 10A.51.

The proportion of patients attending PIP practices (proxy for accredited practices) provides useful additional information relating to accreditation. Nationally, the proportion of general practice patient care provided by PIP practices has increased slightly in all jurisdictions from 2010‑11 to 2014‑15 (table 10A.52).

#### Electronic health information systems

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| Box 10.14 Electronic health information systems |
| ‘Electronic health information systems’ is defined as the proportion of general practices enrolled in the PIP that are registered for the PIP eHealth incentive.  A high or increasing proportion can indicate that patient health information at the point of care and coordination of care across multiple providers and services are desirable or are improved, minimising the likelihood of patient harm due to information gaps.  The PIP does not include all practices in Australia. PIP practices provided around 84.6 per cent of general practice patient care in 2014‑15 (Department of Health unpublished; table 10A.52).  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2016 data are available for all jurisdictions. |
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‘Electronic health information systems’ is an indicator of governments’ objective that primary and community health services are high quality and safe (box 10.14).

The PIP eHealth Incentive aims to encourage general practices to keep up to date with the latest developments in electronic health information systems. Current eligibility requirements require practices to:

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

Nationally, the proportion of PIP practices using electronic health systems was 91.0 per cent in May 2016 (figure 10.17). The proportion of PIP practices using electronic health systems increased in all areas between May 2013 and May 2016, remaining lower in remote and very remote areas than in other areas (table 10A.63).

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| Figure 10.17 PIP practices using electronic health systems**a** |
| |  | | --- | | Figure 10.17 PIP practices using electronic health systems  More details can be found within the text surrounding this image. | |
| a See box 10.14 and table 10A.62 for detailed definitions, footnotes and caveats. |
| *Source*: Department of Health (unpublished) MBS and PIP data collections; table 10A.62. |
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#### Quality — Responsiveness — Patient satisfaction

‘Patient satisfaction’ is an indicator of governments’ objective that primary and community health services are high quality and account for individual patient needs (box 10.15).

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| Box 10.15 Patient satisfaction |
| ‘Patient satisfaction’ is defined as the quality of care as perceived by the patient. It is measured as patient experience of aspects of care that are key factors in patient outcomes and can be readily modified. Two measures of patient experience of communication with health professionals — a key aspect of care — are reported:   * the proportion of people who saw a GP in the previous 12 months where the GP always or often: listened carefully to them; showed respect; and spent enough time with them * the proportion of people who saw a dental professional in the previous 12 months where the dental professional always or often: listened carefully to them; showed respect; and spent enough time with them.   High or increasing proportions can indicate improved satisfaction with communication with health professionals. Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions.   The PExS does not include people living in discrete Aboriginal and Torres Strait Islander communities, which affects the comparability of the NT results. |
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Nationally in 2015‑16, the majority of respondents reported that the GP always or often:

* listened carefully to them (91.6 per cent)
* showed respect (94.0 per cent)
* spent enough time with them (90.3 per cent) (figure 10.18).

Data for Aboriginal and Torres Strait Islander Australians are not comparable to the data presented here (table 10A.66).

Nationally in 2015‑16, the majority of respondents reported that dentists always or often:

* listened carefully to them (95.5 per cent)
* showed respect (96.3 per cent)
* spent enough time with them (96.6 per cent) (figure 10.19).

Data for both measures are presented by remoteness area in tables 10A.67‑68.

| Figure 10.18 People whose GP always or often listened carefully, showed respect, spent enough time, 2015‑16**a, b** |
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| | Figure 10.18 People whose GP always or often listened carefully, showed respect, spent enough time, 2015-16  More details can be found within the text surrounding this image. | | --- | |
| a See box 10.15 and tables 10A.64‑65 for detailed definitions, footnotes and caveats. b Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) Patient Experience Survey 2015‑16, Cat. no. 4839.0; tables 10A.64‑65 |
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| Figure 10.19 People whose dental professional always or often listened carefully, showed respect, spent enough time, 2015‑16**a, b** |
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| | Figure 10.19 People whose dental professional always or often listened carefully, showed respect, spent enough time, 2015-16  More details can be found within the text surrounding this image. | | --- | |
| a See box 10.15 and tables 10A.67‑68 for detailed definitions, footnotes and caveats. b Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) Patient Experience Survey 2015‑16, Cat. no. 4839.0; tables 10A.67‑68. |
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#### Quality — continuity — Continuity of chronic disease management

Continuity of chronic disease management is an indicator of government’s objective that services are well co-ordinated to ensure continuity of care where more than one service type, and/or ongoing service provision is required (box 10.16).

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| Box 10.16 Continuity of chronic disease management |
| Continuity of chronic disease management is defined as the proportion of GPs who used the MBS chronic disease management items for care planning or case conferencing at least once during a 12 month period.  A high or increasing proportion of GPs who use chronic disease management items is desirable.  Chronic disease management items in the MBS allow for the preparation and regular review of care plans for individuals with complex, multidisciplinary care needs due to chronic or terminal medical conditions, through GP managed or multidisciplinary team based care. Individual compliance with management measures is also a critical determinant of the occurrence and severity of complications for patients with chronic disease.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions up to 2015-16. |
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Nationally, the proportion of GPs who used chronic disease management MBS items for care planning or case conferencing remained steady over the five years to 2015‑16   
(97.2 per cent in 2015‑16) (table 10A.59).

### Efficiency

#### Sustainability

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

#### Cost to government of general practice per person

‘Cost to government of general practice per person’ is an indicator of governments’ objective to provide primary healthcare services in an efficient manner (box 10.17).

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| Box 10.17 Cost to government of general practice per person |
| ‘Cost to government of general practice per person’ is defined as the cost to government of general practice per person in the population.  This indicator needs to be interpreted with care. A low or decreasing cost per person can indicate higher efficiency, provided services are equally or more effective. It can also reflect service substitution between primary healthcare and hospital or specialist services — potentially at greater expense.  Cost to government of general practice does not capture costs of salaried GP service delivery models, used particularly in rural and remote areas, where primary healthcare services are provided by salaried GPs in community health settings, through emergency departments, and Aboriginal and Torres Strait Islander primary healthcare services. So, costs are understated for jurisdictions where a large proportion of the population live in rural and remote areas.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012‑13 onwards are not comparable to data for previous years * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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Nationally in 2015-16, total expenditure on general practice was $8.7 billion, translating to a rate of $365 per person (figure 10.20).

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| Figure 10.20 Australian Government fee‑for‑service expenditure per person on GPs (2015‑16 dollars)**a** |
| |  | | --- | | Figure 10.20 Australian Government fee-for-service expenditure per person on GPS in 2015-16 dollars  More details can be found within the text surrounding this image. | |
| a See box 10A.17 and table 10A.2 for detailed definitions, footnotes and caveats. |
| *Source*: Department of Health (unpublished) MBS Statistics; DVA (unpublished), DVA data collection; table 10A.2. |
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### Outcomes

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

#### Child immunisation coverage

‘Child immunisation coverage’ is an indicator of governments’ objective to prevent illness (box 10.18).

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| Box 10.18 Child immunisation coverage |
| ‘Child immunisation coverage’ is defined by three measures:   * the proportion of children aged 12 months to less than 15 months who are fully immunised (at this age, immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis b, *Haemophilus influenzae* type b and pneumococcal) * the proportion of children aged 24 months to less than 27 months who are fully immunised (at this age, against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B, measles, mumps and rubella and meningococcal C and varicella [chickenpox]) * the proportion of children aged 60 months to less than 63 months who are fully immunised (at this age, against diphtheria, tetanus, whooping cough, polio, and measles, mumps and rubella).   A high or increasing proportion of children who are fully immunised indicates a reduction in the risk of children contracting a range of vaccine preventable diseases.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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The proportion of children fully immunised in 2015-16 was:

* For children aged 12 to less than 15 months, 93.0 per cent
* For children aged 24 to less than 27 months, 90.7 per cent
* For children aged 60 to less than 63 months, 92.9 per cent (figure 10.21).

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| Figure 10.21 Children who were fully immunised, by age (months)  2015‑16**a** |
| |  | | --- | | Figure 10.21 Children who were fully immunised, by age in months, 2015-16  More details can be found within the text surrounding this image. | |
| a See box 10.18 and tables 10A.70–72 for detailed definitions, footnotes and caveats. |
| *Source*: Department of Health (unpublished) ACIR data collection; tables 10A.70–72. |
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#### Notifications of selected childhood diseases

‘Notifications of selected childhood diseases’ is an indicator of governments’ objective to manage illness (box 10.19).

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| Box 10.19 Notifications of selected childhood diseases |
| Notifications of selected childhood diseases’ is defined as the number of notifications of measles, pertussis and invasive *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System (NNDSS) by State and Territory health authorities for children aged 0–14 years, per 100 000 children in that age group.  A low or reducing notification rate for the selected diseases indicates that the immunisation program is more effective.  Measles, pertussis (whooping cough) and invasive *Haemophilus influenzae* type b are nationally notifiable vaccine preventable diseases, and notification to the relevant State or Territory authority is required on diagnosis.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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Nationally in 2015‑16, the rate of notifications for children aged 0–14 years was:

* 0.2 per 100 000 for *Haemophilus influenzae* type b (table 10A.75)
* 0.5 per 100 000 for measles (table 10A.73)
* 288.4 per 100 000 for pertussis (whooping cough) (figure 10.22 and table 10A.74).

Historical data for ten years of reporting are in tables 10A.73–75.

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| Figure 10.22 Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years**a** |
| |  | | --- | | Figure 10.22 Notifications of pertussis (whooping cough) per 100 000 children aged 0-14 years  More details can be found within the text surrounding this image. | |
| a See box 10.19 and table 10A.74 for detailed definitions, footnotes and caveats. |
| *Source*: Department of Health (unpublished) NNDSS, ABS (various years) Population by Age and Sex, Australian States and Territories, Cat. no. 3201.0; table 10A.74. |
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#### Participation for women in breast cancer screening

‘Participation for women in breast cancer screening’ is an indicator of governments’ objective to prevent illness through the provision of early detection services (box 10.20).

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| Box 10.20 Participation for women in breast cancer screening |
| Participation for women in breast cancer screening’ is defined as the number of women aged 50–74 years who are screened in the BreastScreen Australia Program over a 24 month period, divided by the estimated population of women aged 50–74 years and reported as a rate.  A high or increasing participation rate is desirable.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time. A break in series with the change of target age group from 50-69 years to 50-74 years means that data from 2014–2015 onwards are not comparable to earlier time periods * complete (subject to caveats) for the current reporting period. All required data for the 24‑month period 2014–2015 are available for all jurisdictions. |
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The national age standardised participation rate for women aged 50–74 years for the 24 month reference period 2014–2015 was 53.2 per cent (figure 10.23).

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| Figure 10.23 Participation in BreastScreen Australia screening programs — women aged 50–74 years 2014-2015 (24 month period)**a** |
| |  | | --- | | Figure 10.23 Participation in BreastScreen Australia screening programs, women aged 50-74 years, for the 24 month period covering 2014-2015  More details can be found within the text surrounding this image. | |
| a See box 10.20 and table 10A.76 for detailed definitions, footnotes and caveats. |
| *Source*: State and Territory governments (unpublished); ABS (various years) Population by Age and Sex, Australian States and Territories, Cat. no. 3201.0; table 10A.76. |
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Aboriginal and Torres Strait Islander women, women from non‑English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas can experience particular language, cultural and geographic barriers to accessing breast cancer screening. Participation rates for community groups at or close to those for the total population indicate equitable access to early detection services. Data are not directly comparable within or across community groups as Indigenous and NESB status identification in administrative records varies.

For the 24‑month period 2014–2015, the participation rate for women aged 50–74 years was 37.1 per cent for Aboriginal and Torres Strait Islander women and 49.1 per cent for NESB women (tables 10A.77-78). State and Territory data by remoteness area showed that participation rates were highest in outer regional areas (58.2 per cent) and the major cities (56.6 per cent) (table 10A.79).

#### Participation for women in cervical screening

‘Participation for women in cervical screening’ is an indicator of governments’ objective to prevent illness through the provision of early detection services (box 10.21).

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| Box 10.21 Participation for women in cervical screening |
| ‘Participation for women in cervical screening’ is defined as the proportion of the estimated eligible population of women aged 20–69 years who are screened over a 24 month period, reported as a rate. Eligible women are those who have not had a hysterectomy.  A high or increasing proportion of eligible women aged 20–69 years who have been screened is desirable.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required data for the 24‑month period 2014–2015 are available for all jurisdictions. |
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For the 24 month period 2014–2015, the national age‑standardised participation rate for women aged 20–69 years in cervical screening was 56.9 per cent, a slight decrease from 57.3 per cent for the 24‑month period 2010–2011 (figure 10.24). Data are presented for a ten year time series in table 10A.80.

Nationally in 2012‑13, the age standardised proportion of Aboriginal and Torres Strait Islander women aged 20–69 years responding to the National Aboriginal and Torres Strait Islander Health survey who reported having a Pap smear at least every 2 years was 53.4 per cent (table 10A.81).

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| Figure 10.24 Participation rate for women aged 20–69 years in cervical screening (24 month period)**a** |
| |  | | --- | | Figure 10.24 Participation rate for women aged 20-69 years in cervical cancer screening, by 24 month period  More details can be found within the text surrounding this image. | |
| a See box 10.21 and table 10A.80 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (unpublished) State and Territory Cervical Cytology Registry data collections; table 10A.80. |
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#### Influenza vaccination coverage for older people

‘Influenza vaccination coverage for older people’ is an indicator of governments’ objective to prevent illness (box 10.22).

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| Box 10.22 Influenza vaccination coverage for older people |
| ‘Influenza vaccination coverage for older people’ is defined as the proportion of people aged 65 years or over who have been vaccinated against seasonal influenza.  A high or increasing proportion of older people vaccinated against influenza is desirable.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * not available for the current reporting period. |
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Updated data were not available for the general population for the 2017 Report — historical data are presented in table 10A.82. Nationally in 2012‑13, an estimated 25.3 per cent Aboriginal and Torres Strait Islander aged 50 years or over were fully vaccinated against influenza and pneumococcal disease (table 10A.83).

#### Selected potentially preventable hospitalisations

‘Selected potentially preventable hospitalisations’ is an indicator of governments’ objective to prevent and to manage illness and injury effectively in the community (box  10.23).

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| Box 10.23 Selected potentially preventable hospitalisations |
| ‘Selected potentially preventable hospitalisations’ is defined as hospital admissions that may be avoided by effective management of illness and injury in the primary and community healthcare sector or, in some cases, by preventing illness and injury altogether. Three measures of selected potentially preventable hospitalisations are reported by jurisdiction of residence:   * Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions * Potentially preventable hospitalisations for diabetes * Potentially preventable hospitalisations of older people for falls.   Low or decreasing separation rates for selected potentially preventable hospitalisations can indicate more effective management of selected conditions in the primary and community healthcare sector and/or more effective preventative programs. Factors outside the control of the primary and community healthcare sector also influence hospitalisation rates for these conditions. For example, the underlying prevalence of conditions, patient compliance with management and older people’s access to aged care services and other support.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time, except for the diabetes measure * complete (subject to caveats) for the current reporting period except for the diabetes measure for which data are not published for Tasmania, the ACT and the NT. All other required 2014‑15 data are available for other jurisdictions. |
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##### Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions

Nationally, the age‑standardised hospital separation rate for the selected vaccine preventable, acute and chronic conditions was 25.2 per 1000 people in 2014‑15 (table 10.2). Of these, 48.4 per cent were for acute and 45.2 per cent for chronic conditions (table 10A.84).

The age‑standardised hospital separation rate was higher for Aboriginal and Torres Strait Islander Australians than for other Australians in all jurisdictions for the five years 2010‑11 to 2014‑15 and, for the three previous years, in all jurisdictions for which Indigenous status data are of sufficient quality for statistical reporting purposes (table 10A.85).

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| Table 10.2 Separations for selected potentially preventable hospitalisations per 1000 people, 2014‑15 (ASR)**a** |
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| a See box 10.23 and table 10A.84 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (unpublished) Admitted patient care 2014–15: Australian hospital statistics; table 10A.84. |
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##### Potentially preventable hospitalisations for diabetes

Nationally in 2014‑15, the age standardised hospital separation rate for Type 2 diabetes mellitus as principal diagnosis was 111.2 separations per 100 000 people (table 10A.92). Of these, 27.3 per cent were same day separations (table 10A.93). The age standardised separation rate for diabetes (excluding separations for diabetes complications as an additional diagnosis) for Aboriginal and Torres Strait Islander people was almost four times the rate for all Australians (table 10A.91).

The three complications of Type 2 diabetes most commonly leading to hospitalisation in 2014‑15 were circulatory ophthalmic, and renal complications. Across almost all jurisdictions for which data are published, the highest age standardised hospital separation rates were for circulatory complications (table 10A.92). Serious circulatory complications of diabetes can necessitate lower limb amputation. In 2014‑15, there were 17.2 age standardised hospital separations per 100 000 people for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (table 10A.94).

##### Potentially preventable hospitalisations of older people for falls

The age standardised rate of hospital separations for older people with a reported external cause of falls per 1000 older people increased from 54.0 in 2010‑11 to 60.5 in 2014‑15 (figure 10.25).

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| Figure 10.25 Separations for older people with a reported external cause of falls (ASR)**a, b** |
| |  | | --- | | Figure 10.25 Separations for older people with a reported external cause of falls, age standardised rate  More details can be found within the text surrounding this image. | |
| a See box 10.23 and table 10A.95 for detailed definitions, footnotes and caveats. b Data for the NT are not available for 2010-11 and are not included in the Australian total. |
| *Source*: AIHW (unpublished) National Hospital Morbidity Database; table 10A.95. |
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## 10.4 Definitions of key terms

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| Age standardised | Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age‑specific rates for each jurisdiction by the national age distribution. |
| Annual cycle of care for people with diabetes mellitus within general practice | The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice. based on RACGP guidelines.  MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines. |
| Asthma Action Plan | An asthma action plan is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional.  *Source*: ACAM (Australian Centre for Asthma Monitoring) 2007, *Australian asthma indicators: Five‑year review of asthma monitoring in Australia*. Cat. no. ACM 12, AIHW. |
| Closed treatment episode | A closed treatment episode is a period of contact between a client and an alcohol and other drug treatment agency. It has defined dates of commencement and cessation, during which the principal drug of concern, treatment delivery setting and main treatment type did not change. Reasons for cessation of a treatment episode include treatment completion, and client non‑participation in treatment for 3 months or more. Clients may have more than one closed treatment episode in a data collection period. |
| Community health services | Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities. |
| Comparability | Data are considered comparable if (subject to caveats) they can be used to inform an assessment of comparative performance. Typically, data are considered comparable when they are collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data. |
| Completeness | Data are considered complete if all required data are available for all jurisdictions that provide the service. |
| Consultations | The different types of services provided by GPs. |
| Cost to government of general practice per person | Cost to the Australian Government of total non‑referred attendances by non‑specialist medical practitioners per person. |
| Full time service equivalents (FSE) | FSE (Full Service Equivalent) is an estimated measure of medical workforce based on Medicare claims information. Although Medicare claims data does not include information on hours worked it does have sufficient time‑based items to estimate a proxy for hours worked. The FSE methodology models total hours worked for each practitioner based on the number of days worked, volume of services, and schedule fees. One FSE is approximately equivalent to a workload of 7.5 hours per day, five days per week. The FSE for each practitioner is capped at 2.5. |
| General practice | The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a ‘population’ of patients and may include services for specific populations, such as women’s health or Aboriginal and Torres Strait Islander health. |
| General practitioner (GP) | Vocationally registered GPs — medical practitioners who are vocationally registered under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. From 1996 vocational registration is available only to GPs who attain Fellowship of the RACGP or (from April 2007) the ACRRM, or hold a recognised training placement.  Other medical practitioners (OMP) — medical practitioners who are not vocationally registered GPs. |
| GP‑type services | Non‑referred attendances by vocationally registered GPs and OMPs, and practice nurses. |
| *Haemophilus influenzae* type b | A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (Department of Health 2013a). |
| Non‑referred attendances | GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be ‘referred’ to receive DHS Medicare reimbursement. |
| Nationally notifiable disease | A communicable disease that is on the Communicable Diseases Network Australia’s endorsed list of diseases to be notified nationally (Department of Health 2013b). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority. |
| Other medical practitioner (OMP) | A medical practitioner other than a vocationally registered GP who has at least half of the schedule fee value of his/her DHS Medicare billing from non‑referred attendances. These practitioners are able to access only the lower A2 DHS Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs. |
| Pap smear | A procedure for the detection of cancer and pre‑cancerous conditions of the female cervix. |
| PBS doctor’s bag | Emergency drug supplies provided without charge to prescribers for use in medical emergencies in the clinic or the community at no charge to the patient. |
| Per person benefits paid for GP ordered pathology | Total benefits paid under DHS Medicare for pathology tests requested by GPs, divided by the population. |
| Per person benefits paid for GP referred diagnostic imaging | Total benefits paid for diagnostic imaging services performed on referral by GPs, divided by the population. |
| Practice Incentives Program (PIP) | The Practice Incentives Program (PIP) aims to support general practice activities through providing incentives. These activities include continual improvements, quality care, enhanced capacity, and improved access and health outcomes for patients. |
| Primary healthcare | The primary and community healthcare sector includes services that:   * provide the first point of contact with the health system * have a particular focus on illness prevention or early intervention * are intended to maintain people’s independence and maximise their quality of life through care and support at home or in local community settings. |
| Primary Health Networks | Primary Health Networks (PHNs) are a national network of independent primary health care organisations (replacing Medicare Locals (MLs) from 1 July 2015) with the objective to improve the efficiency and effectiveness of medical services for patients at risk of poor health outcomes and to improve coordination of care, particularly for those with chronic and complex conditions. |
| Prevalence | The proportion of the population suffering from a disorder at a given point in time (point prevalence) or given period (period prevalence). |
| Public health | The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at‑risk groups) and complements clinical provision of healthcare services. |
| Recognised immunisation provider | A provider recognised by DHS Medicare as a provider of immunisation to children. |
| Recognised specialist | A medical practitioner classified as a specialist by the Medical Board of Australia and on the DHS Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner’s field of specialist recognition. |
| Screening | The performance of tests on apparently well people to detect a medical condition earlier than would otherwise be possible. |
| Triage category | The urgency of the patient’s need for medical and nursing care:   * category 1 — resuscitation (immediate within seconds) * category 2 — emergency (within 10 minutes) * category 3 — urgent (within 30 minutes) * category 4 — semi‑urgent (within 60 minutes) * category 5 — non‑urgent (within 120 minutes). |
| Vocationally registered general practitioner | A medical practitioner who is vocationally registered under s.3F of the *Health Insurance Act 1973* (Cwlth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her DHS Medicare billing from non‑referred attendances. |

## 10.5 References

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