11 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).

This chapter covers general practice, primary healthcare services for Indigenous people, drug and alcohol treatment, public dental services, maternal and child health, the Pharmaceutical Benefits Scheme (PBS) and a range of other health-related community services.

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 2007a).

The reporting of primary and community health in this Report has been improved by the introduction of a new indicator of equity of access, 'early detection and early treatment for Indigenous people'.

Indigenous data in the primary and community health chapter

The primary and community health chapter in the *Report on Government Services 2008* (2008 Report) contains the following information on Indigenous people:

- estimated episodes of healthcare provided by Indigenous primary healthcare services for which SAR data are reported, 2001-02 to 2005-06
- older people who received an annual health assessment by Indigenous status, 2006-07
- older Indigenous people who received an annual health assessment, 2002-03–2006-07
- Indigenous people who received a voluntary health check or assessment, by age
- Indigenous primary healthcare services for which SAR data are reported that provided early detection services, 2001-02 to 2005-06
- child immunisation coverage — per cent of valid vaccinations supplied to children under 7 years of age by Indigenous health service/worker, 1996–2007
- separations of Indigenous people for vaccine preventable conditions, 2005-06
- separations for vaccine preventable conditions by Indigenous status, 2005-06
- separation rate ratios of Indigenous people to all people for infectious pneumonia, 2005-06
- separations of Indigenous people for potentially preventable acute conditions, 2005-06
- separations for potentially preventable acute conditions by Indigenous status, 2005-06
- separations of Indigenous people for potentially preventable chronic conditions, 2005-06
- separations for potentially preventable chronic conditions by Indigenous status, 2005-06
- ratio of separation rates of Indigenous people to all people for all diabetes diagnoses, 2005-06.

The primary and community health attachment contains additional data relating to Indigenous people including:

- Indigenous primary healthcare services for which service activity reporting (SAR) data are reported (number)
- services and episodes of healthcare by services for which service activity

reporting (SAR) data are reported, by remoteness category (number)

- proportion of services for which service activity reporting (SAR) data are reported that undertook selected health related activities, 2005-06 (per cent)
- full time equivalent health staff employed by Indigenous primary healthcare services, as at 30 June 2006
- ratio of separations for Indigenous people to all people, 2005-06.

Attachment tables

Attachment tables for data within the primary and community health chapter of this compendium are contained in attachment 11A of the compendium. These tables are identified in references throughout this chapter by an 'A' suffix (for example, table 11A.3 is table 3 in the primary and community health attachment). As the data are directly sourced from the 2008 Report, the compendium also notes where the original table, figure or text in the 2008 Report can be found. For example, where the compendium refers to '2008 Report, p. 11.15' this is page 15 of chapter 11 of the 2008 Report, and '2008 Report, table 11A.2' is attachment table 2 of attachment 11A of the 2008 Report.

Indigenous community healthcare services

Indigenous Australians use 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 healthcare services, health programs for Indigenous Australians are funded by a number of jurisdictions. In 2006-07 these programs included services such as health information, promotion, education and counselling; alcohol, tobacco and other drug services; sexual health services; allied health services; disease/illness prevention; and improvements to nutrition standards (tables 11A.12–11A.19).

Information on Aboriginal and Torres Strait Islander primary healthcare services that receive funding from the Australian Government 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 2005-06, SAR data are reported for 150 Indigenous primary healthcare services (table 11A.1). Of these services, 55 (36.7 per cent) were located in remote or very remote areas (table 11A.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 11A.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 1.7 million episodes of healthcare were provided by participating services in 2005-06 (table 11.1). Of these, around 560 000 (33.3 per cent) were in remote or very remote areas (table 11A.2). The services included in the SAR data collection employed 1920 full time equivalent health staff (as at 30 June 2006). Of these, 1158 were Indigenous (60.3 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous were relatively low (4.5 per cent and 13.8 per cent respectively), although for doctors this was considerably higher than for the previous year (0.9 per cent). Caution should be exercised in interpreting this rise, as the number of Indigenous doctors was low in both years (SCRGSP 2007b; table 11A.7).

Table 11.1 **Estimated episodes of healthcare for Indigenous people by services for which SAR data are reported ('000)[a]**

	NSW and ACT[b]	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*NT*	*Aust*
2001-02	357	136	214	313	144	18	233	1 416
2002-03	423	130	234	337	140	20	216	1 499
2003-04	430	169	267	302	142	22	280	1 612
2004-05	415	151	254	274	145	23	323	1 585
2005-06[c]	507	177	240	282	103	29	347	1 685

[a] An episode of healthcare involves contact between an individual client and service staff to provide healthcare. Group work is not included. Transport is included only if it involves provision of healthcare/ information by staff. Outreach provision, for example episodes at outstation visits, park clinics and satellite clinics, is included. Episodes of health care delivered over the phone are included. [b] Data for NSW and the ACT have been combined for confidentiality purposes. [c] 2005-06 data are preliminary results.

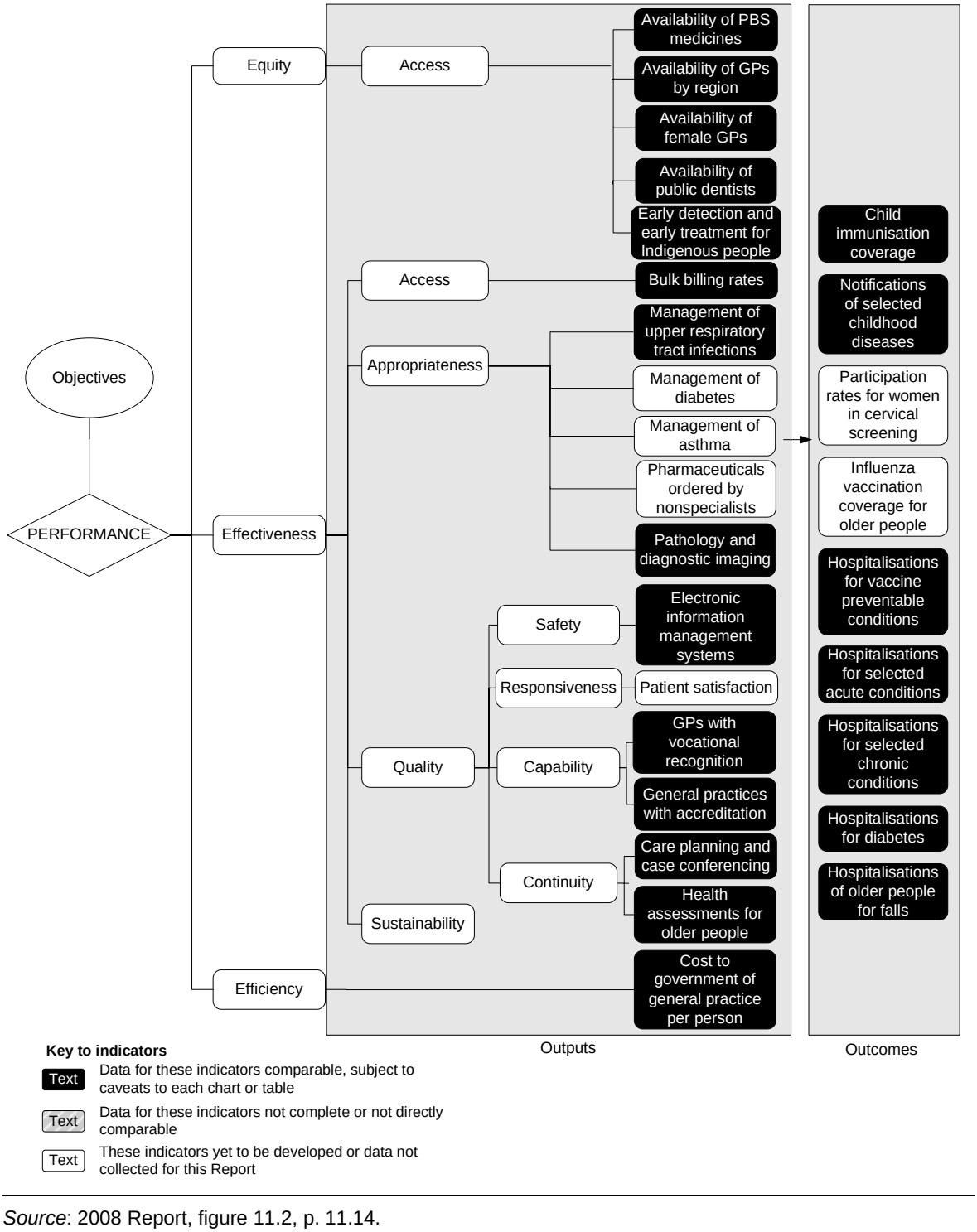
Source: DoHA (unpublished); 2008 Report, table 11.5, p. 11.12.

Framework of performance indicators

Data for Indigenous people are reported for a subset of the performance indicators for primary and community health in the 2008 Report. It is important to interpret these data in the context of the broader performance indicator framework outlined in figure 11.1. The performance indicator framework shows which data are comparable in the 2008 Report. For data that are not considered directly

comparable, the text includes relevant caveats and supporting commentary.

Figure 11.1 **Performance indicators for primary and community health**



Source: 2008 Report, figure 11.2, p. 11.14.

Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see 2008 Report, chapter 1, section 1.5).

Equity

For the purposes of this Report, equity is defined in terms of adequate access to government services for all Australians. Many people experience difficulties in accessing services due to factors such as gender, age, limited English language proficiency, disability, ethnicity or geography (see 2008 Report, chapter 1). Such barriers contribute to the generally poor health status of Indigenous people relative to other Australians (see the 'Health Preface' and SCRGSP 2007a). Ensuring adequate access to government services for all Australians requires that barriers experienced by particular groups be addressed.

Access

'Early detection and early treatment for Indigenous people' (box 11.1) is one of five indicators of equity of access to primary and community health services reported this year.

Early detection and early treatment for Indigenous people

Box 11.1 **Early detection and early treatment for Indigenous people**

The high prevalence of preventable and/or treatable health conditions in the Indigenous population is strongly associated with relatively poor health outcomes for Indigenous people (AIHW 2007a; SCRGSP 2007a). Early detection and early treatment refers to the identification of individuals who are at high risk for, or in the early stages of, such conditions. Early detection and early treatment services provide opportunities for timely prevention and intervention measures to improve and maintain health. Such services have the potential to improve access to appropriate healthcare for Indigenous people.

(Continued on next page)

Box 11.1 **(Continued)**

Voluntary health assessments and checks are Medicare Benefit Schedule (MBS) items that allow GPs to undertake comprehensive examinations of patient health, including physical, psychological and social functioning. They are available for older Australians as well as for Indigenous people of all ages, as the prevalence of preventable and/or treatable conditions is high in both population groups. The availability and uptake of early detection and early treatment services is understood to be a significant determinant of people's health.

Four measures are presented for this indicator:

- older people who received a voluntary health assessment by Indigenous status
- older Indigenous people who received a voluntary health assessment, time series
- Indigenous people who received a voluntary health assessment or check by age group
- Aboriginal and Torres Strait Islander primary healthcare services that provided early detection services.

A reduction in the gap between the proportion of all older people and older Indigenous people that received a health assessment indicates improved access to early detection and early treatment services for Indigenous people. An increase in the proportion of Indigenous people that received a health assessment or check indicates improved access to these services. An increase in the proportion of Aboriginal and Torres Strait Islander primary healthcare services providing early detection activities indicates improved access to these services for Indigenous Australians.

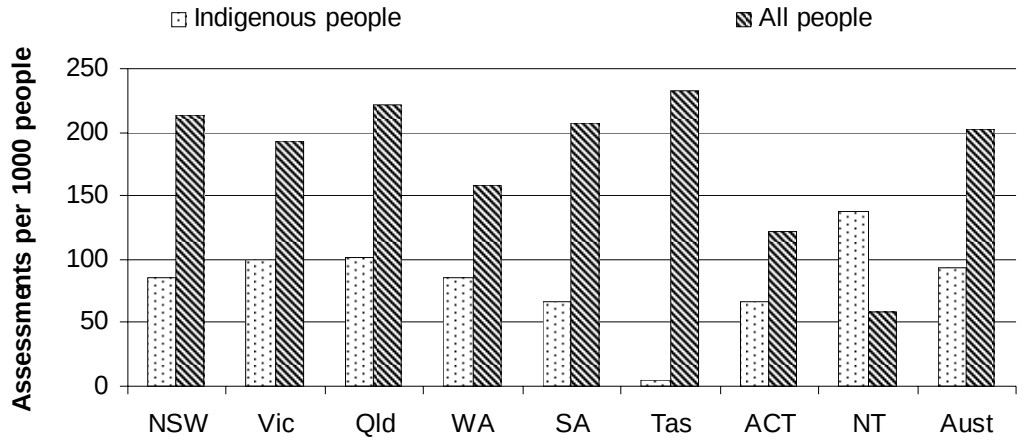
This indicator provides no information about early detection and early treatment services that are not provided under Medicare. Such services are provided by salaried GPs in community health settings, hospitals and Indigenous-specific primary health care services, particularly in rural and remote areas. Accordingly, this indicator understates the proportion of people who received early detection and early treatment services.

For this indicator, older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. The larger age range for Indigenous people recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the 'Health preface').

Figure 11.2 shows that in 2006-07 the proportion of Indigenous older people who received an annual health assessment was considerably lower than the proportion of all older people who received an annual health assessment. This suggests that access

to early detection and early treatment services for older Indigenous people is inequitable.

Figure 11.2 **Older people who received an annual health assessment by Indigenous status, 2006-07[a, b]**

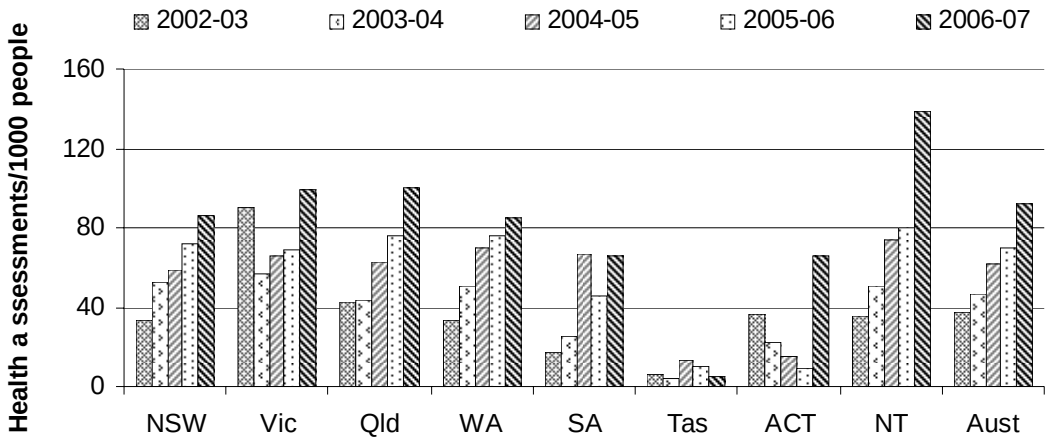


a Older people are defined as Indigenous people aged 55 years and over and non-Indigenous people aged 75 years and over. **b** Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to affect the overall proportions significantly, due to the relatively low average life expectancy of Indigenous people.

Source: Medicare Australia (unpublished); ABS (2004, 2006a, 2006b) 3238.0; 3101.0; 3222.0; table 11A.5; 2008 Report, figure 11.8, p. 11.23.

Figure 11.3 shows that the proportion of older Indigenous people who received an annual health assessment steadily increased between 2002-03 and 2006-07 in most jurisdictions. This indicates that access to early detection and early treatment services has improved for this population in most jurisdictions.

Figure 11.3 **Older Indigenous people who received an annual health assessment[a]**



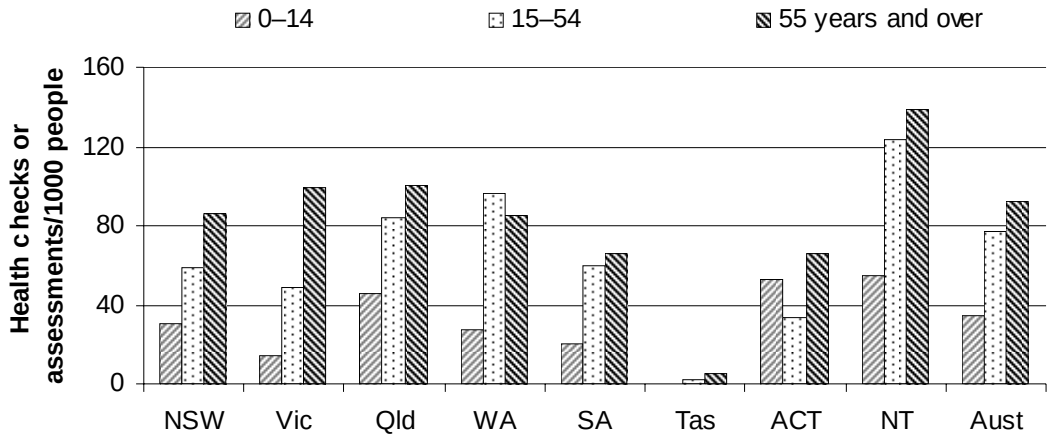
a Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to significantly affect the overall proportions due to the relatively low average life expectancy of Indigenous people.

Source: Medicare Australia (unpublished); ABS Cat. No. 3238.0; table 11A.6; 2008 Report, figure 11.9, p. 11.24.

Health check MBS items were introduced for Indigenous people aged 15–54 years in May 2004, and Indigenous children aged 0–14 years in May 2006. Health checks are available annually for children aged 0–14 years, and biennially for 15–54 year-olds.

Figure 11.4 shows that the proportion of the eligible Indigenous population that received a health assessment or check was highest for older people and lowest for children aged 0–14 years in most jurisdictions. This may in part reflect differences in how long the items have been available, as factors such as awareness and additional administrative requirements affect the uptake of new MBS items (AIHW 2007b).

Figure 11.4 **Indigenous people who received a health check or assessment by age[a, b]**

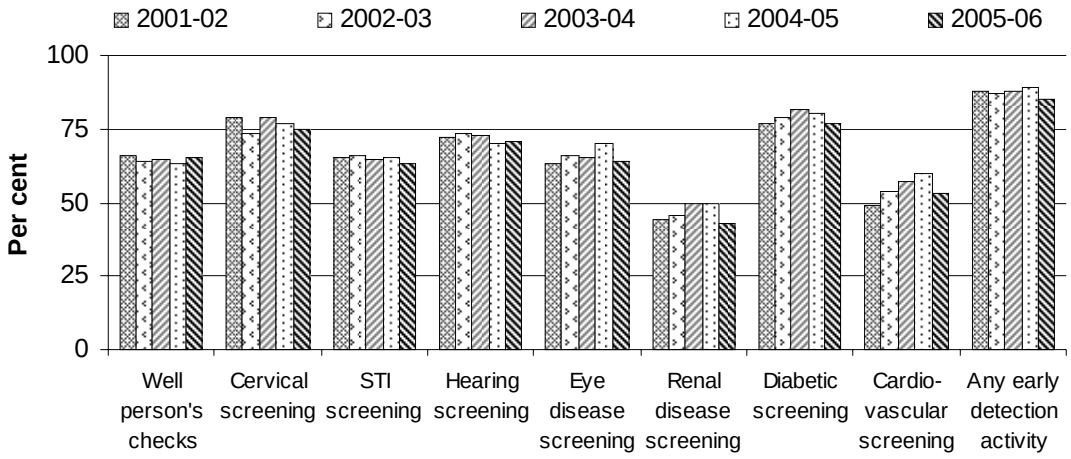


a Indigenous status is determined by self-identification. Indigenous people aged 75 years and over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to significantly affect the overall proportions due to the relatively low average life expectancy of Indigenous people. **b** Health checks for 0–14 year olds, and health assessments for those aged 55 years and over, are available annually. Data for these age groups are for the period 1 July 2006 to 30 June 2007. Health checks for 15–54 year olds are available biennially, and these data are for the period 1 July 2005 to 30 June 2007.

Source: Medicare Australia (unpublished); ABS Cat. No. 3238.0; table 11A.7; 2008 Report, figure 11.10, p. 11.25.

Figure 11.5 shows the proportion of Indigenous primary healthcare services for which SAR data are reported that provided various early detection services over the five year period to 2005-06.

Figure 11.5 **Indigenous primary healthcare services for which SAR data are reported that provided early detection services**



Source: DoHA (unpublished); table 11A.8; 2008 Report, figure 11.11, p. 11.25.

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 11.2.

Table 11.2 **Valid vaccinations supplied to children under 7 years of age, by provider type, 1996–2007 (per cent)[a, b]**

Provider	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[c]	*NT*	*Aust*
GP	83.8	52.6	82.5	63.5	68.6	86.2	39.5	3.1	70.7
Council	6.0	46.0	7.3	6.9	18.1	12.9	–	–	17.3
State or Territory health department	–	–	–	5.9	0.1	0.1	22.6	0.3	1.0
Flying doctor service	–	–	0.3	–	0.1	–	–	–	0.1
Public hospital	2.2	0.4	3.1	5.4	3.0	0.2	0.8	7.6	2.3
Private hospital	0.1	–	–	–	–	–	–	0.9	0.1
Indigenous health service	0.5	0.1	0.7	0.6	0.5	–	0.2	9.1	0.6
Indigenous health worker	–	–	0.5	–	0.1	–	–	0.2	0.1
Community health centre	7.4	0.8	5.6	17.7	9.6	0.6	36.8	78.8	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 2007. Data relate 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. **c** Due to changes in provider classification in the ACT between 1996 to 2007, some vaccinations undertaken by ACT Health's Maternal and Child Health nurses are reported under 'State or Territory health departments' and some are reported under 'Community health centre'. The total proportion of vaccinations provided by ACT Health during this period was 59.4 per cent. – Nil or rounded to zero.

Source: DoHA (unpublished); table 11A.9; 2008 Report, table 11.6, p. 11.44.

Potentially preventable hospitalisations

The following outcome indicators relate to potentially preventable hospitalisations for a range of conditions. The first three indicators — hospitalisations for vaccine preventable conditions (box 11.3), selected acute conditions (box 11.4) and selected chronic conditions (box 11.5) — were developed by the National Health Performance Committee, based on empirical research (box 11.2). The other outcome indicator in this category relates to hospitalisations for diabetes (box 11.6).

Box 11.2 **Potentially preventable hospitalisation indicators**

Potentially preventable hospitalisations refer to hospital admissions that may be avoided by appropriate management in the primary healthcare sector and/or the broader community. They include vaccine preventable, acute and chronic conditions, defined according to the *Victorian Ambulatory Care Sensitive Conditions Study* (DHS 2002). This study built on research into ambulatory care sensitive conditions (for example, Billings, Anderson and Newman 1996; Bindman *et al.* 1995; Weissman, Gatsonis and Epstein 1992) that had recently been the subject of systematic review and empirical analysis.

These studies show that the availability of non-hospital care explains a significant proportion of the variation between geographic areas in hospitalisation rates for the specified conditions. Other explanations for this variation include variation in the underlying prevalence of the conditions, clinical coding standards and the likelihood that a patient will be treated as an outpatient rather than an admitted patient. Potentially preventable hospitalisations will never be entirely eliminated, but the variation across geographic areas demonstrates considerable potential for strengthening the effectiveness of non-hospital care.

Source: NHPC (2004).

Data are reported against these indicators for Indigenous Australians as well as for all Australians. The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. The AIHW (2005) report *Improving the Quality of Indigenous Identification in Hospital Separations Data* found that Indigenous patient data were of acceptable quality for analytical purposes only for Queensland, WA, SA, and public hospitals in the NT. Following new assessments of the quality of Indigenous identification in 2007, the National Health Information Management Principal Committee (NHIMPC) has recently approved NSW Indigenous patient data as acceptable in quality, for analytical purposes, from the 2004-05 reference year. A proposal to accept Victorian data as acceptable was being considered by the NHIMPC in late 2007. Efforts to improve Indigenous identification across states and territories are ongoing.

Reported data are not necessarily representative of other jurisdictions. Indigenous patients are underidentified, to an extent that varies across jurisdictions. Because of improvements in data quality over time, caution also should be used in time series analysis.

Vaccine preventable hospitalisations

'Vaccine preventable hospitalisations' is an indicator of primary and community healthcare outcomes (box 11.3).

Box 11.3 **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 1000 people. This indicator is reported for Indigenous people as well as for all people. Adjustments are made to account for differences in the age structures of these 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.

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

The age standardised hospital separation rate of Indigenous people for all vaccine preventable conditions was 3.1 per 1000 Indigenous people in 2005-06 for NSW, 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 2005-06 (table 11.3).

Table 11.3 **Separations of Indigenous people for vaccine preventable conditions, per 1000 Indigenous people, 2005-06[a, b]**

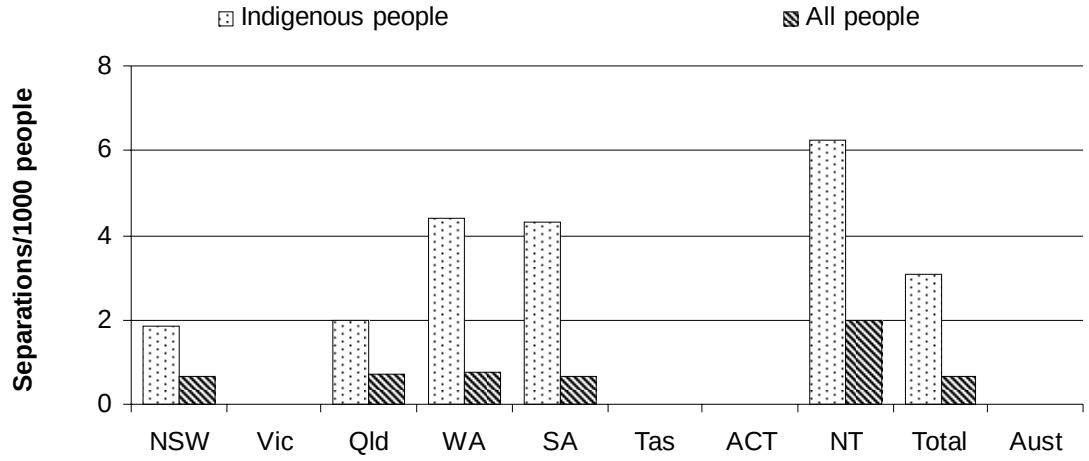
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[c]	*Aust*
Influenza and pneumonia	1.7	np	1.5	3.9	3.8	np	np	4.6	2.5	np
Other conditions	0.2	np	0.5	0.5	0.5	np	np	1.6	0.5	np
Total	**1.8**	**np**	**2.0**	**4.4**	**4.3**	**np**	**np**	**6.3**	**3.1**	**np**

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

Source: AIHW (unpublished); 2008 Report, table 11.8, p. 11.53.

The age standardised hospital separation rate of Indigenous people for vaccine preventable conditions was higher than that for all people in 2005-06 in all jurisdictions for which data were published (figure 11.6).

Figure 11.6 **Separations for vaccine preventable conditions, 2005-06**[a, b, c, d]



[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Includes data only for NSW, Queensland, WA, SA, and the NT (NT data are for public hospitals only), for which the quality of Indigenous identification is considered acceptable for purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Data for the five states and territory are not necessarily representative of other jurisdictions. [c] Total comprises NSW, Queensland, WA, SA and the NT only. [d] 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); 2008 Report, figure 11.30, p. 11.53.

Age standardised hospital separation rate 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 the age structures of the populations. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage. For both males and females there was a marked difference in 2005-06 between the separation rates for Indigenous people and those for the total population for infectious pneumonia diagnoses. For NSW, Queensland, WA, SA and the NT combined, the separation rate for Indigenous males was higher than that for all Australian males, and the separation rate for Indigenous females was higher than the rate for all females (tables 11A.10 and 11A.11).

Hospitalisations for selected acute conditions

Box 11.4 **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.

This indicator is defined as the number of hospital separations for the selected acute conditions per 1000 people. The indicator is reported for Indigenous people as well as for all people. Adjustments are made to account for differences in the age structures of these populations across states and territories.

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 also influence the rates of hospitalisation, for example, the underlying prevalence of the conditions. Public health measures not covered in this chapter may also influence hospitalisation rates.

The age standardised hospital separation rate of Indigenous people for all potentially preventable acute conditions was 32.1 per 1000 Indigenous people in 2005-06 for NSW, Queensland, WA, SA and the NT combined. Over half of potentially preventable acute separations for Indigenous people were accounted for by convulsions and epilepsy, pyelonephritis, and cellulitis in 2005-06 (table 11.4).

Table 11.4 **Separations of Indigenous people for potentially preventable acute conditions, per 1000 Indigenous people, 2005-06[a, b]**

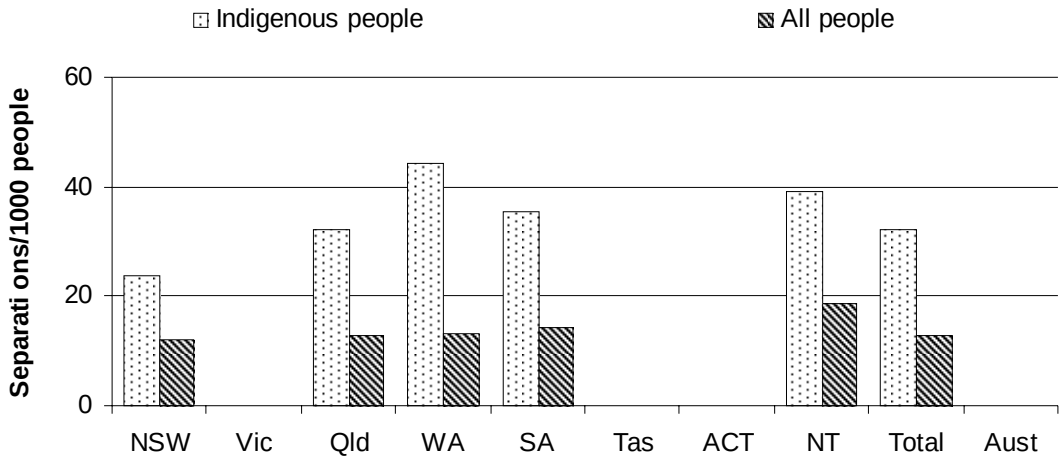
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[c]	*Aust*
Dehydration and gastroenteritis	2.7	np	4.2	5.1	5.8	np	np	3.9	3.9	np
Pyelonephritis[d]	4.8	np	7.1	7.8	5.2	np	np	7.5	6.4	np
Perforated/bleeding ulcer	0.4	np	0.4	0.2	0.2	np	np	0.2	0.3	np
Cellulitis	2.9	np	5.8	7.1	3.9	np	np	7.5	4.8	np
Pelvic inflammatory disease	0.4	np	0.6	1.0	1.1	np	np	1.6	40.7	np
Ear, nose and throat infections	3.0	np	3.7	4.3	4.7	np	np	3.4	3.6	np
Dental conditions	2.9	np	2.9	3.7	3.1	np	np	2.9	3.0	np
Appendicitis	0.2	np	0.2	0.2	0.2	np	np	0.4	0.2	np
Convulsions and epilepsy	6.1	np	6.4	12.3	10.8	np	np	10.0	8.0	np
Gangrene	0.4	np	0.9	2.5	0.5	np	np	1.8	1.1	np
Total	**23.8**	**np**	**32.2**	**44.3**	**35.4**	**np**	**np**	**39.2**	**32.1**	**np**

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

Source: AIHW (unpublished); 2008 Report, table 11.10, p. 11.56.

The age standardised hospital separation rate of Indigenous people for all potentially preventable acute conditions was higher than that for all people in 2005-06 in all jurisdictions for which data were published (figure 11.7).

Figure 11.7 **Separations for potentially preventable acute conditions, 2005-06[a, b, c, d]**



a Separation rates are directly age standardised to the Australian population at 30 June 2001. **b** Includes data only for NSW, Queensland, WA, SA, and the NT (NT data are for public hospitals only), for which the quality of Indigenous identification is considered acceptable for purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Data for the five states and territory are not necessarily representative of other jurisdictions. **c** Total comprises NSW, Queensland, WA, SA and the NT only. **d** 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); 2008 Report, figure 11.31, p. 11.57.

Hospitalisations for selected chronic conditions

Box 11.5 **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; angina; iron deficiency anaemia; hypertension; nutritional deficiencies; and rheumatic heart disease. Diabetes is considered in detail in a separate indicator.

This indicator is defined as the number of hospital separations for the selected chronic conditions per 1000 people. This indicator is reported for Indigenous people as well as for all people. Adjustments are made to account for differences in the age structures of these populations across states and territories.

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 also influence the rates of hospitalisation, for example, 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 60.7 per 1000 Indigenous people in 2005-06 for NSW, Queensland, WA, SA and the NT combined. The quality of Indigenous identification is considered acceptable for the purpose of analysis only for these jurisdictions. Excluding diabetes (discussed below), chronic obstructive pulmonary disease, congestive cardiac failure and angina had the highest potentially preventable chronic hospitalisation rates for Indigenous people in 2005-06 (table 11.5).

Table 11.5 **Separations of Indigenous people for potentially preventable chronic conditions, per 1000 Indigenous people, 2005-06[a, b]**

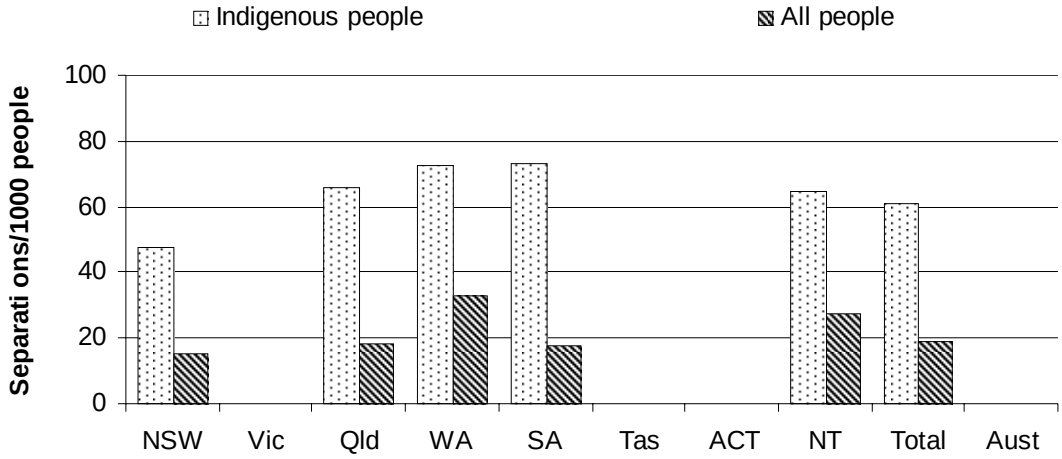
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[c]	*Aust*
Asthma	4.1	np	4.7	6.6	6.9	np	np	2.8	4.7	np
Congestive cardiac failure	4.9	np	9.4	9.4	7.5	np	np	6.7	7.3	np
Diabetes complications[d]	21.4	np	34.1	42.7	42.2	np	np	34.2	31.6	np
Chronic obstructive pulmonary disease	13.8	np	14.7	12.2	15.9	np	np	16.5	14.2	np
Angina	4.8	np	6.7	5.4	6.4	np	np	5.1	5.6	np
Iron deficiency anaemia	1.4	np	1.2	2.8	1.4	np	np	2.4	1.7	np
Hypertension	1.1	np	1.6	1.0	0.9	np	np	0.8	1.2	np
Nutritional deficiencies	0.0	np	0.0	0.0	0.0	np	np	0.1	0.0	np
Rheumatic heart disease[e]	0.1	np	1.0	0.8	0.4	np	np	2.2	0.8	np
Total	**47.3**	**np**	**65.9**	**72.3**	**73.2**	**np**	**np**	**64.7**	**60.7**	**np**

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

Source: AIHW (unpublished); 2008 Report, table 11.12, p. 11.59.

The age standardised hospital separation rate of Indigenous people for all potentially preventable chronic conditions was higher than that for all people in 2005-06 in all jurisdictions for which data were published (figure 11.8).

Figure 11.8 **Separations for potentially preventable chronic conditions, 2005-06[a, b, c]**



a Separation rates are directly age standardised to the Australian population at 30 June 2001. **b** Includes data only for NSW, Queensland, WA, SA, and the NT (NT data are for public hospitals only), for which the quality of Indigenous identification is considered acceptable for purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Data for the five states and territory are not necessarily representative of other jurisdictions. **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); 2008 Report, figure 11.32, p. 11.60.

Hospitalisations for diabetes

Box 11.6 **Hospitalisations for diabetes**

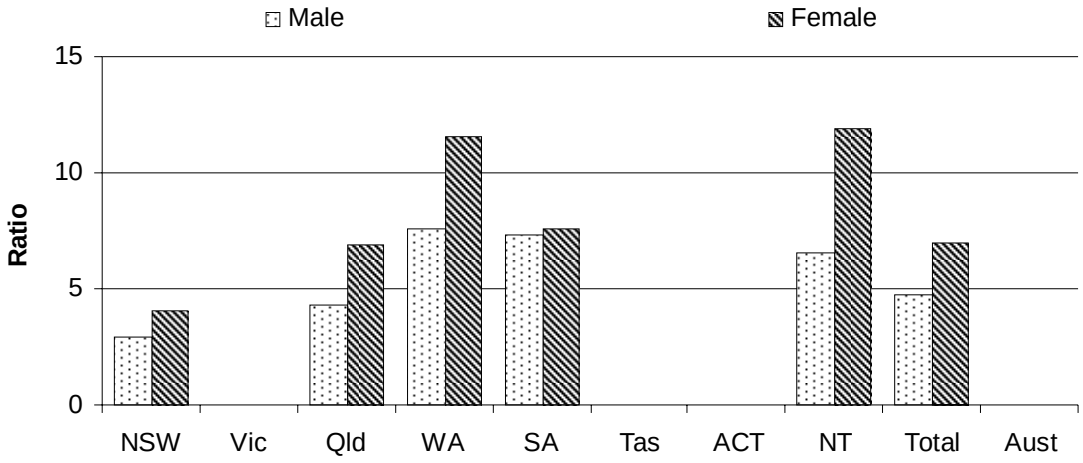
The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for diabetes.

The ratio of Indigenous people to all people for age standardised hospital separation rates for all diabetes diagnoses is reported. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, 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[1] illustrate differences between the rate of hospital admissions for Indigenous people and that for all Australians, taking into account differences in the age structures of the two populations. For both males and females there was a marked difference in 2005-06 between the separation rates for Indigenous people and those for the total population for all diabetes diagnoses. The quality of Indigenous identification is considered acceptable for the purpose of analysis only for NSW, Queensland, WA, SA and the NT. For these jurisdictions combined, the separation rate for Indigenous males was 7.3 times higher than those for all Australian males. The separation rate for Indigenous females was 12.2 times the rate for all females (figure 11.9).

Figure 11.9 **Ratio of separation rates of Indigenous people to all people for all diabetes diagnoses, 2005-06**[a, b, c, d, e]



a The ratios are directly age-standardised to the estimated resident population at 30 June 2001. **b** The total includes data only for NSW, Queensland, WA, SA and the NT (NT data for public hospitals only), for which the quality of Indigenous identification is considered acceptable for purposes of analysis. Data for the five states and territory are not necessarily representative of the other jurisdictions. **c** 'All diabetes' refers to separations with a principal and/or additional diagnosis of diabetes, except where dialysis is the principal diagnosis. **d** Patients aged 75 years and over are excluded. **e** Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality.

Source: AIHW (unpublished); tables 11A.10 and 11A.11; 2008 Report, figure 11.36, p. 11.64.

1 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes, except where dialysis is the principal diagnosis.

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 'early detection and early treatment' indicator of accessibility of primary and community health services to Indigenous people has been included in the 2008 Report. The Steering Committee will continue to examine options for the inclusion of further such indicators. The Aboriginal and Torres Strait Islander Health Performance Framework developed under the auspices of the Australian Health Ministers' Advisory Council will inform the selection of future indicators of primary and community health services to Indigenous people.

The completeness of Indigenous identification in hospital admitted patient statistics remains variable across states and territories. There has been some improvement, for example, NSW data are now considered to be of acceptable quality, whereas on previous assessment this was not the case. Victorian data are being considered for publication. The quality of data for Tasmania and the ACT is considered to be too poor for publication. Continued efforts to improve Indigenous identification are necessary in order to better measure the performance of primary and community health services in relation to the health of Indigenous Australians. The AIHW is currently undertaking a project to develop best practice guidelines for identification.

Attachment tables

Attachment 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 11A.3 is table 3 in the primary and community health attachment). The tables included in the attachment are listed below.

Table 11A.1 Indigenous primary healthcare services for which service activity reporting (SAR) data are reported (number)

Table 11A.2 Services and episodes of healthcare by services for which service activity reporting (SAR) data are reported, by remoteness category (number)

Table 11A.3 Proportion of services for which service activity reporting (SAR) data are reported that undertook selected health related activities, 2005-06 (per cent)

Table 11A.4 Full time equivalent (FTE) health staff employed by services for which service activity reporting (SAR) data are reported, as at 30 June 2006 (number)

Table 11A.5 Voluntary annual health assessments for older people by Indigenous status, 2006-07

Table 11A.6 Older Indigenous people who received an annual health assessment (per 1000 people)

Table 11A.7 Indigenous people who received a voluntary health check or assessment, by age (per 1000 people)

Table 11A.8 Early detection activities provided by services for which service activity reporting (SAR) data are reported

Table 11A.9 Valid vaccinations supplied to children under seven years of age, by type of provider, 1996–2007

Table 11A.10 Ratio of separations for Indigenous males to all males, 2005-06

Table 11A.11 Ratio of separations for Indigenous females to all females, 2005-06

Table 11A.12 New South Wales, community health services programs

Table 11A.13 Victoria, community health services programs

Table 11A.14 Queensland, community health services programs

Table 11A.15 Western Australia, community health services programs

Table 11A.16 South Australia, community health services programs

Table 11A.17 Tasmania, community health services programs

Table 11A.18 Australian Capital Territory, community health services programs

Table 11A.19 Northern Territory, community health services programs

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