11 Primary and community health

CONTENTS

**Indigenous data in the primary and community health chapter 11.2**

**Profile of primary and community health 11.3**

**Community health services 11.3**

**Dental services 11.4**

**Funding 11.4**

**General practice 11.4**

**Size and scope 11.5**

**General practice 11.5**

**Framework of performance indicators 11.7**

**Early detection and early treatment for Indigenous Australians 11.9**

**Developmental health checks 11.14**

**Effectiveness of access to GPs 11.16**

**Effectiveness of access to GPs — GP-type presentations to emergency departments 11.18**

**Chronic disease management — asthma 11.18**

**Health assessments for older people 11.18**

**Efficiency — Cost to government of general practice per person 11.19**

**Outcomes 11.20**

**Child immunisation coverage 11.20**

**Participation for women in breast cancer screening 11.22**

**Participation for women in cervical screening 11.23**

**Influenza vaccination coverage for older people 11.24**

**Selected potentially preventable hospitalisations 11.25**

**Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions 11.26**

**Potentially preventable hospitalisations for diabetes 11.30**

**Future directions in performance reporting 11.32**

**Indigenous health 11.32**

**Definitions of key terms and indicators 11.34**

**List of attachment tables 11.35**

**References 11.37**

|  |
| --- |
| Attachment tables |
| Attachment tables are identified in references throughout this Indigenous Compendium by an ‘A’ prefix (for example, in this chapter, table 11A.1). As the data are directly sourced from the 2013 Report, the Compendium also notes where the original table, figure or text in the 2013 Report can be found. For example, where the Compendium refers to ‘2013 Report, p. 11.1’ this is page 1 of chapter 11 of the 2013 Report, and ‘2013 Report, table 11A.1’ is attachment table 1 of attachment 11A of the 2013 Report. A list of attachment tables referred to in the Compendium is provided at the end of this chapter, and the full attachment tables are available from the Review website at www.pc.gov.au/gsp. |
|  |
|  |

The Primary and community health chapter (chapter 11) in the *Report on Government Services 2013* (2013 Report) reports on the performance of primary and community health services in Australia. Data are reported for Indigenous Australians for a subset of the performance indicators reported in that chapter — those data are compiled and presented here.

Primary and community health services include general practice, allied health services, dentistry, alcohol and other drug treatment, maternal and child health, the Pharmaceutical Benefits Scheme (PBS) and a range of other community health services. Reporting in this chapter focuses mainly on general practice, primary healthcare services targeted to Indigenous Australians, public dental services, drug and alcohol treatment and the PBS.

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

### Indigenous data in the primary and community health chapter

The primary and community health chapter in the 2013 Report contains the following data items on Indigenous Australians:

* Indigenous primary healthcare services and episodes of healthcare
* Indigenous primary healthcare services and episodes of healthcare by remoteness
* proportion of Indigenous primary healthcare services that undertook selected health related activities
* full time equivalent (FTE) health staff employed by Indigenous primary healthcare services
* older Indigenous Australians who received an annual health assessment
* Indigenous Australians who received a health assessment by age group
* early detection activities provided by Indigenous primary healthcare services
* potentially avoidable General Practitioner (GP)-type presentations to emergency departments
* management of asthma
* participation rates for Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds)
* cervical screening rates
* valid vaccinations supplied to children under 7 years of age, by provider type, 2007–2012
* potentially preventable hospitalisations for selected vaccine preventable conditions
* potentially preventable hospitalisations for selected chronic conditions
* potentially preventable hospitalisations for diabetes.

### Profile of primary and community health

#### Community health services

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

#### Dental services

The Australian Government and the State and Territory governments have different roles in supporting dental services in Australia’s mixed system of public and private dental healthcare. State and Territory governments have the main responsibility for the delivery of major public dental programs, primarily directed at children and disadvantaged adults. The Australian Government supports the provision of dental services primarily through the private health insurance rebate and, through DHS, Medicare, for a limited range of oral surgical procedures. Private dental services were also funded through DHS, Medicare for people with chronic conditions and complex care needs until 1 December 2012. In addition, the Australian Government provides funding for the dental care of war veterans and members of the Australian Defence Force and has a role in the provision of dental services through Indigenous Primary Health Care Services. Each jurisdiction determines its own eligibility requirements for accessing public dental services, usually requiring a person to hold a concession card issued by Centrelink.

**Funding**

*General practice*

Australian Government expenditure on general practice in 2011-12 was $6.7 billion, or $299 per person (2013 Report, figure 11.36, 2013 Report, table 11A.2).

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

### Size and scope

#### General practice

There were 29 011 vocationally registered GPs and other medical practitioners (OMPs) billing Medicare Australia, based on MBS claims data, in 2011‑12. On a full time workload equivalent (FWE) basis, there were 21 119 vocationally registered GPs and OMPs (see section 11.5 for a definition of FWE). This was equal to 93.9 FWE registered GPs and OMPs per 100 000 people (table 11A.5). These data exclude services provided by GPs working in Indigenous primary healthcare services, public hospitals and the Royal Flying Doctor Service. In addition, for some GPs — particularly in rural areas — MBS claims provide income for only part of their workload. Compared with metropolitan GPs, those in rural or remote areas spend more of their time working in local hospitals, for which they are not paid through DHS, Medicare. The numbers of FWE vocationally registered GPs and OMPs per 100 000 people across jurisdictions are shown in 2013 Report, figure 11.1.

##### Alcohol and other drug treatment

Alcohol and other drug treatment activities range from a brief intervention to   
long term residential treatment. Types of treatment include detoxification, pharmacological treatment (also known as substitution or maintenance treatment), counselling and rehabilitation. The data included in the 2013 Report have been sourced from a report on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) — a collection of data from publicly funded government and non-government treatment services (AIHW 2012a). Treatment activities excluded from that collection include treatment with medication for dependence on opioid drugs such as heroin (opioid pharmacotherapy treatment) where no other treatment is provided, the majority of services for Indigenous Australians that are funded by the Australian Government, treatment services within the correctional system, and treatment units associated with acute care and psychiatric hospitals.

##### Indigenous community healthcare services

Indigenous Australians use a range of primary healthcare services, including private GPs and Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services. There are Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services in all jurisdictions. 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 2011‑12, 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 (2013 Report, tables 11A.88–11A.96).

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

For 2010‑11, OSR data are reported for 235 Indigenous primary healthcare services (table 11A.11). Of these services, 90 (38.3 per cent) were located in remote or very remote areas (table 11A.12). 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.13). An episode of healthcare is defined in the OSR data collection as contact between an individual client and staff of a service to provide healthcare. Around 2.5 million episodes of healthcare were provided by participating services in 2010‑11 (table 11.1). Of these, around 1.2 million (47.6 per cent) were in remote or very remote areas (table 11A.12).

Table 11.1 Estimated episodes of healthcare for Indigenous Australians by services for which OSR data are reported (‘000)**a**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
| 2008-09 | 452.1 | 160.2 | 335.7 | 305.7 | 191.3 | 34.7 | 23.2 | 593.0 | 2 095.9 |
| 2009-10 | 542.4 | 184.8 | 378.8 | 408.8 | 191.6 | 36.2 | 25.7 | 614.6 | 2 382.9 |
| 2010-11 | 521.8 | 200.5 | 309.7 | 473.1 | 221.8 | 37.7 | 29.7 | 703.8 | 2 498.1 |

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

*Source*: AIHW (2012 and previous issues) *Aboriginal and Torres Strait Islander health services report*: *OATSIH services reporting - key results*, Cat. no.s IHW 31, 56 and 79; table 11A.11; 2013 Report, table 11.6, p. 11.14.

The services included in the OSR data collection employed around 3644 full time equivalent health staff (as at 30 June 2011). Of these, 1934 were Indigenous Australians (53.1 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous Australians were relatively low (7.2 per cent and 9.1 per cent, respectively) (table 11A.14).

### Framework of performance indicators

The performance indicator framework is based on shared government objectives for primary and community health (2013 Report, box 11.1). The framework will evolve as better indicators are developed and as the focus and objectives for primary and community health change. In particular, the Steering Committee plans to develop and report against more indicators relating to community health services.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of health services (figure 11.1). The performance indicator framework shows which data are comparable in the 2013 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report wide perspective (see 2013 Report, section 1.6).

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

Figure 11.1 Primary and community health performance indicator framework

|  |
| --- |
| Figure 11.1 - Primary and community health performance indicator framework  More details can be found within the text surrounding this image. |

*Source*: 2013 Report, figure 11.3, p. 11.16.

### Early detection and early treatment for Indigenous Australians

‘Early detection and early treatment for Indigenous Australians’ is an indicator of governments’ objective to provide equitable access to primary and community healthcare services for Indigenous Australians (box 11.1).

|  |
| --- |
| Box 11.1 Early detection and early treatment for Indigenous Australians |
| ‘Early detection and early treatment for Indigenous Australians’ is defined as:   * the identification of individuals who are at high risk for, or in the early stages of, preventable and/or treatable health conditions (early detection) * the provision of appropriate prevention and intervention measures in a timely fashion (early treatment).   Four measures of early detection and early treatment for Indigenous Australians are reported:   * The proportion of older people who received a health assessment by Indigenous status, where * older people are defined as non-Indigenous Australians aged 75 years or over and Indigenous Australians aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. The relatively young age at which Indigenous Australians become eligible for ‘older’ people’s services recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health sector overview) * health assessments are MBS items that allow comprehensive examinations of patient health, including physical, psychological and social functioning. The assessments are intended to facilitate timely prevention and intervention measures to improve patient health and wellbeing. * The proportion of older Indigenous Australians who received a health assessment in successive years of a five year period. * The proportion of Indigenous Australians who received a health assessment or check by age group — health assessment/checks are available for Indigenous children (0–14 years), adults (15–54 years) and older people (55 years or over). * The proportion of Aboriginal and Torres Strait Islander primary healthcare services that provided early detection services. |
| (Continued next page) |
|  |
|  |

|  |
| --- |
| Box 11.1 (Continued) |
| A low or decreasing gap between the proportion of all older people and older Indigenous Australians who received a health assessment can indicate more equitable access to early detection and early treatment services for Indigenous Australians. An increase over time in the proportion of older Indigenous Australians who received a health assessment is desirable as it indicates improved access to these services. A low or decreasing gap between the proportion of Indigenous Australians in different age groups who received a health assessment/check can indicate more equitable access to early detection and treatment services within the Indigenous population. An increase in the proportion of Aboriginal and Torres Strait Islander primary healthcare services that included early detection activities is desirable as it indicates improved access to early detection and treatment services for Indigenous Australians.  This indicator provides no information about the proportion of people who receive early detection and early treatment services that are not listed in the MBS. Such services are provided by salaried GPs in community health settings, hospitals and Aboriginal and Torres Strait Islander primary healthcare services, particularly in rural and remote areas. Accordingly, this indicator understates the proportion of people who received early detection and early treatment services.  Data for this indicator are comparable.  Data quality information for this indicator is under development. |
|  |
|  |

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

In 2011‑12, the proportion of Indigenous older Australians who received an annual health assessment was lower than the proportion of non‑Indigenous older Australians who received an annual health assessment in all jurisdictions except the NT and Queensland (figure 11.2). This suggests that access to early detection and early treatment services may not be equitable.

Figure 11.2 Older people who received an annual health assessment by Indigenous status, 2011-12**a, b**

|  |
| --- |
| Figur 11.2 Older people who received an annual health assessment by Indigenous status, 2011-12   More details can be found within the text surrounding this image. |

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

*Source*: Derived from DoHA (unpublished) MBS Statistics, ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; ABS (2011) *Australian demographic statistics June quarter 2011*, Cat. no. 3101.0; table 11A.21; 2013 Report, figure 11.9, p. 11.26.

The proportion of older Indigenous Australians who received an annual health assessment increased in nearly all jurisdictions between 2007‑08 and 2011‑12 (figure 11.3).

Figure 11.3 Older Indigenous Australians who received an annual health assessment**a**

|  |
| --- |
| Figure 11.3 Older Indigenous Australians who received an annual health assessment  More details can be found within the text surrounding this image. |

a Older people are defined as Indigenous Australians aged 55 years or over. Indigenous status is determined by self-identification. Indigenous Australians aged 75 years or over may receive a health assessment under the ‘all older people’ MBS items. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous Australians.

*Source*: Derived from DoHA (unpublished) MBS data collection and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.22; 2013 Report, figure 11.10, p. 11.27.

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

The proportion of the eligible Indigenous population who received a health assessment or check was highest for older people and lowest for children aged  
0–14 years in most jurisdictions (figure 11.4). This can, in part, reflect differences in how long the items have been available, as factors such as awareness and administrative requirements affect the uptake of new MBS items (AIHW 2008a).

Figure 11.4 Indigenous Australians who received a health check or assessment by age, 2011-12**a**

|  |
| --- |
| Figure 11.4 Indigenous Australians who received a health check or assessment by age, 2011-12  More details can be found within the text surrounding this image. |

a Indigenous status is determined by self-identification. Indigenous Australians 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 overall proportions due to the relatively low average life expectancy of Indigenous Australians.

*Source*: Derived from DoHA (unpublished) MBS Statistics and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.23; 2013 Report, figure 11.11, p. 11.28.

Nationally, the proportion of Indigenous primary healthcare services providing early detection services varied little in the period 2008-09 to 2010-11 (figure 11.5).

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

|  |
| --- |
| Figure 11.5 Indigenous primary healthcare services for which OSR data are reported that provided early detection services  More details can be found within the text surrounding this image. |

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

*Source*: AIHW (2012 and previous issues) *Aboriginal and Torres Strait Islander health services report: OATSIH services reporting - key results, 2008-09, 2009-10 and 2010-11*, Cat. no.s IHW 31, 56 and 79; table 11A.24; 2013 Report, figure 11.12, p. 11.29.

### Developmental health checks

‘Developmental health checks’ is an indicator of governments’ objective to provide equitable access to early detection and intervention services for children (box 11.2).

|  |
| --- |
| Box 11.2 Developmental health checks |
| ‘Developmental health checks’ is defined as the proportion of children who received a fourth year developmental health check under DHS, Medicare, by health check type. Health check type is considered as a proxy for Indigenous status. The ‘Healthy Kids Check’ MBS health assessment item is available to children aged 3 or 4 years, while the ‘Aboriginal and Torres Strait Islander Peoples Health Assessment’ item is available to Indigenous Australians.  A high or increasing proportion of children receiving a fourth year developmental health check is desirable as it suggests improved access to these services.  The proportion of Indigenous children aged 3 or 4 years who received the Aboriginal and Torres Strait Islander Peoples Health Assessment is considered as a proxy for the proportion of Indigenous children who received a fourth year developmental health check. This should be considered a minimum estimate as the data exclude checks received by Indigenous children under the Healthy Kids Check item.  Fourth year developmental health checks are intended to assess children’s physical health, general wellbeing and development. They enable identification of children who are at high risk for or, have early signs of, delayed development and/or illness. Early identification provides the opportunity for timely prevention and intervention measures that can ensure that children are healthy, fit and ready to learn when they start schooling.  This indicator provides no information about developmental health checks for children that are provided outside DHS, Medicare, as comparable data for such services are not available for all jurisdictions. These checks are provided in the community, for example, maternal and child health services, community health centres, early childhood settings and the school education sector. Accordingly, this indicator understates the proportion of children who receive a fourth year developmental health check.  Data for this indicator are comparable.  Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/ rogs/2013. |
|  |
|  |

Nationally, 45.8 per cent of children received a fourth year developmental health check under DHS, Medicare in 2011-12. The proportion of Indigenous children who received an Aboriginal and Torres Strait Islander Peoples Health Assessment in their fourth year was higher than the proportion of children who received a Healthy Kids Check in most jurisdictions (figure 11.6).

Figure 11.6 Children who received a fourth year developmental health check, by health check type, 2011-12**a, b, c, d, e, f**

|  |
| --- |
| Figure 11.6 Children who received a fourth year developmental health check by health check type, 2011-12  More details can be found within the text surrounding this image. |

a Limited to health checks available under DHS, Medicare. b Aboriginal and Torres Strait Islander Peoples Health Assessment data include claims for MBS Item 715 for children aged 3–5 years. c Healthy Kids Check data include claims for MBS Items 701, 703, 705, 707 and 10 986 for children aged 3–5 years. d Children are counted once only; where a child received both types of health check during the reference period they are counted against the Aboriginal and Torres Strait Islander Peoples Health assessment. e Healthy Kids Check data include Indigenous children who received a Healthy Kids Check provided they did not also receive an Aboriginal and Torres Strait Islander Peoples Health Assessment during the reference period. f Aboriginal and Torres Strait Islander Peoples Health assessment data for Tasmania and the ACT are not published due to small numbers, but are included in the data for Australia.

*Source*: DoHA (unpublished) MBS Statistics; ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 11A.25; 2013 Report, figure 11.13, p. 11.31.

### Effectiveness of access to GPs

‘Effectiveness of access to GPs’ is an indicator of governments’ objective to provide effective access to primary healthcare services (box 11.3). The effectiveness of services can vary according to the affordability and timeliness of services that people can access.

|  |
| --- |
| Box 11.3 Effectiveness of access to GPs |
| ‘Effectiveness of access to GPs’ is defined by four measures:   * bulk billing rates, defined as the number of GP visits that were bulk billed as a proportion of all GP visits * people deferring visits to GPs due to financial barriers, defined as the proportion of people who delayed seeing or did not see a GP due to cost * GP waiting times, defined as the number of people who saw a GP for urgent medical care within specified waiting time categories in the previous 12 months, divided by the number of people who saw a GP for urgent medical care in the previous 12 months. Specified waiting time categories are:   – less than 4 hours  – 4 to 24 hours  – more than 24 hours   * selected potentially avoidable GP-type presentations to emergency departments, defined as the number of ‘GP-type presentations’ to emergency departments divided by the total number of presentations to emergency departments, where  GP-type presentations are those:   – allocated to triage category 4 or 5  – not arriving by ambulance, with police or corrections  – not admitted or referred to another hospital  – who did not die.  A high or increasing proportion of bulk billed attendances can indicate more affordable access to GP services. GP visits that are bulk billed do not require patients to pay part of the cost of the visit, while GP visits that are not bulk billed do. This measure does not provide information on whether the services are appropriate for the needs of the people receiving them.  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. A low or decreasing proportion of GP-type presentations to emergency departments can indicate better access to primary and community health care.  Data for the first three measures of this indicator are comparable, while data for the fourth measure — selected potentially avoidable GP-type presentations to emergency departments — are not directly comparable.  Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/ rogs/2013. |
|  |
|  |

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

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

Nationally, there were around 2.1 million GP-type presentations to public hospital emergency departments in 2011-12 (2013 Report, table 11.7). Data are presented by Indigenous status and remoteness in table 11A.31.

#### Chronic disease management — asthma

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

Updated data were not available for the 2013 Report for the proportion of people with current asthma reporting that they have a written asthma action plan. Nationally, this proportion was 20.8 per cent for all ages and 47.8 per cent for children aged 0–14 years in 2007‑08 (2013 Report, figure 11.26). Data are reported by geographical region in table 11A.47. Data for 2004‑05 are reported by Indigenous status in table 11A.48.

### Health assessments for older people

‘Health assessments for older people’ is an indicator of governments’ objective to improve population health outcomes through the provision of prevention as well as early detection and treatment services (box 11.4).

|  |
| --- |
| Box 11.4 Health assessments for older people |
| ‘Health assessments for older people’ is defined as the proportion of older people who received a health assessment. Older people are defined as non-Indigenous Australians aged 75 years or over and Indigenous Australians aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. Annual health assessments for older people are MBS items that allow a GP to undertake an in-depth assessment of a patient’s health. Health assessments cover the patient’s health and physical, psychological and social functioning, and aim to facilitate more timely preventive actions or treatments to enhance the health of the patient (see also box 11.1).  A high or increasing proportion of eligible older people who received a health assessment can indicate a reduction in health risks for older people, through early and timely prevention and intervention measures to improve and maintain health.  Data for this indicator are comparable.  Data quality information for this indicator is under development. |
|  |
|  |

The targeted age range for Indigenous Australians of 55 years or over recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health sector overview). Results for Indigenous Australians are reported under equity indicators (box 11.1).

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

‘Cost to government of general practice per person’ is an indicator of governments’ objective to provide primary healthcare services in an efficient manner (box 11.5).

|  |
| --- |
| Box 11.5 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.  A low or decreasing cost per person can indicate higher efficiency. However, this is likely to be the case only where the low or decreasing cost is associated with services of equal or superior effectiveness.  This indicator needs to be interpreted with care. A low or decreasing cost per person can reflect service substitution between primary healthcare and hospital or specialist services — potentially at greater expense. This indicator does not include costs for primary healthcare services provided by salaried GPs in community health settings, particularly in rural and remote areas, through emergency departments, and Indigenous-specific primary healthcare services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, where a salaried GP services delivery model is used.  Data for this indicator are comparable.  Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/ rogs/2013. |
|  |
|  |

Nationally, the recurrent cost to the Australian Government of general practice was $299 per person in 2011-12 (2013 Report, figure 11.36).

### Outcomes

#### Child immunisation coverage

‘Child immunisation coverage’ is an indicator of governments’ objective to achieve high immunisation coverage levels for children to prevent selected vaccine preventable diseases (box 11.6).

|  |
| --- |
| Box 11.6 Child immunisation coverage |
| ‘Child immunisation coverage’ is defined by three measures:   * the proportion of children aged 12 months to less than 15 months who are fully immunised, where children assessed as fully immunised at 12 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b and hepatitis B * data quality information for this measure is under development * the proportion of children aged 24 months to less than 27 months who are fully immunised, where children assessed as fully immunised at 24 months are immunised against diphtheria, tetanus, whooping cough, polio, Haemophilus influenzae type b, hepatitis B, and measles, mumps and rubella * data quality information for this measure is under development * the proportion of children aged 24 months to less than 27 months who are fully immunised, where children assessed as fully immunised at 24 months are immunised against diphtheria, tetanus, whooping cough, polio, Haemophilus influenzae type b, hepatitis B, and measles, mumps and rubella * information about data quality for this measure is at www.pc.gov.au/ gsp/reports/rogs/2013.   A high or increasing proportion of children who are fully immunised indicates a reduction in the risk of children contracting a range of vaccine preventable diseases, including measles, whooping cough and *Haemophilus influenzae* type b.  Data for this indicator are comparable. |
|  |
|  |

Many providers deliver child immunisation services (table 11.2). GPs are encouraged to achieve high immunisation coverage levels under the General Practice Immunisation Incentives Scheme, which provides incentives for the immunisation of children under 7 years of age.

Table 11.2 Valid vaccinations supplied to children under 7 years of age, by provider type, 2007–2012 (per cent)**a, b, c**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Provider | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
| GP | 84.4 | 53.4 | 82.8 | 64.4 | 69.2 | 87.1 | 42.4 | 4.4 | 71.3 |
| Council | 5.6 | 45.3 | 7.0 | 6.4 | 18.4 | 12.1 | – | – | 16.8 |
| State or Territory health department | – | – | – | 6.1 | 0.1 | 0.1 | 19.1 | 0.3 | 0.9 |
| Public hospital | 2.0 | 0.5 | 3.0 | 4.4 | 2.6 | 0.2 | 0.8 | 7.5 | 2.1 |
| Private hospital | 0.1 | – | – | – | – | – | – | 0.9 | – |
| Indigenous health service | 0.5 | – | 1.1 | 0.6 | 0.5 | – | 0.2 | 10.8 | 0.7 |
| Community health centre | 7.3 | 0.7 | 5.7 | 18.1 | 9.1 | 0.5 | 37.5 | 76.0 | 8.0 |
| Otherd | – | – | 0.3 | – | 0.1 | – | – | – | 0.1 |
| **Total** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** |

a Data are for the period 1 July 2007 to 30 June 2012. b Data are based on State/Territory in which the immunisation provider was located. c A valid vaccination is a National Health and Medical Research Council’s Australian Standard Vaccination Schedule vaccination administered to a child under the age of 7 years. d Other includes Divisions of GP, Flying Doctors Services, Indigenous Health Workers, Community nurses and unknown. – Nil or rounded to zero.

*Source*: DoHA (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 11A.59; 2013 Report, table 11.8, p. 11.65.

#### Participation for women in breast cancer screening

‘Participation for women in breast cancer screening’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer through the provision of early detection services (box 11.7).

|  |
| --- |
| Box 11.7 Participation for women in breast cancer screening |
| ‘Participation for women in breast cancer screening’ is defined as the number of women aged 50–69 years who are screened in the BreastScreen Australia Program over a 24 month period, divided by the estimated population of women aged  50–69 years and reported as a rate.  A high or increasing participation rate is desirable.  Data reported for this indicator are comparable.  Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/ rogs/2013. |
|  |
|  |

Indigenous women, women from non‑English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas can experience particular language, cultural and geographic barriers to accessing breast cancer screening. Participation rates for community groups at or close to those for the total population indicate equitable access to early detection services.

Participation rates in the BreastScreen Australia Program for women from selected community groups are shown in table 11.3. In the 24 month period 2010 and 2011, the national age standardised participation rate for Indigenous women aged 50–69 years (36.1 per cent) was below the total participation rate in that age group (53.9 per cent), although this can in part reflect under-reporting of Indigenous status in screening program records (table 11A.68). For NESB women for the same 24 month period and age group, the national participation rate of 51.1 per cent was also lower than that of the national total female population (2013 Report,   
table 11A.69). Care needs to be taken when comparing data across jurisdictions as there is variation in the collection of Indigenous and NESB identification data, and in the collection of residential postcodes data. Updated State and Territory data for participation rate by remoteness area were not available for the 2013 Report — data for previous years as well as national data for 2010–2011 are reported in   
2013 Report, table 11A.70.

Table 11.3 Age standardised participation rate for women aged   
50–69 years from selected communities in BreastScreen Australia programs, 2010 and 2011 (24 month period) (per cent)**a, b, c**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | NSW | Vic | Qld | WA | SA | Tas | ACTd | NT | Aust |
| Indigenouse | 34.5 | 29.8 | 46.4 | 33.4 | 33.3 | 46.1 | 47.5 | 24.8 | 36.1 |
| NESBf | 52.5 | 43.6 | 67.8 | 67.1 | 51.3 | 45.0 | 14.7 | 38.7 | 51.1 |
| All women aged 50–69 years | 49.6 | 54.3 | 56.4 | 58.2 | 57.4 | 57.0 | 51.1 | 40.7 | 53.9 |

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

*Source*: State and Territory governments (unpublished); ABS (2011) *Population by Age and Sex, Australian States and Territories*, June 2011, Cat. no. 3201.0; ABS (unpublished) Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 1991 to 2021, Cat. no. 3238.0; ABS (unpublished) 2006 Census of Population and Housing; table 11A.68; 2013 Report, tables 11A.66–11A.69; 2013 Report, table 11.9, p. 11.73.

#### Participation for women in cervical screening

‘Participation for women in cervical screening’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to cervical cancer through the provision of early detection services (box 11.8).

|  |
| --- |
| Box 11.8 Participation for women in cervical screening |
| ‘Participation for women in cervical screening’ is defined as the number of women aged 20–69 years who are screened over a two year period, divided by the estimated population of eligible women aged 20–69 years and reported as a rate. Eligible women are those who have not had a hysterectomy.  A high or increasing proportion of eligible women aged 20–69 years who have been screened is desirable.  Data for this indicator are comparable.  Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/ rogs/2013. |
|  |
|  |

The national age-standardised participation rate for women aged 20–69 years in cervical screening dropped from 59.4 per cent for the 24 month period 1 January 2006 to 31 December 2007 to 57.2 per cent for the 24 months 1 January 2010 to 31 December 2011 (2013 Report, figure 11.44). For most jurisdictions, participation rates have dropped slightly since the screening period of 2006 and 2007. Data for Indigenous women for 2004-05 are presented in table 11A.72.

#### Influenza vaccination coverage for older people

‘Influenza vaccination coverage for older people’ is an indicator of governments’ objective to reduce the morbidity and mortality attributable to vaccine preventable disease (box 11.9).

|  |
| --- |
| Box 11.9 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. This does not include pandemic influenza such as H1N1 Influenza (commonly known as ‘swine flu’).  A high or increasing proportion of older people vaccinated against influenza reduces the risk of older people contracting influenza and suffering consequent complications. Each year, influenza and its consequences result in the hospitalisation of many older people, as well as a considerable number of deaths.  Data for this indicator are comparable.  Data quality information for this indicator is under development. |
|  |
|  |

Influenza vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (DoHA and NHMRC 2008). Free vaccines for Australians aged 65 years or over have been funded since 1999 by the Australian Government through the National Influenza Vaccine Program for Older Australians. GPs provide the majority of these vaccinations.

Pneumococcal disease is also a vaccine preventable disease that can result in hospitalisation and/or death. Free vaccinations against pneumococcal disease became available to older Australians in 2005. Data for 2009 for older adults fully vaccinated against both influenza and pneumococcal disease are presented by remoteness in 2013 Report, table 11A.74. Data for Indigenous Australians fully vaccinated against influenza and pneumococcal disease in 2004‑05 are presented in table 11A.75.

### Selected potentially preventable hospitalisations

‘Selected potentially preventable hospitalisations’ is an indicator of governments’ objective to reduce potentially preventable hospitalisations through the delivery of effective primary healthcare services (box 11.10).

|  |
| --- |
| Box 11.10 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:   * potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions, as defined in the Victorian Ambulatory Care Sensitive Conditions Study (AIHW 2012b; DHS 2002) * potentially preventable hospitalisations for diabetes * potentially preventable hospitalisations of older people for falls.   Low or decreasing separation rates for selected potentially preventable hospitalisations can indicate improvements in the effectiveness of preventative programs and/or more effective management of selected conditions in the primary and community healthcare sector.  Factors outside the control of the primary and community healthcare sector also influence hospitalisation rates for these conditions (AIHW 2008b, 2012b). For example, the underlying prevalence of conditions, patient compliance with treatment and older people’s access to aged care services and other support.  Data for this indicator are comparable.  Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/ rogs/2013. |
|  |
|  |

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

Studies have shown that hospitalisation rates for selected vaccine preventable, acute and chronic conditions are significantly affected by the availability of care in the primary and community healthcare sector (DHS 2002). These are conditions for which hospitalisation can potentially be avoided, through prevention of the condition — for example, through vaccination — or, prevention of exacerbations or complications requiring hospitalisation — through effective management of the condition in the primary and community healthcare sector. While not all hospitalisations for the selected conditions can be prevented, strengthening the effectiveness of primary and community healthcare has considerable potential to reduce the need for hospitalisation for these conditions.

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

Data presented by Indigenous status are adjusted to account for differences in the age structures of these populations across states and territories.

Nationally, the age standardised hospital separation rate for the selected vaccine preventable, acute and chronic conditions reported here was 23.3 per 1000 people in 2010-11 (2013 Report, table 11.10). Of these, 47.7 per cent were for chronic and 49.4 per cent for acute conditions (2013 Report, table 11A.76). Data are presented disaggregated by Indigenous status in table 11A.77 and remoteness in 2013 Report, table 11A.78. National data by Indigenous status and remoteness are presented in table 11A.79.

The age standardised hospital separation rate for vaccine preventable conditions was higher for Indigenous Australians than for non‑Indigenous Australians in 2010‑11, in most jurisdictions (figure 11.7).

Figure 11.7 Separations for vaccine preventable conditions by Indigenous status**a, b, c, d, e**

|  |
| --- |
| Figure 11.7 Separations for vaccine preventable conditions by Indigenous status - Indigenous Australians  More details can be found within the text surrounding this image.  Figure 11.7 Separations for vaccine preventable conditions by Indigenous status - Non-Indigenous Australians  More details can be found within the text surrounding this image. |

a Separation rates are directly age standardised to the Australian population at 30 June 2001. b Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. c Separation rates are based on State/Territory of usual residence. d NT data for Indigenous Australians are for public hospitals only. e Total comprises NSW, Victoria, Queensland, WA, SA and the NT (public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes. Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.

*Source*: AIHW (unpublished) National Hospital Morbidity Database; table 11A.77; 2013 Report, figure 11.45, p. 11.79.

The age standardised hospital separation rate for the selected acute conditions was higher for Indigenous Australians than for non‑Indigenous Australians in all jurisdictions in 2010‑11 (figure 11.8).

Figure 11.8 Separations for selected acute conditions by Indigenous status**a, b, c, d, e, f**

|  |
| --- |
| Figure 11.8 Separations for selected acute conditions by Indigenous status - Indigenous Australians  More details can be found within the text surrounding this image.  Figure 11.8 Separations for selected acute conditions by Indigenous status - Non-Indigenous Australians  More details can be found within the text surrounding this image. |

a Excludes separations for dehydration and gastroenteritis. b Separation rates are directly age standardised to the Australian population at 30 June 2001. c Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. d Separation rates are based on State/Territory of usual residence. e NT data for Indigenous Australians are for public hospitals only. f Total comprises NSW, Victoria, Queensland, WA, SA and the NT (public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes. Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.

*Source*: AIHW (unpublished) National Hospital Morbidity Database; table 11A.77; 2013 Report, figure 11.46, p. 11.81.

The age standardised hospital separation rate for the selected chronic conditions was higher for Indigenous Australians than for non‑Indigenous Australians in all jurisdictions in 2010‑11 (figure 11.9).

Figure 11.9 Separations for selected chronic conditions by Indigenous status**a, b, c, d, e, f**

|  |
| --- |
| Figure 11.9 Separations for selected chronic conditions by Indigenous status - Indigenous Australians  More details can be found within the text surrounding this image.  Figure 11.9 Separations for selected chronic conditions by Indigenous status - Non-Indigenous Australians  More details can be found within the text surrounding this image. |

a Excludes separations for diabetes complications (all diagnoses). b Separation rates are directly age standardised to the Australian population at 30 June 2001. c Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. d Separation rates are based on State/Territory of usual residence. e Total comprises NSW, Victoria, Queensland, WA, SA and the NT (public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes. f Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.

*Source*: AIHW (unpublished) National Hospital Morbidity Database; table 11A.77.

#### Potentially preventable hospitalisations for diabetes

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

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

Nationally, the age standardised hospital separation rate for Type 2 diabetes mellitus as principal diagnosis was 95.5 separations per 100 000 people in 2010-11 (2013 Report, figure 11.48).

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

There was a marked difference in 2010-11 between the separation rates for Indigenous Australians and those for the total population for diabetes diagnoses. The quality of Indigenous identification is considered acceptable for analysis only for NSW, Victoria, Queensland, WA, SA and the NT. For these jurisdictions combined, the separation rate for Indigenous Australians was 4.4 times as high as the separation rate for all Australian people (figure 11.10).

Figure 11.10 Ratio of separation rates of Indigenous Australians to all people for diabetes, 2010-11**a, b, c, d, e, f, g**

|  |
| --- |
| Figure 11.10 Ratio of separation rates of Indigenous Australians to all people for diabetes, 2010-11  More details can be found within the text surrounding this image. |

a Excludes separations with diabetes complications as an additional diagnosis. b Ratios are directly age standardised to the Australian population at 30 June 2001. c Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. d Patients aged 75 years or over are excluded. e Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. f NT data are for public hospitals only. g Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT.

*Source*: AIHW (unpublished) National Hospital Morbidity Database; table 11A.83; 2013 Report, figure 11.51, p. 11.87.

### Future directions in performance reporting

#### Indigenous health

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

Continued efforts to improve the quality of Indigenous data, particularly Indigenous identification and completeness, are necessary to better measure the performance of primary and community health services in relation to the health of Indigenous Australians. Work being undertaken by the ABS and AIHW includes an ongoing program to improve identification of Indigenous status in Australian, State and Territory government administrative systems. Work on improving Indigenous identification in hospital admitted patient data across states and territories is ongoing, with the inclusion of data for Tasmania and the ACT in national totals a priority.

### Definitions of key terms and indicators

|  |  |
| --- | --- |
| 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. |
| Asthma Action Plan | An asthma action plan is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional.  *Source*: ACAM (Australian Centre for Asthma Monitoring) 2007, Australian asthma indicators: Five-year review of asthma monitoring in Australia. Cat. no. ACM 12, AIHW, Canberra. |
| Community health services | Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities. |
| 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 workload equivalents (FWE) | A measure of medical practitioner supply based on claims processed by DHS, Medicare in a given period, calculated by dividing the practitioner’s DHS, Medicare billing by the mean billing of full time practitioners for that period.  Full time equivalents (FTE) are calculated in the same way as FWE except that FTE are capped at 1 per practitioner. |
| Fully immunised at 12 months | A child who has completed three doses of diphtheria, tetanus, pertussis vaccine, three doses of polio vaccine, three doses of Hepatitis B vaccine and three doses of *Haemophilus influenzae* type B vaccine. |
| Fully immunised at 24 months | A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of polio vaccine, three doses of Hepatitis B vaccine, four doses of *Haemophilus influenzae* type B and one dose of measles, mumps and rubella vaccine. |
| Fully immunised at 60 months | A child who has received the necessary doses of diphtheria, tetanus, whooping cough, polio, and measles, mumps and rubella vaccines. |
| General practice | The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a ‘population’ of patients and may include services for specific populations, such as women's health or Indigenous health. |
| General practitioner (GP) | Vocationally registered GPs — medical practitioners who are vocationally registered under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. From 1996 vocational registration is available only to GPs who attain Fellowship of the RACGP or (from April 2007) the ACRRM, or hold a recognised training placement.  Other medical practitioners (OMP) — medical practitioners who are not vocationally registered GPs. |
| GP‑type services | Non‑referred attendances by vocationally registered GPs and OMPs, and practice nurses. |
| *Haemophilus influenzae* type b | A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (DoHA 2008). |
| Immunisation coverage | The proportion of a target population fully immunised with National Immunisation Program specified vaccines for that age group. |
| 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. |
| 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. |
| Primary healthcare | The primary and community healthcare sector includes services that:  provide the first point of contact with the health system  have a particular focus on illness prevention or early intervention  are intended to maintain people’s independence and maximise their quality of life through care and support at home or in local community settings. |
| Prevalence | The proportion of the population suffering from a disorder at a given point in time (point prevalence) or given period (period prevalence). |
| 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). |

### List of 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 a ‘11A’ prefix (for example, table 11A.1 is table 1 in the Primary and community health attachment). Attachment tables are on the Review website (www.pc.gov.au/gsp).

|  |  |
| --- | --- |
| **Table 11A.11** | Indigenous primary healthcare services and episodes of healthcare (number) |
| **Table 11A.12** | Indigenous primary healthcare services and episodes of healthcare, by remoteness category (number) |
| **Table 11A.13** | Proportion of Indigenous primary healthcare services that undertook selected health related activities (per cent) |
| **Table 11A.14** | Full time equivalent (FTE) health staff employed by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, as at 30 June 2011 (number) |
| **Table 11A.21** | Annual health assessments for older people by Indigenous status (per cent) |
| **Table 11A.22** | Older Indigenous people who received an annual health assessment (per cent) |
| **Table 11A.23** | Indigenous people who received a health check or assessment, by age (per cent) |
| **Table 11A.24** | Early detection activities provided by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported |
| **Table 11A.25** | Proportion of children receiving a fourth year developmental health check, by type of health check (per cent) |
| **Table 11A.31** | Selected potentially avoidable GP-type presentations to emergency departments by Indigenous status and remoteness, 2011-12 (number) |
| **Table 11A.48** | Proportion of people with asthma with a written asthma plan, by Indigenous status, 2004-05 |
| **Table 11A.59** | Valid vaccinations supplied to children under seven years of age, by type of provider, 2007–2012 |
| **Table 11A.68** | Participation rates for Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) |
| **Table 11A.72** | Cervical screening rates among Indigenous women aged 20 to 69 years, who reported having a Pap smear at least every 2 years, 2004-05 (per cent) |
| **Table 11A.75** | Proportion of Indigenous Australians aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease, 2004-05 |
| **Table 11A.77** | Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) |
| **Table 11A.79** | Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia (per 1000 people) |
| **Table 11A.80** | Separations for selected vaccine preventable conditions by Indigenous status, 2010-11 (per 1000 people) |
| **Table 11A.81** | Separations for selected acute conditions by Indigenous status, 2010-11 (per 1000 people) |
| **Table 11A.82** | Separations for selected chronic conditions by Indigenous status, 2010-11 (per 1000 people) |
| **Table 11A.83** | Ratio of separations for Indigenous Australians to all Australians, diabetes, 2010-11 |
| **Community health programs** | |
| **Table 11A.88** | Australian Government, community health services programs |
| **Table 11A.89** | New South Wales, community health services programs |
| **Table 11A.90** | Victoria, community health services programs |
| **Table 11A.91** | Queensland, community health services programs |
| **Table 11A.92** | Western Australia, community health services programs |
| **Table 11A.93** | South Australia, community health services programs |
| **Table 11A.94** | Tasmania, community health services programs |
| **Table 11A.95** | Australian Capital Territory, community health services programs |
| **Table 11A.96** | Northern Territory, community health services programs |

### References

AIHW (Australian Institute of Health and Welfare) 2008a, *Aboriginal and Torres Strait Islander Health Performance Framework, 2008 report: detailed analyses*, AIHW Cat. no. IHW 22, Canberra.

—— 2008b, *Australia’s health 2008*, Cat. no. AUS 99, Canberra.

—— 2008b, *Diabetes: A****u****stralian facts*, Cat. no. CVD 40, Diabetes series no. 8, Canberra.

—— 2012a, *Alcohol and other drug treatment services in Australia 2010‑11: report on the National Minimum Data Set*, Cat. no. HSE 128, Drug treatment series no. 18, Canberra.

—— 2012b, Australian hospital statistics 2010-11, Cat. no. HSE 117, Canberra.

DoHA (Australian Government Department of Health and Ageing) 2008, *Immunisation Myths and Realities: responding to arguments against immunisation*, 4th edn, Canberra.

DHS (Department of Human Services) 2002, *Victorian Ambulatory Care Sensitive Conditions Study: Preliminary Analyses*, Victorian Government, Melbourne.

DoHA and NHMRC (National Health and Medical Research Council) 2008, *The Australian Immunisation Handbook*, 9th edn, Canberra.

Quality Improvement Council 1998, *Australian Health and Community Service Standards: Community and Primary Health Care Services Module*, Melbourne.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2011, *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra.

Van Konkelenberg, R. Esterman, A. Van Konkelenberg, J. 2003, Literature Reviews: Factors Influencing use of Emergency Departments and Characteristics of Patients Admitted Through Emergency Departments, www.publications.health.sa.gov.au/cgi/viewcontent.cgi?article=1002&context=  
ecc (accessed 11 August 2011).