# 10 Primary and community health

CONTENTS

Aboriginal and Torres Strait Islander data in the Primary and community health chapter 10.2

Profile of primary and community health 10.4

Funding 10.5

Size and scope 10.5

Framework of performance indicators 10.8

Early detection and early treatment for Aboriginal and Torres Strait Islander Australians 10.10

Developmental health checks 10.14

Effectiveness of access to GPs 10.16

Financial barriers to PBS medicines 10.18

Public dentistry waiting times 10.19

Chronic disease management 10.20

Quality — responsiveness — patient satisfaction 10.23

Quality — continuity — health assessments for older people 10.24

Efficiency — Cost to government of general practice per person 10.25

Outcomes 10.26

Future directions in performance reporting 10.37

Definitions of key terms 10.39

List of attachment tables 10.41

References 10.43

|  |
| --- |
| **Attachment tables** |
| Attachment tables are identified in references throughout this Indigenous Compendium by an ‘A’ prefix (for example, in this chapter, table 10A.1). As the data are directly sourced from the 2015 Report, the Compendium also notes where the original table, figure or text in the 2015 Report can be found. For example, where the Compendium refers to ‘2015 Report, p. 10.1’ this is page 1 of chapter 10 of the 2015 Report, and ‘2015 Report, table 10A.1’ is attachment table 1 of attachment 10A of the 2015 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/research/recurring/report-on-government-services. |
|  |
|  |

The Primary and community health chapter (chapter 11) in the *Report on Government Services 2015* (2015 Report) reports on the performance of primary and community health services in Australia. Data are reported for Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander 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 the prevention of ill health, the detection and management of illness and injury and the effective management of chronic disease — through direct service provision and through referral to acute (hospital) or other healthcare services, as appropriate.

### Aboriginal and Torres Strait Islander data in the Primary and community health chapter

The Primary and community health chapter in the 2015 Report contains the following data on Aboriginal and Torres Strait Islander Australians:

* Australian Government expenditure on PBS medicines supplied to Aboriginal Health Services in remote areas
* Australian Government funding of Aboriginal and Torres Strait Islander Primary Health Care Services
* Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare, including by remoteness
* proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities
* full time equivalent (FTE) health staff employed by Aboriginal and Torres Strait Islander primary healthcare services which provide data for Online Services Reporting (OSR)
* annual health assessments for older people by Indigenous status
* older Aboriginal and Torres Strait Islander people who received a health assessment by age group
* proportion of children receiving a fourth year developmental health check, by type of health check
* Aboriginal and Torres Strait Islander people deferring access to GPs due to cost
* Aboriginal and Torres Strait Islander people deferring access to prescribed medication due to cost
* waiting times for public dentistry, Aboriginal and Torres Strait Islander people, by remoteness
* proportion of people with asthma with a written asthma plan, by Indigenous status
* client experience of GPs by remoteness, by Indigenous status
* valid vaccinations supplied to children under seven years of age, by type of provider
* participation rates for Aboriginal and Torres Strait Islander women screened by BreastScreen Australia (24 month period) (first and subsequent rounds)
* cervical screening rates among Aboriginal and Torres Strait Islander women aged 20 to 69 years, who reported having a Pap smear at least every 2 years
* proportion of Aboriginal and Torres Strait Islander people aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease
* separations for selected potentially preventable hospitalisations by Indigenous status, including by remoteness
* separations for selected potentially preventable hospitalisations by Indigenous status and remoteness
* separations for selected vaccine preventable, acute and chronic conditions by Indigenous status
* ratio of separations for Aboriginal and Torres Strait Islander Australians to all Australians 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). There is no national strategy for community health and there is considerable variation in the services provided across jurisdictions.

Community health 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 has the main responsibility for Aboriginal and Torres Strait Islander primary healthcare services, which have the objective of addressing the disproportionate ill-health experienced by Aboriginal and Torres Strait Islander people. Around 60 per cent of these are Aboriginal and Torres Strait Islander community-controlled or managed — planned and governed by local Aboriginal and Torres Strait Islander communities with the aim of delivering holistic and culturally appropriate primary healthcare and health related services.

#### 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 contributes to funding of public dental services through the National Partnership Agreement on Treating More Public Dental Patients that commenced in January 2013.

The Australian Government supports the provision of dental services primarily through the private health insurance rebate and through DHS Medicare. Through DHS Medicare, funding is available for a limited range of oral surgical procedures and, from January 2014, for private and public dental services provided to eligible children aged 2 to 17 years under the Child Dental Benefits Schedule. Funding of private dental services was also available through DHS Medicare for people with chronic conditions and complex care needs until 1 December 2012. Public and private dental services were available through DHS Medicare under the Teen Dental Plan until 31 December 2013. 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 Aboriginal and Torres Strait Islander Primary Health Care Services.

### Funding

#### General practice

Australian Government total expenditure on general practice in 2013-14 was $7.9 billion (2015 Report, table 10A.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, Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander Australians and people living in rural and remote areas.

#### Community health services

In 2012-13, government expenditure on community health and public health was   
$9.1 billion, of which State, Territory and local governments provided 74.4 per cent and the Australian Government 25.6 per cent (2015 Report, table 10.1).

Australian Government expenditure on Aboriginal and Torres Strait Islander Primary health care services was $582 million in 2013-14 (table 10A.8).

### Size and scope

#### General practice

There were 32 401 vocationally registered GPs and OMPs — 23 194 on a full time workload equivalent (FWE) basis — billing Medicare Australia, based on MBS claims data, in 2013-14 (see 2015 Report, section 10.5 for a definition of FWE). This equated to 99.5 FWE registered GPs and OMPs per 100 000 people (figure 10.2, table 10A.9). MBS claims data do not include services provided by GPs working in Aboriginal and Torres Strait Islander 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.

Nationally, around 5889 general practitioner‑type services per 1000 population were provided under DHS Medicare in 2013-14 (2015 Report, figure 10.3).

#### Community health services

The range of community health services available varies considerably across jurisdictions. Tables 10A.107–115 provide information on community health programs in each jurisdiction. The more significant of these programs are described below. Other community health programs provided by some jurisdictions include:

* women’s health services that provide services and health promotion programs for women across a range of health-related areas
* men’s health programs (mainly promotional and educational programs)
* allied health services
* community rehabilitation programs.

Community health programs that address mental health, home and community care, and aged care assessments are reported in chapters 12 (Mental health management), 13 (Aged care services) and 14 (Services for people with disability).

##### 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 2014b). Treatment activities are excluded from that collection if the agencies provide medication for dependence on opioid drugs such as heroin (opioid pharmacotherapy treatment) where no other treatment is provided, are located within prisons or detention centres, or in acute care and psychiatric hospitals providing treatment only to admitted patients. While in scope, the majority of primary healthcare services for Aboriginal and Torres Strait Islander Australians that are funded by the Australian government do not report to the AODTS NMDS.

##### Aboriginal and Torres Strait Islander Primary Health Care Services

Aboriginal and Torres Strait Islander people use a range of primary healthcare services, including private GPs and Aboriginal and Torres Strait Islander Primary Health Care Services. The latter, available in all jurisdictions, provide comprehensive primary health care and/or substance use, social and emotional wellbeing and mental health services, to Aboriginal and Torres Strait Islander people. They are funded by Australian, State and Territory governments, with the Australian Government contributing the greater share.

In addition, other health programs for Aboriginal and Torres Strait Islander Australians are funded by a number of jurisdictions. In 2012‑13, these programs included services such as health promotion, education and counselling; alcohol, tobacco and other drug services; sexual health services; allied health services; disease/illness prevention; and improvements to nutrition standards (tables 10A.107–115).

From the 2008‑09 reporting period, data on Aboriginal and Torres Strait Islander primary healthcare services that receive funding from the Australian Government have been collected through the Online Services Report (OSR) questionnaire. Many of the services receive additional funding from State and Territory governments and other sources. The OSR data reported here represent funding from all sources.

For 2012‑13, OSR data are reported for 205 Aboriginal and Torres Strait Islander primary healthcare services (table 10A.15). Of these services, 92 (44.9 per cent) were located in remote or very remote areas (table 10A.16). They provided a range of primary healthcare services (table 10A.17 — historical data are reported in table 10A.18). 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 3.1 million episodes of healthcare were provided by participating services in 2012‑13 (table 10.1). Of these, around 1.4 million (45.4 per cent) were in remote or very remote areas (table 10A.16).

|  |
| --- |
| Table 10.1 Estimated episodes of healthcare for Aboriginal and Torres Strait Islander Australians by services for which OSR data are reported (‘000)**a** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | 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 | | 2012-13 | 622 | 238 | 575 | 583 | 217 | 53 | 38 | 743 | 3 068 | |
| 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 (2014 and previous issues) *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results*, Cat. nos IHW 31, 56, 79, 104 and 139; table 10A.15; 2015 Report, table 10.5, p. 10.15. |
|  |
|  |

The services included in the OSR data collection employed around 4344 full time equivalent healthcare staff (as at 30 June 2013). Of these, 2386 were Aboriginal and Torres Strait Islander Australians (54.9 per cent). The proportions of doctors and nurses employed by surveyed services who were Aboriginal and Torres Strait Islander Australians, while remaining relatively low, have increased in the period 2010–2013 — rising from   
4.8 per cent to 7.2 per cent for doctors and from 10.4 per cent to 14.4 per cent for nurses (table 10A.19).

### Framework of performance indicators

The performance indicator framework is based on shared government objectives for primary and community health (2015 Report, box 10.1). 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) 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 Aboriginal and Torres Strait Islander Australians. Both agreements include sets of performance indicators. Performance indicators reported in this chapter are aligned with health performance indicators in the most recent version of the NHA, where relevant.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of health services (figure 10.1). The performance indicator framework shows which data are comparable in the   
2015 Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability and data completeness from a Report‑wide perspective (see 2015 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 Aboriginal and Torres Strait Islander- and ethnic status) (chapter 2).

|  |
| --- |
| Figure 10.1 Primary and community health performance indicator framework |
| |  | | --- | | Figure 10.4 Primary and community health performance indicator framework   More details can be found within the text surrounding this image. | |
|  |
|  |

*Source*: 2015 Report, figure 10.4, p. 10.17.

### Early detection and early treatment for Aboriginal and Torres Strait Islander Australians

‘Early detection and early treatment for Aboriginal and Torres Strait Islander Australians’ is an indicator of governments’ objective to provide equitable access to primary and community healthcare services for Aboriginal and Torres Strait Islander Australians   
(box 10.1).

|  |
| --- |
| Box 10.1 Early detection and early treatment for Aboriginal and Torres Strait Islander Australians |
| ‘Early detection and early treatment for Aboriginal and Torres Strait Islander Australians’ is 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).   Three measures of early detection and early treatment for Aboriginal and Torres Strait Islander Australians are reported:   * the proportion of older people who received a health assessment under DHS Medicare by Indigenous status * older people are defined as Aboriginal and Torres Strait Islander Australians aged  55 years or over and other Australians aged 75 years or over, excluding hospital inpatients and people living in aged care facilities. The relatively young age at which Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander and other Australians (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 Aboriginal and Torres Strait Islander Australians who received a health assessment under DHS Medicare in successive years of a five year period * the proportion of Aboriginal and Torres Strait Islander Australians who received a health assessment or check under DHS Medicare by age group — health assessment/checks are available for Aboriginal and Torres Strait Islander children (0–14 years), adults (15–54 years) and older people (55 years or over).   (continued next page) |
|  |
|  |

|  |
| --- |
| Box 10.1 (continued) |
| A low or decreasing gap between the proportion of Aboriginal and Torres Strait Islander and other Australians who received a health assessment can indicate more equitable access to early detection and early treatment services for Aboriginal and Torres Strait Islander Australians. An increase over time in the proportion of older Aboriginal and Torres Strait Islander Australians who received a health assessment is desirable as it indicates improved access to these services. A low or decreasing gap between the proportion of Aboriginal and Torres Strait Islander Australians in different age groups who received a health assessment/check can indicate more equitable access to early detection and treatment services within the Aboriginal and Torres Strait Islander population.  This indicator provides no information about health assessments provided outside DHS Medicare. Such services are provided under service delivery models used, for example, in remote and very remote areas and therefore accessed predominantly by Aboriginal and Torres Strait Islander Australians. Accordingly, this indicator understates the proportion of Aboriginal and Torres Strait Islander 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 2013‑14.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
|  |
|  |

The high prevalence of preventable and/or treatable health conditions in the Aboriginal and Torres Strait Islander population is strongly associated with relatively poor health outcomes for Aboriginal and Torres Strait Islander Australians (AIHW 2008a;   
SCRGSP 2014). The availability and uptake of early detection and early treatment services is understood to be a significant determinant of people’s health.

Nationally, the proportion of older people receiving a health assessment was 30.4 per cent for Aboriginal and Torres Strait Islander people and 31.1 per cent for other Australians in 2013-14 (figure 10.2). There was considerable variation across States and Territories in the relative proportion of older people receiving a health assessment for these populations.

|  |
| --- |
| Figure 10.2 Older people who received an annual health assessment by Indigenous status, 2013-14**a, b, c, d** |
| |  | | --- | |  | |
| a Older people are defined as Aboriginal and Torres Strait Islander Australians aged 55 years or over and other Australians aged 75 years or over. b The population of Aboriginal and Torres Strait Islander people is determined by self-identification. Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander Australians. c Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Aboriginal and Torres Strait Islander Australians. Data for Aboriginal and Torres Strait Islander Australians are therefore likely to understate the proportion who access health assessments. d Rates are derived using the ABS’ final  2011 Census rebased estimates and projections. See chapter 2 (tables 2A.13-14 and 2015 Report, table 2A.2) for details. |
| *Source*: Derived from Department of Health (unpublished) MBS Statistics, ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; ABS (various years) *Australian demographic statistics*,Cat. no. 3101.0; table 10A.30; 2015 Report,  figure 10.10, p. 10.28. |
|  |
|  |

The proportion of older Aboriginal and Torres Strait Islander Australians who received an annual health assessment increased in all jurisdictions between 2009-10 and 2013-14 (figure 10.3).

|  |
| --- |
| Figure 10.3 Older Aboriginal and Torres Strait Islander Australians who received an annual health assessment**a, b, c** |
| |  | | --- | | Figure 10.11 Older Aboriginal and Torres Strait Islander Australians who received an annual health assessment  More details can be found within the text surrounding this image. | |
| a For Aboriginal and Torres Strait Islander people, older is defined as aged 55 years or over. The population of Aboriginal and Torres Strait Islander people is determined by self-identification. Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander Australians. b Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Aboriginal and Torres Strait Islander people. Data are therefore likely to understate the proportion who access health assessments. c Rates are revised to the ABS’ final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (2015 Report, tables 2A.13-14) for details. |
| *Source*: Derived from Department of Health (unpublished) MBS data collection and ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; table 10A.31; 2015 Report, figure 10.11, p. 10.29. |
|  |
|  |

Health check MBS items were introduced for Aboriginal and Torres Strait Islander people 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 Aboriginal and Torres Strait Islander children aged 0–14 years, introduced in May 2006.

The proportion of the eligible Aboriginal and Torres Strait Islander 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 10.4). 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).

The proportion of Aboriginal and Torres Strait Islander primary healthcare services that provided selected early detection services, sourced from OSR data, was included in previous reports as a supplementary measure for this indicator. However, the data are no longer available due to changes in the OSR data collection instrument, and the measure is not included in the 2015 Report.

|  |
| --- |
| Figure 10.4 Aboriginal and Torres Strait Islander Australians who received a health assessment by age, 2013-14**a, b, c** |
| |  | | --- | | Figure 10.12 Aboriginal and Torres Strait Islander Australians who received a health assessment by age, 2013-14  More details can be found within the text surrounding this image. | |
| a The population of Aboriginal and Torres Strait Islander people is determined by self-identification. Aboriginal and Torres Strait Islander Australians aged 75 years or over my 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 Aboriginal and Torres Strait Islander Australians. b Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Aboriginal and Torres Strait Islander Australians. Data are therefore likely to understate the proportion who access health assessments. c Rates are derived using the ABS’ final 2011 Census rebased estimates and projections. See chapter 2 (2015 Report, tables 2A.13-14) for details. |
| *Source*: Derived from Department of Health (unpublished) MBS Statistics and ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; table 10A.32; 2015 Report, figure 10.12, p. 10.30. |
|  |
|  |

### 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 10.2).

|  |
| --- |
| Box 10.2 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 Aboriginal and Torres Strait Islander people of all ages.  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 Aboriginal and Torres Strait Islander children aged 3 to 5 years who received the Aboriginal and Torres Strait Islander Peoples Health Assessment is reported as a proxy for the proportion of Aboriginal and Torres Strait Islander children who received a fourth year developmental health assessment. The proportion of other children who received either a Healthy Kids Check (at the age of 3 or 4 years), or a Health assessment at the age of 5 years, is reported as a proxy for the proportion of other children who received a fourth year developmental health assessment.  Fourth year developmental health assessments 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, in 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 from 2012-13 are not comparable to data for previous years * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
|  |
|  |

Nationally, the proportion of children who received a fourth year developmental health check under DHS Medicare was 55.6 per cent in 2013-14 (table 10A.33). The proportion was higher for Aboriginal and Torres Strait Islander children than for other children in 2013-14, although there was considerable variation across jurisdictions (figure 10.5).

|  |
| --- |
| Figure 10.5 Children who received a fourth year developmental health check, by health check type, 2013-14**a, b, c, d, e, f, g** |
| |  | | --- | | Figure 10.13 Children who received a fourth year developmental health check, by health check type, 2013-14  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. A child is counted only if not counted for a previous year. Where a child received both types of health check they are counted against the Aboriginal and Torres Strait Islander Peoples Health assessment. e Healthy Kids Check data include Aboriginal and Torres Strait Islander children who received a Healthy Kids Check and do not receive an Aboriginal and Torres Strait Islander Peoples Health Assessment. f The denominator is the population of 4 year olds and is not directly comparable to the numerator, which is the sum of children who, for the first time at the age of 3, 4 or 5 years, received a health assessment under the MBS. Using this methodology, the estimated proportion of Aboriginal and Torres Strait Islander children in the NT who received a health check exceeds 100 per cent. g Rates are derived using the ABS’ final 2011 Census rebased estimates and projections. See chapter 2 (table 2A.14, 2015 Report, table 2A.2) for details. |
| *Source*: Department of Health (unpublished) MBS Statistics; ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 10A.33; 2015 Report, figure 10.13, p. 10.32. |
|  |
|  |

### 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 10.3). The effectiveness of services can vary according to the affordability and timeliness of services that people can access.

|  |
| --- |
| Box 10.3 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 (interim measure), defined as: * 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 2013‑14 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.  Data reported for this measure are:   * comparable (subject to caveats) across jurisdictions and comparable over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions. |
| (continued next page) |
|  |
|  |

|  |
| --- |
| Box 10.3 (continued) |
| 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 * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Potentially avoidable presentations to emergency departments — an interim measure for this indicator — are presentations for conditions that could be appropriately managed in the primary and community health sector. In some cases, this can be determined only retrospectively and presentation to an emergency department is appropriate. A low or decreasing proportion of potentially avoidable presentations to emergency departments can indicate better access to primary and community health care.  Data reported for this measure are:   * comparable (subject to caveats) within some jurisdictions over time but not comparable within other jurisdictions over time or across jurisdictions (see caveats in attachment tables for specific jurisdictions) * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
|  |
|  |

##### Effectiveness of access to GPs — people deferring visits to GPs due to financial barriers

Data for Aboriginal and Torres Strait Islander Australians deferring access to GPs due to cost, collected for the first time from the ABS 2012-13 AATSIHS (Australian Aboriginal and Torres Strait Islander Health Survey), are presented in table 10A.38. However, differences in survey design and methodology mean data from the 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 10.4).

|  |
| --- |
| Box 10.4 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 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
|  |
|  |

Nationally, in 2013-14, 7.6 per cent of respondents delayed or did not purchase prescribed medicines due to cost in the previous 12 month period (2015 Report, figure 10.18). Data for Aboriginal and Torres Strait Islander Australians were collected for the first time from the ABS 2012‑13 AATSIHS and are presented in 2015 Report, table 10A.44. 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 10.5).

|  |
| --- |
| Box 10.5 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 received a public dental service 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 * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
|  |
|  |

Nationally, 23.4 per cent of people who were on a public dental waiting list waited for less than 1 month to see a dental professional at a government dental clinic in 2013-14   
(2015 Report, figure 10.19). Data are presented by remoteness in the 2015 Report,   
table 10A.46. Data for Aboriginal and Torres Strait Islander Australians that are reported in table 10A.47 are not comparable to data for all Australians.

### Chronic disease management

‘Chronic disease management’ is an indicator of governments’ objective to ensure appropriate and effective management of chronic disease in the primary and community health sector (box 10.6).

|  |
| --- |
| Box 10.6 Chronic disease management |
| ‘Chronic disease management’ is defined by four measures:   * management of diabetes — PIP diabetes incentive, defined as the proportion of general practices enrolled in the Practice Incentives Program (PIP) that are registered for the PIP diabetes incentive * management of diabetes — HbA1c, defined as the proportion of people with diabetes with HbA1c (glycosolated haemoglobin) below 7 per cent (the number of people with diabetes with HbA1c below 7 per cent, divided by the estimated number of people with diabetes) * management of asthma, defined as the proportion of people with asthma who have a written asthma action plan * care planning/case conferencing, defined as the proportion of GPs who used the MBS chronic disease management items for care planning or case conferencing at least once during a 12 month period.   A high or increasing proportion of PIP practices registered for the PIP diabetes incentive, people with diabetes with HbA1c below 7 per cent, people with asthma who have a written asthma action plan, and GPs who use chronic disease management items, is desirable.  Registration for the PIP diabetes incentive requires the implementation of management strategies for patients with diabetes that are based on RACGP clinical guidelines for appropriate Type 2 diabetes management in general practice. Appropriate management of diabetes in the primary and community health sector can prevent or minimise the severity of complications (AIHW 2008b). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.  HbA1c measures the level of glucose in the blood averaged over the preceding three months. HbA1c levels below 7 per cent are indicative of appropriate management of diabetes in that period.  Written asthma action plans have been included in clinical guidelines for asthma management for around 20 years. They enable people with asthma to recognise and respond quickly and appropriately to deteriorating asthma symptoms, thereby preventing or reducing the severity of acute asthma episodes (ACAM 2008). |
| (continued next page) |
|  |
|  |

|  |
| --- |
| Box 10.6 (continued) |
| A high or increasing proportion of GPs who use chronic disease management items can indicate an improvement in the continuity of care provided to people with complex, multidisciplinary care needs. Chronic disease management items in the MBS allow for the preparation and regular review of care plans for individuals with complex, multidisciplinary care needs due to chronic or terminal medical conditions, through GP managed or multidisciplinary team based care. Individual compliance with management measures is also a critical determinant of the occurrence and severity of complications for patients with chronic disease.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions for management of diabetes — PIP diabetes incentive and for care planning/case conferencing. All required 2011‑12 data are available for all jurisdictions for management of diabetes — HbA1c and management of asthma.   Data quality information (DQI) is at www.pc.gov.au/research/recurring/report-on-government-services for the measures management of diabetes — HbA1c and management of asthma. DQI is under development for the measures management of diabetes — PIP diabetes incentive and care planning/case conferencing. |
|  |
|  |

#### 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 Aboriginal and Torres Strait Islander people with asthma reporting that they have a written asthma action plan was 27.3 per cent for people of all ages and 50.9 per cent for children aged 0–14 years in 2012-13 (figure 10.6; table 10A.61). Data for people of all ages are reported by Indigenous status for 2004-05 and 2011–13 in table 10A.62.

|  |
| --- |
| Figure 10.6 Proportion of people with asthma who have a written asthma action plan by age, by Indigenous status, 2011–13**a, b, c** |
| |  | | --- | | Figure 10.28 Proportion of people with asthma who have a written asthma action plan by age, by Indigenous status, 2011–13  Legend to figure  More details can be found within the text surrounding this image. Figure 10.28 Proportion of people with asthma who have a written asthma action plan by age, by Indigenous status, 2011–13  Legend to figure  More details can be found within the text surrounding this image. Figure 10.28 Proportion of people with asthma who have a written asthma action plan by age, by Indigenous status, 2011–13  More details can be found within the text surrounding this image.  Figure 10.28 Proportion of people with asthma who have a written asthma action plan by age, by Indigenous status, 2011–13  Legend to figure  More details can be found within the text surrounding this image. Figure 10.28 Proportion of people with asthma who have a written asthma action plan by age, by Indigenous status, 2011–13  Legend to figure  More details can be found within the text surrounding this image. | |
| a Rates for ‘all ages’ are age standardised to the Australian population at 30 June 2001. b Error bars represent the 95 per cent confidence interval associated with each point estimate. c Data for ‘other Australians’ for the NT should be used with care as exclusion of very remote areas from the NHS translates to the exclusion of around 23 per cent of the NT population. |
| *Source*: ABS (unpublished) *Australian Health Survey, 2011–13* (2011-12 NHS component),  Cat. no. 4364.0; ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey* (2012-13 National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0; table 10A.61; 2015 Report, figure 10.28, p. 10.56. |
|  |
|  |

### 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 10.7).

|  |
| --- |
| Box 10.7 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 2013-14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
|  |
|  |

#### Patient satisfaction — experience with selected key aspects of GP care

Nationally, the majority of respondents reported that, in 2013-14, the GP always or often (2015 Report, figure 10.35):

* listened carefully to them (90.6 per cent)
* showed respect (93.3 per cent)
* spent enough time with them (89.3 per cent).

Data for Aboriginal and Torres Strait Islander Australians that are reported in table 10A.74 are not comparable to the data presented here.

### Quality — continuity — 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 10.8).

|  |
| --- |
| Box 10.8 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 Aboriginal and Torres Strait Islander Australians aged 55 years or over and other Australians aged 75 years or over, excluding hospital inpatients and people living in aged care facilities. 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 10.1).  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 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
|  |
|  |

The targeted age range for Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander and non-Indigenous populations (see the Health sector overview). Results for Aboriginal and Torres Strait Islander people are reported under equity indicators (box 10.1).

### 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 10.9).

|  |
| --- |
| Box 10.9 Cost to government of general practice per person |
| ‘Cost to government of general practice per person’ is defined as the cost to government of general practice per person in the population.  This indicator needs to be interpreted with care. A low or decreasing cost per person can indicate higher efficiency, provided services are equally or more effective. It can also reflect service substitution between primary healthcare and hospital or specialist services — potentially at greater expense.  Cost to government of general practice does not capture costs of salaried GP service delivery models, used particularly in rural and remote areas, where primary healthcare services are provided by salaried GPs in community health settings, through emergency departments, and Aboriginal and Torres Strait Islander primary healthcare services. 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 and over time but a break in time series means that data from 2012-13 are not comparable to data for previous years * complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
|  |
|  |

Nationally, Australian Government fee-for-service expenditure on general practice was $7.3 billion — $299 per person — in 2013-14 (2015 Report, figure 10.38).

### 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 10.10).

|  |
| --- |
| Box 10.10 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, pertussis (whooping cough), polio, hepatitis b, Haemophilus influenzae type b and, from the quarter ending 31 December 2013, pneumococcal * 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 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
|  |
|  |

Many providers deliver child immunisation services (table 10.2). High immunisation coverage levels are encouraged through a range of measures, including incentives for parents that link immunisation to tax and childcare benefits and rebates. Incentives for providers were in place under the General Practice Immunisation Incentives Scheme to   
30 June 2013.

|  |
| --- |
| Table 10.2 Valid vaccinations supplied to children under 7 years of age, by provider type, 2009–2014 (per cent)**a, b, c** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Provider** | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | GP | 88.8 | 59.5 | 84.6 | 69.2 | 73.0 | 93.1 | 59.6 | 71.8 | 75.9 | | Council | 3.2 | 38.8 | 5.8 | 3.6 | 18.5 | 6.4 | – | – | 13.5 | | State or Territory health department | – | – | – | 4.9 | – | – | 1.2 | 0.1 | 0.6 | | Public hospital | 0.9 | 1.2 | 2.8 | 1.3 | 0.7 | 0.4 | 0.3 | 2.4 | 1.5 | | Aboriginal and Torres Strait Islander health service / worker | 0.5 | 0.2 | 0.3 | 0.4 | 0.7 | – | – | 6.8 | 0.7 | | Community health centre | 6.5 | 0.3 | 6.0 | 20.5 | 7.0 | 0.1 | 38.9 | 18.8 | 7.7 | | Otherd | 0.1 | – | 0.5 | 0.1 | 0.1 | – | – | 0.1 | 0.2 | | **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 2009 to 30 June 2014. 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, Aboriginal and Torres Strait Islander Health Workers, community nurses, private hospitals and unknown. – Nil or rounded to zero. |
| *Source*: Department of Health (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 10A.78; 2015 Report, table 10.7, p. 10.73. |
|  |
|  |

#### 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 10.11).

|  |
| --- |
| Box 10.11 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 2012 and 2013 are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
|  |
|  |

Aboriginal and Torres Strait Islander women, women from non‑English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas can experience particular language, cultural and geographic barriers to accessing breast cancer screening. Participation rates for community groups at or close to those for the total population indicate equitable access to early detection services. Care needs to be taken when comparing data across jurisdictions as identification of Aboriginal and Torres Strait Islander women and NESB women varies, as does the collection of residential postcodes data.

Participation rates in the BreastScreen Australia Program for women from selected community groups are shown in table 10.3. In the 24 month period 2012 and 2013, the national age standardised participation rate for Aboriginal and Torres Strait Islander women aged 50–69 years was 35.1 per cent (table 10A.87). A low participation rate can in part reflect under-reporting of Aboriginal and Torres Strait Islander status in screening program records.

|  |
| --- |
| Table 10.3 Age standardised participation rate for women aged  50–69 years from selected communities in BreastScreen Australia programs, 2012 and 2013 (24 month period)  (per cent)**a, b, c, d, e, f** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NSW | Vic | Qld | WA | SA | Tas | ACT**d** | NT | Aust | | Aboriginal and Torres Strait Islander womene | 31.3 | 30.4 | 45.0 | 34.4 | 27.4 | 28.8 | 28.2 | 28.8 | 35.1 | | NESBf | 48.0 | 52.2 | 62.8 | 63.3 | 46.1 | 46.2 | 25.7 | 39.6 | 51.4 | | All women aged 50–69 years | 50.9 | 54.6 | 57.3 | 56.8 | 53.0 | 57.8 | 54.4 | 41.0 | 54.3 | |
| 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 In general, women resident in the jurisdiction represent 98.9 per cent or more of the women screened in each jurisdiction, except for the ACT (where 2.2 per cent of those screened in the 2012–2013 reference period were not ACT residents). 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) *Australian Demographic Statistics*, *June*, Cat. no. 3201.0; ABS (2014) *Experimental Estimates and Projections, Aboriginal And Torres Strait Islander Australians, 2001 to 2026*, Cat. no. 3238.0; ABS (unpublished) *2011 Census of Population and Housing*; tables 10A.87, 2015 Report, tables 10A.85–86 and 10A.88; 2015 Report, table 10.8, p. 10.82. |
|  |
|  |

##### 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 10.12).

|  |
| --- |
| Box 10.12 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 2012 and 2013 are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
|  |
|  |

In 2012-13, around 53.4 per cent of Aboriginal and Torres Strait Islander women aged   
20–69 years who responded to the National Aboriginal and Torres Strait Islander Health survey reported having a Pap smear at least every 2 years (table 10A.91).

##### 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 10.13).

|  |
| --- |
| Box 10.13 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. |
|  |
|  |

Influenza and pneumococcal disease vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (Department of Health 2013a). Free vaccines for all Australians aged 65 years or over and for Aboriginal and Torres Strait Islander people aged 50 years or over became available for influenza in 1999 and for pneumococcal disease in 2005.

Nationally, 25.3 per cent of Aboriginal and Torres Strait Islander people aged 50 years or over were fully vaccinated against influenza and pneumococcal disease in 2012-13   
(table 10A.94).

#### 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 10.14).

|  |
| --- |
| Box 10.14 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 * 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 2014a, 2014c). 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 2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
|  |
|  |

##### Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic 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 Aboriginal and Torres Strait Islander 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 23.9 per 1000 people in 2012‑13 (2015 Report, table 10.9). Of these, 49.5 per cent were for acute and 47.2 per cent for chronic conditions (2015 Report, table 10A.95). Data are presented disaggregated by Indigenous status in table 10A.96 and remoteness in 2015 Report, table 10A.97. National data by Indigenous status and remoteness are presented in table 10A.98.

Identification of Aboriginal and Torres Strait Islander people in hospital administrative data is considered acceptable for analysis in all states and territories from the 2010-11 reporting period. The age standardised hospital separation rate for vaccine preventable conditions was higher for Aboriginal and Torres Strait Islander Australians than for other Australians in all jurisdictions in 2012‑13 (figure 10.7). The age standardised hospital separation rate for the selected acute conditions was higher for Aboriginal and Torres Strait Islander Australians than for other Australians in almost all jurisdictions in 2012‑13   
(figure 10.8). The age standardised hospital separation rate for the selected chronic conditions was higher for Aboriginal and Torres Strait Islander Australians than for other Australians in all jurisdictions in 2012‑13 (figure 10.9).

.

|  |
| --- |
| Figure 10.7 Separations for vaccine preventable conditions by Indigenous status**a, b, c, d, e, f, g** |
| |  | | --- | | Figure 10.47  Separations for vaccine preventable conditions by Indigenous status  Aboriginal and Torres Strait Islander Australians  More details can be found within the text surrounding this image.  Figure 10.47 Separations for vaccine preventable conditions by Indigenous status  Other 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 Separation rates are based on State/Territory of usual residence. c Data are revised in line with a nationally agreed revised definition of selected potentially preventable hospitalisations and may differ from previous reports. See DQI for more information. d Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. e Caution should be used in comparing data over time due to changes in international classifications and associated Australian coding standards. See DQI for more information. f NT data from 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. g From 2010-11, identification of Aboriginal and Torres Strait Islander people in hospital administrative data is 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 10A.99 and 2015 Report, table 10A.95; 2015 Report, figure 10.47, p. 10.87. |
|  |
|  |

|  |
| --- |
| Figure 10.8 Separations for selected acute conditions by Indigenous status**a, b, c, d, e, f, g** |
| |  | | --- | | Figure 10.48 Separations for selected acute conditions by Indigenous status  Aboriginal and Torres Strait Islander Australians  More details can be found within the text surrounding this image.  Figure 10.48 Separations for selected acute conditions by Indigenous status  Other 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 Separation rates are based on State/Territory of usual residence. c Data are revised in line with a nationally agreed revised definition of selected potentially preventable hospitalisations and may differ from previous reports. See DQI for more information. d Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. e Caution should be used in comparing data over time due to changes in international classifications and associated Australian coding standards. See DQI for more information. f NT data from 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. g From 2010-11, identification of Aboriginal and Torres Strait Islander people in hospital administrative data is 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 10A.100 and 2015 Report,  table 10A.95; 2015 Report, figure 10.48, p. 10.88. |
|  |
|  |

|  |
| --- |
| Figure 10.9 Separations for selected chronic conditions by Indigenous status**a, b, c, d, e, f, g** |
| |  | | --- | | Figure 10.49 Seperations for selected chronic conditions by Indigenous status  Aboriginal and Torres Strait Islander Australians  More details can be found within the text surrounding this image.  Figure 10.49 Separations for selected chronic conditions by Indigenous status  Other 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** Separation rates are based on State/Territory of usual residence. **c**Data are revised in line with a nationally agreed revised definition of selected potentially preventable hospitalisations and may differ from previous reports. See DQI for more information. **d** Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. **e** Caution should be used in comparing data over time due to changes in international classifications and associated Australian coding standards. See DQI for more information. **f** NT data from 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. **g** From 2010-11, identification of Aboriginal and Torres Strait Islander people in hospital administrative data is 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 10A.101 and 2015 Report,  table 10A.95; 2015 Report, figure 10.49, p. 10.89. |
|  |
|  |

##### 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 107.0 separations per 100 000 people in 2012‑13 (2015 Report, figure 10.50).

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 Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander and all people can indicate greater equity of access to primary healthcare services.

There was a marked difference in 2012-13 between the separation rates for Aboriginal and Torres Strait Islander people and those for the total population for diabetes diagnoses (figure 10.10).

|  |
| --- |
| Figure 10.10 Ratio of separation rates of Aboriginal and Torres Strait Islander people to all people for diabetes, 2012-13**a, b, c, d, e, f, g** |
| |  | | --- | | Figure 10.53 Ratio of separation rates of Aboriginal and Torres Strait Islander people to all people for diabetes, 2012-13  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 Reporting of diabetes as a principal diagnosis increased by an average of 29.6 per cent between 2011-12 and 2012-13, primarily due to changes in coding standards. Data for 2012-13 are not comparable with data for previous years. e Patients aged 75 years or over are excluded. f Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. g NT data are for public hospitals only. |
| *Source*: AIHW (unpublished) National Hospital Morbidity Database; table 10A.102; 2015 Report,  figure 10.53, p. 10.93. |
|  |
|  |

## Future directions in performance reporting

#### Aboriginal and Torres Strait Islander health

Barriers to accessing primary health services contribute to the poorer health status of Aboriginal and Torres Strait Islander Australians compared to other Australians (see the Health sector overview). The Steering Committee has identified primary and community health services for Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander Australians.

Continued efforts to improve the quality of Aboriginal and Torres Strait Islander data, particularly Aboriginal and Torres Strait Islander identification and completeness, are necessary to better measure the performance of primary and community health services in relation to the health of Aboriginal and Torres Strait Islander Australians. Work being undertaken by the ABS and the AIHW includes an ongoing program to improve identification of Aboriginal and Torres Strait Islander status in Australian, State and Territory government administrative systems.

### Definitions of key terms

|  |  |
| --- | --- |
| 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 (Australian Institute of Health and Welfare), Canberra. |
| Community health services | Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities. |
| Comparability | Data are considered comparable if, (subject to caveats) they can be used to inform an assessment of comparative performance. Typically, data are considered comparable when they are collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data. |
| Completeness | Data are considered complete if all required data are available for all jurisdictions that provide the service. |
| 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 a 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, by the age of 1 year, completed: three doses of diphtheria, tetanus, pertussis vaccine; three doses of polio vaccine; two or three doses (depending on the type of vaccine used) of Hepatitis B vaccine; two or three doses (depending on the type of vaccine used) of *Haemophilus influenzae* type B vaccine; and, from the quarter ending 31 December 2013, pneumococcal disease. |
| Fully immunised at 24 months | A child who has, by the age of 2 years, received three or four doses (depending on the type of vaccine used) of diphtheria, tetanus, pertussis vaccine, three doses of polio vaccine, three doses of Hepatitis B vaccine, three or four doses (depending on the type of vaccine used) of *Haemophilus influenzae* type B and one dose of measles, mumps and rubella vaccine. |
| Fully immunised at 60 months | A child who has, by the age of 5 years, received the necessary doses of diphtheria, tetanus, whooping cough, polio, and measles, mumps and rubella vaccines — four or five doses (depending on the type of vaccine used) of diphtheria, tetanus, pertussis vaccine, four doses of polio vaccine, three doses of Hepatitis B vaccine, three or four doses (depending on the type of vaccine used) of *Haemophilus influenzae* type B and two doses of measles, mumps and rubella vaccine. |
| General practice | The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a ‘population’ of patients and may include services for specific populations, such as women's health or Aboriginal and Torres Strait Islander health. |

|  |  |
| --- | --- |
| General practitioner (GP) | Vocationally registered GPs — medical practitioners who are vocationally registered under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. From 1996 vocational registration is available only to GPs who attain Fellowship of the RACGP or (from April 2007) the ACRRM, or hold a recognised training placement.  Other medical practitioners (OMP) — medical practitioners who are not vocationally registered GPs. |
| GP‑type services | Non‑referred attendances by vocationally registered GPs and OMPs, and practice nurses. |
| *Haemophilus influenzae* type b | A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (Department of Health 2013). |
| Immunisation coverage | The proportion of a target population fully immunised with National Immunisation Program specified vaccines for that age group. |
| Management of upper respiratory tract infections | Number of prescriptions ordered by GPs for the oral antibiotics most commonly used in the treatment of upper respiratory tract infections per 1000 people with PBS concession cards. |
| 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). |

|  |  |
| --- | --- |
| Public health | The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services. |
| 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 an ‘A’ prefix (for example, table 10A.1 is table 1). Attachment tables are provided on the Review website (www.pc.gov.au/research/recurring/report-on-government-services).

|  |  |
| --- | --- |
| **Table 10A.6** | Australian Government expenditure on PBS medicines supplied to Aboriginal Health Services in remote areas |
| **Table 10A.8** | Australian Government funding of Aboriginal and Torres Strait Islander Primary Health Care Services |
| **Table 10A.15** | Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare (number) |
| **Table 10A.16** | Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare, by remoteness category (number) |
| **Table 10A.17** | Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities, 2012-13 (per cent) |
| **Table 10A.18** | Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities, 2008-09 to 2011-12 (per cent) |
| **Table 10A.19** | Full time equivalent (FTE) health staff employed by Aboriginal and Torres Strait Islander primary healthcare services which provide data for Online Services Reporting (OSR) as at 30 June (number) |
| **Table 10A.30** | Annual health assessments for older people by Indigenous status (per cent) |
| **Table 10A.31** | Older Aboriginal and Torres Strait Islander people who received an annual health assessment (per cent) |
| **Table 10A.32** | Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent) |
| **Table 10A.33** | Proportion of children receiving a fourth year developmental health check, by type of health check (per cent) |
| **Table 10A.38** | Aboriginal and Torres Strait Islander people deferring access to GPs due to cost, 2012-13 (per cent) |
| **Table 10A.44** | Aboriginal and Torres Strait Islander people deferring access to prescribed medication due to cost, 2012-13 (per cent) |
| **Table 10A.47** | Waiting times for public dentistry, Aboriginal and Torres Strait Islander people, by remoteness, Australia, 2012-13 (per cent) |
| **Table 10A.61** | Proportion of people with asthma with a written asthma plan, by Indigenous status, by age, 2011–13 |
| **Table 10A.62** | Proportion of people with asthma with a written asthma plan, by Indigenous status |
| **Table 10A.74** | Client experience of GPs by remoteness, Aboriginal and Torres Strait Islander people, Australia, 2012-13 |
| **Table 10A.78** | Valid vaccinations supplied to children under seven years of age, by type of provider, 2009–2014 |
| **Table 10A.87** | Participation rates for Aboriginal and Torres Strait Islander women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) |
| **Table 10A.91** | Cervical screening rates among Aboriginal and Torres Strait Islander women aged 20 to 69 years, who reported having a Pap smear at least every 2 years (per cent) |
| **Table 10A.94** | Proportion of Aboriginal and Torres Strait Islander people aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease |
| **Table 10A.96** | Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) |
| **Table 10A.98** | Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia, 2012-13 (per 1000 people) |
| **Table 10A.99** | Separations for selected vaccine preventable conditions by Indigenous status, 2012-13 (per 1000 people) |
| **Table 10A.100** | Separations for selected acute conditions by Indigenous status, 2012-13 (per 1000 people) |
| **Table 10A.101** | Separations for selected chronic conditions by Indigenous status, 2012-13 (per 1000 people) |
| **Table 10A.102** | Ratio of separations for Aboriginal and Torres Strait Islander people to all Australians, diabetes, 2012-13 |
| **Community health programs** | |
| **Table 10A.107** | Australian Government, community health services programs |
| **Table 10A.108** | New South Wales, community health services programs |
| **Table 10A.109** | Victoria, community health services programs |
| **Table 10A.110** | Queensland, community health services programs |
| **Table 10A.111** | Western Australia, community health services programs |
| **Table 10A.112** | South Australia, community health services programs |
| **Table 10A.113** | Tasmania, community health services programs |
| **Table 10A.114** | Australian Capital Territory, community health services programs |
| **Table 10A.115** | 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, *Diabetes: A****u****stralian facts*, Cat. no. CVD 40, Diabetes series no. 8, Canberra.

—— 2014a, *Australia’s health 2014*, Cat. no. AUS 178, Canberra.

—— 2014b, *Alcohol and other drug treatment services in Australia 2012-13*, Cat. no. HSE 150, Drug treatment series no. 24, Canberra.

—— 2014c, *Australian hospital statistics 2012-13*, Cat. no. HSE 145, Health services series no. 54, Canberra.

Department of Health (formerly the Department of Health and Ageing) 2013, *Immunisation Myths and Realities: responding to arguments against immunisation*,   
5th edn, www.health.gov.au/internet/immunise/publishing.nsf/Content/uci-myths-guideprov (accessed 8 January 2014).

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

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) 2014, *Overcoming Indigenous Disadvantage: Key Indicators 2014*, Productivity Commission, Canberra.