11 Primary and community health

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| 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 2014 Report, the Compendium also notes where the original table, figure or text in the 2014 Report can be found. For example, where the Compendium refers to ‘2014 Report, p. 11.1’ this is page 1 of chapter 11 of the 2014 Report, and ‘2014 Report, table 11A.1’ is attachment table 1 of attachment 11A of the 2014 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. |
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The Primary and community health chapter (chapter 11) in the *Report on Government Services 2014* (2014 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.

Major improvements in reporting on primary and community health in this edition include reporting of Australian Government expenditure on Indigenous primary healthcare services is reported for the first time.

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

The Primary and community health chapter in the 2014 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 which provide data for Online Services Reporting (OSR)
* 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 service for which OATSIH Services Reporting (OSR) data are reported
* Indigenous Australians deferring access to general practitioners (GPs) due to cost
* Indigenous people deferring access to prescribed medication due to cost
* waiting times for public dentistry, Indigenous Australians, by remoteness
* proportion of people with asthma with a written asthma plan, by Indigenous status
* client experience of GPs by remoteness, Indigenous people
* participation rates for Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds)
* cervical screening rates among Indigenous women aged 20 to 69 years, who reported having a Pap smear at least every 2 years
* separations for selected potentially preventable hospitalisations by Indigenous status
* proportion of Indigenous Australians aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease
* separations for selected potentially preventable hospitalisations by Indigenous status
* separations for selected vaccine preventable conditions by Indigenous status
* separations for selected acute conditions by Indigenous status
* separations for selected chronic conditions by Indigenous status
* ratio of separations for Indigenous Australians to all Australians, 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

State and Territory governments and the Australian Government 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. Each jurisdiction determines its own eligibility requirements for accessing public dental services, usually requiring a person to hold a concession card issued by Centrelink.

The Australian Government supports the provision of dental services primarily through the private health insurance rebate and, through Department of Human Services (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. 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.

**Funding**

*General practice*

Australian Government total expenditure on general practice in 2012-13 was   
$7.4 billion (2014 Report, table 11A.2).

Not all Australian Government funding of primary healthcare services is captured in these 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.

#### Community health services

Overall government expenditure data relating only to the primary and community health services covered in this chapter are not available. Expenditure data reported here also cover public health services such as food safety regulation and media campaigns to promote health awareness, as well as private dental services (funded by health insurance premium rebates and non‑government expenditure)   
(2014 Report, table 11.2).

In 2011-12, government expenditure on community and public health was   
$9.3 billion, of which State, Territory and local governments provided 70.8 per cent, and the Australian Government 29.2 per cent (2014 Report, table 11.2). In that year, Australian Government direct outlay expenditure on dental services, predominantly through the Department of Veterans’ Affairs and the Department of Health, was $1.1 billion. State, Territory and local government expenditure on dental services was $718 million in 2011-12. Additional expenditure is incurred by some states and territories through schemes that fund the provision of dental services to eligible people by private practitioners. Dental expenditure by state and territory is provided in 2014 Report, table 11A.7.

Australian Government expenditure on Aboriginal medical services was   
$531 million in 2012-13 (table 11A.8).

### Size and scope

#### General practice

There were 30 681 vocationally registered GPs and other medical practitioners (OMPs) billing Medicare Australia, based on the Medicare Benefits Schedule (MBS) claims data, in 2012-13. On a full time workload equivalent (FWE) basis, there were 22 087 vocationally registered GPs and OMPs (see 2014 Report, section 11.5 for a definition of FWE). This was equal to 96.4 FWE registered GPs and OMPs per 100 000 people (2014 Report, table 11A.9). 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 2014 Report, figure 11.2.

#### Pharmaceutical Benefits Scheme

Australian Government expenditure on the PBS is reported by service category. Expenditure on general, concessional and doctor’s bag categories was $7.1 billion in 2012‑13 (2014 Report, tables 11A.4 and 11A.5). Other categories administered under special arrangements to improve access to PBS medicines include the supply of medicines to Aboriginal Services in remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — Australian Government expenditure on this category was $36.9 million in 2012-13 (table 11A.6).

##### 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. Data included here 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 2013). 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, planned and governed by local Indigenous communities with the aim of delivering 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 2012‑13, 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.105–113).

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) 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 2011‑12, OSR data are reported for 224 Indigenous primary healthcare services (table 11A.15). Of these services, 90 (40.2 per cent) were located in remote or very remote areas (table 11A.16). 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.17). 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 2.6 million episodes of healthcare were provided by participating services in 2011‑12 (table 11.1). Of these, around 1.2 million   
(47.0 per cent) were in remote or very remote areas (table 11A.16).

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

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
| 2008-09 | 452 | 160 | 336 | 306 | 191 | 35 | 23 | 586 | 2 089 |
| 2009-10 | 542 | 185 | 379 | 409 | 192 | 36 | 26 | 622 | 2 391 |
| 2010-11 | 522 | 201 | 310 | 473 | 222 | 38 | 30 | 704 | 2 498 |
| 2011-12 | 516 | 234 | 475 | 462 | 216 | 44 | 34 | 641 | 2 621 |

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 (2013 and previous issues) *Aboriginal and Torres Strait Islander health services report*: *online services report - key results*, Cat. no.s IHW 31, 56, 79 and 104; table 11A.15; 2014 Report, table 11.5,   
p. 11.16.

The services included in the OSR data collection employed around 3469 full time equivalent healthcare staff (as at 30 June 2012). Of these, 1946 were Indigenous Australians (56.1 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous Australians were relatively low   
(5.9 per cent and 12.9 per cent, respectively) (table 11A.18).

### Framework of performance indicators

The performance indicator framework is based on shared government objectives for primary and community health (2014 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 Council of Australian Governments (COAG) has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations).

The *National Healthcare Agreement* (NHA) covers the areas of health and aged care services, and health indicators in the *National Indigenous Reform Agreement* establish specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. Both agreements include sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with health performance indicators in the NHA. The NHA was reviewed in 2011, 2012 and 2013 resulting in changes that have been reflected in this Report, as relevant.

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 2014 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   
2014 Report, section 1.6).

The Report’s statistical context chapter 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) (chapter 2).

Figure 11.1 Primary and community health performance indicator framework

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

*Source*: 2014 Report, figure 11.4, p. 11.15.

### 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).

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| 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 and timely prevention and intervention measures (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. |
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| 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. A high or increasing 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 health assessments provided outside DHS Medicare. Such services are provided under service delivery models used, for example, in remote and very remote areas and therefore accessed predominantly by Indigenous Australians. Accordingly, this indicator understates the proportion of Indigenous Australians who received early detection and early treatment services.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions for 2012‑13 for the three health assessment measures, and for 2011-12 for the measure primary healthcare services providing early detection services.   Data quality information for this indicator is under development. |
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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 2012-13, the proportion of Indigenous older Australians who received an annual health assessment was higher than the proportion of non‑Indigenous older Australians who received an annual health assessment in all jurisdictions except Victoria, SA and Tasmania (figure 11.2).

Figure 11.2 Older people who received an annual health assessment by Indigenous status, 2012-13**a, b, c, d**

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| Figure 11.2 Older people who received an annual health assessment by Indigenous status, 2012-13  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 the mainstream MBS Health Assessment for people aged 75 years or over. This is unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Indigenous Australians. c Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data for Indigenous Australians are therefore likely to understate the proportion who access health assessments. d The populations used to derive the Indigenous Australians and non‑Indigenous Australians’ rates are based on the 2006 Census.

*Source*: Derived from Department of Health (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.27; 2014 Report, figure 11.10, p. 11.30.

The proportion of older Indigenous Australians who received an annual health assessment increased in all jurisdictions between 2008-09 and 2012-13   
(figure 11.3).

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

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| 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 the mainstream MBS Health Assessment for people aged 75 years or over. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous Australians. b Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data are therefore likely to understate the proportion who access health assessments.

*Source*: Derived from Department of Health (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.28; 2014 Report, figure 11.11, p. 11.31.

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 assessment by age, 2012-13**a, b**

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| Figure 11.4 Indigenous Australians who received a health assessment by age, 2012-13  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 receive the mainstream MBS Health Assessment for people aged 75 years or over. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous Australians. b Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data are therefore likely to understate the proportion who access health assessments.

*Source*: Derived from Department of Health (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.29; 2014 Report, figure 11.12, p. 11.32.

Nationally, the proportion of Indigenous primary healthcare services providing early detection services varied little in the period 2008-09 to 2011-12 (figure 11.5).

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

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| 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: online services report - key results, 2008-09, 2009-10 and 2010-11*, Cat. no.s IHW 31, 56 and 79; table 11A.30;   
2014 Report, figure 11.13, p. 11.33.

### 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).

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| Box 11.2 Developmental health checks |
| ‘Developmental health checks’ is defined as the proportion of children who received a fourth year developmental health assessment under DHS Medicare, by health assessment type. 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 assessment is desirable as it suggests improved access to these services.  The proportion of Indigenous children aged 3 to 5 years who received the Aboriginal and Torres Strait Islander Peoples Health Assessment is reported as a proxy for the proportion of Indigenous children who received a fourth year developmental health assessment. The proportion of non-Indigenous children who received a Healthy Kids Check or, for those who did not receive a Healthy Kids Check, received a Health assessment at the age of 5 years, is reported as a proxy for the proportion of non‑Indigenous children who received a fourth year developmental health assessment.  Fourth year developmental health assessment 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 reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data for 2012-13 are not comparable to historical data * complete (subject to caveats) for the current reporting period. All required 2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Nationally, 52.8 per cent of children received a fourth year developmental health check under DHS Medicare in 2012-13. 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, 2012-13**a, b, c, d, e, f**

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| Figure 11.6 Children who received a fourth year developmental health check, by health check type, 2012-13  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 a Aboriginal and Torres Strait Islander Peoples Health Assessment during the same or a previous reference period. f The populations used to derive the Indigenous Australians and non-Indigenous Australians’ rates are based on the 2006 Census.

*Source*: Department of Health (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.31; 2014 Report, figure 11.14,   
p. 11.35.

### 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.

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| 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 less than 24 hours * 24 hours or more * potentially avoidable presentations to emergency departments — two measures, defined as: * the proportion of people who visited a hospital emergency department for care they thought at the time could have been provided by a GP * the number of selected ‘GP-type presentations’ to emergency departments, where selected 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.  Data reported for this measure are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2012‑13 data are available for all jurisdictions.   A low or decreasing proportion of people deferring visits to GPs due to financial barriers indicates more widely affordable access to GPs. |
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| Box 11.3 (Continued) |
| Data reported for this measure are:   * comparable (subject to caveats) across jurisdictions but not comparable over time * complete (subject to caveats) for the current reporting period. All required 2012‑13 data are available for all jurisdictions.   A high or increasing proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs.  Data reported for this measure are:   * comparable (subject to caveats) across jurisdictions and comparable over time for 2011-12 and 2012-13 but not for previous years * complete (subject to caveats) for the current reporting period. All required 2012‑13 data are available for all jurisdictions.   A low or decreasing proportion of potentially avoidable presentations to emergency departments can indicate better access to primary and community health care.  Data reported for this measure are:   * comparable (subject to caveats) within some jurisdictions over time but are not comparable within other jurisdictions over time or across jurisdictions (see caveats in attachment tables for specific jurisdictions) * complete (subject to caveats) for the current reporting period. All required 2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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#### Effectiveness of access to GPs — people deferring visits to GPs due to financial barriers

Data for Indigenous Australians deferring access to GPs due to cost, available for the first time from the ABS 2011-12 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS), are presented in table 11A.36. Differences in survey design and methodology mean data for all Australians, which are sourced from the ABS Patient experience survey, and the AATSIHS are not comparable.

### Financial barriers to PBS medicines

‘Financial barriers to PBS medicines’ is an indicator of governments’ objective to ensure effective access to prescribed medicines (box 11.4).

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| Box 11.4 Financial barriers to PBS medicines |
| ‘Financial barriers to PBS medicines’ is defined as the proportion of people who delayed getting or did not get a prescription filled due to cost.  A low or decreasing proportion of people deferring treatment due to financial barriers indicates more widely affordable access to medications.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Nationally, in 2012-13, 8.5 per cent of respondents delayed or did not purchase prescribed medicines due to cost in the previous 12 month period (2014 Report, figure 11.19). National data by remoteness are reported in 2014 Report,   
table 11A.44. Data for Indigenous Australians are available for the first time from the ABS 2011-12 AATSIHS and are presented in table 11A.42. However, differences in survey design and methodology mean data from the Patient experience survey and the AATSIHS are not comparable.

**Public dentistry waiting times**

‘Public dentistry waiting times’ is an indicator of governments’ objective to ensure timely access to public dental services for eligible people (box 11.5).

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| Box 11.5 **Public dentistry waiting times** |
| ‘Public dentistry waiting times’ is defined as the time waited between being placed on  a public dentistry waiting list and being seen by a dental professional. It is measured  as the proportion of people on a public dental waiting list who saw a dental professional at a government dental clinic, within specified waiting time categories.  A high or increasing proportion of people waiting shorter periods to see a dental professional indicates more timely access to public dental services.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but not over time. Data for 2012-13 are not comparable with data for 2011-12 and previous years * complete (subject to caveats) for the current reporting period. All required 2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Nationally, 30.5 per cent of people who were on a public dental waiting list for waited less than 1 month to see a dental professional at a government dental clinic in 2012-13 (2014 Report, figure 11.20). Data are presented by remoteness in   
table 11A.44. Data for Indigenous Australians that are reported in table 11A.45.

#### 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.

Nationally, the proportion of people with current asthma reporting that they have a written asthma action plan was 24.6 per cent for all ages and 40.9 per cent for children aged 0–14 years in 2011-12 (2014 Report, figure 11.29). Data for 2007-08 are reported by geographical region in 2014 Report, table 11A.60. Data for 2004‑05 are reported by Indigenous status in table 11A.61.

**Quality — responsiveness — Patient satisfaction**

‘Patient satisfaction’ is an indicator of governments’ objective to ensure primary and community health services are high quality and account for individual patient needs (box 11.16).

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| Box 11.6 **Patient satisfaction** |
| ‘Patient satisfaction’ is defined as the quality of care as perceived by the patient. It is measured as patient experience of and/or satisfaction around ‘key aspects of care’ —that is, aspects of care that are key factors in patient outcomes and can be readily modified. Two measures of patient experience of communication with health professionals — a key aspect of care — are reported:   * experience with selected key aspects of GP care, defined as the number of people who saw a GP in the previous 12 months where the GP always or often: listened carefully to them; showed respect; and spent enough time with them, divided by the number of people who saw a GP in the previous 12 months * experience with selected key aspects of dental professional care, defined as the number of people who saw a dental professional in the previous 12 months where the dental practitioner always or often: listened carefully to them; showed respect; and spent enough time with them, divided by the number of people who saw a dental practitioner in the previous 12 months.   High or increasing proportions can indicate that more patients experienced communication with health professionals as satisfactory.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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##### Patient satisfaction — experience with selected key aspects of GP care

Nationally, the majority of respondents reported that, in 2012-13, the GP always or often (2014 Report, figure 11.36):

* listened carefully to them (89.3 per cent)
* showed respect (92.5 per cent)
* spent enough time with them (88.0 per cent).

Data for Indigenous Australians are reported in table 11A.72.

### 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 11.7).

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| Box 11.7 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 reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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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 11.8).

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| Box 11.8 Cost to government of general practice per person |
| ‘Cost to government of general practice per person’ is defined as the cost to government of general practice per person in the population.  This indicator needs to be interpreted with care. A low or decreasing cost per person can indicate higher efficiency, provided services are equally or more effective. It can also reflect service substitution between primary healthcare and hospital or specialist services — potentially at greater expense.  Cost to government of general practice does not capture costs of salaried GP service delivery models, used particularly in rural and remote areas, where primary healthcare services are provided by salaried GPs in community health settings, through emergency departments, and Indigenous primary healthcare services. Consequently, costs for primary care are understated for jurisdictions where a large proportion of the population live in rural and remote areas.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions for 2012-13, but not comparable to data for previous years * complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Nationally, the recurrent cost to the Australian Government of general practice was $286 per person in 2012-13 (2014 Report, figure 11.39).

### 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 11.9).

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| Box 11.9 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 * 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 * the proportion of children aged 60 months to less than 63 months who are fully immunised, where children assessed as fully immunised at 60 months are immunised against diphtheria, tetanus, whooping cough, polio, and measles, mumps and rubella.   A high or increasing proportion of children who are fully immunised indicates a reduction in the risk of children contracting a range of vaccine preventable diseases, including measles, whooping cough and *Haemophilus influenzae* type b.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Many providers deliver child immunisation services (table 11.2). High immunisation coverage levels have been encouraged under the General Practice Immunisation Incentives Scheme, which provided incentives for the immunisation of children under 7 years of age to 30 June 2013.

Table 11.2 Valid vaccinations supplied to children under 7 years of age, by provider type, 2008–2013 (per cent)**a, b, c**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Provider | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
| GP | 89.1 | 59.2 | 86.7 | 68.7 | 74.2 | 92.9 | 58.2 | 13.2 | 76.3 |
| Council | 3.5 | 40.3 | 6.1 | 3.7 | 18.5 | 7.1 | – | – | 14.2 |
| State or Territory health department | – | – | – | 6.4 | – | – | 1.2 | 0.5 | 0.8 |
| Public hospital | np | np | np | np | np | np | np | np | np |
| Private hospital | – | – | – | – | – | – | – | 0.8 | – |
| Indigenous health service | 0.6 | 0.2 | 0.7 | 0.4 | 0.6 | – | – | 21.9 | 0.8 |
| Community health centre | 6.8 | 0.3 | 6.4 | 20.8 | 6.6 | – | 40.6 | 63.5 | 7.9 |
| Otherd | – | 0.1 | 0.1 | 0.1 | 0.1 | – | – | – | 0.1 |
| **Total** | **100** | **100** | **100** | **100** | **100** | **100** | **100** | **100** | **100** |

a Data are for the period 1 July 2008 to 30 June 2013. 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. **np** Not published.

*Source*: Department of Health (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 11A.76; 2014 Report, table 11.7, p. 11.75.

#### 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 11.10).

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| Box 11.10 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 against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required data for the 24 month period 2011 and 2012 are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Indigenous 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. 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.

Participation rates in the BreastScreen Australia Program for women from selected community groups are shown in table 11.3. In the 24 month period 2011 and 2012, the national age standardised participation rate for Indigenous women aged 50–69 years was 37.7 per cent (table 11A.85). A low participation rate can in part reflect under-reporting of Indigenous status in screening program records. Rates for Indigenous women are derived using projected populations based on the 2006 Census and are not comparable with rates for all women or NESB women which are derived using Estimated Resident Populations (ERPs) based on the 2011 Census.

Table 11.8 Age standardised participation rate for women aged   
50–69 years from selected communities in BreastScreen Australia programs, 2011 and 2012 (24 month period)   
(per cent)**a, b, c, d, e, f**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | NSW | Vic | Qld | WA | SA | Tas | ACTd | NT | Aust |
| Indigenouse | 36.4 | 30.5 | 47.7 | 36.9 | 34.0 | 47.5 | 50.1 | 24.6 | 37.7 |
| NESBf | 46.8 | 50.7 | 62.2 | 64.2 | 52.1 | 44.1 | 19.0 | 37.8 | 50.6 |
| All women aged 50–69 years | 50.4 | 54.3 | 57.1 | 57.8 | 58.8 | 57.8 | 53.5 | 41.6 | 54.5 |

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.85 and 2014 Report, tables 11A.83–84 and 11A.86; 2014 Report, table 11.8, p. 11.84.

#### 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 11.11).

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| Box 11.11 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 reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required data for the 24 month period 2011 and 2012 are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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The national age-standardised participation rate for women aged 20–69 years in cervical screening dropped from 59.8 per cent for the 24 month period 1 January 2007 to 31 December 2008 to 57.7 per cent for the 24 months 1 January 2011 to   
31 December 2012 (2014 Report, figure 11.47). For most jurisdictions, participation rates have decreased since the screening period of 2007 and 2008. Data for Indigenous women for 2004-05 are presented in table 11A.89.

#### 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 11.12).

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| Box 11.12 Influenza vaccination coverage for older people |
| ‘Influenza vaccination coverage for older people’ is defined as the proportion of people aged 65 years or over who have been vaccinated against seasonal influenza.  A high or increasing proportion of older people vaccinated against influenza 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 reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * not available for the current reporting period.   Data quality information for this indicator is under development. |
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Influenza vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (Department of Health 2013a). Free vaccines for Australians aged 65 years or over have been funded since 1999 by the Australian Government through the Immunisation Program. 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 2014 Report, table 11A.91. Data for Indigenous Australians fully vaccinated against influenza and pneumococcal disease in 2004‑05 are presented in table 11A.92

### 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 11.13).

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| Box 11.13 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 (the first measure is reported against the indicator of the same name in the NHA):   * potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions as defined in the Victorian Ambulatory Care Sensitive Conditions Study (AIHW 2013b; 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, 2013b). For example, the underlying prevalence of conditions, patient compliance with treatment and older people’s access to aged care services and other support.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time except for the measure potentially preventable hospitalisations for diabetes * complete (subject to caveats) for the current reporting period except for the measure potentially preventable hospitalisations for diabetes, for which data are not published for Tasmania, the ACT and the NT. All other required 2011‑12 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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#### Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions

This measure has improved for the 2014 Report with data for all states and territories included in Australian totals for the first time. Indigenous identification in 2011-12 hospital administrative data is considered acceptable for analysis in all states and territories from the 2011-12 reporting period.

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.

Nationally, the age‑standardised hospital separation rate for the selected vaccine preventable, acute and chronic conditions reported here was 24.0 per 1000 people in 2011-12 (2014 Report, table 11.9). Of these, 47.1 per cent were for chronic and   
49.9 per cent for acute conditions (2014 Report, table 11A.93). Data are presented disaggregated by Indigenous status in table 11A.94 and remoteness in 2014 Report, table 11A.95. National data by Indigenous status and remoteness are presented in table 11A.96.

The age standardised hospital separation rate for vaccine preventable conditions was higher for Indigenous Australians than for non‑Indigenous Australians in 2011‑12, in most jurisdictions (figure 11.7).

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

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| 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 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. e For 2011-12, Indigenous status data are of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.

*Source*: AIHW (unpublished) National Hospital Morbidity Database; table 11A.97; 2014 Report, figure 11.48, p. 11.91.

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 2011‑12 (figure 11.8).

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

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| 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 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. f For 2011-12, Indigenous status data are of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.

*Source*: AIHW (unpublished) National Hospital Morbidity Database; table 11A.98; 2014 Report, figure 11.49, p. 11.93.

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 2011‑12 (figure 11.9).

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

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| 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 as additional diagnosis. 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 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. f From 2011-12, Indigenous status data are of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.

*Source*: AIHW (unpublished) National Hospital Morbidity Database; table 11A.99; 2014 Report, figure 11.50, p. 11.95.

#### 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 2008c). 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 93.8 separations per 100 000 people in 2011‑12 (2014 Report, figure 11.51).

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 2011-12 between the separation rates for Indigenous Australians and those for the total population for diabetes diagnoses (figure 11.10).

Figure 11.10 Ratio of separation rates of Indigenous Australians to all people for diabetes, 2011-12**a, b, c, d, e, f**

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| --- |
| Figure 11.10 Ratio of separation rates of Indigenous Australians to all people for diabetes, 2011-12  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 Separation 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.

*Source*: AIHW (unpublished) National Hospital Morbidity Database; table 11A.100; 2014 Report, figure 11.54, p. 11.99.

### 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.

### Definitions of key terms

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| --- | --- |
| **Age standardised** | Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution. |
| **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 influenza* 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. |
| ***Haemophilus influenzae* type b** | A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (Department of Health 2013b). |
| **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).

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