10 Primary and community health

The primary and community health sector is the part of the healthcare system most frequently used by Australians. It is important in providing preventative care, diagnosis and treatment of illness, and referral to other healthcare services.

In Australia, general practices are an important source of primary healthcare. The services they provide include: diagnosing and treating illness (both chronic and acute); providing preventative care through to palliative care; referring patients to consultants, allied health professionals, community health services and hospitals; and acting as gatekeepers for other healthcare services (DHFS 1996).

Community health services usually consist of multidisciplinary teams of salaried health professionals who aim to protect and promote the health of particular communities (Quality Improvement Council 1998). They are either provided directly by governments (including local governments) or funded by government and managed by a local health service or community organisation. State and Territory governments are responsible for most community health services. There is no national strategy for community health, and there is considerable variation in the services provided across jurisdictions. The Australian Government's main role in the community health services covered in this chapter is in health services for Indigenous people.

Problems with accessing primary and community health services have contributed to the generally poor health status of Indigenous people relative to other Australians (see the 'Health Preface' and SCRGSP 2005).

The following improvements have been made in the reporting of primary and community health in this Report:

- Indigenous data are reported for the 'hospitalisations for vaccine preventable conditions', 'potentially preventable acute conditions' and 'potentially preventable chronic conditions' indicators.

Indigenous data in the primary and community health chapter

The primary and community health chapter in the *Report on Government Services 2007* (2007 Report) contains the following information on Indigenous people:

- estimated episodes of healthcare provided by Indigenous primary healthcare services, 2000-01 to 2004-05
- full time equivalent health staff employed by Indigenous primary healthcare services, as at 30 June 2005
- valid vaccinations supplied to children under seven years of age, by Indigenous healthcare providers, 1996–2006
- standardised hospital separations for vaccine preventable conditions, 2004-05
- ratio of age standardised hospital separation rates of Indigenous people to all people for infectious pneumonia, by gender, 2004-05
- standardised hospital separations for potentially preventable acute conditions, 2004-05
- standardised hospital separations for potentially preventable chronic conditions, 2004-05
- ratio of age standardised hospital separation rates of Indigenous people to all people for all diabetes diagnoses, by gender 2004-05.

Supporting tables

Supporting tables for data within the primary and community health chapter of this compendium are contained in attachment 10A of the compendium. These tables are identified in references throughout this chapter by an 'A' suffix (for example, table 10A.3 is table 3 in the primary and community health attachment). As the data are directly sourced from the 2007 Report, the compendium also notes where the original table, figure or text in the 2007 Report can be found. For example, where the compendium refers to '2007 Report, p. 10.15' this is page 15 of chapter 10 of the 2007 Report, and '2007 Report, table 10A.2' is attachment table 2 of attachment 10 of the 2007 Report.

Indigenous community healthcare services

Indigenous Australians utilise a range of primary health care services including private general practitioners and Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services. There are Aboriginal and Torres Strait

Islander Community Controlled Primary Health Care Services in all jurisdictions. These services are planned and governed by local Indigenous communities and aim to deliver holistic and culturally appropriate health and health-related services. Funding is provided by Australian, State and Territory governments. In addition to these health care services, health programs for Indigenous Australians are funded by a number of jurisdictions. In 2005-06 these programs included services such as health information, promotion, education and counselling; alcohol, tobacco and other drug services; sexual health services; allied health services; disease/illness prevention; and improvements to nutrition standards (tables 10A.8–10A.10).

The Australian Government also funds Aboriginal and Torres Strait Islander primary healthcare services. Information on these services is collected through service activity reporting (SAR) questionnaires. Many of these services receive additional funding from State and Territory governments and other sources. The SAR data reported here represent the health-related activities, episodes and workforce funded from all sources.

For 2004-05, SAR data are reported for 141 Indigenous primary healthcare services (table 10A.1). Of these services, 53 (37.6 per cent) were located in remote or very remote areas (table 10A.2). They provided a wide range of primary healthcare services, including the diagnosis and treatment of illness and disease, the management of chronic illness, immunisations and transportation to medical appointments (table 10A.3). An episode of healthcare is defined in the SAR data collection as contact between an individual client and staff of a service to provide healthcare. Nearly 1.6 million episodes of healthcare were provided by participating services in 2004-05 (table 10.1). Of these, around 548 000 (34.6 per cent) were in remote or very remote areas (table 10A.2). The services included in the SAR data collection employed 1845 full time equivalent health staff (as at 30 June 2005). Of these health staff, 1141 were Indigenous (61.8 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous, however, were relatively low (0.9 per cent and 14.4 per cent respectively) (table 10A.4).

Table 10.1 **Estimated Indigenous episodes of healthcare by surveyed services ('000)[a]**

	NSW and ACT	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*NT*	*Aust*
2000-01	349	131	187	327	147	12	189	1342
2001-02	357	136	214	313	144	18	233	1416
2002-03	423	130	234	337	140	20	216	1499
2003-04	430	169	267	302	142	22	280	1612
2004-05	415	151	254	274	145	23	323	1585

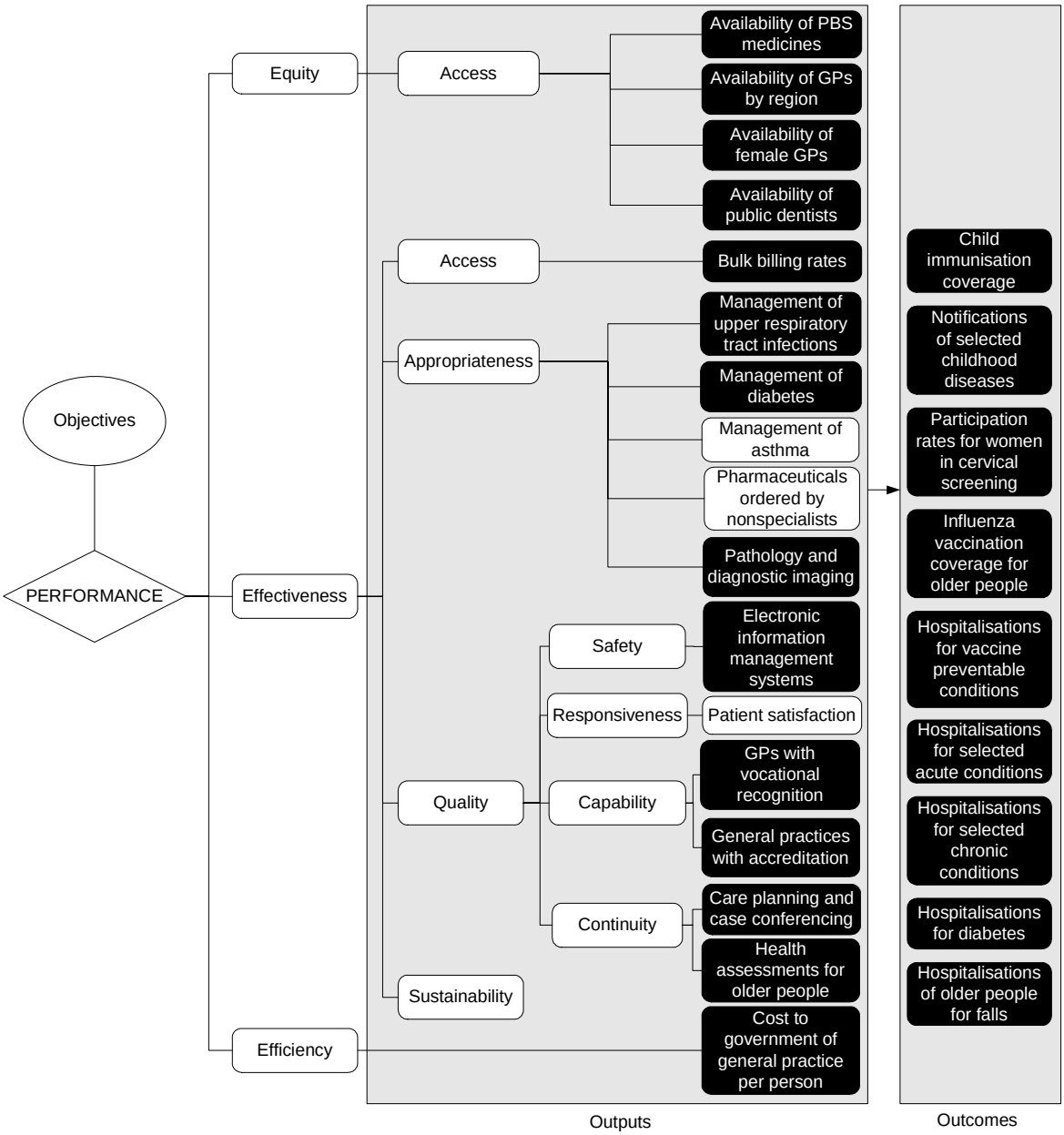
a An episode of healthcare involves contact between an individual client and staff of a service to provide healthcare. Group work is not included. Transport is included only if it involves provision of healthcare/information by staff. Episodes of healthcare provided at outreach locations are included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

Source: DoHA SAR (unpublished); 2007 Report, table 10.5, p. 10.11.

Framework of performance indicators

Data for Indigenous people are reported for a subset of the performance indicators for primary and community health in the 2007 Report. It is important to interpret these data in the context of the broader performance indicator framework outlined in figure 10.1. The performance indicator framework shows which data are comparable in the 2007 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

Figure 10.1 **Performance indicators for primary and community health**



Source: 2007 Report, figure 10.2, p. 10.13.

Child immunisation coverage

Many providers deliver child immunisation services. Data on valid vaccinations supplied to children under 7 years of age from the Australian Childhood Immunisation Register (ACIR) are shown in table 10.2.

Table 10.2 **Valid vaccinations supplied to children under 7 years of age, by provider type, 1996–2006 (per cent)[a, b]**

Provider	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP	83.6	52.3	82.6	63.5	68.7	85.9	38.2	3.2	70.5
Council	6.1	46.4	7.4	7.1	17.5	13.2	–	–	17.4
State or Territory health department	–	–	–	5.8	0.1	0.1	24.5	0.3	1.0
Flying doctor service	–	–	0.3	–	0.1	–	–	–	0.1
Public hospital	2.3	0.4	3.0	5.4	3.3	0.2	0.9	7.5	2.3
Private hospital	0.1	–	–	–	–	–	–	0.9	0.1
Indigenous health service	0.5	0.1	0.7	0.6	0.4	–	0.2	8.9	0.6
Indigenous health worker	–	–	0.5	–	0.1	–	–	0.2	0.1
Community health centre	7.3	0.8	5.5	17.7	9.8	0.6	36.3	79.0	8.0
Community nurse	–	–	–	–	–	–	–	–	–
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

a 1 January 1996 to 30 June 2006. Data relates to the State or Territory in which the immunisation provider was located. **b** A valid vaccination is a National Health and Medical Research Council's Australian Standard Vaccination Schedule vaccination administered to a child under the age of 7 years. – Nil or rounded to zero.

Source: DoHA (unpublished); table 10A.5; 2007 Report, table 10.7, p. 10.39.

Vaccine preventable hospitalisations

'Vaccine preventable hospitalisations' is an indicator of primary and community healthcare outcomes (box 10.1).

Box 10.1 **Vaccine preventable hospitalisations**

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for vaccine preventable conditions. This influence occurs mainly through the provision of vaccinations and the encouragement of high rates of vaccination coverage for target populations.

This indicator is defined as the number of hospital separations for influenza and pneumonia, and other vaccine preventable conditions per 100 000 people. (Adjustments are made to account for differences in the age structure of populations across states and territories.)

A reduction in hospitalisation rates may indicate improvements in the effectiveness of the vaccination program. Effective treatment by primary health providers may also reduce hospitalisations.

A comparison of Indigenous people and all other people is also made by presenting the ratio of age standardised hospital separation rates of Indigenous people to all people. A ratio of close to one is desirable as it implies that Indigenous people have similar separation rates to all people.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation for vaccine preventable conditions. Examples are the number and virulence of influenza strains from year to year.

Australia-wide, the age standardised hospital separation rate for all vaccine preventable conditions was 0.7 per 1000 people in 2004-05. Nationally, influenza and pneumonia accounted for 77.6 per cent of age standardised hospitalisations for vaccine preventable conditions in 2004-05 (2007 Report, table 10.8).

The age standardised hospital separation rate of Indigenous people for all vaccine preventable conditions was 3.7 per 1000 Indigenous people in 2004-05 for Queensland, WA, SA and the NT combined. The quality of Indigenous identification is considered acceptable for the purposes of analysis for these jurisdictions. Over 80 per cent of vaccine preventable separations for Indigenous people were accounted for by influenza and pneumonia in 2004-05 (table 10.3).

Table 10.3 **Standardised hospital separations of Indigenous people for vaccine preventable conditions, per 1000 Indigenous people, 2004-05[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total[c]*	*Aust*
Influenza and pneumonia	np	np	1.4	4.4	2.2	np	np	4.9	3.0	np
Other conditions	np	np	0.4	0.9	0.5	np	np	1.2	0.7	np
Total	**np**	**np**	**1.9**	**5.3**	**2.8**	**np**	**np**	**6.2**	**3.7**	**np**

a Separation rates are directly age standardised to the Indigenous population at 30 June 2001. **b** Includes data only for Queensland, WA, SA, and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the four states and territories are not necessarily representative of the other jurisdictions. **c** Total comprises Queensland, WA, SA and the NT only. **np** not published.

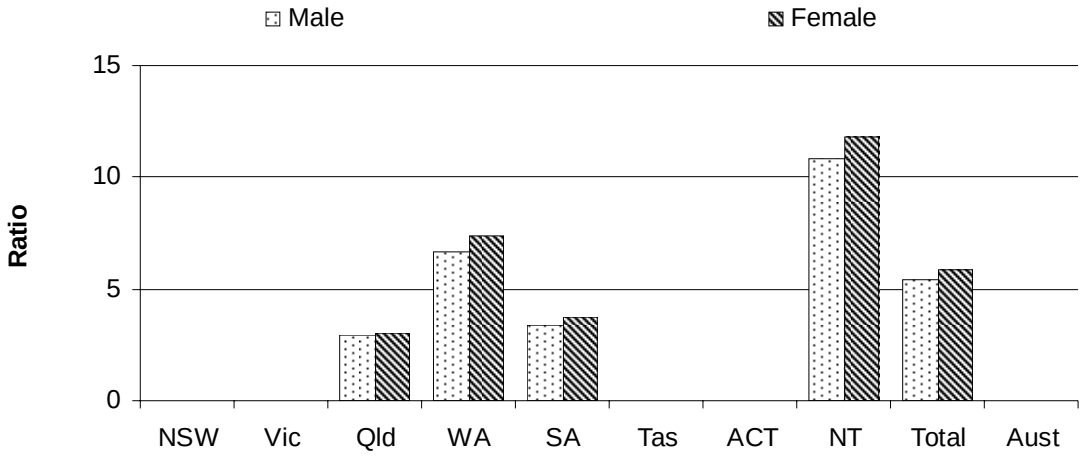
Source: AIHW (unpublished); 2007 Report, table 10.9, p. 10.47.

Data on Indigenous patients are limited by the accuracy and extent to which Indigenous people are identified in hospital records. Identification varies across states and territories. The report prepared by the AIHW and endorsed by relevant Australian Health Ministers' Advisory Council committees titled *Improving the Data Quality of Indigenous Identification in Hospital Separations Data* recommends the following:

- Only data from Queensland, WA, SA and the NT should be used for analytical purposes (either at the individual or aggregate level).
- Analyses based on data for Queensland, WA, SA and the NT in aggregate are limited by jurisdictional differences in data quality and the data are not necessarily representative of the jurisdictions excluded.
- Caution should be exercised in using Queensland, WA, SA and the NT time series data for analysis (either individually or in aggregate). Changes in hospitalisation rates for Indigenous people may be a result of changes in the ascertainment of Indigenous status for Indigenous patients (AIHW 2005b).

Standardised hospital separation ratios for infectious pneumonia illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in age distributions. For both males and females there was a marked difference in 2004-05 between the separation rates for Indigenous people and those for the total population for infectious pneumonia diagnoses. For Queensland, WA, SA and the NT combined the separation rate for Indigenous males was 5.4 times higher than those for all Australian males. The separation rate for Indigenous females was 5.9 times the rate for all females (figure 10.2).

Figure 10.2 **Ratio of age standardised hospital separation rates of Indigenous people to all people for infectious pneumonia, 2004-05[a, b, c, d, e]**



a The ratios are indirectly standardised using the estimated resident populations of Indigenous people and non-Indigenous people at 30 June 2004, and hospital separations data for Queensland, WA, SA, and the NT public hospitals. **b** Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete and completeness varies among jurisdictions. The variation in the number of Indigenous separations per 1000 Indigenous population across the states and territories suggests variation in the proportion of Indigenous persons who were identified as such in the hospital morbidity data collections and/or in the total population. The AIHW advised that only data from Queensland, WA, SA and the NT are considered to be of acceptable quality. **c** NT data are for public hospitals only. **d** Total comprises Queensland, WA, SA and the NT only. A total for Australia is not available. **e** Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. Care should be taken when comparing the two.

Source: AIHW (unpublished); tables 10A.6 and 10A.7; 2007 Report, figure 10.27, p. 10.48.

Hospitalisations for selected acute conditions

Box 10.2 **Hospitalisations for selected acute conditions**

The effectiveness of primary and community healthcare services has a significant influence on the rates of hospitalisation for the following selected acute conditions: dehydration and gastroenteritis; pyelonephritis (kidney inflammation caused by bacterial infection); perforated/bleeding ulcer; cellulitis; pelvic inflammatory disease; ear, nose and throat infections; dental conditions; appendicitis; convulsions and epilepsy; and gangrene.

(Continued on next page)

Box 10.2 **(Continued)**

Hospital separation rates for the selected acute conditions are calculated per 100 000 people and adjusted to account for differences in age distributions across State and Territory populations.

A reduction in hospitalisation rates may indicate improvements in the effectiveness of primary and community healthcare providers' treatment of these conditions.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation. An example is the underlying prevalence of the conditions. Public health measures not covered in this chapter may also influence the hospitalisation rates.

The age standardised hospital separation rate of Indigenous people for all potentially preventable acute conditions was 36.8 per 1000 Indigenous people in 2004-05 for Queensland, WA, SA and the NT combined. The quality of Indigenous identification is considered acceptable for the purposes of analysis for these jurisdictions. Over half of potentially preventable acute separations for Indigenous people were accounted for by convulsions and epilepsy, pyelonephritis and cellulitis in 2004-05 (table 10.4).

Table 10.4 **Standardised hospital separations of Indigenous people for potentially preventable acute conditions, per 1000 Indigenous people, 2004-05[a, b]**

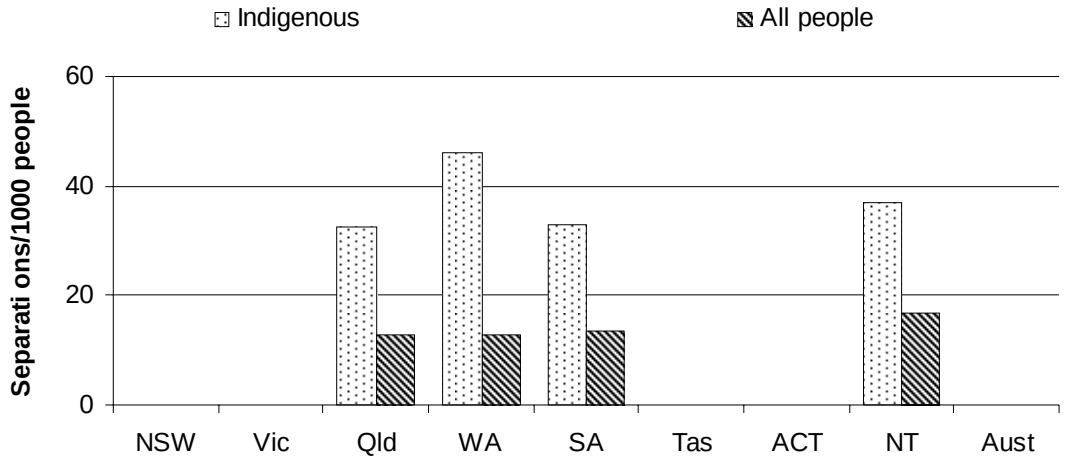
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[c]	*Aust*
Dehydration and gastroenteritis	np	np	3.1	4.7	5	np	np	4.0	3.9	np
Pyelonephritis[d]	np	np	7.3	9.2	5.7	np	np	7.8	7.7	np
Perforated/bleeding ulcer	np	np	0.4	0.6	0.4	np	np	0.2	0.4	np
Cellulitis	np	np	5.9	6.1	2.4	np	np	6.7	5.8	np
Pelvic inflammatory disease	np	np	0.6	0.9	0.6	np	np	1.5	0.9	np
Ear, nose and throat infections	np	np	4.0	5.2	3.8	np	np	3.2	4.1	np
Dental conditions	np	np	3.0	3.7	3.3	np	np	2.9	3.2	np
Appendicitis	np	np	0.2	0.4	0.3	np	np	0.3	0.3	np
Convulsions and epilepsy	np	np	6.4	13.3	10.9	np	np	8.9	9.0	np
Gangrene	np	np	1.6	1.9	0.4	np	np	1.5	1.5	np
Total	**np**	**np**	**32.6**	**46.0**	**32.9**	**np**	**np**	**37.0**	**36.8**	**np**

a Separation rates are directly age standardised to the Indigenous population at 30 June 2001. **b** Includes data only for Queensland, WA, SA, and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the four states and territories are not necessarily representative of the other jurisdictions. **c** Total comprises Queensland, WA, SA and the NT only. **d** Kidney inflammation caused by bacterial infection. **np** Not published.

Source: AIHW (unpublished); 2007 Report, table 10.11, p. 10.50.

The age standardised hospital separation rate of Indigenous people for all potentially preventable acute conditions was higher than that for all people in 2004-05 for Queensland, WA, SA and the NT (figure 10.3).

Figure 10.3 **Standardised hospital separations for potentially preventable acute conditions, 2004-05[a, b, c]**



a Indigenous separation rates are per 1000 of the Indigenous population and are directly age standardised to the Indigenous population at 30 June 2001. All people separation rates are per 1000 people and are directly age standardised to the Australian population at 30 June 2001. **b** Includes data only for Queensland, WA, SA, and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the four states and territories are not necessarily representative of the other jurisdictions. A total for Australia is not available. **c** Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. Care should be taken when comparing the two.

Source: AIHW (unpublished); 2007 Report, figure 10.28, p. 10.51.

Hospitalisations for selected chronic conditions

Box 10.3 **Hospitalisations for selected chronic conditions**

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for the following selected chronic conditions: asthma; congestive cardiac failure; diabetes complications; chronic obstructive pulmonary disease; iron deficiency anaemia; hypertension; and nutritional deficiencies. (Diabetes is considered in detail in a separate indicator.)

Hospital separation rates for the selected chronic conditions are calculated per 1000 people and adjusted to account for differences in age distributions across State and Territory populations.

A reduction in hospitalisation rates may indicate improvements in the effectiveness of primary and community healthcare providers' treatment of these conditions.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation. An example is the underlying prevalence of the conditions. Public health measures that are not reported in this chapter may also influence the hospitalisation rates.

The age standardised hospital separation rate of Indigenous people for all potentially preventable chronic conditions was 65.7 per 1000 Indigenous people in 2004-05 for Queensland, WA, SA and the NT combined. The quality of Indigenous identification is considered acceptable for the purposes of analysis only for these jurisdictions. Excluding diabetes, which is discussed below, chronic obstructive pulmonary disease, congestive cardiac failure and angina were the three highest sources of potentially preventable chronic separations for Indigenous people in 2004-05 (table 10.5).

Table 10.5 **Standardised hospital separations of Indigenous people for potentially preventable chronic conditions, per 1000 Indigenous people, 2004-05[a, b]**

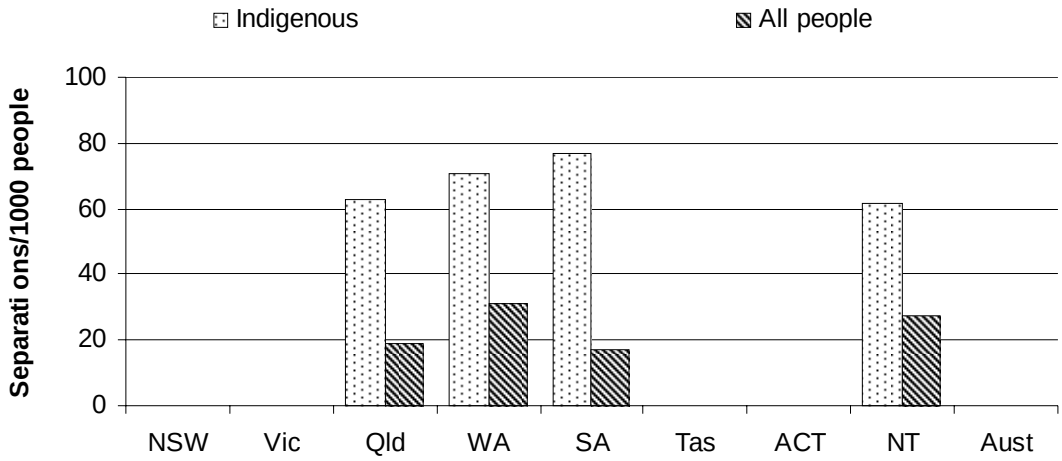
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[c]	*Aust*
Asthma	np	np	4.2	8.6	4.9	np	np	2.6	5.1	np
Congestive cardiac failure	np	np	7.7	8.5	11.2	np	np	6.5	8.0	np
Diabetes complications[d]	np	np	33.4	38.0	44.4	np	np	30.6	34.9	np
Chronic obstructive pulmonary disease	np	np	14.0	13.4	16.0	np	np	18.0	14.8	np
Angina	np	np	7.1	6.0	6.2	np	np	5.6	6.4	np
Iron deficiency anaemia	np	np	1.2	2.3	1.3	np	np	2.4	1.7	np
Hypertension	np	np	1.7	0.9	2.0	np	np	0.6	1.3	np
Nutritional deficiencies	np	np	–	–	–	np	np	–	–	np
Rheumatic heart disease[e]	np	np	–	–	–	np	np	–	–	np
Total	**np**	**np**	**63.0**	**70.5**	**77.0**	**np**	**np**	**61.6**	**65.7**	**np**

[a] Separation rates are directly age standardised to the Indigenous population at 30 June 2001. [b] Includes data only for Queensland, WA, SA, and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the four states and territories are not necessarily representative of the other jurisdictions. [c] Total comprises Queensland, WA, SA and the NT only. [d] Diabetes complications does not include records with a principal diagnosis of renal dialysis and an additional diagnosis of diabetes. [e] Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease. – Nil or rounded to zero. **np** Not published.

Source: AIHW (unpublished); 2007 Report, table 10.13, p. 10.53.

The age standardised hospital separation rate of Indigenous people for all potentially preventable chronic conditions was higher than that for all people in 2004-05 for Queensland, WA, SA and the NT (figure 10.4).

Figure 10.4 **Standardised hospital separations for potentially preventable chronic conditions, 2004-05[a, b, c]**



a Indigenous separation rates are per 1000 of the Indigenous population and are directly age standardised to the Indigenous population at 30 June 2001. All people separation rates are per 1000 people and are directly age standardised to the Australian population at 30 June 2001. **b** Includes data only for Queensland, WA, SA, and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the four states and territories are not necessarily representative of the other jurisdictions. A total for Australia is not available. **c** Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. Care should be taken when comparing the two.

Source: AIHW (unpublished); 2007 Report, figure 10.29, p. 10.54.

Hospitalisations for diabetes

Box 10.4 **Hospitalisations for diabetes**

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for diabetes.

Hospital separation rates for patients with diabetes mellitus as the principal diagnosis, and for patients with a lower limb amputation and a principal or additional diagnosis of diabetes are reported. These rates are calculated per 100 000 people and adjusted to account for differences in the age distribution of State and Territory populations.

A reduction in these rates may indicate an improvement in GPs and community health providers' management of patients' diabetes.

(Continued on next page)

Box 10.4 **(Continued)**

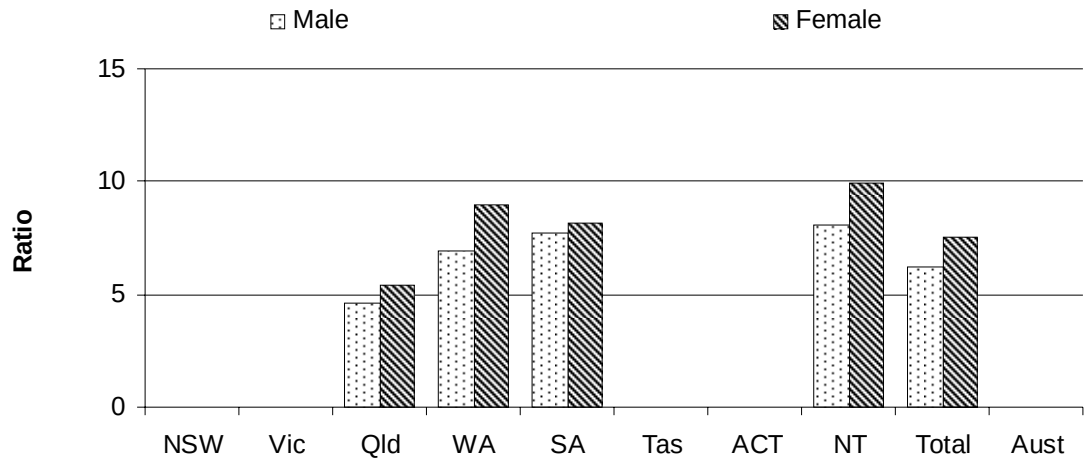
A comparison of Indigenous and all other people is made by presenting the ratio of age standardised hospital separation rates of Indigenous people to all people. A ratio of close to one is desirable as it implies that Indigenous people have similar separation rates to all people.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation. An example is the underlying prevalence of the conditions. Public health measures that are not reported in this chapter may also influence the hospitalisation rates.

Age standardised hospital separation ratios for all diabetes diagnoses illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in age distributions. For both males and females there was a marked difference in 2004-05 between the separation rates for Indigenous people and those for the total population for all diabetes diagnoses.[1] The quality of Indigenous identification is considered acceptable for the purposes of analysis for Queensland, WA, SA and the NT. For these jurisdictions combined the separation rate for Indigenous males was 9.3 times higher than those for all Australian males. The separation rate for Indigenous females was 12.5 times the rate for all females (figure 10.5).

1 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes.

Figure 10.5 **Ratio of age standardised hospital separation rates of Indigenous people to all people for all diabetes diagnoses, 2004-05[a, b, c, d, e, f]**



a The ratios are indirectly standardised using the estimated resident populations of Indigenous people and non-Indigenous people at 30 June 2004, and hospital separations data for Queensland, WA, SA, and the NT public hospitals. **b** Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete and completeness varies among jurisdictions. The variation in the number of Indigenous separations per 1000 Indigenous population across the states and territories suggests variation in the proportion of Indigenous persons who were identified as such in the hospital morbidity data collections and/or in the total population. The AIHW advised that only data from Queensland, WA, SA and the NT are considered to be of acceptable quality. **c** 'All diabetes' refers to separations with a principal and/or additional diagnosis, except where dialysis is the principal diagnosis. **d** NT data are for public hospitals only. **e** Total comprises Queensland, WA, SA and the NT only. A total for Australia is not available. **f** Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. Care should be taken when comparing the two.

Source: AIHW (unpublished); tables 10A.6 and 10A.7; 2007 Report, figure 10.33, p. 10.58.

Future directions in performance reporting

Indigenous health

Barriers to accessing primary health services contribute to the poorer health status of Indigenous people compared to other Australians (see the 'Health preface'). In recognition of this issue, the Steering Committee has identified primary and community health services for Indigenous people as a priority area for future reporting. The Steering Committee will examine options for including indicators of the accessibility of primary and community health services to Indigenous people. The Aboriginal and Torres Strait Islander Health Performance Framework developed under the auspices of the Australian Health Ministers' Advisory Council will inform the selection of future indicators of primary and community health services to Indigenous people (see the 'Health preface').

The availability of hospital separations data for Indigenous people is significantly reduced in the 2007 Report compared to previous Reports. Analysis into the quality of Indigenous identification of hospital admitted patient statistics has shown that while the quality is good in some jurisdictions, in other jurisdictions it is poor (AIHW 2005a). Consequently, Indigenous hospital separations data are only available for Queensland, WA, SA and the NT. Data from NSW, Victoria, Tasmania and the ACT were considered to be of insufficient quality. Although some jurisdictions have improved the quality of Indigenous hospital separations data, the Steering Committee considers that the lack of progress and ongoing evaluation of data quality in other jurisdictions is disappointing as the problem has been known for ten years.

The AIHW is developing a methodology and sampling strategy that will allow each jurisdiction to carry out a validation process to get a more recent indication of the current level of under identification in their hospital data. At the end of this project, the jurisdictions will be in a better position to assess whether the situation has improved. The AIHW is also currently undertaking another project to develop best practice guidelines for identification. The Steering Committee supports the work of the AIHW to assist jurisdictions to assess the quality of their data, however, primary responsibility for improvement rests with jurisdictions and the Steering Committee strongly encourages all jurisdictions to address this issue as a matter of urgency.

Supporting tables

Supporting tables for data within this chapter are contained in the attachment to the compendium. These tables are identified in references throughout this chapter by an 'A' suffix (for example, table 10A.3 is table 3 in the primary and community health attachment). The tables included in the attachment are listed below.

Table 10A.1 Indigenous primary healthcare services for which service activity reporting (SAR) data is reported (number)

Table 10A.2 Services and episodes of healthcare by services for which service activity reporting (SAR) data is reported, by remoteness category (number)

Table 10A.3 Proportion of services for which service activity reporting (SAR) data is reported that undertook selected health related activities, 2004-05 (per cent)

Table 10A.4 Full time equivalent health staff employed by services for which service activity reporting (SAR) data is reported, as at 30 June 2005 (number)

Table 10A.5 Valid vaccinations supplied to children under seven years of age, by type of provider, 1996–2006

Table 10A.6 Ratio of age standardised hospital separations for Indigenous males to all males, 2004-05

Table 10A.7 Ratio of age standardised hospital separations for Indigenous females to all females, 2004-05

Table 10A.8 Queensland, community health services programs

Table 10A.9 Western Australia, community health services programs

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

References

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