

Report on Government Services 2015

Volume E: Health

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for the Steering
Committee for the
Review of Government
Service Provision*

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Publications enquiries

The Productivity Commission acts as the Secretariat for the Steering Committee for the Review of Government Service Provision. This report and previous editions are available from the Productivity Commission website at www.pc.gov.au.

The Steering Committee welcomes enquiries and suggestions on the information contained in this report. Contact the Secretariat by phone: (03) 9653 2100 or email: gsp@pc.gov.au

Foreword

This year marks the twentieth edition of the Report on Government Services — a remarkable milestone for a unique report providing comparative information on the performance of a wide range of government services.

The Report was commissioned in 1993 by Heads of Government (now COAG), with the first report produced in 1995. A new terms of reference issued in 2010 emphasised the dual roles of the Report in improving service delivery, efficiency and performance, and increasing accountability to governments and the public.

Improving the equity and effectiveness of the services included in the Report can affect the community in significant ways. Some services form an important part of the social welfare system (for example, social housing and child protection services), some are provided to people with specific needs (for example, aged care and disability services), and others are typically used by each person in the community at some stage during their life (for example, education and training, health services and police and emergency services). Improving the efficiency of government services can also have economic pay-offs. Governments spent over \$184 billion on the services covered by this Report, representing about 69 per cent of general government expenditure in 2013-14, around 12 per cent of Australia's gross domestic product.

The development of the comprehensive Report we have today involved the dedication and hard work of many people over many years. I commend all governments for their long-term commitment to transparency and accountability. Few exercises that rely on cooperation and consensus across governments and departments continue to thrive over two decades — and it is particularly challenging to maintain government support for a report that is often used to criticise the performance of governments. I also acknowledge the contributions of the previous chairs of the Steering Committee, Bill Scales and Gary Banks, past and present Steering Committee and working group members, and the many staff of the Productivity Commission who provided Secretariat services over the years.

Peter Harris
Chairman

January 2015

Contents

Volume E

VOLUME E HEALTH

E	Health sector overview	E.1
E.1	Introduction	E.1
E.2	Sector performance indicator framework	E.11
E.3	Cross cutting and interface issues	E.59
E.4	Future directions in performance reporting	E.60
E.5	Jurisdictions' comments	E.61
E.6	List of attachment tables	E.71
E.7	References	E.73
10	Primary and community health	10.1
10.1	Profile of primary and community health	10.2
10.2	Framework of performance indicators	10.16
10.3	Key performance indicator results	10.18
10.4	Future directions in performance reporting	10.94
10.5	Definitions of key terms	10.96
10.6	List of attachment tables	10.100
10.7	References	10.104
11	Public hospitals	11.1
11.1	Profile of public hospitals	11.2
11.2	Framework of performance indicators for public hospitals	11.14
11.3	Key performance indicator results for public hospitals	11.16
11.4	Profile of maternity services	11.64
11.5	Framework of performance indicators for maternity services	11.66

11.6	Key performance indicator results for maternity services	11.68
11.7	Future directions in performance reporting	11.86
11.8	Definitions of key terms	11.88
11.9	List of attachment tables	11.92
11.10	References	11.97
12	Mental health management	12.1
12.1	Framework for measuring health management performance	12.2
12.2	Profile of mental health management	12.3
12.3	Framework of performance indicators for mental health management	12.18
12.4	Key performance indicators for mental health management	12.23
12.5	Future directions in performance reporting	12.73
12.6	Definitions of key terms	12.74
12.7	List of attachment tables	12.79
12.8	References	12.83

Steering Committee

This report was produced under the direction of the Steering Committee for the Review of Government Service Provision (SCRGSP). The Steering Committee comprises the following current members:

Mr Peter Harris	Chairman	Productivity Commission
Mr Daryl Quinlivan	Acting Chair	Productivity Commission
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Ms Sam Reinhardt	Aust. Govt.	The Treasury
Ms Josephine Laduzko	Aust. Govt.	Department of the Prime Minister and Cabinet
Mr Rick Sondalini	NSW	NSW Treasury
Ms Michelle Dumazel	NSW	Department of Premier and Cabinet
Ms Katherine Whetton	Vic	Department of Premier and cabinet
Mr Jeremy Nott	Vic	Department of Treasury and Finance
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Ms Janelle Thurlby	Qld	Queensland Treasury
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Ms Linda Weatherhead	NT	Department of the Chief Minister
Ms Tracey Scott	NT	Department of Treasury and Finance
Mr Peter Harper		Australian Bureau of Statistics
Mr David Kalisch		Australian Institute of Health & Welfare

People who also served on the Steering Committee during the production of this Report include:

Ms Madonna Morton	Aust. Govt.	Department of the Prime Minister and Cabinet
Mr Peter Robinson	Aust. Govt.	The Treasury
Ms Janet Schorer	NSW	Department of Premier and Cabinet
Mr David Reynolds	SA	Department of Treasury and Finance
Ms Nicole Masters	ACT	Chief Minister's Directorate
Mr Leigh Eldridge	NT	Department of the Chief Minister
Mr Craig Graham	NT	Department of Treasury and Finance
Mr Bruce Michael	NT	Department of Treasury and Finance

Acronyms and abbreviations

AACR	Australasian Association of Cancer Registries
AAGR	average annual growth rates
AAT	Administrative Appeals Tribunal
AATSIHS	Australian Aboriginal and Torres Strait Islander Health Survey
ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ACAT	Aged Care Assessment Team
ACARA	Australian Curriculum and Assessment Reporting Authority
ACE	adult community education
ACECQA	Australian Children's Education and Care Quality Authority
ACER	Australian Council for Educational Research
ACFI	Aged Care Funding Instrument
ACHS	Australian Council on Healthcare Standards
ACIR	Australian Childhood Immunisation Register
ACOSS	Australian Council of Social Services
ACSAA	Aged Care Standards and Accreditation Agency
ACSES	The Australian Council of State Emergency Services
ACSQHC	Australian Commission for Safety and Quality in Health Care
ACT	Australian Capital Territory

ACTAS	ACT Ambulance Service
ADL	activities of daily living
ADR	Alternative Dispute Resolution
AEDC	Australian Early Development Census
AEDI	Australian Early Development Index
AFAC	Australasian Fire and Emergency Services Authorities Council
AFP	Australian Federal Police
AGD	Attorney-General's Department
AGCCC	Australian Government Census of Child Care Services
AGCCPS	Australian Government Child Care Provider Survey
AGPAL	Australian General Practice Accreditation Limited
AGSRC	Average Government School Recurrent Costs
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AHS	Australian Health Survey
AHV	Aboriginal Housing Victoria
AIC	Australian Institute of Criminology
AICTEC	Australian Information and Communications Technology Education Committee
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AJJA	Australian Institute of Judicial Administration
AIPAR	Australian Institute for Population Ageing Research
AJJA	Australasian Juvenile Justice Administrators
ALLS	Adult Literacy and Life Skills

ANZEMC	Australia-New Zealand Emergency Management Committee
ANZPAA	Australia and New Zealand Police Advisory Agency
ANZSCO	Australian and New Zealand Standard Classification of Occupations
ANZSIC	Australian and New Zealand Standard Industrial Classification
AODTS-NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
AQF	Australian Qualifications Framework
AQFC	Australian Qualifications Framework Council
AR-DRG v 5.1	Australian refined diagnosis related group, version 5.1
AR-DRGs	Australian refined diagnosis related groups
ARHP	Aboriginal Rental Housing Program
ARIA	Accessibility and Remoteness Index for Australia
ARO	Authorised Review Officer
ASCED	Australian Standard Classification of Education
ASGC	Australian Standard Geographical Classification
ASGS	Australian Statistical Geography Standard
ASM	Active Service Model
ASO	ambulance service organisation
ASOC	Australian Standard Offence Classification
ASR	Age-standardised rate
ASSNP	core activity need for assistance
ASQA	Australian Skills Quality Authority
ATC	Australian Transport Commission
Aust	Australia

AVETMISS	Australian Vocational Education and Training Management Information Statistical Standard
BBF	Building a Better Future
BEACH	Bettering the Evaluation and Care of Health
BMI	Body Mass Index
CAA	Council of Ambulance Authorities
CACP	Community Aged Care Package
CAD	computer aided dispatch
CAEPR	Centre for Aboriginal Economic Policy Research
CALD	culturally and linguistically diverse
CAP	Conditional Adjustment Payment
CAP	Crisis Accommodation Program
Cat. no.	Catalogue number
CWG	Courts Working Group
CCB	Child Care Benefit
CCET	Child care, education and training
CCMS	Child Care Management System
CCR	Child Care Rebate
CDSMAC	Community and Disability Services Ministers' Advisory Council
CEaCS	Childhood Education and Care Survey
CEPS	Australian Research Council Centre of Excellence in Policing and Security
CFA	Country Fire Authority
CFCs	Child and Family Centres
CGC	Commonwealth Grants Commission

CGRIS	Coordinator-General for Remote Indigenous Services
CHDSMC	Community, Housing and Disability Services Ministers' Conference
CHIP	Community Housing and Infrastructure Program
CHOS	Canadian National Occupancy Standard
CI	confidence interval
CIS	Complaints Investigation Scheme
CISC	COAG Industry and Skills Council
CMHC	Community Mental Health Care
COAG	Council of Australian Governments
CPG	Court Practitioners Group
CPI	Consumer Price Index
CRA	Commonwealth Rent Assistance
CRC	COAG Reform Council
CR	Crude rate
CRS	Commonwealth Rehabilitation Services
CRS	Complaints Resolution Scheme
CRYPAR	Coordinated Response to Young People at Risk
CSASAW	Commonwealth-State Agreement for Skilling Australia's Workforce
CSHA	Commonwealth State Housing Agreement
CSIRO	Commonwealth Scientific and Industrial Research Organisation
CSMAC	Community Services Ministers' Advisory Council
CSTDA	Commonwealth State/Territory Disability Agreement
CURF	confidentialised unit record file

DACC	Defence Assistance to the Civil Community
DDHCS	Department of Disability, Housing and Community Services
DFD	Domestic Final Demand
DHAC	Department of Health and Aged Care
DHS	Department of Human Services
DHSH	Department of Human Services and Health
DIISRTE	Department of Industry, Innovation, Science, Research and Tertiary Education
DiRCS	Differences in Recorded Crime Statistics
DoCS	Department of Community Services (NSW)
DoHA	Department of Health and Ageing
DPIE	Department of Primary Industries and Energy
DPMPC	Data and Performance Measurement Principal Committee
DQI	data quality information
DSS	Department of Social Services
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
EACH-D	EACH Dementia
ECEC	Early childhood education and care
ECEC NMDS	Early Childhood Education and Care National Minimum Data Set
ECG	electrocardiogram
EMWG	Emergency Management Working Group
ERP	estimated resident population
FaCS	Department of Family and Community Services

FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
FDC	family day care
FFR	Federal Financial Relations
FLAG	Flexible Learning Advisory Group
FSO	fire services organisation
FTE	full time equivalent
FWE	full time workload equivalent
FYA	Foundation for Young Australians
GDP	gross domestic product
GFS	Government Finance Statistics
GGFCE	General Government Final Consumption Expenditure
GP	general practitioner
GPII	General Practice Immunisation Incentives Scheme
GSAIG	Green Skills Agreement Implementation Group
GSP	gross state product
GSS	General Social Survey
GST	goods and services tax
HACC	Home and Community Care
HAF	Housing Affordability Fund
HDSC	Health Data Standards Committee
HECS	Higher Education Contribution Scheme
HELP	Higher Education Loan Program
HHWR	Hospitals and Health Workforce Reform
HILDA	Household Income and Labour Dynamic Australia
HIP	Home Independence Project

HMAC	Housing Ministers' Advisory Council
HOIST	New South Wales Population Health Survey 2007
HoTS	Heads of Treasuries
HREOC	Human Rights and Equal Opportunity Commission
HRSCEET	House of Representatives Standing Committee on Employment, Education and Training
IAEA	International Association for Educational Assessment
ICD	International Classification of Diseases
ICD-10-AM	Australian modification of the International Standard Classification of Diseases and Related Health Problems, version 10
ICILS	International Computer and Information Literacy Study
ICH	Indigenous community housing
ICHO	Indigenous Community Housing Organisation
ICT	information and communication technologies
IEA	International Association for the Evaluation of Educational Achievement
IER	Indigenous Expenditure Report
IGA	Intergovernmental Agreement
IMR	Infant mortality rate
IPD	Implicit Price Deflator
IPS	Independent Public Schools (WA)
IRG	Independent Reference Group
IRSD	Index of Relative Socio-economic Disadvantage
ISO	International Organisation for Standardisation
ISA	Insurance Statistics Australia
ISS	Inclusion Support Subsidy

ISSR	Institute for Social Science Research
JCIE	Joint Committee on International Education
JJ NMDS	Juvenile Justice National Minimum Data Set
JJ RIG	Juvenile Justice Research and Information Group
K10	Kessler Psychological Distress Scale
KPIs	key performance indicators
LBOTE	Language background other than English
LCCSC	Law, Crime and Community Safety Council
LCL	lower confidence limit
LDC	long day care
LFS	Labour Force Survey
LGCSA	Local Government Community Services Association of Australia
LMO	local medical officer
LOTE	Language other than English
LSOP	Long Stay Older Patients
LSAC	Longitudinal Study of Australian Children
LSAY	Longitudinal Surveys of Australian Youth
MBI	Modified Barthel Index
MBS	Medicare Benefits Schedule
MCATSA	Ministerial Council on Aboriginal and Torres Strait Islander Affairs
MCEECDYA	Ministerial Council for Education, Early Childhood Development and Youth Affairs
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MCFFR	Ministerial Council on Federal Financial Relations

MCTEE	Ministerial Council of Tertiary Education and Employment
MFS	Metropolitan Fire Service
MHE	Mental Health Establishments
MHS	mental health services
MPS	Multi-Purpose Services
NA	National Agreement
na	not available
NAHA	National Affordable Housing Agreement
NAP	National Assessment Program
NAPLAN	National Assessment Program — Literacy and Numeracy
NASWD	National Agreement for Skills and Workforce Development
NATESE	National Advisory for Tertiary Education, Skills and Employment
NMVTRC	National Motor Vehicle Theft Reduction Council
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NCAG	National Corrections Advisory Group
NCCH	National Centre for Classification in Health
NCIRS	National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases
NCJSF	National Criminal Justice Statistical Framework
NCPASS group	National Child Protection and Support Services data working group
NCSIMG	National Community Services Information Management Group
NCVER	National Centre for Vocational Education Research
NDA	National Disability Agreement
NDIA	National Disability Insurance Agency

NDIS	National Disability Insurance Scheme
NEA	National Education Agreement
NEAT	Department of Natural Resources Environment and the Arts
NECECC	National Early Childhood Education and Care Collection
NECECWC	National Early Childhood Education and Care Workforce Census
NESB	non-English speaking background
NGOs	non-government organisations
NHA	National Healthcare Agreement
NHMP	National Homicide Monitoring Program
NHMRC	National Health and Medical Research Council
NHPAC	National Health Priority Action Council
NHPC	National Health Performance Committee
NHRA	National Health Reform Agreement
NHS	National Health Survey
NIA ECEC	National Information Agreement on Early Childhood Education and Care
NIDP	National Information Development Plan
NIHEC	National Indigenous Health Equality Council
NIRA	National Indigenous Reform Agreement
NISC	National Industry Skills Committee
NMDS	national minimum data set
NMHS	National Mental Health Strategy
NMS	National Minimum Standard
NNDS	National Notifiable Diseases Surveillance System

no.	number
NOOSR	National Office of Overseas Skills Recognition
NP	National Partnership
np	not published
NPAs	National Partnership Agreements
NPMC	Navigation Projects Management Committee
NQAITS	National Quality Agenda Information Technology System
NQF	National Quality Framework
NQS	National Quality Standard
NRCP	National Respite for Carers Program
NRF	National Reporting Framework
NRSS	National Road Safety Strategy
NSCSP	National Survey of Community Satisfaction with Policing
NSOC	National Senior Officials Committee
NSPS	National Security and Preparedness Survey
NSSC	National Schools Statistics Collection
NSSC	National Skills Standards Council
NSMHS	National Standards for Mental Health Services
NSW RFS	New South Wales Rural Fire Service
NSW	New South Wales
NT	Northern Territory
NTCET	Northern Territory Certificate of Education and Training
NTES	National Territory Emergency Services
NVEAC	National VET Equity Advisory Council
NYPR	National Youth Participation Requirement

OCYFS	Office for Children, Youth and Family Support (ACT)
OECD	Organisation for Economic Co-operation and Development
OID	Overcoming Indigenous Disadvantage
OMP	other medical practitioner
OSHC	outside school hours care
OSR	Online services report
PBS	Pharmaceutical Benefits Scheme
PC	Productivity Commission
PDF	Portable Document Format
PDWG	Performance and Data Working Group
PEP	Personal Enablement Program
PES	Post Enumeration Survey
PhARIA	Pharmacy Access/Remoteness Index of Australia
PIAAC	Programme for the International Assessment of Adult Competencies
PIF	performance indicator framework
PIP	Practice Incentives Program
PIRLS	Progress in International Reading Literacy Study
PISA	Programme for International Student Assessment
PKI	Public Key Infrastructure
PSM	ABS Population Survey Monitor
PSTRE	Problem solving in technology-rich environments
PWI	personal wellbeing index
QE	Qualification Equivalents
QFRS	Queensland Fire and Rescue Service
QFES	Queensland Fire and Emergency Service

QIAS	Quality Improvement and Accreditation System
Qld	Queensland
QMF	Quality Management Framework
RACGP	Royal Australian College of General Practitioners
RCS	resident classification scale
Report	Report on Government Services
RISS	Remote and Indigenous Service Support
ROSC	return of spontaneous circulation
RPBS	Repatriation Pharmaceutical Benefits Scheme
RPL	recognition of prior learning
RRMA	Rural, Remote and Metropolitan Areas
RSE	relative standard error
RTO	Registered Training Organisation
SA	South Australia
SAAP	Supported Accommodation Assistance Program
SAAS	SA Ambulance Service
SCCHDS	Standing Council on Community, Housing and Disability Services
SCDC	Strategic Cross Sectoral Data Committee
SCOTESE	Standing Council on Tertiary Education, Skills and Employment
SCRCSPP	Steering Committee for the Review of Commonwealth/State Service Provision
SCRGSP	Steering Committee for the Review of Government Service Provision
SCSEEC	Standing Council for School Education and Early Childhood

SDAC	Survey of Disability, Ageing and Carers
SE	standard error
SEIFA	Socio Economic Indexes for Areas
SEM	standard error of the mean
SES	socioeconomic status
SES	State and Territory Emergency Services
SEW	Survey of Education and Work
SHSC	Specialist Homelessness Services collection
SIQ	standard Indigenous question
SLA	statistical local area
SMHWB	National Survey of Mental Health and Wellbeing
SMR	standardised mortality ratios
SOMIH	State-owned and managed Indigenous housing
SPP	specific purpose payment or special purpose payment
SPRC	Social Policy Research Centre
SSAT	Social Security Appeals Tribunal
SWPE	standardised whole patient equivalent
TAC	Training Accreditation Council
TAFE	technical and further education
Tas	Tasmania
TAS	Tasmanian Ambulance Service
TCP	Transition Care Program
TEQSA	Tertiary Education Quality Standards Agency
TFS	Tasmania Fire Service
TGR	total growth rate

The Report	The Report on Government Services
TIMSS	Trends in International Mathematics and Science Study
UCC	user cost of capital
UCL	upper confidence limit
UK	United Kingdom
URTI	upper respiratory tract infection
USA	United States of America
U-Turn	U-Turn diversionary program for young motor vehicle offenders
VCAT	Victorian Civil and Administrative Tribunal
VET	vocational education and training
VF	ventricular fibrillation
VHC	Veterans' Home Care
Vic	Victoria
VRQA	Victorian Registration Quality Authority
VT	ventricular tachycardia
WA	Western Australia
WSDPC	Workforce Development Supply and Demand Principal Committee
WGIR	Working Group on Indigenous Reform
WHO	World Health Organisation
YAT	Youth Attainment and Transitions
YBFS	Year before full time schooling
YPIRAC	Younger people in residential aged care

Glossary

Access	Measures how easily the community can obtain a delivered service (output).
Appropriateness	Measures how well services meet client needs and also seeks to identify the extent of any underservicing or overservicing.
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.
Constant prices	See ‘real dollars’.
Cost effectiveness	Measures how well inputs (such as employees, cars and computers) are converted into outcomes for individual clients or the community. Cost effectiveness is expressed as a ratio of inputs to outcomes. For example, cost per life year saved is a cost effectiveness indicator reflecting the ratio of expenditure on breast cancer detection and management services (including mammographic screening services, primary care, chemotherapy, surgery and other forms of care) to the number of women’s lives that are saved.
Current prices	See ‘nominal dollars’.
Descriptors	Descriptive statistics included in the Report that relate, for example, to the size of the service system, funding arrangements, client mix and the environment within which government services are delivered. These data are provided to highlight and make more transparent the differences among jurisdictions.
Effectiveness	Reflects how well the outputs of a service achieve the stated objectives of that service (also see program effectiveness).

Efficiency	Reflects how resources (inputs) are used to produce outputs and outcomes, expressed as a ratio of outputs to inputs (technical efficiency), or inputs to outcomes (cost effectiveness). (Also see ‘cost effectiveness’ and ‘technical efficiency’.)
Equity	Measures the gap between service delivery outputs or outcomes for special needs groups and the general population. Equity of access relates to all Australians having adequate access to services, where the term adequate may mean different rates of access for different groups in the community (see chapter 1 for more detail).
Inputs	The resources (including land, labour and capital) used by a service area in providing the service.
Nominal dollars	Refers to financial data expressed ‘in the price of the day’ and which are not adjusted to remove the effects of inflation. Nominal dollars do not allow for inter-year comparisons because reported changes may reflect changes to financial levels (prices and/or expenditure) and adjustments to maintain purchasing power due to inflation.
Output	The service delivered by a service area, for example, a completed episode of care is an output of a public hospital.
Outcome	The impact of the service on the status of individuals or a group, and the success of the service area in achieving its objectives. A service provider can influence an outcome but external factors can also apply. A desirable outcome for a school, for example, would be to add to the ability of the students to participate in, and interact with, society throughout their lives. Similarly, a desirable outcome for a hospital would be to improve the health status of an individual receiving a hospital service.
Process	Refers to the way in which a service is produced or delivered (that is, how inputs are transformed into outputs).
Program effectiveness	Reflects how well the outcomes of a service achieve the stated objectives of that service (also see effectiveness).
Quality	Reflects the extent to which a service is suited to its purpose and conforms to specifications.
Real dollars	Refers to financial data measured in prices from a constant base year to adjust for the effects of inflation. Real dollars allow the inter-year comparison of financial levels (prices and/or expenditure) by holding the purchasing power constant.

Technical
efficiency

A measure of how well inputs (such as employees, cars and computers) are converted into service outputs (such as hospital separations, education classes or residential aged care places). Technical efficiency reflects the ratio of outputs to inputs. It is affected by the size of operations and by managerial practices. There is scope to improve technical efficiency if there is potential to increase the quantity of outputs produced from given quantities of inputs, or if there is potential to reduce the quantities of inputs used in producing a certain quantity of outputs.

Unit costs

Measures average cost, expressed as the level of inputs per unit of output. This is an indicator of efficiency.

Terms of Reference

The Report on Government Services

1. The Steering Committee will measure and publish annually data on the equity, efficiency and cost effectiveness of government services through the Report on Government Services (ROGS). Outputs and objectives
2. The ROGS facilitates improved service delivery, efficiency and performance, and accountability to governments and the public by providing a repository of meaningful, balanced, credible, comparative information on the provision of government services, capturing qualitative as well as quantitative change. The Steering Committee will seek to ensure that the performance indicators are administratively simple and cost effective.
3. The ROGS should include a robust set of performance indicators, consistent with the principles set out in the Intergovernmental Agreement on Federal Financial Relations; and an emphasis on longitudinal reporting, subject to a program of continual improvement in reporting.
4. To encourage improvements in service delivery and effectiveness, ROGS should also highlight improvements and innovation.
5. The Steering Committee exercises overall authority within the ROGS reporting process, including determining the coverage of its reporting and the specific performance indicators that will be published, taking into account the scope of National Agreement reporting and avoiding unnecessary data provision burdens for jurisdictions. Steering Committee authority
6. The Steering Committee will implement a program of review and continuous improvement that will allow for changes to the scope of the ROGS over time, including reporting on new service areas and significant service delivery areas that are jurisdiction-specific.
7. The Steering Committee will review the ROGS every three years and advise COAG on jurisdictions' compliance with data provision requirements and of potential improvements in data collection. It may also report on other matters, for example, ROGS's scope, relevance and usefulness; and other matters consistent with the Steering Committee's terms of reference and charter of operations. Reporting to COAG

E Health sector overview

CONTENTS

E.1	Introduction	E.1
E.2	Sector performance indicator framework	E.11
E.3	Cross cutting and interface issues	E.59
E.4	Future directions in performance reporting	E.60
E.5	Jurisdictions' comments	E.61
E.6	List of attachment tables	E.71
E.7	References	E.73

Attachment tables

Attachment tables are identified in references throughout this chapter by a 'EA' prefix (for example, table EA.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

E.1 Introduction

This sector overview provides an introduction to the Primary and community health (chapter 10), Public hospitals (chapter 11), and Mental health management (chapter 12) chapters of this Report. It provides an overview of the health sector, presenting both contextual information and high level performance information.

Improvements to reporting in this edition's Health sector overview include:

- data for the incidence of heart attacks (acute coronary events) are reported for the first time for states and territories
- data for the prevalence of type 2 diabetes are reported by Indigenous status for the first time
- allied health workforce data are reported for the first time
- data for the risk factors prevalence of overweight and obesity and rate of daily smokers by Indigenous status are updated.

Other improvements in reporting are identified in each of the service-specific health chapters.

Health services are concerned with promoting, restoring and maintaining a healthy society. They involve illness prevention, health promotion, the detection and treatment of illness and injury, and the rehabilitation and palliative care of individuals who experience illness and injury. The health system also includes a range of activities that raise awareness of health issues, thereby reducing the risk and onset of illness and injury.

Policy context

All levels of government in Australia fund, deliver and regulate health services, with most of the activity performed by the Australian, State and Territory governments. The Australian Government's health services activities include:

- funding State and Territory governments to assist with the cost of providing public hospital and public health services in line with the National Health Reform Agreement and the National Healthcare Agreement (NHA)
- providing rebates to patients and regulating medical services provided by General Practitioners (GPs) and specialists, practice nurses, and some services provided by allied health professionals (such as Medicare), and delivering public health programs
- funding and regulating the Pharmaceutical Benefits Scheme (PBS)
- funding and regulating private health insurance rebates
- funding improved access to primary health care, including Aboriginal and Torres Strait Islander-specific primary health guided by the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, specialist services and infrastructure for rural and remote communities
- promulgating and coordinating health regulations
- undertaking health policy research and policy coordination across the Australian, State and Territory governments
- funding hospital services and the provision of other services through the Department of Veterans' Affairs
- funding hearing services for eligible Australians through the Australian Government Hearing Services Program
- funding the Medicare Safety Net.

State and Territory governments contribute funding for, and deliver, a range of health care services (including services specifically for Aboriginal and Torres Strait Islander Australians) such as:

- community health services

-
- mental health programs
 - specialist palliative care
 - public hospital services
 - public dental services
 - patient transport
 - health policy research and policy development
 - public health (such as health promotion programs and disease prevention)
 - the regulation, inspection, licensing and monitoring of premises, institutions and personnel.

Local governments are generally involved in environmental control and a range of community-based and home care services, although the exact nature of their involvement varies across jurisdictions. The non-government sector plays a significant role in the health system, delivering general practice and specialist medical and surgical services, dental services, a range of other allied health services (such as optometry and physiotherapy) and private hospitals.

Sector scope

Health services in Australia are delivered by a variety of government and non-government providers in a range of service settings. This Report primarily concentrates on the performance of primary and community health services (including general practice) (chapter 10), public hospitals (chapter 11) and mental health management (chapter 12). These services are selected for reporting as they:

- make an important contribution to the health of the community
- reflect government priorities, for example, they fall within the National Health Priority Areas
- represent significant components of government expenditure on healthcare
- have common objectives across jurisdictions.

High level residential aged care services and patient transport (ambulance) services are not covered in the health chapters in this Report, but are reported separately in chapter 13 ('Aged care services') and chapter 9 ('Fire, road rescue and ambulance').

Other major areas of government involvement in health provision not covered in the health chapters, or elsewhere in the Report, include:

- public health programs, other than those for mental health
- funding for specialist medical practitioners.

Profile of health sector

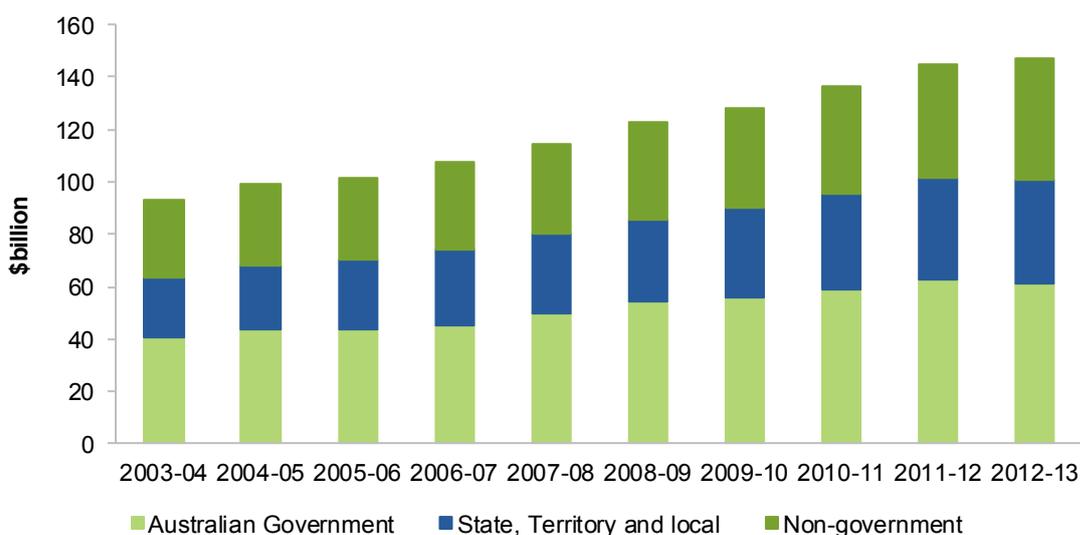
Detailed profiles for the services within the health sector are reported in chapters 10, 11 and 12, and cover health service funding and expenditure as well as the size and scope of the individual service types.

Descriptive statistics

Descriptive statistics for the health sector are included in this section. Additional descriptive data for each jurisdiction are presented in tables EA.5–EA.6.

Total expenditure (recurrent and capital) on health care services in Australia was estimated to be \$147.4 billion in 2012-13 (figure E.1). This total was estimated to account for 9.7 per cent of gross domestic product in 2012-13, an increase of 1.2 percentage points from the 8.5 per cent of GDP in 2003-04 (AIHW 2014a).

Figure E.1 **Total health expenditure, by source of funds (2012-13 dollars)^{a, b, c, d, e}**



^a Data are adjusted to 2012-13 dollars using a combination of deflators (see table EA.7). ^b Includes recurrent and capital expenditure. ^c Includes expenditure on ambulance services (reported in chapter 9). ^d Expenditure by Australian Government and non-government sources has been adjusted for tax expenditure in relation to private health incentives claimed through the taxation system. ^e 'Non-government' includes expenditure by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurers.

Source: AIHW (2014) *Health Expenditure Australia 2012-13*, Health and Welfare Expenditure Series no. 52, Cat. no. HWE 61; table EA.1.

In 2012-13, the combined health expenditure of the Australian, State and Territory, and local governments was \$100.8 billion, representing 68.4 per cent of total health

expenditure within Australia. The Australian Government accounted for the largest proportion of health care expenditure — \$61.0 billion or 41.4 per cent of the total in 2012-13. State and Territory, and local governments contributed \$39.8 billion or 27.0 per cent of total health expenditure in that year (AIHW 2014a). The remainder was paid by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurance providers (tables EA.1 to EA.7).

Between 2003-04 and 2012-13, the average annual rate of growth in real expenditure was 4.4 per cent for the Australian Government, 5.6 per cent for State, Territory and local governments, and 5.4 per cent for non-government sources (table EA.1).

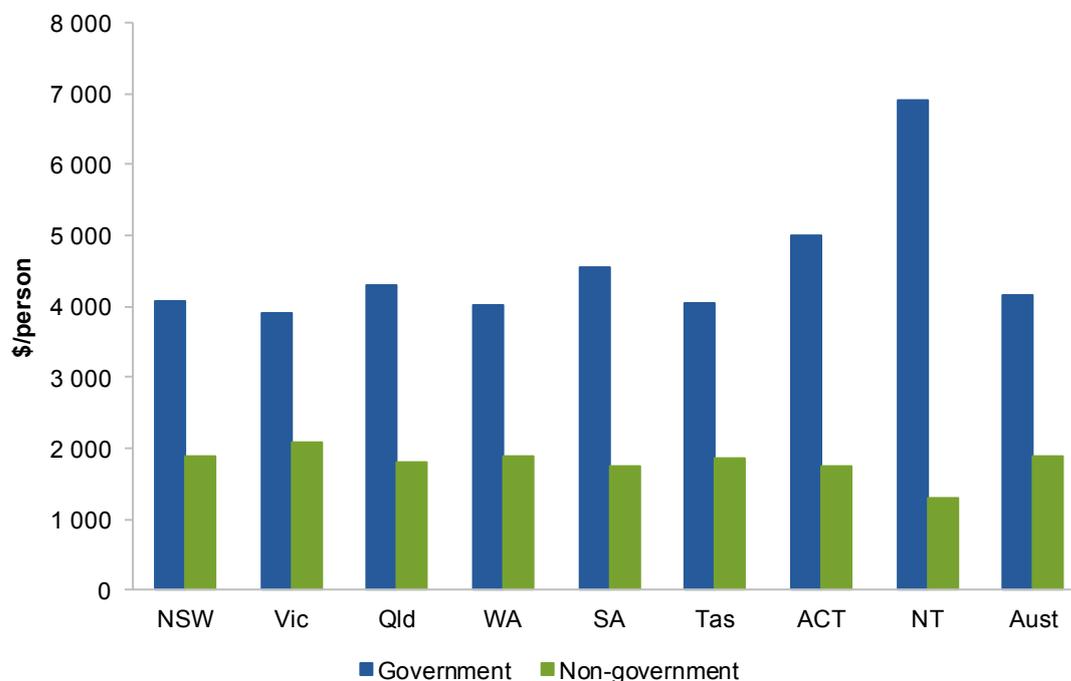
The Health chapters (Part E) provide performance information on Australian, State and Territory, and local governments health services that account for \$69.9 billion of total recurrent health expenditure (or 73.5 per cent of all government recurrent expenditure on health — \$95.2 billion — in 2012-13 (table EA.4)). The services covered are:

- primary and community health (chapter 10) — medical services (including payments to general practitioners [GPs] and other health practitioners), community and public health, medications and public dental services
- public hospitals (chapter 11)
- specialist mental health services (chapter 12).

Health expenditure per person in each jurisdiction is affected by different policy initiatives and socioeconomic and demographic characteristics. Nationally, total recurrent health expenditure per person in Australia increased from \$4476 in 2003-04 to \$6055 in 2012-13 (expressed in 2012-13 dollars) (table EA.5). Government real recurrent health expenditure per person in Australia increased from \$3124 in 2003-04 to \$4153 in 2012-13 (expressed in 2012-13 dollars). Non-government recurrent expenditure per person in Australia increased from \$1352 in 2003-04 to \$1901 in 2012-13 (expressed in 2012-13 dollars) (figure E.2 and table EA.6).

In 2010-11, Australian, State and Territory government total expenditure on health for Aboriginal and Torres Strait Islander Australians was \$4.2 billion (AIHW 2013b; table E.1). Health expenditure by area of expenditure in 2010-11 is presented for Aboriginal and Torres Strait Islander and other Australians in table E.2.

Figure E.2 Recurrent health expenditure per person, by source of funds, 2012-13 ^{a, b, c}



^a Includes expenditure on ambulance services (reported in chapter 9). ^b Government expenditure includes expenditure by the Australian, State, Territory and local governments. ^c ACT expenditure includes substantial expenditure for NSW residents which may inflate expenditure per person data. ^d Excludes expenditure on high level residential aged care.

Source: AIHW (2014) *Health Expenditure Australia 2012-13*, Health and Welfare Expenditure Series no. 52, Cat. no. HWE 61; table EA.6.

Table E.1 Health funding for Aboriginal and Torres Strait Islander and other Australians by source of funding, 2010-11

<i>Source of funding</i>	<i>Amount (\$ million)</i>			<i>Aboriginal and Torres Strait Islander Australians share (%)</i>
	<i>Aboriginal and Torres Strait Islander Australians</i>	<i>Other Australians</i>	<i>Total</i>	
State and Territory governments	2 119.2	28 172.0	30 291.2	7.0
Australian Government	2 040.7	52 967.2	55 007.8	3.7
Direct Australian Government	1 245.0	33 078.3	34 323.3	3.6
Indirect through Australian State/Territory governments	746.1	13 493.9	14 240.0	5.2
Indirect through non-government ^a	49.6	6 394.9	6 444.5	0.8
<i>All governments</i>	4 159.9	81 139.2	85 299.0	4.9
Non-government	392.1	37 964.9	38 357.1	1.0
Total health	4 552.0	119 104.1	123 656.1	3.7

^a Includes private health insurance rebates for all Australians. Also includes Specific Purpose Payments covering highly specialised drugs in private hospitals and other payments.

Source: AIHW (2013) *Expenditure on health for Aboriginal and Torres Strait Islander people 2010-11*, Health and Welfare Expenditure Series no. 48, Cat. no. HWE 57.

Table E.2 Expenditure on health services for Aboriginal and Torres Strait Islander and other Australians, 2010-11

Area of expenditure	Expenditure (\$ million)			Expenditure per person (\$)			
	Aboriginal and Torres Strait Islander Australians	Other Australians	Total	Aboriginal and Torres Strait Islander Australians share (%)	Aboriginal and Torres Strait Islander Australians	Other Australians	Ratio
Total hospital services	2 178.0	47 527.6	49 705.7	4.4	3 825.6	2 169.4	1.8
Public hospitals ^a	2 067.4	36 870.4	38 937.8	5.3	3 631.3	1 683.0	2.2
Admitted patients ^b	1 748.7	31 106.6	32 855.4	5.3	3 071.6	1 419.9	2.2
Non-admitted patients	333.0	5 749.4	6 082.4	5.5	584.9	262.4	2.2
Private hospitals ^c	110.7	10 657.3	10 767.9	1.0	194.4	486.5	0.4
Patient transport	183.4	2 601.4	2 784.7	6.6	322.1	118.7	2.7
Medical	376.3	22 148.2	22 524.5	1.7	660.9	1 011.0	0.7
Medicare	286.0	17 380.7	17 666.8	1.6	502.4	793.3	0.6
Other	90.2	4 767.5	4 857.7	1.9	158.5	217.6	0.7
Dental	84.8	7 780.8	7 865.5	1.1	148.9	355.2	0.4
Community health ^d	1 119.6	5 172.0	6 291.6	17.8	1 966.5	236.1	8.3
Other professional	43.8	4 053.4	4 097.2	1.1	77.0	185.0	0.4
Public health	185.7	1 810.3	1 996.1	9.3	326.2	82.6	4.0
Medications	209.9	18 215.2	18 425.0	1.1	368.7	831.4	0.4
Aids and appliances	15.2	3 616.6	3 631.8	0.4	26.7	165.1	0.2
Research	124.2	4 158.5	4 282.7	2.9	218.2	189.8	1.2
Health administration	31.1	2 020.1	2 051.2	1.5	54.6	92.2	0.6
Total health	4 552.0	119 104.1	123 656.1	3.7	7 995.4	5 436.5	1.5

^a Excludes dental services, patient transport services, community health services, public health and health research undertaken by the hospital. ^b Admitted patient expenditure estimates are adjusted for under-identification of Aboriginal and Torres Strait Islander people. ^c Includes State/Territory governments' expenditure for services provided for public patients in private hospitals. The estimates are not comparable to previous estimates due to improved methodology. ^d Includes other recurrent expenditure on health not elsewhere classified, such as family planning previously reported under 'Other health services (n.e.c.)'. State and Territory expenditure on Closing the Gap initiatives have been allocated to this category for the first time.

Source: AIHW (2013) *Expenditure on health for Aboriginal and Torres Strait Islander people 2010-11*, Health and Welfare Expenditure Series no. 48, Cat. no. HWE 57.

Factors affecting demand for services

Health status is linked to demand for health services and is associated with a range of demographic and socioeconomic factors. Financial, educational, geographic and cultural barriers can reduce access to health services and contribute to poorer health outcomes.

Social and economic factors

It has been well documented that people who experience social and economic disadvantage are at risk of negative health outcomes. Those who are disadvantaged are more likely to report their health as fair or poor than those that do not suffer the same disadvantage as measured by the Socio Economic Indexes for Areas (SEIFA). They are also more likely to have high rates of health risk factors such as smoking and obesity and to have shorter lives (AIHW 2014b). Burden-of-disease studies indicate greater burden among people who are relatively disadvantaged in society (Begg et al. 2007).

Higher income and wealth are associated with better health. People with higher income are better able to access health services in a timely manner, and are also able to access goods and services that have health benefits such as better housing, food and other healthy pursuits (AIHW 2012). People with higher education levels, which are also associated with higher incomes and better access to health care, are likely to have better health (AIHW 2012).

Geographic location

Geographic distance to health services, particularly in remote and very remote areas, can contribute to poor health. People living in rural and remote areas tend to have higher levels of disease risk factors and illness than those in major cities (AIHW 2014b).

Nationally, 2.3 per cent of the population lived in remote and very remote areas in 2013 (table 2A.12). Those living in remote and very remote areas made up less than 7 per cent of the population in each State and Territory except the NT, where the figure was 43.4 per cent — 20.6 per cent in remote and 22.8 per cent in very remote areas.

Indigenous status

Aboriginal and Torres Strait Islander people are more likely than are other Australians to experience poor health, to die at younger ages and to experience disability (AIHW 2014b; tables EA.46 and EA.48). A recent study found socioeconomic disadvantage to be the leading health risk for Aboriginal and Torres Strait Islander Australians in the NT, accounting for 42 to 54 per cent of the life expectancy gap between Aboriginal and Torres Strait Islander and other Australians (Zhao et al. 2013).

Aboriginal and Torres Strait Islander people have low employment and income levels when compared to other Australians (see chapter 2, tables 2A.32–2A.34 and 2A.39–2A.46). Aboriginal and Torres Strait Islander Australians have relatively high rates for many health risk factors and are more likely to smoke and to consume alcohol at risky levels (ABS 2013a, 2014a; Zhao et al. 2013). Aboriginal and Torres Strait Islander Australians are more likely to live in inadequate and overcrowded housing (SCRGSP 2014) and in remote areas with more limited access to health services. In 2006, 51 992 Aboriginal and Torres Strait Islander Australians were living in discrete Aboriginal and Torres Strait Islander communities that were 100 kilometres or more from the nearest hospital (ABS 2007).

Nationally, 3.0 per cent of the total population identified as Aboriginal and Torres Strait Islander in 2011. The projected population of those identifying as Aboriginal and Torres Strait Islander people made up less than 5 per cent of the population in each State and Territory except the NT, where the figure was 29.7 per cent, in 2013 (tables 2A.1 and 2A.14).

Service-sector objectives

Government involvement in health services is predicated on the desire to improve the health of all Australians and to ensure equity of access and the sustainability of the Australian health system. Box E.1 presents the overall objectives of the health system as summarised for this Report, which are consistent with the objectives outlined in the National Healthcare Agreement (MCFFR 2012). Governments provide a variety of services in different settings to fulfil these objectives.

Box E.1 Overall objectives of the health system

Government involvement in the health system is aimed at efficiently and effectively improving health outcomes for all Australians and ensuring the sustainability of the Australian health system, achieving the following outcomes:

- Australians are born and remain healthy
- Australians receive appropriate high quality and affordable primary and community health services
- Australians receive appropriate high quality and affordable hospital and hospital related care
- Australians have positive health care experiences which take account of individual circumstances and care needs
- Australians have a health system that promotes social inclusion and reduces disadvantage, especially for Aboriginal and Torres Strait Islander Australians
- Australians have a sustainable health system.

Measuring the equity, effectiveness and efficiency of Australia's health system is a complex task. It must account for the performance of a range of services (such as

prevention and medical intervention) and service providers (such as community health centres, GPs and public hospitals), and account for the overall outcomes generated by the health system. The appropriate mix of services — including the prevention of illness and injury, and medical treatment (prevention versus medical intervention) — and the appropriate mix of service delivery mechanisms (community-based versus hospital-based) plays an important role in determining outcomes. Other relevant factors are external to the health system, such as the socioeconomic and demographic characteristics of the population, available infrastructure and the environment.

E.2 Sector performance indicator framework

This sector overview is based on a sector performance indicator framework made up of the following elements (figure E.3):

- Sector objectives — three sector objectives are a précis of the key objectives of the health system and reflect the outcomes in the NHA (box E.1).
- Sector-wide indicators — seven sector-wide indicators relate to the overarching service sector objectives identified in the NHA.
- Information from the service-specific performance indicator frameworks that relate to health services. Discussed in more detail in chapters 10, 11 and 12, the service-specific frameworks provide comprehensive information on the equity, effectiveness and efficiency of these services.

This sector overview provides an overview of relevant performance information. Chapters 10, 11 and 12 and their associated attachment tables provide more detailed information.

Figure E.3 Health services sector performance indicator framework

Sector objectives

Australians are born and remain healthy

Australians have a sustainable health system

*Australians have a health system that promotes social inclusion and reduces disadvantage, especially for Indigenous Australians**

Sector-wide indicators

Babies born of low birthweight*

Profile of employed health workforce

Access to services compared to need*

Prevalence of risk factors to the health of Australians*

Selected potentially preventable diseases*

Potentially avoidable deaths*

Mortality and life expectancy*

*Selected indicators disaggregated by: Indigenous status; disability status; remoteness area; and socio-economic status, where appropriate.

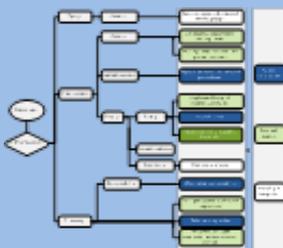
Service-specific performance indicator frameworks

Chapter 10 – Primary and community health – p. 10.17



Chapter 11 – Public hospitals

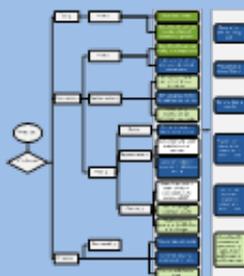
Public hospitals — p. 11.15



Maternity services — p. 11.67



Chapter 12 Mental health management – p. 12.22



Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the ABS (Australian Bureau of Statistics) data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and note key data gaps and issues identified by the Steering Committee. All DQI for the 2015 Report can be found at www.pc.gov.au/rogs/2015.

Sector-wide performance indicators

This section includes high level indicators of health outcomes. While many factors affect outcomes — not solely the performance of government services — outcomes inform the development of appropriate policies and delivery of government services.

Babies born of low birth weight

‘Babies born of low birth weight’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.2). Birthweight is a key indicator of infant health and a principal determinant of a baby’s chance of prospective survival, good health, development and wellbeing (AIHW NPESU and AIHW 2013). Low birth weight babies have a greater risk of poor health and dying and are more likely to develop chronic diseases later in life (AIHW 2014c).

Box E.2 Low birth weight of babies

Babies’ birth weight is defined as low if they weigh less than 2500 grams, very low if they weigh less than 1500 grams and extremely low if they weigh less than 1000 grams (Li et al. 2013).

A low or decreasing number of low birth weight babies is desirable.

Factors external to the health system also have a strong influence on the birth weight of babies. Some factors contributing to low birth weight include socioeconomic status, size of parents, age of mother, number of babies previously born, mother’s nutritional status, smoking and alcohol intake, and illness during pregnancy (Li et al. 2013).

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012 data are available for all jurisdictions.

Data quality Information for this indicator is at www.pc.gov.au/rogs/2015.

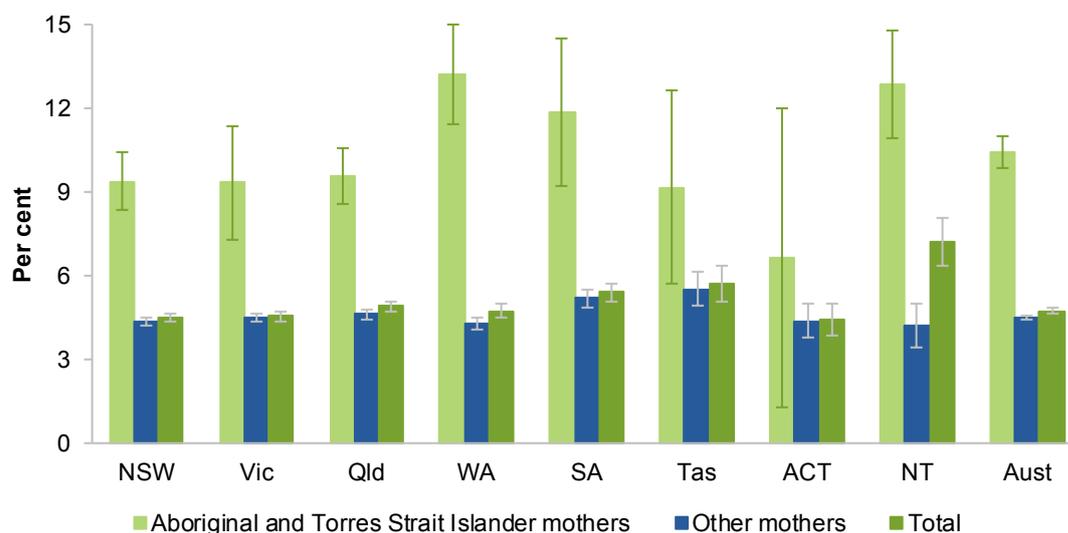
In 2012, 95.2 per cent of liveborn babies in Australia weighed 2500 grams or over and 4.8 per cent weighed less than 2500 grams (table EA.8). This included 1.0 per cent of

babies with a very low birth weight — less than 1500 grams (table EA.9). The average birth weight for all live births was 3367 grams in 2012 (table EA.9).

Nationally, rates of low birth weight babies increased with remoteness, rising from 4.6 per cent in major cities to 5.2 per cent in outer regional areas, and 7.7 per cent in very remote areas in 2012 (table EA.11).

Nationally, the average birth weight for liveborn babies of Aboriginal and Torres Strait Islander mothers was 3211 grams in 2012 (table EA.10). Among liveborn singleton babies born to Aboriginal and Torres Strait Islander mothers in 2012, the proportion with low birth weight was more than twice that of those born to other mothers (figure E.4).

Figure E.4 Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status, 2012^{a, b, c, d, e}



^a Low birth weight is defined as less than 2500 grams. ^b Disaggregation by State/Territory is by place of usual residence of the mother. ^c Data excludes Australian non-residents, residents of external territories and where State/Territory of residence was not stated. ^d Excludes stillbirths and multiple births. Births were included if they were at least 20 weeks gestation or at least 400 grams birth weight. ^e Birth weight data on babies born to Aboriginal and Torres Strait Islander mothers residing in the ACT and Tasmania should be viewed with caution as they are based on small numbers of births.

Source: AIHW (unpublished) National Perinatal Data Collection; table EA.8.

Prevalence of risk factors to the health of Australians

‘Prevalence of risk factors to the health of Australians’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.3).

A number of behaviours create risks to health outcomes; for example, lack of exercise, smoking, excessive alcohol consumption, excessive sun exposure and unhealthy dietary

habits (AIHW 2014b). Health services are concerned with promoting, restoring and maintaining a healthy society. An important part of this activity is aimed at raising awareness of health issues to reduce the risk and onset of illness and injury.

Box E.3 Prevalence of risk factors to the health of Australians

'Prevalence of risk factors to the health of Australians' is defined by the following measures:

- Prevalence of overweight and obesity — the number of people with a Body Mass Index (BMI) in the categories of either overweight or obese, as a percentage of the population. BMI is calculated as weight (kg) divided by the square of height (m). BMI values are grouped according to World Health Organization and National Health and Medical Research Council guidelines.

Among adults, a BMI of 25 to less than 30 is considered overweight and a BMI of 30 or over is considered to be obese (WHO 2000; NHMRC 2013).

Children are defined as people aged 5–17 years. For children, obesity is defined as BMI (appropriate for age and sex) that is likely to be 30 or more at age 18 years.

- Rates of current daily smokers — number of people aged 18 years or over who smoke tobacco every day as a percentage of the population aged 18 years or over.
- Risk of alcohol related harm over a lifetime — people aged 18 years or over assessed as having an alcohol consumption pattern that puts them at risk of long-term alcohol related harm, as a percentage of the population aged 18 years or over.

'Lifetime risk of alcohol related harm' is defined according to the 2009 National Health and Medical Research Council guidelines: for males and females, no more than two standard drinks on any day. This has been operationalised as: for both males and females, an average of more than 2 standard drinks per day in the last week.

Rates for all three measures are age standardised.

A low or decreasing rate is desirable for each health risk factor.

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 2011–2013 data are available for all jurisdictions.

Data quality Information for this indicator is at www.pc.gov.au/rogs/2015.

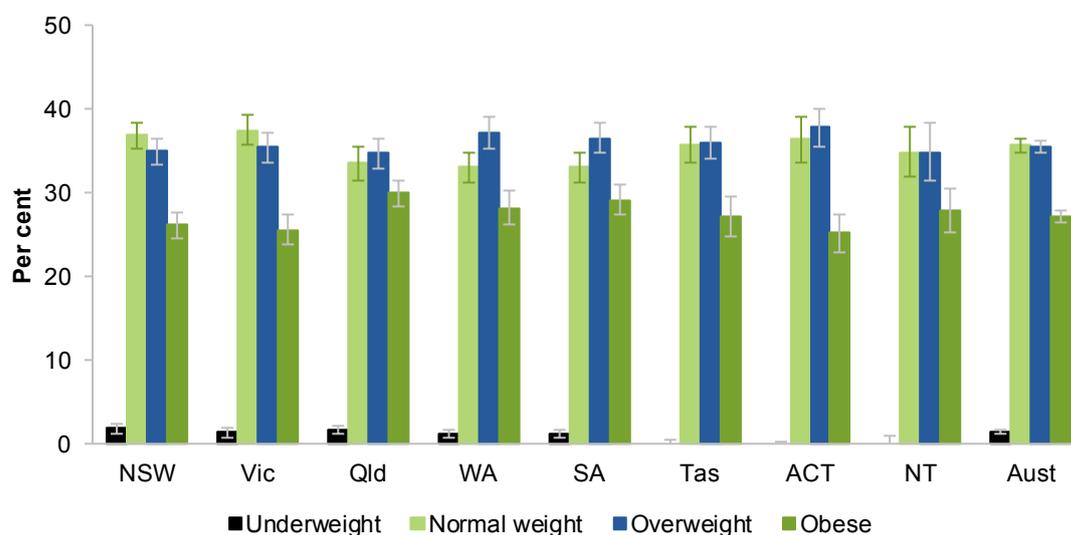
Prevalence of overweight and obesity

Being overweight or obese increases the risk of an individual developing diseases such as heart disease, stroke and Type 2 diabetes. In 2011-12, over a third of Australians' measured BMI was in the overweight range and over a quarter were obese (figure E.5; table EA.12).

The percentage of adults who were overweight or obese tended to be higher in remote (70.1 per cent) and outer regional areas (67.8 per cent), than in major cities (60.9 per cent)

in 2011-12 (table EA.13). The percentage of people who were overweight or obese increased from 2007-08 in all areas of Australia (table EA.13).

Figure E.5 Proportion of adults in BMI categories, 2011-12^{a, b, c, d, e}



^a Adults are defined as people aged 18 years and over. ^b Obesity for adults is defined as BMI equal to or greater than 30. ^c Measured people only. ^d Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population. ^e Data for the NT should be used with care as exclusion of very remote areas from the 2011-13 Australian Health Survey (AHS) translates to the exclusion of around 23 per cent of the NT population.

Source: ABS (Australian Bureau of Statistics) (unpublished) *Australian Health Survey 2011-13* (2011-12 Core component) Cat. no. 4364.0; table EA.12.

The percentage of people who were overweight or obese tended to be higher in older age groups, peaking at age 70-74 for males and females (83.8 per cent and 74.0 per cent respectively) in 2011-12. Overall, the percentage of males and females that were overweight or obese increased from 2007-08 (by 2.1 percentage points for males and 0.9 percentage points for females) although the change varied by age category (table EA.15).

Nationally, the rate of overweight and obesity was higher for Aboriginal and Torres Strait Islander adults (72.4 per cent) than for other adults (62.6 per cent) in 2011-13 (table EA.16). Data for the rate of overweight and obesity for children by Indigenous status are reported in table EA.18.

Rates of current daily smokers

Smoking is an important risk factor for heart disease, stroke and lung cancer. These were the three leading causes of death in Australia in 2011 (ABS 2014b). Smoking is

responsible for around 80 per cent of all lung cancer deaths and 20 per cent of all cancer deaths (HealthInsite 2011).

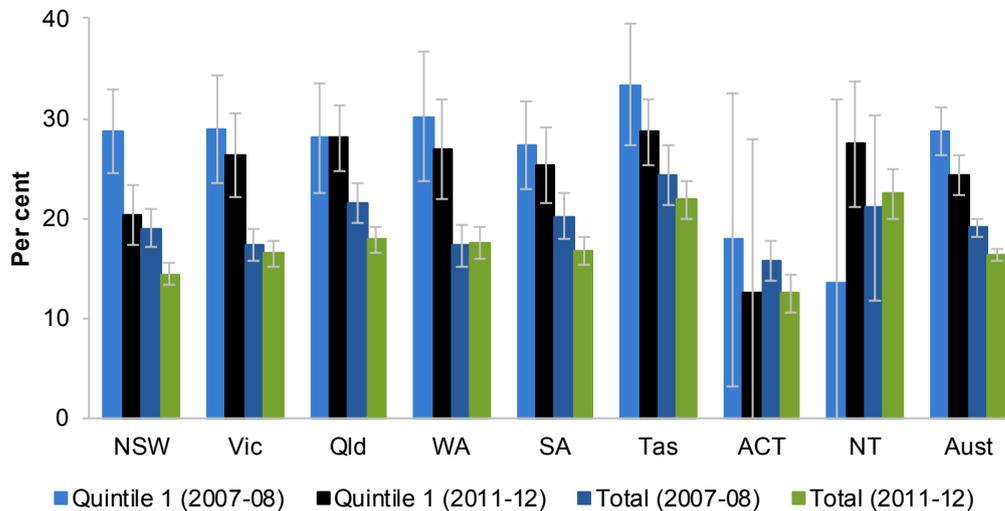
The proportion of adult daily smokers aged 18 years or over accounted for 16.3 per cent of the population in 2011-12, a decrease of 2.8 percentage points from 2007-08 (figure E.6 and table EA.19).

Nationally, people from more disadvantaged socioeconomic backgrounds have a higher propensity to smoke (age standardised). In 2011-12, 24.3 per cent of adults living in areas from the first quintile of the SEIFA — the areas of greatest relative disadvantage — were daily smokers, compared with 9.0 per cent from the fifth quintile — the areas of least relative disadvantage — (figure E.6 and table EA.20).

Adults from more remote locations also had a higher propensity to smoke (age standardised). In 2011-12, daily smokers accounted for 26.1 per cent of the population in remote geographical areas, gradually decreasing as remoteness of residence decreases, accounting for 22.6 per cent of the population in outer regional areas, 19.5 per cent in inner regional areas and 14.7 per cent in major cities (table EA.19).

Nationally, Aboriginal and Torres Strait Islander Australians had higher age-standardised rates of daily smoking (42.0 per cent) than other Australians (16.0 per cent) in 2011–13 (table EA.21).

Figure E.6 **Proportion of adults who are daily smokers, by State and Territory^{a, b, c, d, e, f}**



^a Rates for total are age-standardised by State and Territory to the 2001 Estimated Resident Population (5 year ranges from 18 years). ^b A lower SEIFA quintile indicates relatively greater disadvantage and a lack of advantage in general. A higher SEIFA quintile indicates a relative lack of disadvantage and greater advantage in general. ^c Total includes persons for whom an Index of disadvantage of residence score was not known. ^d Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use. ^e Data for 2011-12 have been revised and differ from data published in the 2013 Report. ^f Data for the NT should be used with care as exclusion of very remote areas from the AHS translates to the exclusion of around 23 per cent of the NT population.

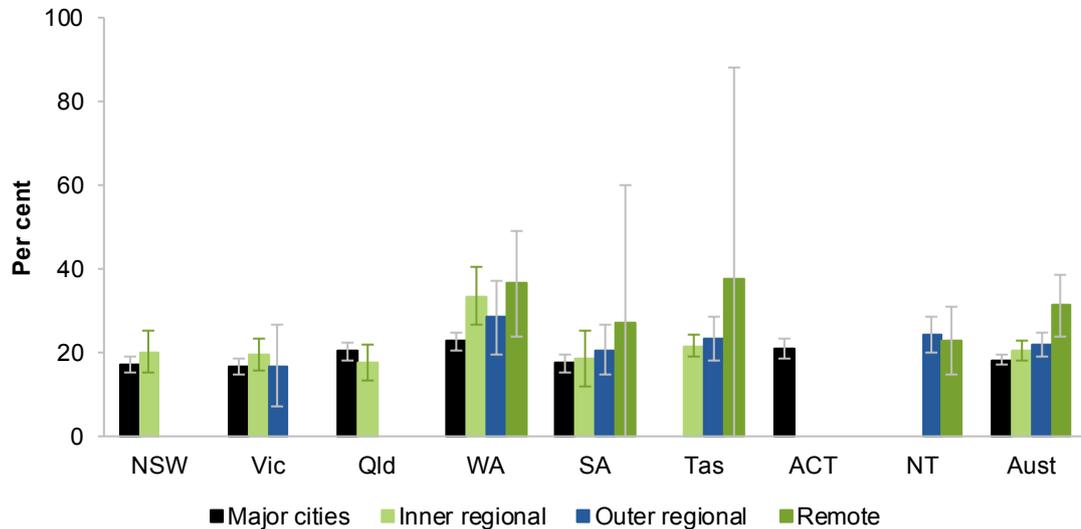
Source: ABS (unpublished) *Australian Health Survey 2011–13* (2011-12 Core component), Cat. no. 4364.0; ABS (unpublished) *National Health Survey 2007-08*, Cat. no. 4364.0; table EA.20.

Levels of risky alcohol consumption

The National Health and Medical Research Council (NHMRC) reports that excessive long term alcohol consumption increases the risk of heart disease, diabetes, liver cirrhosis and some types of cancers. It can contribute to injury and death through accidents, violence, suicide and homicide, and also to financial problems, family breakdown, and child abuse and neglect (NHMRC 2009).

Adults are defined as at risk of alcohol related harm over a lifetime if they consume more than two standard drinks a day, based on the 2009 NHMRC guidelines (NHMRC 2009). Across Australia, 19.4 per cent of adults were at risk of alcohol related harm over a lifetime in 2011-12, although the age standardised rates varied among jurisdictions (table EA.22). Adults who are at risk of alcohol related harm over a lifetime gradually decreased as remoteness of residence decreased in 2011-12 (figure E.7). There is no statistically significant difference between socioeconomic categories of the proportion of Australians at risk of alcohol related harm over a lifetime (table EA.23).

Figure E.7 **Proportion of adults at risk of alcohol related harm over a lifetime, by remoteness, 2011-12^{a, b, c, d, e, f}**



^a Rates are based on the 2009 NHMRC guidelines and can be used for the purposes of comparisons over time. ^b Rates are age standardised by State and Territory to the 2001 Estimated Resident Population (5 year ranges from 18 years). ^c Rates are based on consumption in the week before interview — does not take into account whether more, less than, or the same as, usual consumption. ^d There are no major cities in Tasmania; no outer regional or remote areas in the ACT; no major cities or inner regional areas in the NT. ^e Very remote data were not collected. ^f Data for the NT should be used with care as exclusion of very remote areas from the AHS translates to the exclusion of around 23 per cent of the NT population.

Source: ABS (unpublished) *Australian Health Survey 2011-13* (2011-12 NHS (National Health Survey) component); ABS (unpublished) *National Health Survey 2007-08*; table EA.22.

Nationally, the age standardised proportion of adults at risk of alcohol related harm over a lifetime (2009 NHMRC guidelines) was similar for Aboriginal and Torres Strait Islander Australians (19.2 per cent) and other Australians (19.5 per cent) in 2011–13, although results varied across jurisdictions (table EA.24). Nationally, the age standardised proportion of adults who abstained from alcohol in the previous 12 months was higher for Aboriginal and Torres Strait Islander people (26.1 per cent) than for other Australians (16.3 per cent) in 2011–13 (table EA.25).

Selected potentially preventable diseases

‘Selected potentially preventable diseases’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.4).

Selected potentially preventable diseases are diseases that can potentially be prevented through reducing health risk factors such as obesity, smoking and harmful drinking. Note that a similarly named indicator ‘selected potentially preventable hospitalisations’ is reported in chapter 11 Primary and community health. Selected potentially preventable

hospitalisations are hospital admissions that could potentially be reduced by more effective management of illness and injury in the primary and community healthcare sector.

Box E.4 Selected potentially preventable diseases

‘Selected potentially preventable diseases’ is defined by the following measures:

- Incidence of selected cancers — incidence of selected cancers of public health importance.
 - For melanoma, lung and bowel cancer, the measure is defined as the number of new cases in the reported year expressed as a directly age standardised rate.
 - For breast and cervical cancer in females, the measure is defined as the number of new cases in women in the reported year expressed as a directly age standardised rate.
 - Data reported for this measure are:
 - ... comparable (subject to caveats) across jurisdictions and over time except for NSW and the ACT, for which data for 2010 and 2011 are estimated
 - ... incomplete for the current reporting period. Data for 2010 and 2011 were not available for NSW or the ACT and estimates are reported for these jurisdictions.
- Incidence of heart attacks (acute coronary events) — the number of deaths recorded as acute coronary heart disease deaths plus the number of non-fatal hospitalisations for acute myocardial infarction or unstable angina not ending in a transfer to another acute hospital, expressed as a directly age-standardised rate.
 - Data reported for this measure are:
 - ... comparable (subject to caveats) over time at the national level but are not comparable across jurisdictions
 - ... complete for the current reporting period. All required 2012 data are reported for all jurisdictions.
- Prevalence of type 2 diabetes — the number of people recorded as having Type 2 diabetes as a percentage of the total population aged 18 years or over.
 - Data reported for this measure are:
 - ... comparable across jurisdictions except for the NT where people in very remote areas, for which data are not available, comprise around 23 per cent of the population (see caveats in attachment tables) but are not comparable over time
 - ... complete for the current reporting period except for the NT. All required 2011–13 data are reported for all jurisdictions except the NT.

A low or decreasing rate is desirable for each incidence/prevalence rate.

Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.

Prevalence is defined as the proportion of the population suffering from a disorder.

Data quality Information for this indicator is at www.pc.gov.au/rogs/2015.

As well as addressing health risk factors, well-planned disease prevention and early intervention programs help prevent a number of diseases (or more successfully treat diseases through early identification). A number of programs form an important element of preventing disease and improving the health of Australians (NPHT 2009), such as:

-
- immunisation
 - cancer screening and early treatment
 - early detection and intervention
 - individual disease risk assessments and early intervention for biomedical risk factors such as: high blood pressure, high blood cholesterol, or impaired glucose tolerance
 - childhood infectious diseases control
 - sexually transmitted infections control.

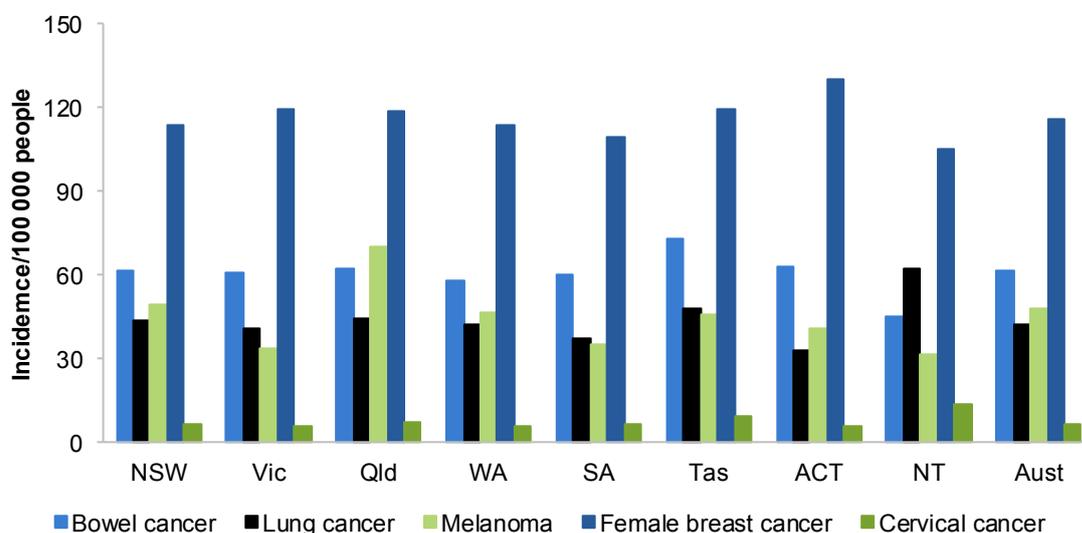
Incidence of selected cancers

Health service efforts to prevent cancer and minimise its impacts include (AIHW 2013c):

- *public health programs* — programs to reduce the major risk factors; tobacco consumption, poor diet, insufficient physical activity, being overweight or obese, unsafe alcohol use, infectious diseases and exposure to ultraviolet radiation
- *early detection* — screening programs for cancers in Australia have contributed to substantial declines in associated mortality. Screening can also help prevent the development of cancer if changes can be found before they become cancer
- *research support* — such as provided through the National Health and Medical Research Council.

Nationally, the age standardised rate of lung cancer was 42.5 new cases per 100 000 people in 2011. Bowel cancer, which has been linked to diet, occurred at a rate of 61.5 new cases per 100 000 people in 2011 (table EA.26). Other cancers such as melanoma are also largely preventable. The incidence of these cancers for 2011, along with breast and cervical cancer, are reported in figure E.8. Tables EA.27–29 report the incidence of the selected cancers by remoteness, SEIFA IRSD quintiles and Indigenous status.

Figure E.8 Incidence of selected cancers, per 100 000 people, 2011^{a, b, c}



^a Age-standardised to the Australian population as at 30 June 2001 using five-year age groups to 85 years+, and expressed per 100 000 persons (per 100 000 females for female breast cancer and cervical cancer). ^b Due to the low incidence of cancers in some jurisdictions, comparisons across time and between jurisdictions should be made with caution. ^c Data for NSW and the ACT are estimates as incidence data are not available for 2011 and are not comparable with data for other jurisdictions.

Source: AIHW (Australian Institute of Health and Welfare) (unpublished) Australian Cancer Database 2011; ABS (2013) *Australian Demographic Statistics, 2012*, Cat. no. 3101.0; table EA.26.

Incidence of heart attacks (acute coronary events)

Cardiovascular disease is the largest cause of premature death in Australia. Although death rates for cardiovascular disease have declined considerably in recent decades, it continues to be one of the biggest health problems requiring attention in Australia (AIHW 2013c).

The major, preventable risk factors for cardiovascular disease are: tobacco smoking; high blood pressure; high blood cholesterol; insufficient physical activity; overweight and obesity; poor nutrition; and diabetes.

Nationally, the rate of heart attacks (acute coronary events) was 406 new cases per 100 000 people in 2012 (table EA.30). The incidence of heart attacks (acute coronary events) was more than twice as high for Aboriginal and Torres Strait Islander people as for other Australians (table EA.31).

Data for states and territories are reported for the first time in tables EA.32 to EA.39.

Prevalence of type 2 diabetes

Diabetes mellitus is a chronic condition in which the body makes too little of the hormone insulin or cannot use it properly. Type 2 diabetes is the most common form of diabetes,

occurring mostly in people aged 50 years and over, and accounting for 85-90 per cent of all cases of diabetes mellitus (AIHW 2013c).

Diabetes mellitus and its complications contribute significantly to ill health, disability, poor quality of life and premature death. It also increases the risk of a variety of complications including end-stage kidney disease, coronary heart disease, stroke and other vascular diseases. Type 2 diabetes is more common in people who do insufficient physical activity and are overweight or obese. It is strongly associated with high blood pressure, high cholesterol and excess weight carried around the waist (Better Health Channel 2013). Thus, early intervention and treatment programs have the potential to reduce the cases and severity of the disease.

Prevalence of type 2 diabetes is derived using a combination of fasting blood glucose and self-reported information on diabetes diagnosis and medication use. Data include all newly diagnosed diabetes cases as the vast majority can be assumed to be type 2 diabetes. See DQI for further detail.

Nationally, an estimated 4.3 per cent of people aged 18 years or over had type 2 diabetes in 2011-12 (table EA.40). The prevalence of type 2 diabetes among Aboriginal and Torres Strait Islander adults was around three times higher than for other Australians in the period 2011-13 (tables EA.41-42).

Potentially avoidable deaths

‘Potentially avoidable deaths’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.5). Avoidable deaths reflect the effectiveness of current and past preventative health activities.

Box E.5 Potentially avoidable deaths

‘Potentially avoidable deaths’ is defined as deaths from conditions that are potentially preventable through individualised care and/or treatable through timely and effective primary or hospital care.

A low or decreasing potentially avoidable death rate is desirable.

Most components of the health system can influence potentially avoidable death rates, although there can be decades between the action and the effect. Factors external to the health system also have a strong influence on potentially avoidable death rates.

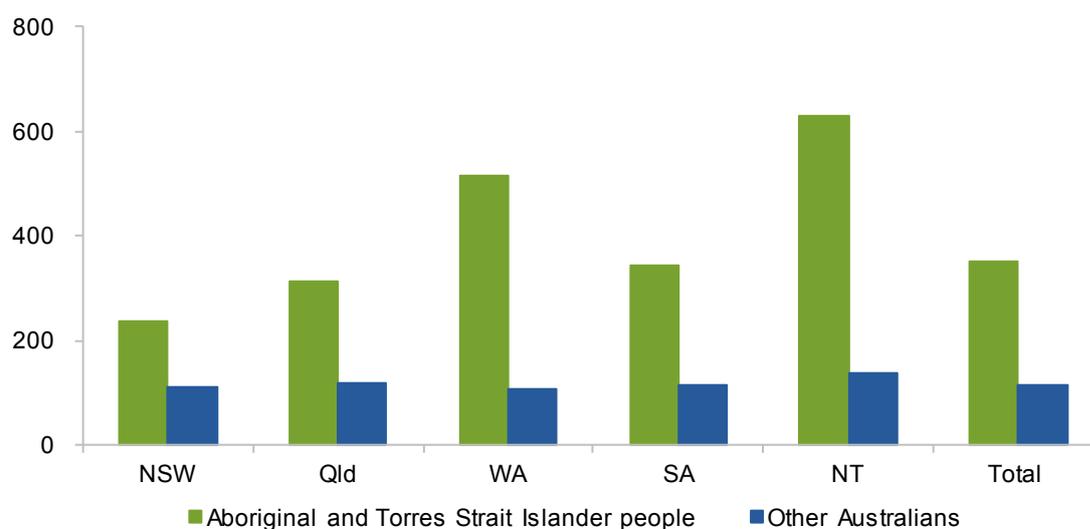
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Nationally, there were 107.8 avoidable deaths per 100 000 people in 2012 (table EA.43). The rate of avoidable deaths was considerably higher for Aboriginal and Torres Strait Islander people than for other Australians in all jurisdictions for which data were available in the period 2008–2012 (figure E.9 and table EA.44).

Figure E.9 Age standardised mortality rates for potentially avoidable deaths, under 75 years, 2008–2012^{a, b, c, d, e, f, g, h, i, j}



^a Standardised death rates calculated using the direct method, age-standardised by 5 year age groups to less than 75 years. ^b Excludes deaths where Indigenous status was not provided. ^c Potentially avoidable deaths refer to deaths from certain conditions that are considered avoidable given timely and effective health care. Specifications for avoidable deaths have been revised and data are not comparable to data in previous reports. ^d Data based on year of registration. ^e Data are reported by jurisdiction of residence only for NSW, Queensland, WA, SA and the NT — these jurisdictions have sufficient level of identification and number of Aboriginal and Torres Strait Islander deaths to support mortality analysis. ^f Queensland deaths data for 2010 were adjusted to minimise the impact of late registration of deaths on mortality indicators. ^g For WA, Aboriginal and Torres Strait Islander deaths data for 2007, 2008 and 2009 have been revised. ^h Total includes data for NSW, Queensland, WA, SA and the NT only. ⁱ See DQI for more information.

Source: ABS (unpublished) *Causes of Deaths, Australia, 2012*, Cat. no. 3303.0; ABS (unpublished) *Estimated Resident Population*; ABS (2014) *Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*, Cat. no. 3238.0; table EA.44.

The mortality and life expectancy of Australians

‘The mortality and life expectancy of Australians’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.6).

Comparing mortality and life expectancy data across populations, including cause, age, sex, population group and geographical distribution, provide important insights into the overall health of Australians (AIHW 2013d). Trends over time in mortality and life

expectancy data can signal changes in the health status of the population, as well as provide a baseline indicator for the effectiveness of the health system.

Box E.6 The mortality and life expectancy of Australians

'The mortality and life expectancy of Australians' is defined by the following measures:

- 'Life expectancy' — the average number of additional years a person of a given age and sex might expect to live if the age-specific death rates of the given period continued throughout his/her lifetime.

A high or increasing life expectancy is desirable.

- 'Median age at death' — the age at which exactly half the deaths registered (or occurring) in a given time period were deaths of people above that age and half were deaths below that age.

A high or increasing median age at death is desirable.

- 'Mortality rates' — the number of registered deaths compared to the total population (expressed as a rate). Rates are provided for:

- Australian mortality rate — age standardised mortality per 1000 people
- infant and child mortality rates — the number of deaths of children under one year of age in a calendar year per 1000 live births in the same year (infant mortality rate) and the number of deaths of children between one and four years of age in a calendar year per 100 000 children (child mortality rate)
- mortality rates by major cause of death — age standardised deaths, by cause of death compared to the total population (expressed as a rate).

A low or decreasing mortality rate is desirable.

Most components of the health system can influence the mortality and life expectancy of Australians, although there can be decades between the action and the effect. Factors external to the health system also have a strong influence.

Data reported for this indicator are:

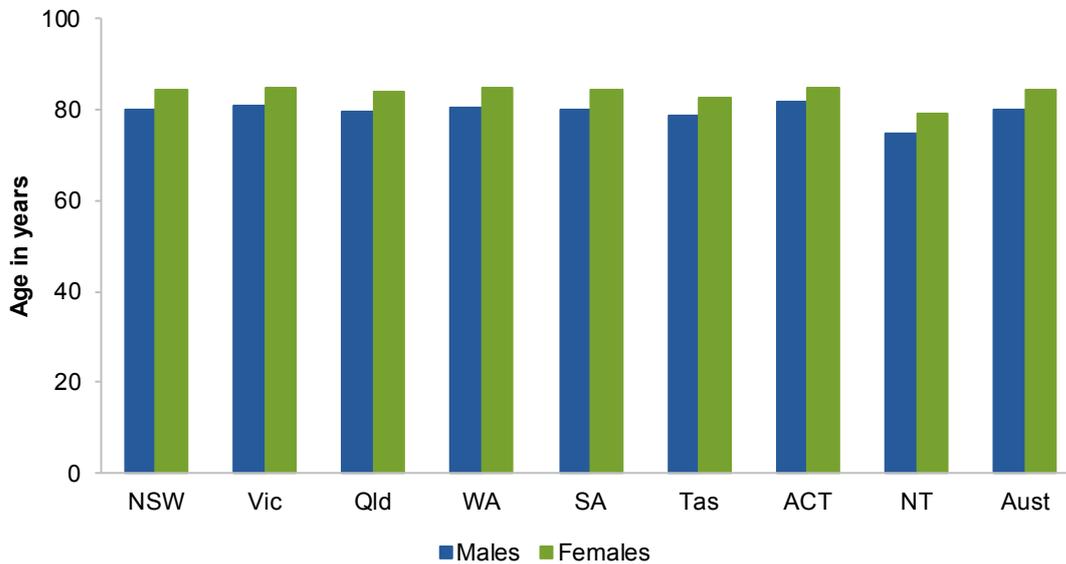
- comparable (subject to caveats) across jurisdictions and over time except for median age at death
- complete (subject to caveats) for the current reporting period. All required 2011–2013 data for life expectancy, 2013 data for median age at death and 2013 data for mortality rates are available for all jurisdictions.

Data quality Information for this indicator is at www.pc.gov.au/rogs/2015.

Life expectancy

The life expectancy of Australians improved dramatically during the twentieth century and so far during the twenty-first century. The average life expectancy at birth in the period 1901–1910 was 55.2 years for males and 58.8 years for females (ABS 2013b). It has risen steadily in each decade since, reaching 80.1 years for males and 84.3 years for females in 2011–2013 (figure E.10).

Figure E.10 All Australians average life expectancy at birth, 2011–2013^a

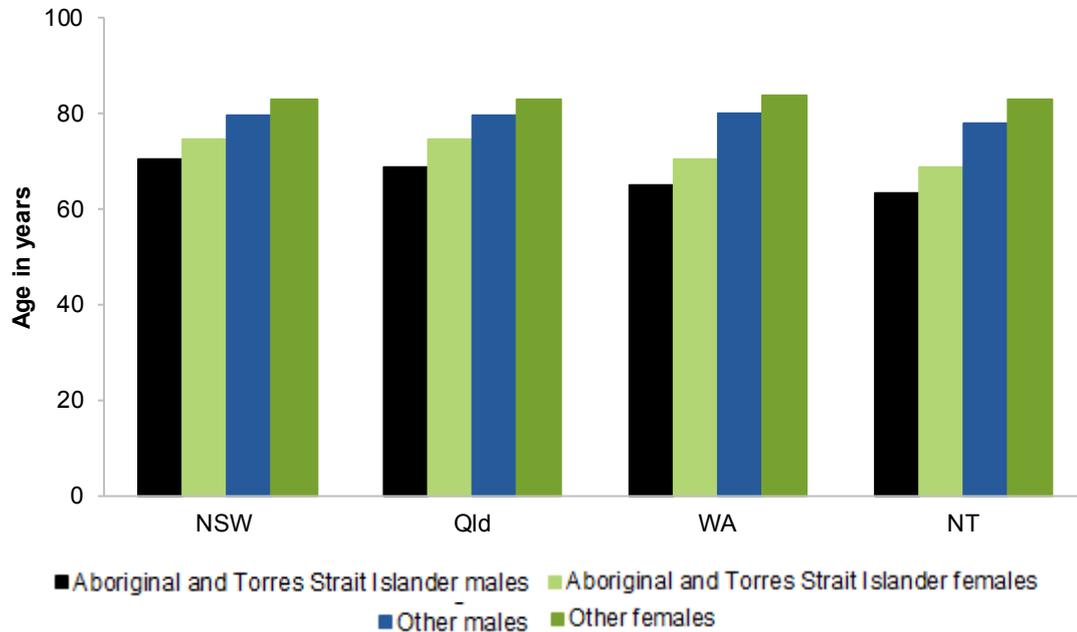


^a Data for Australia include 'other territories'.

Source: ABS (2014) *Life Tables, Australia, States and Territories, 2011-2013*, Cat. no. 3302.0.55.001; table EA.45.

The life expectancies of Aboriginal and Torres Strait Islander Australians are considerably lower than those of other Australians. ABS estimates are available every 5 years. These indicate a life expectancy at birth of 69.1 years for Aboriginal and Torres Strait Islander males and 73.7 years for Aboriginal and Torres Strait Islander females born from 2010 to 2012. In the same time period, life expectancy at birth for other males was 79.7 years and for other females was 83.1 years (table EA.46). Life expectancy at birth by Indigenous status and sex for NSW, Queensland, WA and the NT are presented in figure E.11.

Figure E.11 **Estimated life expectancies at birth, by Indigenous status and sex, 2010–2012 (years)^{a, b}**



^a Aboriginal and Torres Strait Islander estimates of life expectancy are not available for Victoria, SA, Tasmania or the ACT due to the small number of Aboriginal and Torres Strait Islander deaths in these jurisdictions. ^b Life tables are constructed separately for Males and Females.

Source: ABS (2013) *Life Tables for Aboriginal and Torres Strait Islander Australians 2010–2012*, Cat. no. 3302; table EA.46.

Median age at death

The median age at death in 2013 was 78.6 years of age for Australian males and 84.7 years of age for Australian females (table EA.47).

Comparisons of the median age at death for Aboriginal and Torres Strait Islander and other Australians are affected by different age structures in the populations and by differences in the extent of identification of Aboriginal and Torres Strait Islander deaths across jurisdictions and across age groups. Identification of Aboriginal and Torres Strait Islander infant deaths is high, but falls significantly in older age groups. The median age of death for Aboriginal and Torres Strait Islander people is, therefore, likely to be an underestimate.

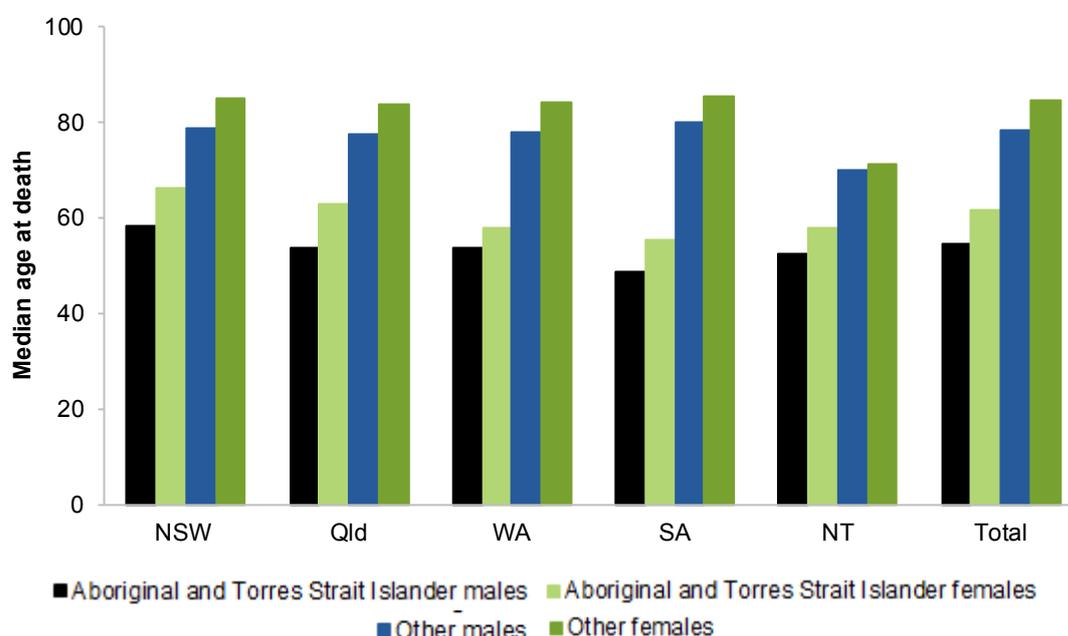
Caution should be taken when comparing median age at death between Aboriginal and Torres Strait Islander people and other populations. Coory and Baade (2003) note that:

- the relationship between a change in median age at death and a change in death rate depends upon the baseline death rate. So comparison of trends in median age at death for Aboriginal and Torres Strait Islander and other Australians is difficult to interpret

- changes in the median age at death of public health importance might be difficult to distinguish from statistical noise.

Nationally, counting only the jurisdictions for which data were available for Aboriginal and Torres Strait Islander Australians, the median age at death for male Aboriginal and Torres Strait Islander Australians was 54.6 years of age. The median age at death for female Aboriginal and Torres Strait Islander Australians was 61.6 years of age (figure E.12 and table EA.48).

Figure E.12 Median age at death, by sex and Indigenous status, 2013^{a, b}



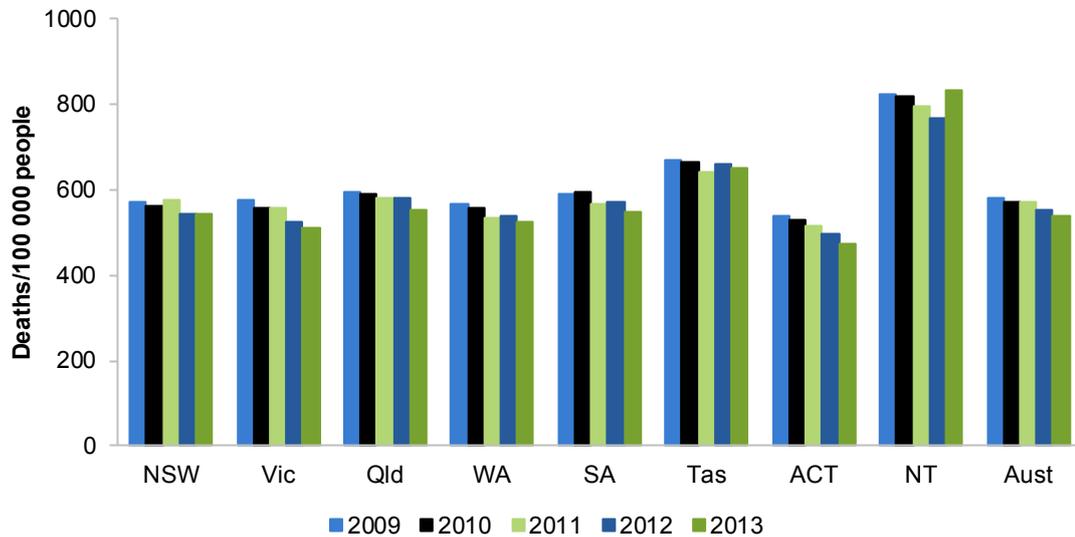
^a Victoria, Tasmania and the ACT are excluded due to small numbers of registered Aboriginal and Torres Strait Islander deaths. ^b The accuracy of Aboriginal and Torres Strait Islander mortality data is variable as a result of varying rates of coverage across jurisdictions and age groups, and of changes in the estimated Aboriginal and Torres Strait Islander population caused by changing rates of identification in the Census and births data.

Source: ABS (2014) *Deaths, Australia, 2013*, Cat. no. 3302.0; table EA.48.

Mortality rates

There were 147 678 deaths registered in Australia in 2013 (ABS 2014c), which translated into an age standardised mortality rate of 540 deaths per 100 000 people (figure E.13). Death rates over the last 20 years have declined for all states and territories (ABS 2014c).

Figure E.13 Mortality rates, age standardised^{a, b, c, d}



^a Deaths are based on year of registration of death. ^b Deaths per 100 000 standard population. Standardised death rates use total people in the 2001 Australian population as the standard population. ^c Rates may differ from previous reports as they have been revised using ERPs based on the 2011 Census. Rates are not comparable with rates for Aboriginal and Torres Strait Islander and other Australians which use ERPs based on the 2006 Census. ^d Australian totals includes all states and territories.

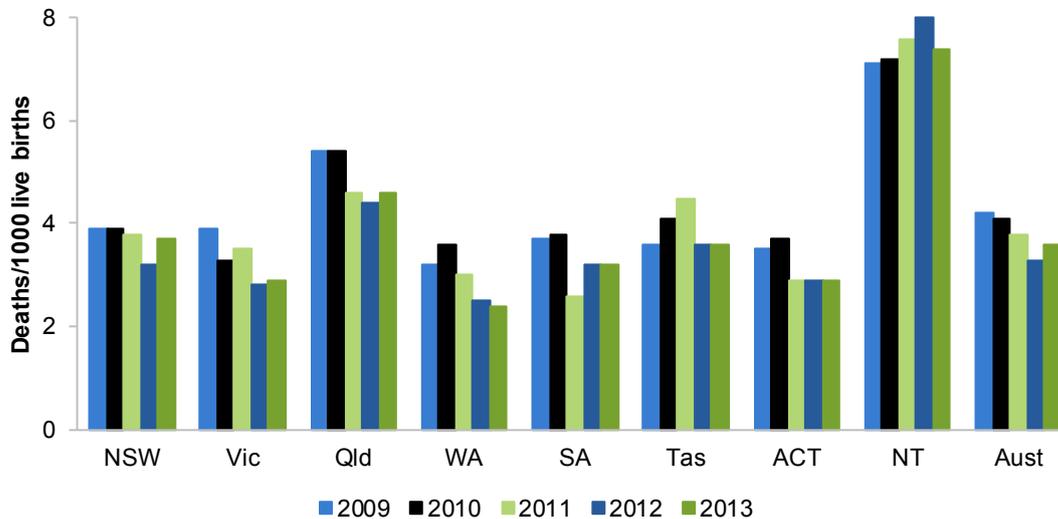
Source: ABS (2014) *Deaths, Australia, 2013*, Cat. no. 3302.0; table EA.49.

Mortality rates — Infant and child

The annual infant mortality rate in Australia declined from an average of 4.7 deaths per 1000 live births in 2004 to 3.6 deaths per 1000 live births in 2013 (table EA.52 and figure E.14).

The Australian infant and child combined mortality rate was 87.2 deaths per 100 000 population in 2011–2013 (children aged 0 to 4 years). Of the total deaths for this age group, 84.0 per cent were infant deaths (table EA.54).

Figure E.14 **Infant mortality rate^{a, b}**



^a Infant deaths per 1000 live births. ^b Data for Australia include all states and territories.

Source: ABS (2014) *Deaths, Australia, 2013*, Cat. no. 3302.0; table EA.52.

Mortality rates — by remoteness

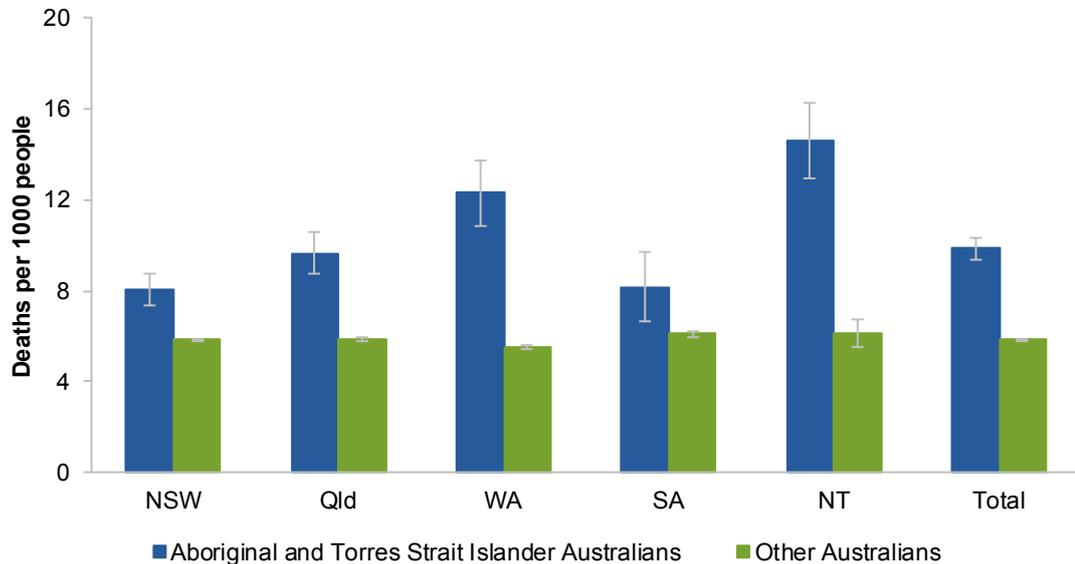
Mortality indicators showed that very remote areas of Australia have had consistently higher mortality rates than have other remoteness areas. In 2012, the age standardised mortality rates were highest in very remote areas (7.8 deaths per 1000 people), while major cities had the lowest mortality rates (5.4 deaths per 1000 people) (ABS 2014c).

Mortality rates — Aboriginal and Torres Strait Islander Australians

Data for Aboriginal and Torres Strait Islander mortality are collected through State and Territory death registrations. The completeness of identification of Aboriginal and Torres Strait Islander Australian deaths in these collections varies significantly across states and territories so care is required when making comparisons.

For the period 2009–2013, NSW, Queensland, WA, SA and the NT have been assessed as having adequate identification and number of Aboriginal and Torres Strait Islander deaths for mortality analysis. For these five jurisdictions combined, the overall age standardised mortality rate for Aboriginal and Torres Strait Islander people was 985.0 per 100 000 people, significantly higher than for other Australians (585.2 per 100 000 people) (figure E.15 and table EA.50). Due to identification completeness issues, mortality rates presented here are likely to be underestimates of the true mortality of Aboriginal and Torres Strait Islander Australians (ABS and AIHW 2008).

Figure E.15 **Mortality rates, age standardised, by Indigenous status, five year average, 2009–2013^{a, b, c, d, e}**



^a Deaths are based on year of registration. ^b Mortality rates are age-standardised to the 2001 Australian standard population. ^c Rates are derived from population estimates and projections revised to the 2011 Census base. See data quality information (DQI) for further detail. ^d Data are reported by jurisdiction of residence only for jurisdictions with a sufficient number and level of identification of Aboriginal and Torres Strait Islander deaths to support mortality analysis — NSW, Queensland, WA, SA and the NT. Total includes data only for those jurisdictions. ^e Error bars represent the 95 per cent variability band associated with each point estimate. See DQI for more information.

Source: ABS (unpublished), *Deaths, Australia*, various years, Cat. no. 3302.0; table EA.50.

Data on long-term trends for WA, SA and the NT suggest that the mortality rate for Aboriginal and Torres Strait Islander infants decreased by 62 per cent between 1991 and 2010 (AHMAC 2012). While this is a significant improvement, mortality rates for Aboriginal and Torres Strait Islander infants and children are still markedly higher than for other infants and children in Australia.

For the period 2009–2013, the average infant mortality rate for Aboriginal and Torres Strait Islander infants (less than one year) was higher than for other infants in the jurisdictions for which there were data available (NSW, Queensland, WA, SA and the NT) (table EA.55). For the same period and the same jurisdictions, the average mortality rate for infants and children combined (0–4 years) per 100 000 children aged 0–4 years was 169.1 for Aboriginal and Torres Strait Islander children and 89.2 for other Australian children (table EA.55).

Mortality rates — by major cause of death

The most common causes of death among Australians in 2012 were cancers, diseases of the circulatory system (including heart disease, heart attack and stroke), and diseases of the respiratory system (including influenza, pneumonia and chronic lower respiratory diseases) (tables E.3 and EA.56).

In the jurisdictions for which age standardised death rates are available by Indigenous status (NSW, Queensland, WA, SA and the NT), death rates were significantly higher for Aboriginal and Torres Strait Islander people than for other Australians in 2009–2013 (table E.4). For these jurisdictions, the leading age-standardised cause of death for Aboriginal and Torres Strait Islander people was circulatory diseases followed by neoplasms (cancer) in 2012 (table EA.57).

Table E.3 Age standardised mortality rates by major cause of death (deaths per 100 000 people), 2012^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Certain infectious and parasitic diseases	10.6	8.4	6.9	7.8	10.9	8.2	6.6	np	9.1
Neoplasms	166.8	162.4	179.2	167.0	166.6	185.7	147.0	211.7	168.4
Diseases of the blood ^c	1.8	1.6	1.7	1.5	1.6	np	np	np	1.7
Endocrine, nutritional and metabolic diseases	20.2	23.0	23.3	23.6	22.6	33.7	24.6	65.2	22.7
Mental and behavioural disorders	27.6	27.2	26.7	27.5	34.7	48.3	25.0	30.9	28.5
Diseases of the:									
• nervous system	23.2	26.8	25.3	30.3	28.5	25.7	24.0	23.7	25.7
• eye and adnexa	np	np	np	np	–	–	–	–	np
• ear and mastoid processes	np	np	np	–	–	–	–	np	np
• circulatory system	160.1	148.1	175.1	144.5	161.5	195.2	141.4	185.3	159.6
• respiratory system	50.7	45.0	50.4	45.9	49.2	62.1	42.0	73.5	49.0
• digestive system	18.8	19.8	20.8	17.6	21.1	22.2	20.5	26.6	19.7
• skin and subcutaneous tissue	1.7	1.4	1.4	1.1	1.2	np	np	np	1.4
• musculoskeletal system and connective tissue	4.0	4.2	5.1	3.3	2.7	8.0	6.6	np	4.3
• kidney	13.4	15.5	11.8	13.6	14.0	13.0	13.1	23.5	13.8
Pregnancy, childbirth and the puerperium	np	np	np	–	np	–	–	–	np
Certain conditions originating in the perinatal period	2.2	2.0	2.8	1.3	2.6	np	np	np	2.3
Congenital conditions ^d	2.4	2.2	2.6	2.0	2.6	np	np	np	2.4
Abnormal findings nec ^e	7.2	3.5	3.7	5.5	13.3	3.5	np	13.3	5.9
External causes of morbidity and mortality	33.8	33.3	43.7	46.2	39.2	44.0	31.7	79.5	37.9
Total	544.5	524.7	580.7	538.9	572.4	658.3	494.9	769.2	552.3

^a Age standardised to the Australian population as at 30 June 2001. ^b Australian total includes 'Other territories'. ^c Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism. ^d Congenital malformations, deformations and chromosomal abnormalities. ^e Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified. – Nil or rounded to zero. **np** Not published.

Source: ABS (unpublished) *Causes of Death Australia, 2012* Cat. no. 3303.0; table EA.56.

Aboriginal and Torres Strait Islander people died from circulatory diseases, endocrine, metabolic and nutritional disorders, cancer and respiratory diseases at higher rates than other Australians (tables E.4 and EA.57).

Table E.4 Major cause of death by Indigenous status — rate differences and rate ratios, 2008–2012^{a, b, c}

	<i>Rate difference — rate for Aboriginal and Torres Strait Islander people less rate for other Australians</i>						<i>Rate ratio — rate for Aboriginal and Torres Strait Islander people divided by rate for other Australians</i>					
	NSW	Qld	WA	SA	NT	Total ^c	NSW	Qld	WA	SA	NT	Total ^c
Circulatory diseases	62.0	79.0	211.9	33.3	176.8	93.9	1.3	1.4	2.3	1.2	2.1	1.5
Cancer	17.9	48.9	81.1	23.2	119.1	46.2	1.1	1.3	1.5	0.9	1.6	1.3
External causes	16.4	19.4	78.2	45.1	63.9	37.0	1.5	1.5	2.9	2.2	2.1	2.0
Endocrine and other disorders ^d	35.7	83.3	138.0	37.2	179.6	80.6	2.7	4.5	6.8	2.5	6.9	4.6
Respiratory diseases	37.9	35.0	61.7	28.7	92.7	46.5	1.7	1.7	2.4	1.6	2.6	1.9
Digestive diseases	9.3	29.5	39.2	34.9	54.4	26.9	1.4	2.4	3.0	2.7	3.2	2.3
Kidney diseases	8.8	15.2	29.4	np	53.4	18.4	1.8	2.6	3.9	np	6.4	2.6
Conditions originating in the perinatal period	0.1	1.4	2.5	np	6.6	1.7	1.0	1.5	2.6	np	3.4	1.7
Infectious and parasitic diseases	4.1	11.4	15.9	11.6	18.6	10.2	1.4	2.6	3.1	2.2	2.4	2.1
Nervous system diseases	- 6.3	- 2.1	5.4	3.7	0.9	- 1.8	0.7	0.9	1.2	1.1	1.0	0.9
Other causes	10.1	24.9	64.7	12.6	74.5	29.4	1.2	1.6	2.5	1.2	2.5	1.6
All causes	196.1	345.9	728.0	195.5	841.0	388.9	1.3	1.6	2.3	1.3	2.3	1.7

^a All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2008–2010 (final), 2011 (revised) and 2012 (preliminary). See data quality information (DQI) for further information. ^b Rate differences and rate ratios are derived from mortality rates data (reported in table EA.57) that are age standardised (using the direct method) to the Australian population as at 30 June 2001. ^c Data are reported by jurisdiction of residence only for jurisdictions with a sufficient number and sufficient level of identification of Aboriginal and Torres Strait Islander deaths to support mortality analysis — NSW, Queensland, WA, SA and the NT. Total includes data only for those jurisdictions. ^d Endocrine, metabolic and nutritional disorders. **np** not published.

Source: ABS (unpublished) *Causes of Death Australia, 2012*, Cat. no. 3303.0; table EA.57.

Profile of employed health workforce

‘Profile of employed health workforce’ is an indicator of governments’ objective that Australians have a sustainable health system (box E.7).

Box E.7 Profile of employed health workforce

'Profile of employed health workforce' is defined by three measures:

- the full time equivalent employed health workforce divided by the population
- the proportion of the full time equivalent employed health workforce under the age of 45 years
- the net growth in the full time equivalent employed health workforce.

High or increasing rates for health workforce measures can give an indication of the sustainability of the health system and its ability to respond and adapt to future needs.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012 data are available for all jurisdictions.

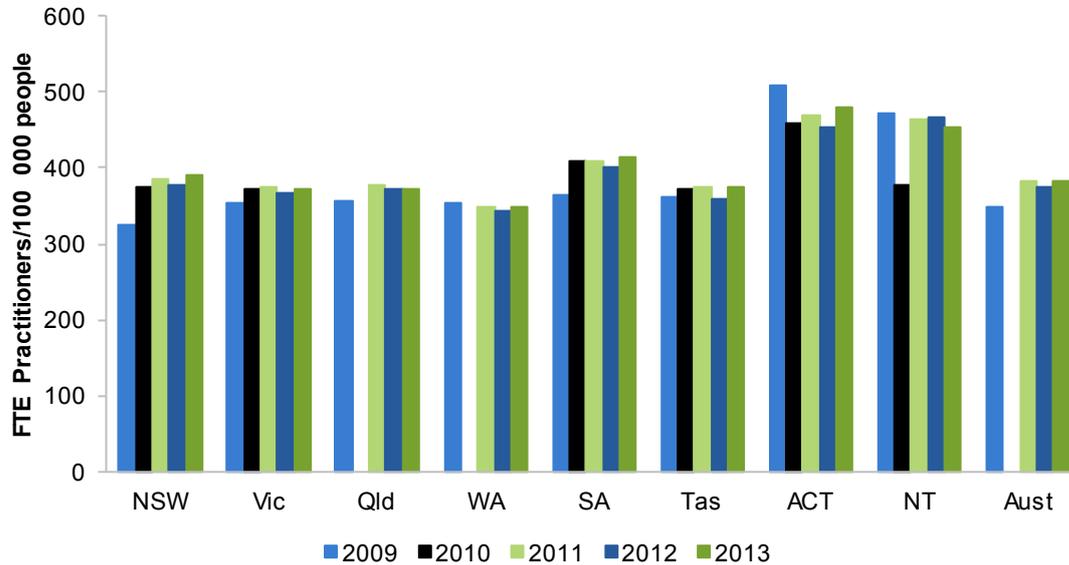
Information about data quality for this indicator is at ww.pc.gov.au/rogs/2015.

In 2013, the majority of employed medical practitioners (commonly referred to as doctors) that were employed in medicine were clinicians (95.2 per cent), of whom 32.7 per cent were general practitioners, 34.7 per cent were specialists, 17.5 per cent were specialists-in-training, 12.3 per cent were hospital non-specialists and 2.8 per cent were other clinicians (AIHW 2014d). The proportion of women increased from 35.7 per cent in 2009 to 38.6 per cent in 2013. The number of full time equivalent (FTE) practitioners per 100 000 people by jurisdiction is illustrated in figure E.16.

In 2013, the number of nurses and midwives registered in Australia was 344 190. In 2013, the number of nurses and midwives registered and employed in Australia was 296 029, or 1280 per 100 000 population (table EA.59). The majority of employed nurses and midwives were clinicians (90.0 per cent). The principal area of the main job of employed registered and enrolled nurses and midwives was aged care (15.6 per cent) followed by medical (9.8 per cent) and surgical (8.7) roles. The average age of employed nurses and midwives changed little between 2009 (44.3 years) and 2013 (44.5 years). The proportion of employed nurses and midwives aged 50 or older increased from 36.3 per cent to 39.3 per cent over this period (AIHW 2014e). The number of FTE nurses and midwives per 100 000 people by jurisdiction is illustrated in figure E.17.

Nationally there were 426.3 FTE allied health practitioners per 100 000 people in 2013 (table EA.60).

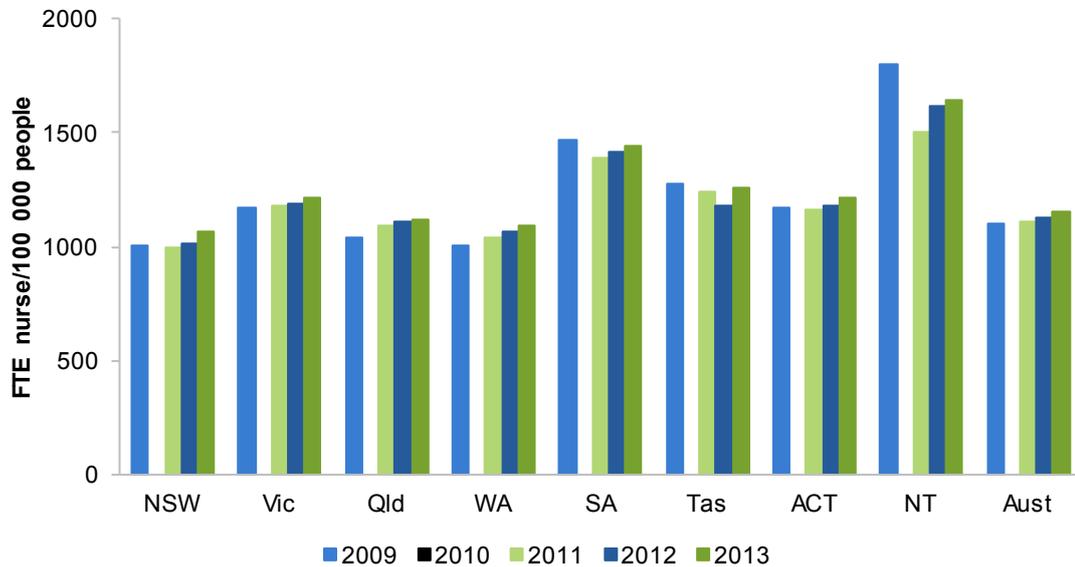
Figure E.16 **Full time equivalent employed medical practitioners^{a, b, c, d, e, f, g}**



^a FTE rate (FTE per 100 000 people) is based on a standard full-time working week of 40 hours. ^b Excludes employed medical practitioners on extended leave. ^c Caution should be used in comparing data for the ACT with other jurisdictions. Rates for the ACT are inflated as many services are provided to southern NSW residents not captured in the denominator. In addition, a relatively high proportion of practitioners work in non-clinical roles, compared to other jurisdictions (AIHW 2014d). ^d From 2010, health workforce labour surveys are conducted at the national level and survey questions are consistent across jurisdictions. For 2009 and previous years, surveys were managed by each jurisdiction's health authority and there were some differences in survey questions between jurisdictions and within jurisdictions over time. This has little impact on the data reported here. However, caution should be used in comparing data between jurisdictions and over time (see DQI for further details). ^e 2010 data exclude Queensland and WA due to closure of the registration period after the national registration deadline. ^f Caution should be used in comparing data for the NT with other jurisdictions from 2010, when changes to doctors' registration requirements meant registration in the NT was no longer required for nationally registered doctors providing fly in fly out services. ^g From 2011, State and Territory is derived from State and Territory of main job where available; otherwise State and Territory of principal practice is used as a proxy unless unavailable, in which case state and territory of residence is used. ^h From 2012, data exclude provisional registrants.

Source: AIHW (unpublished) National Health Workforce Data Set; AIHW (unpublished) Medical Labour Force Survey; ABS (2013, 2014) *Australian demographic statistics*, Cat. no. 3101; table EA.58.

Figure E.17 Full time equivalent employed nurses and midwives^{a, b, c, d, e}



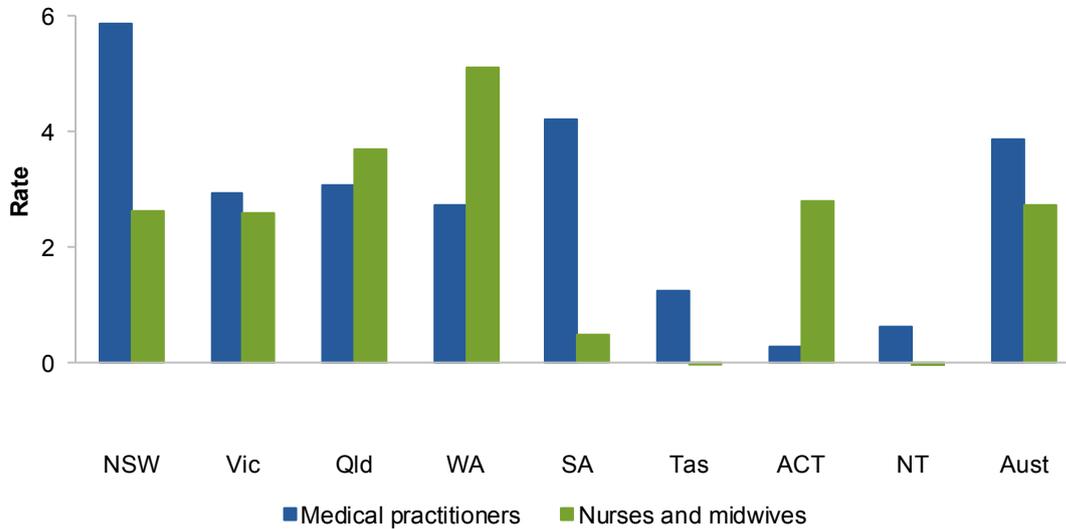
^a FTE nurse rate (per 100 000 people) based on a 38-hour week. ^b Excludes nurses on extended leave. ^c Data are not available for 2010. ^d From 2011, health workforce labour surveys are conducted at the national level and survey questions are consistent across jurisdictions. For 2009 and previous years, surveys were managed by each jurisdiction's health authority and there were some differences in survey questions between jurisdictions and within jurisdictions over time. This has little impact on the data reported here. However, caution should be used in comparing data between jurisdictions and over time (see DQI for further details). ^e From 2011, State and Territory is derived from State and Territory of main job where available; otherwise State and Territory of principal practice is used as a proxy unless unavailable, in which case state and territory of residence is used. ^h From 2012, data exclude provisional registrants.

Source: AIHW (unpublished) National Health Workforce Data Set; ABS (2013, 2014), *Australian demographic statistics*, Cat. no. 3101; table EA.59.

At the national level, 51.5 per cent of employed medical practitioners were under the age of 45 in 2013 (table EA.58). The medical practitioner workforce grew at an average annual rate of 3.9 per cent from 2009 to 2013 (figure E.18). The nursing and midwifery workforce grew at an average rate of 2.8 per cent annually from 2009 to 2013 (figure E.18), and 47.3 per cent of employed nurses were under the age of 45 in 2013 (table EA.59).

Nationally, 0.9 per cent of the nursing and midwifery workforce were Aboriginal and Torres Strait Islander in 2013 (table EA.62). Of people employed in health-related occupations in 2011, 1.6 per cent were Aboriginal and Torres Strait Islander. Within health related occupations in 2011, the occupations with the highest percentage of Aboriginal and Torres Strait Islander Australians were health and welfare support officers, which includes the occupation Aboriginal and Torres Strait Islander Health Workers (tables EA.63–EA.65).

Figure E.18 **Annual average growth in selected workforces, 2009–2013**^{a, b, c, d, e, f}



^a Net growth measures the change in the FTE number in the workforce in the reference year compared to the year prior to the reference year. ^b FTEs calculated based on a 40-hour standard working week for medical practitioners and a 38-hour week for nurses/midwives. ^c From 2010, health workforce labour surveys are conducted at the national level and survey questions are consistent across jurisdictions. For 2009, surveys were managed by each jurisdiction's health authority and there were some differences in survey questions between jurisdictions and within jurisdictions over time. This has little impact on the data reported here. However, caution should be used in comparing data between jurisdictions and over time (see DQI for further details) ^d From 2010, state and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to 'Not stated'. ^e Data for 2009 are for the workforce, including practitioners who are employed, on extended leave and/or looking for work. From 2010, data are only for those employed in the workforce. ^f Caution should be used in comparing medical workforce data for the NT with other jurisdictions from 2010 as this was the first year of changed doctors' registration requirements (in particular, doctors providing fly in fly out services are no longer required to register in the NT where they are registered nationally).

Source: AIHW (unpublished) National Health Workforce Data Set; table EA.61.

Access to services compared to need by type of service

'Access to services compared to need by type of service' is an indicator of governments' objective that Aboriginal and Torres Strait Islander Australians and those living in rural and remote areas or on low incomes achieve health outcomes comparable to the broader population (box E.8).

Results from the 2011-12 Australian Health Survey indicate that the majority of Australians (85.6 per cent) aged 15 years or over reported their health as either good, very good or excellent (ABS 2012). In the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, 76 per cent of Aboriginal and Torres Strait Islander Australians reported their health as either good, very good or excellent (ABS 2013a).

Box E.8 Access to services compared to need by type of service

'Access to services compared to need by type of service' is defined as the number of people aged 15 years or over who accessed a particular health service in the past 12 months (for hospital admissions), 3 months (for dental services) or 2 weeks (for other health services) divided by the population aged 15 years or over, expressed as a percentage. Rates are age standardised and calculated separately for each type of service and by categories of self-assessed health status. Service types are: admitted hospitalisations, casualty/outpatients, GP and/or specialist doctor consultations, consultations with other health professional and dental consultation. Self-assessed health status is categorised as excellent/very good/good and fair/poor. Data are reported for all Australians by remoteness and by Socio Economic Indexes for Areas (SEIFA) and for Aboriginal and Torres Strait Islander Australians.

High or increasing rates of 'access to services compared to need by type of service' are desirable, as are rates for those in disadvantaged groups being close to the rates for those who are not disadvantaged.

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 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is under development.

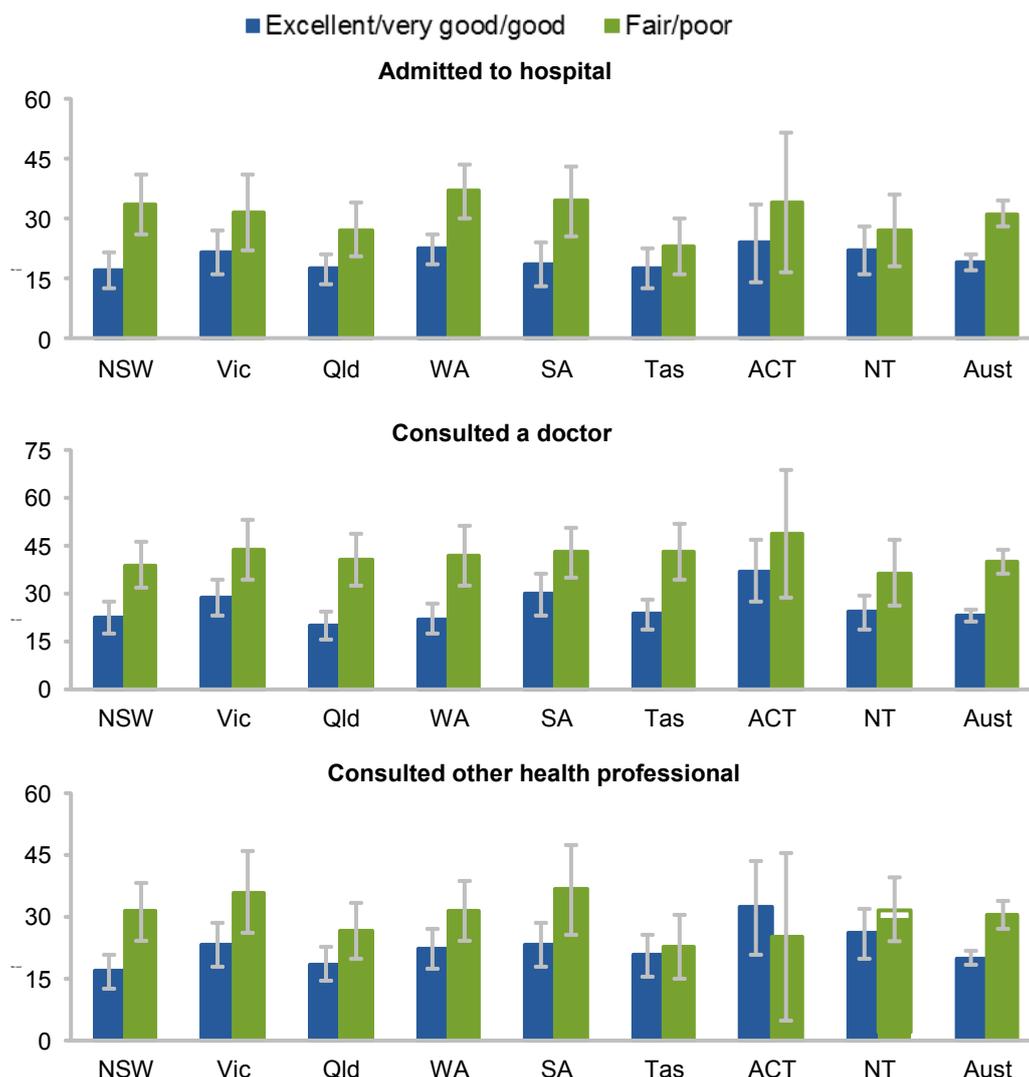
The latest available data for self-assessed health status are from the 2012-13 National Aboriginal and Torres Strait Islander Health Survey for Aboriginal and Torres Strait Islander Australians (ABS 2014a) and from the 2011-12 National Health Survey for other Australians (ABS 2012). Aboriginal and Torres Strait Islander Australians were less likely than other Australians to report very good or excellent health. Taking into account differences in age structure between the populations, Aboriginal and Torres Strait Islander Australians overall were more than twice as likely to report their health as fair or poor than other Australians in 2011-13 (ABS 2013a, 2014a).

Data from the surveys show that 27.1 per cent of Australians who reported their health status as being excellent/very good/good accessed health services in 2011-12, while health services were accessed by 48.5 per cent of people who reported their health status as being fair/poor (table EA.66).

Data for Aboriginal and Torres Strait Islander Australians are not comparable with data for other Australians due to a slightly different methodology. Nationally, the proportion of Aboriginal and Torres Strait Islander Australians who accessed services varied significantly by self-assessed health status for hospital admissions, consultations with doctors and consultations with other health professionals (figure E.19). Data for people accessing health services by Indigenous status in 2004-05 are reported in table EA.69.

Data on the proportion of people who accessed health services by remoteness and SEIFA and data on the types of health services people accessed are reported for 2004-05 and 2011-12 in tables EA.70–EA.73.

Figure E.19 Proportion of Aboriginal and Torres Strait Islander people who accessed health services by health status, 2012-13^{a, b, c, d, e}



^a Rates are age standardised by State/Territory to the 2001 estimated resident population. ^b Data are not comparable with data for all Australians due to differences in methodology. ^c People aged 15 years or over who consulted a doctor or another health professional in the last 2 weeks, or were admitted to hospital in the last 12 months. ^d Error bars represent the 95 per cent confidence intervals associated with each estimate. ^e Figure has been revised and differs from the figure presented in the 2014 Report.

Source: 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 EA.68.

Service-specific performance indicator frameworks

The health service specific frameworks in chapters 10, 11 and 12 reflect both the general Report framework and the National Health Performance Framework.¹ They differ from the general Report framework (see chapter 1) in two respects. First, they include three subdimensions of quality — safety, responsiveness and continuity — and, second, they include an extra dimension of efficiency — sustainability. These additions are intended to address the following key performance dimensions of the health system in the National Health Performance Framework that were not explicitly covered in the general Report framework:

- *safety*: the avoidance, or reduction to acceptable levels, of actual or potential harm from health care services, management or environments, and the prevention or minimisation of adverse events associated with health care delivery
- *responsiveness*: the provision of services that are client oriented and respectful of clients' dignity, autonomy, confidentiality, amenity, choices, and social and cultural needs
- *continuity*: the provision of uninterrupted, timely, coordinated healthcare interventions and actions across programs, practitioners and organisations
- *sustainability*: the capacity to provide infrastructure (such as workforce, facilities and equipment), be innovative and respond to emerging needs (NHPC 2009).

Other aspects of the Steering Committee's framework of performance indicators are defined in chapter 1.

This section summarises information from the following specific indicator frameworks:

- primary and community health (see chapter 10 for more detail)
- public hospitals (see chapter 11 for more detail)
- maternity services (see chapter 11 for more detail)
- mental health management (see chapter 12 for more detail).

Additional information is available to assist the interpretation of these results:

- indicator interpretation boxes, which define the measures used and indicate any significant conceptual or methodological issues with the reported information (chapters 10, 11 and 12)

¹ The former National Health Performance Committee developed the National Health Performance Framework to guide the reporting and measurement of health service performance in Australia. The National Health Performance Framework was reviewed by the National Health Performance Committee and a revised framework was agreed by the National Health Information Standards and Statistics Committee in 2009. A number of groups involved in health performance indicator development have adopted this framework for use within specific project areas and in publications.

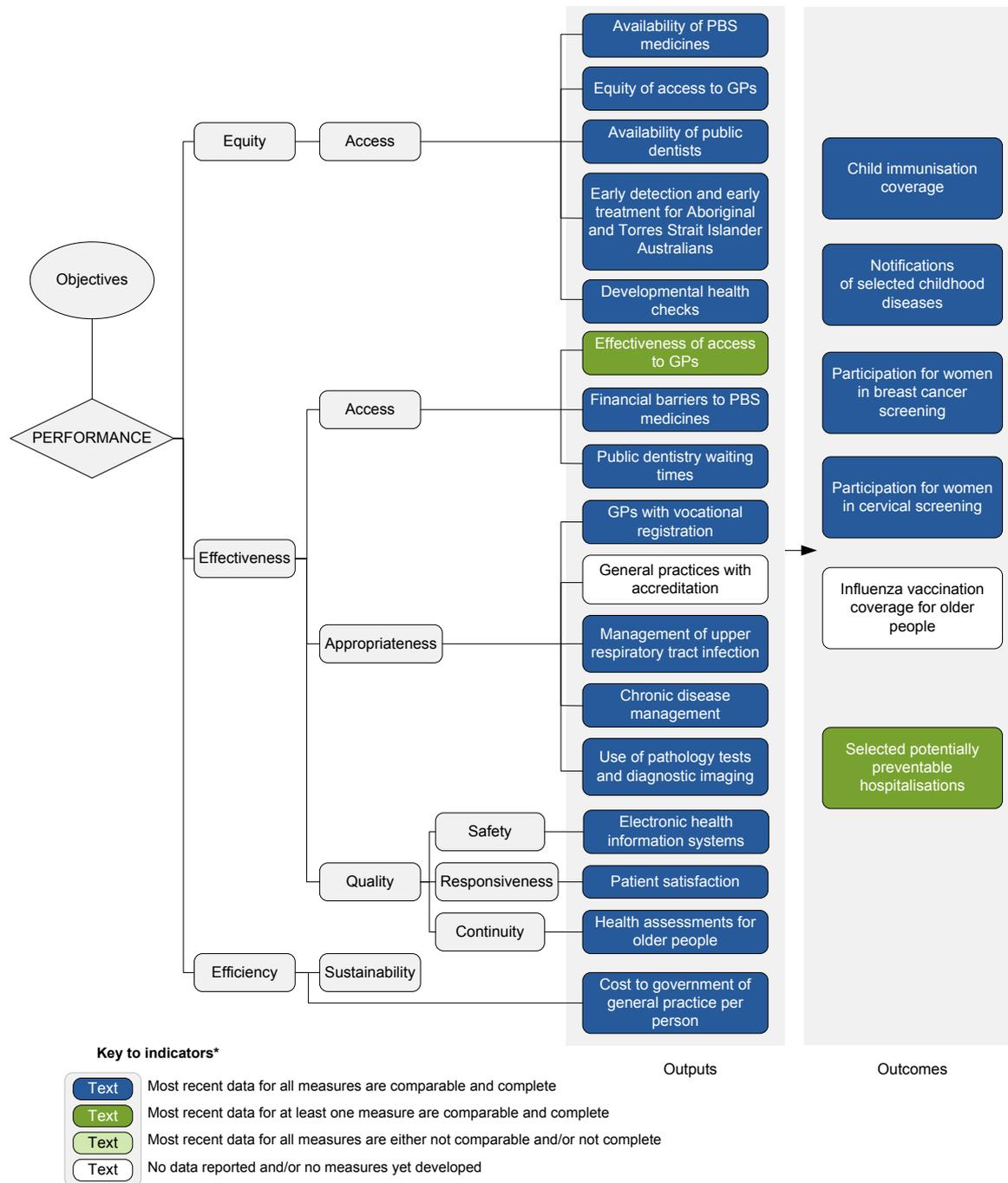
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- caveats and footnotes to the reported data (chapters 10, 11 and 12 and Attachments 10A, 11A and 12A)
 - additional measures and further disaggregation of reported measures (for example, by Indigenous status, remoteness, disability, language background, sex) (chapters 10, 11 and 12 and Attachments 10A, 11A and 12A)
 - data quality information for many indicators, based on the ABS Data Quality Framework (chapters 10, 11 and 12 Data quality information).

A full list of attachment tables and available data quality information is provided at the end of chapters 10, 11 and 12.

Primary and community health

The performance indicator framework for primary and community health is presented in figure E.20. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of primary and community health.

Figure E.20 Primary and community health performance indicator framework



An overview of the primary and community health performance indicator results are presented in table E.5. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 10 and the footnotes in attachment 10A.

Table E.5 Performance indicators for Primary and community health^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Equity — Access indicators									
<i>Availability of PBS medicines — PBS prescriptions filled at concessional rate (per cent), 2013-14</i>									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Proportion of total	89.7	89.9	89.1	85.6	90.8	92.2	79.2	79.7	89.3
<i>Equity of access to GPs, 2013-14</i>									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Full time workload equivalent GPs by remoteness area per 100 000 people, 2013-14									
Major cities, rate	109.1	101.7	107.4	78.6	107.6	..	72.5	..	102.2
Outer regional, rate	84.3	96.7	97.9	84.0	102.1	82.8	..	78.9	91.4
Availability of female GPs per 100 000 females , 2013-14									
Rate	72.1	66.1	69.4	49.6	60.0	66.4	61.0	62.7	66.3
Availability of male GPs per 100 000 males , 2013-14									
Rate	140.8	135.9	136.3	102.9	148.1	119.1	83.2	81.0	132.9
<i>Availability of public dentists — per 100 000 people, 2013</i>									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Rate	6.6	6.2	8.5	7.2	8.3	5.9	5.0	10.0	7.1
<i>Early detection and early treatment for Aboriginal and Torres Strait Islander Australians — Proportion of Older Aboriginal and Torres Strait Islander Australians who received a health assessment, 2013-14</i>									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Proportion	28.1	17.4	37.5	32.7	20.8	12.9	20.4	39.8	30.4
<i>Children receiving a fourth year developmental health check, 2013-14</i>									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Proportion	64.8	27.5	78.1	49.7	52.5	56.8	41.4	69.9	55.6
Source: tables 10A.11–10A.32.									
Effectiveness — Access indicators									
<i>Effectiveness of access to GPs</i>									
Most recent data for this indicator are comparable and complete (subject to caveats) for some but not all measures (chapter 10)									
Bulk billing rates for non-referred patients, 2013-14									
Proportion (%)	87.9	83.2	83.1	75.7	82.2	77.7	57.2	82.8	83.6
GP waiting times for urgent appointment, 2013-14 — less than 4 hours									
Proportion (%)	64.7	63.4	65.4	65.2	64.7	51.8	58.3	78.4	64.2
People deferring treatment due to cost, 2013-14 — deferring visits to GPs									
Proportion (%)	3.5	5.0	5.8	6.2	4.5	6.9	6.9	5.6	4.9
Selected potentially avoidable GP-type presentations to emergency departments, 2013-14									
'000	709.3	572.4	381.4	272.9	113.4	61.2	50.5	39.3	2 200.4

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Table E.5 (Continued)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
<i>Financial barriers to PBS medicines</i>									
People deferring treatment due to cost, 2013-14 — deferring purchase of prescribed medicines Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Proportion (%)	7.0	6.3	9.9	8.4	7.5	8.0	6.7	6.2	7.6
<i>Public dentistry waiting times, 2013-14 — less than 1 month</i> Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Proportion (%)	27.6	17.8	27.2	19.7	18.4	26.2	32.5	24.4	23.4
Source: tables 10A.33–10A.46.									
Effectiveness — Appropriateness indicators									
<i>GPs with vocational registration, 2013-14</i> Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Proportion (%)	90.6	85.5	88.0	89.5	89.5	90.8	91.8	69.8	88.5
<i>Management of upper respiratory tract infections</i> Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Prescriptions for oral antibiotics used to treat upper respiratory tract infections per 1000 people, 2013-14									
Rate	319.1	324.8	292.3	187.8	310.0	314.9	175.5	92.2	295.2
Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, April 2009 to March 2014									
Proportion (%)	33.0	27.4	33.1	25.6	26.7	26.3	25.7	20.9	30.5
<i>Management of chronic disease</i> Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Uptake by Practices in the Practice Incentives Program (PIP) of the PIP Diabetes Incentive, 2013-14									
Proportion (%)	48.6	42.1	54.3	47.8	35.4	36.4	57.7	72.7	47.3
People with asthma who have a written asthma action plan, 2011-12									
Proportion (%)	26.6	25.3	18.4	24.5	29.3	22.6	24.3	33.7	24.6
<i>Pathology tests and diagnostic imaging — Medicare benefits for diagnostic imaging, 2013-14</i> Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
\$ per person	72.9	58.2	69.8	51.5	53.4	53.6	51.1	42.9	63.8

Source: tables 10A.47–10A.67.

Effectiveness — Quality — Safety indicators

<i>Electronic health information systems — general practices using electronic systems, May 2014</i> Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Proportion (%)	85.7	89.0	86.0	83.0	86.7	86.0	84.5	78.2	86.3

Source: tables 10A.68–10A.70.

(Continued next page)

Table E.5 (Continued)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Effectiveness — Quality — Responsiveness indicators									
<i>Patient satisfaction, 2013-14</i>									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Proportion (%) of people who saw a practitioner in the previous 12 months where the practitioner always or often: listened carefully to them									
GP	91.2	91.3	89.8	88.6	90.9	91.3	89.1	84.8	90.6
Dental practitioner	94.8	94.5	92.9	96.5	96.5	93.7	95.4	94.5	94.6
Source: tables 10A.71–10A.75.									
Effectiveness — Quality — Continuity indicators									
<i>Health assessments for older people — proportion of older people assessed, 2013-14</i>									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Proportion (%)	30.52	28.84	35.69	30.75	30.20	34.28	23.21	31.60	31.06
Source: table 10A.76.									
Efficiency indicators									
<i>Cost to government of general practice per person — fee-for-service expenditure (ASR), 2013-14</i>									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
\$ per person	314.8	301.2	314.2	238.6	295.6	272.5	230.7	241.4	298.6
Source: table 10A.2.									
Outcome indicators									
<i>Child immunisation coverage — Children aged 60 to 63 months fully immunised, 2013-14</i>									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Proportion (%)	92.2	92.5	92.3	89.8	91.0	92.7	92.7	91.4	92.0
<i>Notifications of selected childhood diseases — notifications per 100 000 children, 2013-14</i>									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Measles	2.1	2.5	2.2	2.1	3.4	–	–	33.4	2.6
<i>Participation rates for women in breast cancer screening — Ages 50–69, 1 January 2012 to 31 December 2013</i>									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Rate	50.9	54.6	57.3	56.8	53.0	57.8	54.4	41.0	54.3
<i>Participation rates for women in cervical screening — Ages 20–69 (ASR), 1 January 2012 to 31 December 2013</i>									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Rate	57.4	61.6	56.4	55.9	59.0	57.4	58.0	55.1	58.2
<i>Influenza vaccination coverage for older people — 65 years or over, 2009</i>									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10)									
Rate	72.7	75.0	74.6	72.9	81.3	77.5	78.0	69.3	74.6

(Continued next page)

Table E.5 (Continued)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Separations for selected potentially preventable hospitalisations, 2012-13, per 1000 people</i>									
Most recent data for the indicator are comparable and complete (subject to caveats) except for the measure potentially preventable hospitalisations for diabetes (chapter 10)									
Vaccine-preventable	0.7	0.8	1.1	1.0	1.1	1.0	0.8	3.7	0.9
<i>Acute conditions excluding dehydration and gastroenteritis</i>									
	10.8	10.2	13.8	13.6	13.6	9.9	9.3	20.5	11.8
<i>Chronic conditions excluding additional diagnoses of diabetes complications</i>									
	10.4	10.8	12.9	11.3	11.9	10.1	8.3	22.1	11.3

Source: tables 10A.77–10A.94.

^a Caveats for these data are available in Chapter 10 and Attachment 10A. Refer to the indicator interpretation boxes in chapter 10 for information to assist with the interpretation of data presented in this table. ^b Some data are derived from detailed data in Chapter 10 and Attachment 10A.

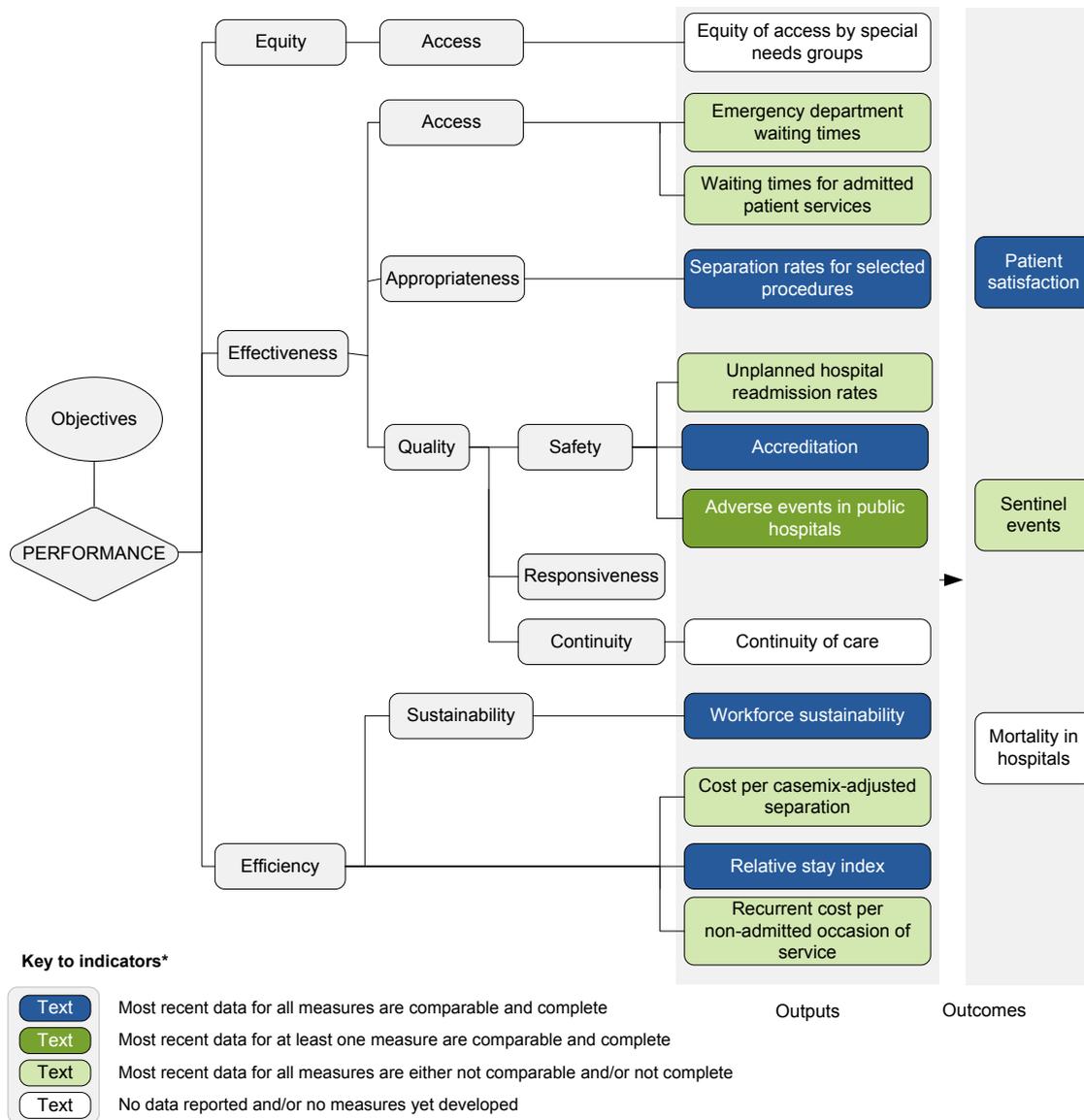
– Nil or rounded to zero. **na** Not available. **np** Not published.

Source: Chapter 10 and Attachment 10A.

Public hospitals

The performance indicator framework for public hospitals is presented in figure E.21. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of public hospitals.

Figure E.21 Public hospitals performance indicator framework



* A description of the comparability and completeness of each measure is provided in indicator interpretation boxes within the chapter

An overview of the public hospital performance indicator results are presented in table E.6. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 11 and the footnotes in attachment 11A.

Table E.6 Performance indicators for public hospitals^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Effectiveness — Access indicators									
<i>Emergency department waiting times, 2013-14</i>									
Proportion of patients seen on time (per cent)									
Most recent data for this measure are complete but not directly comparable (chapter 11)									
Resuscitation	100	100	100	100	100	100	100	100	100
Emergency	83	84	80	86	74	85	83	61	82
Urgent	76	73	67	58	65	66	50	51	70
Semi-urgent	80	71	75	71	77	71	57	53	75
Non-urgent	94	88	92	94	92	90	86	89	92
Total	81	75	73	70	73	72	61	57	75
Percentage of presentations where the time from presentation to physical departure (Emergency Department Stay length) is within four hours									
Most recent data for this measure are complete but not directly comparable (chapter 11)									
%	73.9	69.0	76.3	79.5	64.5	67.7	61.8	61.6	72.7
<i>Waiting times for admitted patient services</i>									
Elective surgery waiting times: Number of days waited, 2013-14									
Most recent data for this measure are complete but not directly comparable (chapter 11)									
50 th percentile	49	35	28	29	35	45	48	36	36
90 th percentile	329	222	186	142	180	401	270	183	262
Elective surgery waiting times: Proportion who waited more than 365 days, 2013-14									
Most recent data for this measure are complete but not directly comparable (chapter 11)									
%	1.8	3.2	2.8	0.7	0.8	11.5	4.7	2.8	2.4
Proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission, public hospitals (per cent), 2013-14									
Most recent data for this measure are complete but not directly comparable (chapter 11)									
Resuscitation	51	57	59	66	54	58	63	46	56
Emergency	43	49	53	58	37	33	45	21	47
Urgent	40	44	51	51	35	25	29	21	43
Semi-urgent	44	45	57	52	42	28	33	22	46
Non-urgent	65	60	68	60	59	44	45	50	62
Total	42	46	53	53	38	28	34	22	45

Source: tables 11A.18, 11A.23, 11A.24 and 11A.47.

Effectiveness — Appropriateness indicators

Separation rates for selected procedures, public hospitals, per 1000 people (age-standardised), 2012-13

Most recent data for this indicator are complete and comparable (chapter 11)

Cataract extraction	2.7	3.0	1.6	4.7	3.4	2.0	4.1	6.7	2.8
Cholecystectomy	1.4	1.5	1.2	1.2	1.5	1.4	1.4	1.2	1.4
Coronary angioplasty	0.9	0.8	0.8	0.8	0.9	1.0	2.0	..	0.9
Coronary artery bypass graft	0.3	0.3	0.3	0.2	0.3	0.3	0.5	..	0.3
Cystoscopy	1.6	2.9	2.0	3.3	2.7	1.6	3.0	2.0	2.3
Haemorrhoidectomy	1.0	0.8	0.3	0.5	0.5	0.6	0.3	0.9	0.7
Hip replacement	0.6	0.7	0.5	0.8	0.7	0.7	1.0	0.6	0.6
Hysterectomy	1.0	1.1	1.0	1.0	1.2	1.2	0.9	0.8	1.0
Inguinal herniorrhaphy	1.0	1.0	0.8	1.0	1.0	1.0	1.0	1.0	1.0
Knee replacement	0.7	0.5	0.5	0.7	0.6	0.4	0.7	0.5	0.6

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Table E.6 (Continued)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Myringotomy	0.5	0.7	0.6	0.8	1.4	0.5	0.5	0.6	0.7
Prostatectomy	0.9	1.0	0.7	0.9	1.0	0.8	1.1	0.5	0.9
Septoplasty	0.3	0.4	0.2	0.2	0.5	0.1	0.3	0.2	0.3
Tonsillectomy	0.9	1.3	0.8	0.9	1.5	0.7	0.8	1.0	1.0
Varicose veins, stripping and ligation	0.2	0.3	0.1	0.1	0.3	<0.1	0.5	0.2	0.2

Source: table 11A.48.

Effectiveness — Quality — Safety indicators

Unplanned hospital readmissions within 28 days of selected surgical admissions, 2012-13

Most recent data for this indicator are complete but not directly comparable (chapter 11)

Surgical, procedure prior to separation, rate per 1000 separations

Knee replacement	21.6	15.1	35.1	22.3	18.6	37.0	–	np	22.4
Hip replacement	18.0	16.1	16.1	15.9	19.3	29.6	12.9	np	17.5
Tonsillectomy and adenoidectomy	30.3	29.1	35.7	42.4	37.5	51.9	44.7	83.0	33.1
Hysterectomy	31.6	25.9	31.8	43.6	28.7	52.0	23.1	np	30.6
Prostatectomy	27.3	26.5	40.7	33.9	28.9	57.8	np	np	31.1
Cataract surgery	3.4	3.0	4.6	2.6	2.9	4.4	0.9	6.0	3.4
Appendectomy	22.4	22.8	22.0	29.0	27.0	26.5	20.4	43.5	23.1

Accreditation, proportion of accredited beds, public hospitals 2012-13

Most recent data for this indicator are complete and comparable (chapter 11)

%	97	100	95	100	100	87	100	100	98
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Adverse events in public hospitals

Healthcare associated infections in acute care hospitals per 10 000 patient days, 2013-14

Most recent data for this measure are complete but not directly comparable (chapter 11)

	0.9	0.8	0.9	0.9	0.6	0.9	0.8	1.0	0.9
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Separations with an adverse event, public hospitals: Events per 100 separations, 2012-13

Most recent data for this measure are complete and comparable (chapter 11)

Total	6.3	6.8	6.3	6.4	7.2	8.2	7.4	3.4	6.5
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Separations for falls resulting in patient harm in hospitals, per 1000 separations, 2012-13

Most recent data for this measure are complete and comparable (chapter 11)

	4.8	3.5	3.5	3.6	4.3	5.3	3.8	1.6	4.0
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Source: tables 11A.50–11A.55.

Efficiency sustainability indicators

Workforce sustainability

Most recent data for this indicator are complete and comparable (chapter 11)

Nursing workforce by age group (per cent), 2013

<30	15.1	17.7	15.1	16.8	14.4	12.7	16.6	18.5	15.9
30-39	20.1	21.0	20.7	20.6	19.2	15.2	21.8	25.7	20.4
40-49	23.9	25.2	27.2	25.7	25.8	26.7	25.5	21.9	25.4
50-59	29.1	26.0	26.8	26.4	30.7	34.4	26.2	24.4	27.7
60+	11.7	10.1	10.3	10.5	9.9	11.0	9.8	9.5	10.6

Medical practitioner workforce by age group (per cent), 2013

<30	8.8	10.6	9.8	12.1	10.2	9.8	9.7	11.0	10.0
30-39	26.3	28.4	28.9	28.3	26.6	24.0	27.3	36.5	27.6

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Table E.6 (Continued)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
40-49	24.0	23.5	25.8	25.5	25.4	25.9	25.5	23.2	24.6
50-59	21.1	20.9	20.9	19.7	20.5	23.7	21.4	17.5	20.9
60+	19.8	16.6	14.5	14.3	17.3	16.6	16.2	11.9	17.0

Source: tables 11A.56–11A.59.

Efficiency indicators

Recurrent cost per casemix adjusted separation, dollars, 2011-12

Most recent data for this indicator are complete but not directly comparable (chapter 11)

Total recurrent	5 280	4 693	5 246	5 733	5 251	6 033	6 384	6 017	5 204
Capital	475	804	424	542	395	427	556	693	493

Relative stay index, 2012-13

Most recent data for this indicator are complete and comparable (chapter 11)

Total	1.04	0.93	0.86	0.98	1.04	1.01	1.02	1.13	0.97
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Recurrent cost per non-admitted occasion of service, 2012-13

Most recent data for this indicator not complete or not directly comparable (chapter 11). Data are available in tables 11A.65–11A.69.

Source: tables 11A.60–11A.72.

Outcome indicators

Patient satisfaction, 2013-14

Most recent data for this indicator are complete and comparable (chapter 11).

Proportion (%) of persons who went to an *emergency department* in the last 12 months reporting:

ED doctors, specialists or nurses always or often listened carefully to them

Doctors/specialists	86.6	84.9	84.4	86.7	86.8	76.9	75.2	90.6	85.4
Nurses	90.2	89.7	90.4	87.0	90.3	85.3	81.7	90.6	89.1

ED doctors, specialists or nurses always or often showed respect to them

Doctors/specialists	87.2	86.2	86.1	87.4	86.3	85.5	77.3	87.2	86.5
Nurses	90.7	90.1	91.7	88.7	90.4	87.6	85.1	92.0	90.2

ED doctors, specialists or nurses always or often spent enough time with them

Doctors/specialists	81.5	80.4	81.3	81.3	81.7	77.9	75.3	85.0	81.0
Nurses	85.9	86.0	86.7	85.5	84.9	79.7	82.5	94.2	85.8

Proportion (%) of persons who were admitted to hospital in the last 12 months reporting:

Hospital doctors, specialists or nurses always or often listened carefully to them

Doctors/specialists	91.3	90.5	88.4	90.0	93.6	88.5	83.9	91.0	90.6
Nurses	92.3	92.5	90.1	91.3	91.4	88.5	83.9	91.3	91.5

hospital doctors, specialists or nurses always or often showed respect to them

Doctors/specialists	92.7	93.0	90.3	91.2	96.0	89.5	84.8	91.8	92.4
Nurses	94.0	93.3	91.4	91.5	92.9	90.9	83.9	94.2	92.6

hospital doctors, specialists or nurses always or often spent enough time with them

Doctors/specialists	87.7	88.4	86.1	86.9	92.3	84.7	79.1	92.3	87.7
Nurses	88.6	91.2	87.2	88.4	88.9	86.2	81.9	94.2	89.0

Source: tables 11A.73–11A.88.

Sentinel events, 2012-13

Most recent data for this indicator are complete but not directly comparable (chapter 11). Data are available in tables 11A.89–11A.97.

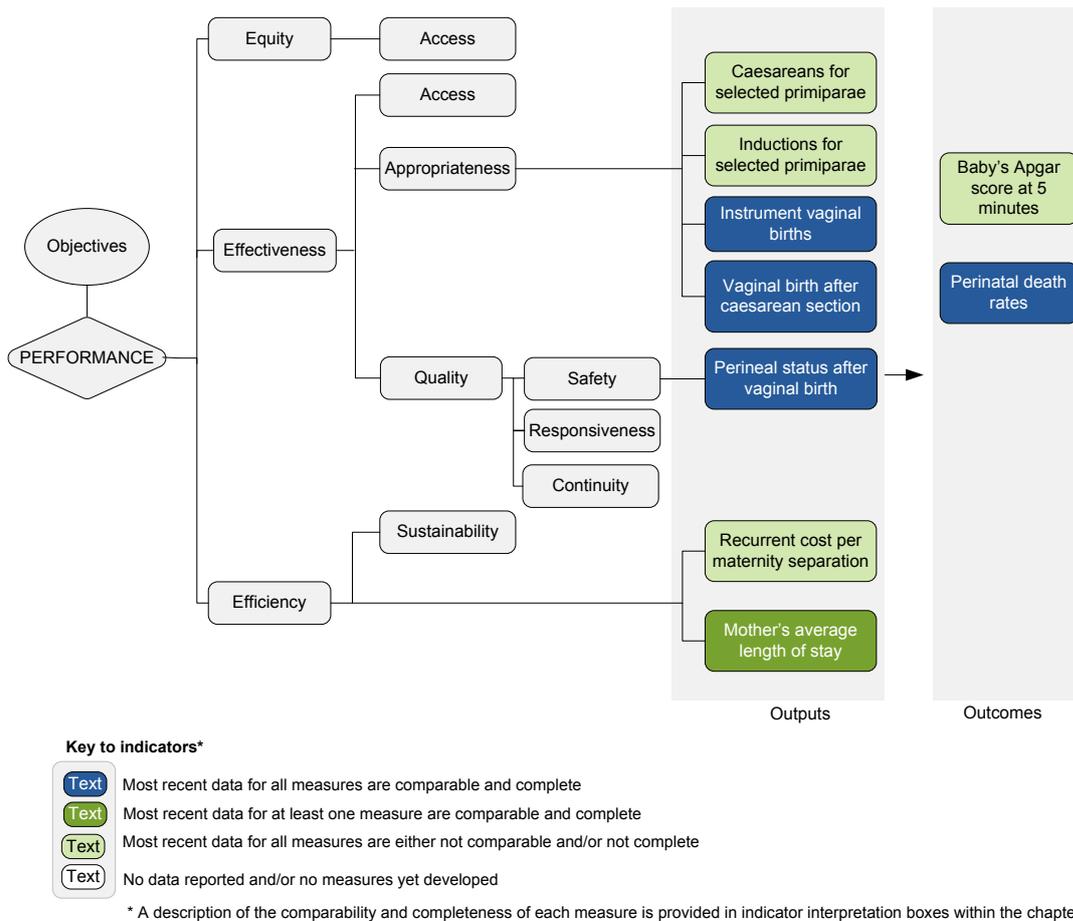
^a Caveats for these data are available in chapter 11 and attachment 11A. Refer to the indicator interpretation boxes in chapter 11 for information to assist with the interpretation of data presented in this table. – Nil or rounded to zero. **na** Not available. **np** Not published.

Source: Chapter 11 and Attachment 11A.

Maternity services

The performance indicator framework for maternity services is presented in figure E.22. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of maternity services.

Figure E.22 **Maternity services performance indicator framework**



An overview of the maternity services performance indicator results are presented in table E.7. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 11 and the footnotes in attachment 11A.

Table E.7 Performance indicators for maternity services^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Effectiveness — Appropriateness indicators									
<i>Caesareans for selected primiparae — Proportion (%) of births that were caesareans, 2013</i>									
Most recent data for this indicator not complete or not directly comparable (chapter 11)									
%	23.2	24.9	22.8	24.8	27.3	na	24.3	30.4	24.2
<i>Inductions for selected primiparae — Proportion (%) of births that were induced, rate, 2013</i>									
Most recent data for this indicator not complete or not directly comparable (chapter 11)									
%	39.4	34.6	29.9	35.9	41.6	na	29.6	35.7	35.8
<i>Instrumental vaginal births, 2012</i>									
Most recent data for this indicator are complete and comparable (chapter 11)									
%	22.7	28.2	21.7	30.2	24.5	26.1	27.4	18.4	24.9
<i>Vaginal birth after caesarean section, 2012</i>									
Most recent data for this indicator are complete and comparable (chapter 11)									
Non-instrumental	12.5	11.6	12.3	9.1	12.4	12.2	12.2	18.7	11.9
Instrumental	3.8	4.3	2.9	3.0	3.7	3.4	5.9	3.5	3.7
Source: tables 11A.102–11A.112.									
Effectiveness — Quality — Safety indicators									
<i>Perineal status after vaginal birth — Mothers with third or fourth degree lacerations after vaginal births, 2012</i>									
Most recent data for this indicator are complete and comparable (chapter 11)									
%	2.0	1.9	2.0	2.3	2.3	1.6	4.1	2.8	2.1
Source: table 11A.113.									
Efficiency indicators									
<i>Cost per maternity separation, without complications, dollars, 2011-12,</i>									
Most recent data for this indicator are complete but not directly comparable (chapter 11)									
Caesarean	8 848	7 889	9 651	13 675	10 712	7 746	12 936	15 333	9 546
Vaginal delivery	4 975	3 634	4 900	6 499	4 911	4 050	5 706	7 503	4 826
<i>Mother's average length of stay, days, 2012-13</i>									
Most recent data for this indicator are complete and comparable (chapter 11)									
Caesarean	3.8	3.7	3.3	3.7	4.0	3.8	3.8	4.4	3.7
Vaginal delivery	1.8	1.8	1.5	1.7	1.7	1.8	1.4	2.1	1.7
Source: tables 11A.114–11A.115.									

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Table E.7 (Continued)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Outcome indicators									
<i>Apgar score at 5 minutes, 2013</i>									
Most recent data for this indicator are not complete and are not directly comparable (chapter 11)									
Percentage of live births with an Apgar score of 3 or lower by birthweight									
<1500g	15.1	18.7	18.6	5.4	8.0	na	13.8	26.0	na
1500g–1999g	1.7	1.3	1.5	1.1	0.6	na	1.4	np	na
2000g–2499g	0.8	0.3	0.6	0.6	0.6	na	1.0	np	na
2500g+	0.3	0.2	0.2	0.2	0.1	na	0.3	0.4	na
<i>Perinatal death rates — deaths per '000 total births, 2012</i>									
Most recent data for this indicator are not complete but are comparable (chapter 11)									
Fetal deaths	5.2	5.6	7.0	7.1	3.5	7.2	7.5	5.6	5.9
Neonatal deaths	2.3	2.1	3.0	1.4	2.4	2.9	2.6	3.9	2.3
Perinatal deaths	7.5	7.7	10.0	8.4	5.9	10.1	10.0	9.4	8.2

Source: tables 11A.116–11A.121.

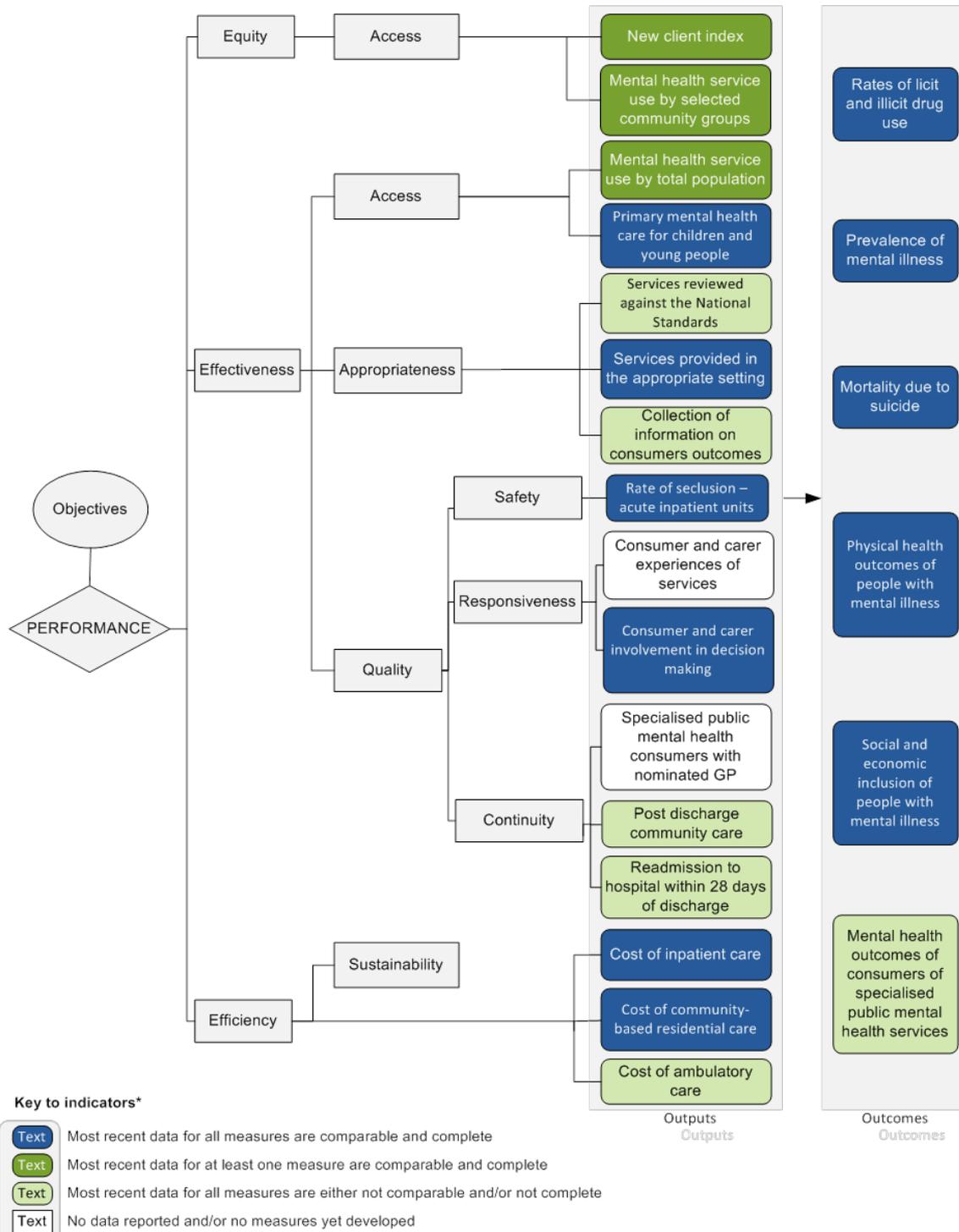
^a Caveats for these data are available in chapter 11 and attachment 11A. Refer to the indicator interpretation boxes in chapter 11 for information to assist with the interpretation of data presented in this table. – Nil or rounded to zero. **na** Not available.

Source: Chapter 11 and Attachment 11A.

Mental health management

The performance indicator framework for mental health management is presented in figure E.23. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of mental health management.

Figure E.23 Mental health management performance indicator framework



* A description of the comparability and completeness of each measure is provided in indicator interpretation boxes within the chapter

An overview of the mental health management performance indicator results are presented in table E.8. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 12 and the footnotes in attachment 12A.

Table E.8 Performance indicators for Mental health management^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Equity — Access indicators									
<i>New client index</i>									
Proportion of total clients of State and Territory specialised public mental health services who are new, 2012-13									
Most recent data for this measure are not comparable nor complete (chapter 12)									
Proportion (%)	40.0	na	45.3	42.6	43.6	58.1	41.5	47.9	42.8
Proportion of total clients of MBS subsidised mental health services who are new									
Most recent data for this measure are comparable and complete (chapter 12)									
Proportion (%)	35.1	33.7	37.3	38.9	34.2	36.8	38.7	48.6	35.6
<i>Mental health service use by selected community groups</i>									
Proportion (%) of the Aboriginal and Torres Strait Islander population using State and Territory specialised public mental health services, compared with the proportion for non-Indigenous population, 2012-13									
Most recent data for this measure are comparable (subject to caveats), but not complete (chapter 12)									
Aboriginal and Torres Strait Islander									
	4.9	na	4.5	5.3	5.9	1.4	6.3	4.1	4.7
Non-Indigenous									
	1.5	na	1.8	1.9	1.8	1.2	2.2	2.4	1.7
Proportion (%) of the Aboriginal and Torres Strait Islander population using MBS and DVA funded mental health services, compared with the proportion for non-Indigenous population, 2012-13									
Most recent data for this measure are comparable and complete (chapter 12)									
Aboriginal and Torres Strait Islander									
	10.7	12.0	7.1	4.0	8.2	8.8	11.4	1.4	7.7
Non-Indigenous									
	7.9	8.7	7.7	5.9	7.6	7.0	6.2	4.1	7.7

Source: table 12A.33, and tables 12A.35-36.

Effectiveness — Access indicators

Mental health service use by total population

Most recent data for this indicator are comparable, but not complete (chapter 12)

Proportion (%) of the population in a State and Territory using a specialised public mental health service or a MBS-subsidised service, 2012-13

Specialised public mental health	1.8	na	1.9	2.1	2.3	1.3	2.4	2.9	1.9
MBS and DVA subsidised service	8.0	8.8	7.8	5.9	7.8	7.1	6.3	3.4	7.8

Primary mental health care for children and young people

Most recent data for this measure are comparable and complete (chapter 12)

Proportion of young people aged under 25 years who had contact with primary mental health care services subsidised through the MBS, 2013-14

Proportion (%)	6.1	6.9	6.1	4.7	6.3	6.2	5.6	2.2	6.1
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Source: tables 12A.41 and 12A.44.

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Table E.8 (Continued)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Effectiveness — Appropriateness indicators									
<i>Services reviewed against national standards</i>									
Most recent data for this indicator are complete, but not comparable (chapter 12)									
Proportion of specialised public mental health services that had completed an external review against national standards and were assessed as meeting 'all Standards' (level 1), June 2013									
Proportion (%)	82.6	78.3	99.7	85.8	42.1	9.2	100.0	–	80.0
<i>Services provided in the appropriate setting</i>									
Most recent data for this measure are comparable and complete (chapter 12)									
Recurrent expenditure on community-based services as a proportion of total expenditure on mental health services, 2012-13									
Proportion (%)	41.6	64.1	55.3	52.9	61.5	58.8	73.3	61.6	53.4
<i>Collection of information on consumers outcomes</i>									
Most recent data for this measure are comparable, but not complete (chapter 12)									
Proportion of episodes with completed consumer outcomes measures collected for people in specialised public mental health services — ongoing community care, 2012-13									
Proportion (%)	19.4	na	41.2	31.4	37.6	26.8	8.7	19.6	28.3
Source: tables 12A.47–49.									
Effectiveness — Quality — Safety indicators									
<i>Rate of seclusion — acute inpatient units</i>									
Most recent data for this indicator are comparable and complete (chapter 12)									
Number of seclusion events per 1000 bed days in specialised public mental health acute inpatient units, 2013-14									
no.	7.4	9.2	11.1	5.0	4.5	15.2	1.1	21.6	8.0
Source: table 12A.50.									
Effectiveness — Quality — Responsiveness indicators									
<i>Consumer and carer involvement in decision making</i>									
Most recent data for this measure are comparable and complete (chapter 12)									
Paid consumer workers (FTE) per 1000 paid direct care, consumer and carer staff (FTE), 2012-13									
no.	2.3	3.2	2.8	1.3	6.3	–	–	0.7	2.7
Source: table 12A.52.									
Effectiveness — Quality — Continuity indicators									
<i>Community follow up for people within the first 7 days of discharge from hospital</i>									
Most recent data for this indicator are not comparable nor complete (chapter 12)									
Proportion of overnight separations from psychiatric inpatient acute services with a community mental health service contact recorded in the 7 days following separation, 2012-13									
Proportion (%)	59.5	na	72.8	53.3	54.0	20.8	73.9	46.6	60.7
<i>Readmissions to hospital within 28 days of discharge</i>									
Most recent data for this indicator are complete, but not comparable (chapter 12)									
Proportion of overnight separations from psychiatric inpatient acute services that were followed by a readmission to a psychiatric inpatient service within 28 days of discharge, 2012-13									
Proportion (%)	14.7	14.7	14.3	13.4	7.7	12.7	14.4	10.7	13.9
Source: tables 12A.53 and 12A.56.									

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Table E.8 (Continued)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Efficiency indicators									
<i>Cost of inpatient care</i>									
Most recent data for this indicator are comparable and complete (chapter 12)									
Cost per inpatient bed day, 2012-13									
General mental health services (acute units)									
\$ per bed day	1 013.22	843.83	921.38	1 238.68	899.55	895.20	868.26	1 376.80	981.17
Public acute hospital with a psychiatric unit or ward (acute units)									
\$ per bed day	1 013.25	843.60	940.69	1 204.42	864.21	1 123.84	843.75	1 376.80	975.73
<i>Average recurrent cost per patient day for community residential services</i>									
Most recent data for this indicator are comparable and complete (chapter 12)									
General adult units — 24-hour staffed units, 2012-13									
\$ per patient day	183.97	514.54	..	408.18	456.02	641.44	671.96	353.46	468.79
<i>Average cost of ambulatory care</i>									
Most recent data for this indicator are not comparable, nor complete (chapter 12)									
Average cost per treatment day of ambulatory care, 2012-13									
\$ per episode	223.84	na	362.05	428.58	332.35	665.90	234.40	439.27	303.28
Source: tables 12A.59, 12A.61–63.									
Outcome indicators									
<i>Rates of licit and illicit drug use</i>									
Most recent data for this indicator are comparable and complete (chapter 12)									
Proportion of people aged 14 years or over who used any illicit drug in the preceding 12 months, 2013									
Proportion (%)	11.4	11.0	12.6	13.7	12.5	13.3	12.4	19.0	12.0
<i>Prevalence of mental illness</i>									
Most recent data for this indicator are comparable and complete (chapter 12)									
Proportion of people with a lifetime mental disorders among adults aged 16–85 years, 2007									
Proportion (%)	20.1 ± 2.2	20.7 ± 2.3	19.2 ± 2.6	21.4 ± 4.1	19.1 ± 3.4	14.1 ± 5.4	np	np	20.0 ± 1.1
<i>Mortality due to suicide</i>									
Most recent data for this indicator are comparable and complete (chapter 12)									
Suicide rate per 100 000 people, 2008–2012									
Rate	8.9	9.7	13.0	13.5	11.8	14.1	9.1	18.1	10.8
<i>Physical health outcomes for people with a mental illness</i>									
Most recent data for this indicator are comparable and complete (chapter 12)									
Proportion of people with a mental illness (compared to the proportion for people without a mental illness) who were daily smokers, 2011-12 (per cent)									
People with mental illness	23.6 ± 4.5	28.9 ± 6.4	25.7 ± 4.6	26.0 ± 5.8	26.7 ± 4.9	32.4 ± 5.7	20.0 ± 5.6	29.1 ± 10.1	26.1 ± 2.4
People without mental illness	13.4 ± 1.5	14.7 ± 1.7	15.8 ± 2.1	15.0 ± 1.9	15.5 ± 2.1	21.5 ± 2.3	11.7 ± 2.7	21.8 ± 3.0	14.7 ± 0.8
(Continued next page)									

Table E.8 (Continued)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
<i>Social and economic inclusion of people with a mental illness</i>									
Most recent data for this indicator are comparable and complete (chapter 12)									
Proportion of people aged 16–64 years with mental or behavioural problems who are employed, 2011-12									
Proportion (%)	65.2 ± 7.7	59.4 ± 6.4	57.7 ± 6.7	65.0 ± 5.9	61.2 ± 7.2	51.6 ± 8.7	72.5 ± 8.2	63.2 ± 10.3	61.7 ± 3.1
<i>Mental health outcomes of consumers of specialised public mental health services</i>									
Most recent data for this indicator are not comparable nor complete (chapter 12)									
Proportion of people discharged from a State or Territory public hospital psychiatric inpatient unit who had a significant improvement in their clinical mental health outcomes, 2012-13									
Proportion (%)	70.0	na	72.7	74.3	72.6	76.4	np	77.3	72.1
Source: tables 12A.66, 12A.75, 12A.81, 12A.85, 12A.87 and 12A.94.									

^a Caveats for these data are available in chapter 12 and attachment 12A. Refer to the indicator interpretation boxes in chapter 12 for information to assist with the interpretation of data presented in this table. – Nil or rounded to zero. .. Not applicable. np Not published

Source: Chapter 12 and Attachment 12A.

E.3 Cross cutting and interface issues

Many determinants affect Australian’s health (AIHW 2012). They include the delivery of an efficient, effective and equitable health service, but also factors such as individuals’ and communities’ social and economic conditions and background.

Major improvements in health outcomes therefore depend on strong partnerships between components of the health system and relationships between the health sector and other government services:

- *Early childhood, education and training services* play an important role in shaping a child’s development, which has consequences for overall health and wellbeing in later life (AIHW 2011).

Good health is critical to a child’s educational development. Impaired hearing, malnutrition, poor general health, including poor eyesight, anaemia, skin diseases, and sleep deprivation have been identified as having adverse effects on the educational attainment of Aboriginal and Torres Strait Islander children (AMA 2001).

- *Justice services* have a critical role in providing a safe and secure society, free from violence. They also enforce laws designed to improve public health such as to prevent road traffic accidents and the use of illicit drugs.

A person’s health can also be a critical factor in a person’s interaction with the justice system. Research shows that prisoners have significantly worse health, with generally higher levels of diseases, mental illness and illicit drug use than Australians overall (AIHW 2012).

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- *Emergency management services* have an important role in the preparation and response to emergency events providing emergency first aid, protection and shelter. Ambulance services are an integral part of a jurisdiction's health service providing emergency as well as non-emergency patient care and transport.
 - *Community services* and health services interact at many levels. People with disability are more likely than others to have poor physical and mental health, and higher rates of risk factors such as smoking and obesity (AIHW 2012). Aged care services can keep people living independently and healthily, without undue call on the health sector. Child protection services act to protect children and ensure their good health (while medical professionals are the source of many child protection notifications).
 - *Housing and homelessness services* play an important role in ensuring the health of Australians. Living conditions (particularly poor housing and infrastructure) are a major contributor to health and well being. People with unmet housing needs tend to experience higher death rates, poor health, and are more likely to have serious chronic illnesses (Garner 2006).

E.4 Future directions in performance reporting

This health sector overview will continue to be developed in future reports.

COAG's National Health Reform Agreement of 2011 included a commitment to introduce clear and transparent performance reporting against a Performance and Accountability Framework. It is anticipated that this will continue to drive improvements in reporting for the health sector.

National clinical quality and safety standards are under development by the Australian Commission on Safety and Quality in Health Care. The National Health Performance Authority was established to:

- provide clear and transparent public reporting of the performance of Local Hospital Networks, public and private hospitals, and primary health care organisations, and monitor their performance
- develop additional performance indicators as appropriate
- maintain the MyHospitals website.

National Health Performance Framework (NHPF) indicators, developed by the National Health Performance Committee and endorsed by the Australian Health Minister's Advisory Council (most recently in in 2009), are currently under review. The NHPF is designed as an overarching framework of indicators that presents information about the health of Australians and the health system (AIHW 2014b). The updated indicator set is expected to be agreed in early 2015, with reporting against this indicator set to be included in the AIHW's *Australia's health 2016*.

The Department of Prime Minister and Cabinet will review the performance of the Australian and State and Territory governments in achieving the jurisdictional level outcomes and performance benchmarks included in the NHA.

The Public hospitals, Primary and community health and Mental health management chapters contain a service-specific section on future directions in performance reporting.

E.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this sector overview.

New South Wales Government comments

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Delivering world class healthcare for NSW

NSW Health is committed to supporting healthy communities and providing world class, integrated healthcare for the people of NSW. Over the last twelve months, we have driven substantial improvements in the delivery of our health services to deliver better outcomes for our patients. All parts of NSW Health – including our local health districts, networks, NSW Ambulance, our six pillar organisations, our statewide services and shared services – have worked together to achieve these outcomes.

NSW elective surgery results are among the best in the country, achieving 2013 targets for treating semi-urgent and non-urgent patients within the clinically recommended time and targets for reducing the days waited by overdue urgent and non-urgent patients. The AIHW (Australian Institute of Health and Welfare) Australian Hospital Statistics 2013-14: Elective Surgery Waiting Times report found NSW is leading the nation in elective surgery procedures being performed on-time (for all urgency categories combined). The proportion of patients who have waited longer than 365 days is the lowest recorded in the last 5 years at just 1.8 per cent - a near three-fold improvement since 2009-10. NSW also had the lowest proportion of adverse events in elective surgery.

The improvements in our performance have also delivered faster emergency patient care, with over 200 000 additional people receiving timelier Emergency Department care across the NSW Health system. One of the most recognised indicators of this improvement is the National Emergency Access Target (NEAT), a measure of the number of patients who complete their ED treatment within four hours. The Council of Australian Governments' Reform Council National Partnership Agreement on Improving Public Hospital Services Report for 2013 found NSW showed the biggest improvement in NEAT results between 2012 and 2013, increasing from 61.1 to 70.8 per cent.

NSW patients have welcomed these improvements. The November 2014 Bureau of Health Information Patient Survey report, based on the responses of 35,000 patients at 80 of the state's public hospitals, found more than 90 per cent of patients rate their overall experience in NSW public hospitals as 'very good or good'. And 86 per cent of patients reported they were 'always' treated with respect and dignity in NSW public hospitals.

The NSW Health Performance Framework for public sector health services provides an integrated process for performance review and management, with the over-arching objectives of improving patient safety, service delivery, quality and efficiency across the NSW Health system. This promotes a high performance culture focused on quality, integrated care and better patient outcomes.

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Victorian Government comments

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Victoria's health services, like those in all jurisdictions, are facing significant and persistent growth in demand, with a growing and ageing population, driving increased service utilisation, and significant growth in the incidence of chronic disease.

In this context, health spending in 2013-14 totalled \$14.3 billion, an increase of 4.8 per cent relative to 2012-13, with hospital budgets increased by 5.3 per cent to \$8.4 billion.

The achievement of a more sustainable level of health expenditure growth reflects a program of reform for Victorian health services to address costs and improve system productivity and effectiveness through a range of supply and demand measures. These reforms have reduced growth in costs while maintaining the delivery of high quality services, reducing elective surgery waiting lists and meeting growth in emergency department presentations. These reforms have built on the innovation and efficiency that is inherent to the Victorian health system.

Healthy Together Victoria is Victoria's flagship preventative health effort. It takes a unique systems approach to reducing population-level chronic disease risk where people live, learn, work and play.

The *Mental Health Act 2014* is now operational and with it a new recovery-oriented framework that will ensure people living with a mental illness are supported to make or participate in decisions about their treatment. In 2013-14, this included an increase in funding to over \$1.2 billion, funding more hospital beds for people with a mental illness and improved access to services. Mental health and drug treatment services were recommissioned to support people to manage their treatment to achieve improved quality of life and connection to other health and community support services.

The Victorian health system continues to transform through a focus on patient-centred care, greater integration of care, and a strong emphasis on translated research.

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Queensland Government comments

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The 2014-2015 Queensland State Budget will see a record amount of over \$13.6 billion invested in the Queensland healthcare system, an increase of 6.4 per cent on the 2013-2014 adjusted budget. The increase is supporting the commitment made under the *Blueprint for better healthcare in Queensland* to build the best health system in the country.

Queensland continues to invest in a range of clinical redesign projects and undertake other reforms to improve health service performance and efficiency. Median waiting times for elective surgery in Queensland are well below the national average and there is a commitment to eliminate long waits for elective surgery by the end of 2014. Significant improvements in wait times for public dental patients have also been achieved with the number of long wait patients now reduced to zero.

Challenges to securing a sustainable public health system remain including a growing and ageing population driving increased demand for services. Significant recent changes and uncertainties around future Commonwealth health funding arrangements are adding to the challenge.

Prevention is key to improving the overall health of Queenslanders and several new initiatives are underway to address preventable health risks. These include the major three year *Healthier. Happier.* campaign which encourages all Queenslanders to make healthier lifestyle changes to reduce the risk of chronic disease.

Queensland has the most decentralised population of any Australian jurisdiction which requires innovative methods of providing health services to those in rural and remote areas. In addition, closing the gap in Aboriginal and Torres Strait Islander health outcomes is an ongoing high priority. New initiatives include the introduction of a Mobile Surgical Van pilot program for rural and remote communities, hearing outreach services for Aboriginal and Torres Strait Islander children and expanding mental health support for rural drought declared communities.

In addition to frontline health initiatives, Queensland is continuing to reform the health system structure and organisation to ensure it is best placed to meet community needs. Further responsibilities in relation to asset ownership and staff employment have recently been transferred to locally run Hospital and Health Services. An independent Queensland Office of the Health Ombudsman has also been established to provide a simpler and more transparent complaints system for healthcare consumers.

Queensland is developing its healthcare infrastructure through a substantial investment program to both upgrade or expand existing facilities and open new state-of-the-art hospitals. The Lady Cilento Children's Hospital in Brisbane, which opened in late 2014, is the biggest public children's hospital in the country and will be the cornerstone of an enhanced state-wide network of children's health services.

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Western Australian Government comments

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WA's public health system performed well for the community in 2013-14, despite strong demand for its services from a fast-growing population and the continuing challenge of delivering its biggest-ever infrastructure program. The sound performance was underpinned by long-term planning, regular and ongoing monitoring and review, innovative reform and a professional workforce. WA Health continues to improve its performance and align its efforts to the four pillars stated in its *Strategic Intent 2010–2015*:

- **Caring for individuals and the community**
Focus continued in 2013-14 on health conditions linked to excess body mass and reducing associated hospital treatment costs. Initiatives were implemented to encourage people to “live lighter” to combat this problem. Medical research also received strong support for new initiatives in addition to existing research funding streams for enhanced capability.
- **Caring for those who need it most**
In 2013-14, the median waiting time for elective surgery in WA was 29 days, the second lowest for all urgency categories among States and Territories. WA also continued to lead the country in the proportion of emergency department visits completed in four hours or less, which at 79 per cent was above the national average of 73 per cent. For Aboriginal people, WA Health renewed its commitment to closing the gap in life expectancy by announcing its new *Footprints to Better Health* strategy. More than 100 dedicated Aboriginal health services will be delivered under the strategy. There was record investment in school health, with the first of 155 new school health staff starting work in WA schools.
- **Making the best use of fund and resources**
To be in the best position for the new Activity Based Funding regime, WA Health has focussed on improvements across the board, but especially in information and communication technology governance and planning, and adopting a professional and consistent approach to procurement. 2013-14 also saw major upgrades completed or planned at 24 regional and remote facilities, in addition to major infrastructure projects including Fiona Stanley Hospital and Perth Children's Hospital.
- **Supporting our team**
Development of a 10-year strategic workforce plan is underway, based on the WA Health Clinical Services Framework 2010–2020, to ensure workforce planning is aligned with demand. The significant challenges faced by WA Health, including the transfer and reconfiguration of staff and resources to new hospitals, were being handled effectively with specialised transition management systems and databases.

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South Australian Government comments

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Guided by the SA Health Care Plan 2007-16, the Department for Health and Ageing consolidated and built on gains made in recent years in its work to improve health outcomes and access to services in SA.

Work continued to deliver the Plan's centrepiece, the new Royal Adelaide Hospital. Scheduled for completion in 2016, the hospital will provide progressive, efficient and state-of-the-art public health care, with the capacity to treat a third more Emergency Department patients each year.

The new Royal Adelaide Hospital is collocated with the SA Health and Medical Research Institute (SAHMRI), officially opened in November 2013. SAHMRI is the state's flagship health and medical research institute, housing state of the art laboratories, equipment and capacity for up to 675 researchers. Together, and in partnership with other planned tertiary education facilities, the new Royal Adelaide Hospital and SAHMRI will form the SAn Health and Biomedical Precinct. When complete, the site will be the largest of its kind in the Southern Hemisphere.

Other major infrastructure projects reached key milestones in 2013-14. The redeveloped 129 bed Glenside Health Service was officially opened on 28 July 2013 and is the centrepiece of our state's mental health reform. The state and federally funded \$69 million Whyalla Hospital redevelopment and Port Pire's \$12.5 million GP Plus Health Care Centre were opened in November. In January, the redeveloped Modbury Hospital Emergency Department was opened, followed by the \$36 million redeveloped Riverland General Hospital in June.

During 2013-14 the Health Enterprise Patient Administration System (EPAS) went live at seven SA Health sites. More than 4500 doctors, nurses, allied health and administrative staff across SA Health now use EPAS in their day to day work.

Other initiatives devised and further developed across SA's health system included new models of care, improved access to diagnostic services and increased support for discharge planning. As a result, SA continues its strong performance in Emergency Department and elective surgery waiting times.

In September, Southern Adelaide Local Health Network became the first in SA to be assessed against all ten National Safety and Quality Health Service Standards and the first to meet all 209 core actions.

Work continued to improve health outcomes for residents of rural and remote parts of the state and ensure country patients can access and receive medical care of the highest quality as close as possible to their homes.

SA continued its efforts to address the disparity in the health outcomes of Aboriginal and non-indigenous Australians through our Closing the Gap initiatives, such as immunisation, oral health, and health checks for Aboriginal adults and children.

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Tasmanian Government comments

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- During 2013-14, the Department of Health and Human Services (DHHS) has continued to focus on its responsibilities to the people of Tasmania. In health, the role of the Department is system manager and purchaser of services on behalf of the Minister for Health.
- The Department does not directly deliver health services, but rather purchases services on behalf of Tasmanians from the three Tasmanian Health Organisations (THOs) and monitors the delivery of those services. The Department also has a regulatory role for the public and private health sector.
- Significantly, Tasmanians elected a new government in March 2014 and while many of our activities are ongoing, new reform priorities were established towards the end of the year in a number of areas.
- 2013-14 saw further maturing of the purchaser/provider model with significant progress made in the management of relationships between the Department (as system manager and purchaser of services on behalf of the Minister for Health) and THOs (as providers of public hospital services and a broad range of health services, including mental health services).
- Service agreements, the key annual accountability document between the Minister for Health and THOs, were successfully negotiated and agreed with all three THOs within the timeframes required by legislation.
- Population Health Services continues to provide significant work to educate Tasmanians about healthy living choices and preventative health. While the life expectancy of Tasmanians is improving and self-reported health is generally good, Tasmania continues to face challenges in encouraging healthy lifestyles and to reducing the prevalence of smoking and obesity associated chronic disease.
- A new *Mental Health Act* 2013 came into effect from February 2014, ensuring there is a more human rights based approach towards clients suffering from mental illness in Tasmania.
- Work continued during the year on the Royal Hobart Hospital redevelopment. The incoming Government placed the development on a care and maintenance footing and created a review taskforce. The Department has continued to provide support for the taskforce and facilitate the review which is expected to be completed towards the end of 2014.
- During the year significant reform has begun across all areas of the DHHS, most notably with the introduction of the State Government's *One State, One Health System, Better Outcomes* reform agenda. This will include the transition to a single Tasmanian Health Service from 1 July 2015.
- The reforms will also include a review of the DHHS, the creation of the Health Council of Tasmania and a white paper process to review and redefine the clinical profile of service delivery.

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Australian Capital Territory Government comments

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ACT Health partners with the community and consumers for better health outcomes by delivering patient and family centred care, strengthening partnerships, promoting good health and well being, improving access to appropriate health care, and having robust safety and quality systems. The total catchment population (Australian Capital Region) extends to the surrounding southern parts of NSW, with Canberra serving as the regional referral centre.

In its 2014-15 budget, the ACT Government provided funding for 500 extra elective surgeries. Hospital capacity will also be boosted through the addition of 36 new hospital beds.

A web-based report called ED Live was released to the public in July 2014. For the first time in the ACT, patients are able to access real-time information on Emergency Department (ED) waiting times across Canberra and Calvary hospitals and make informed decisions on which hospital to visit or to consider alternative service providers.

To support tobacco cessation, smoke-free environments have been introduced in ACT Health facilities with designated smoking areas no longer available from 1 September 2014. In 2013, the ACT Government set a target of 'zero growth' for obesity in the ACT through the *Towards Zero Growth: Healthy Weight Action Plan*. Various initiatives implementing this plan are underway, including promoting healthy food and drink options in school canteens and workplaces.

The Health Infrastructure Program announced in 2008 is progressing with the roll-out of new infrastructure to support health care delivery in the ACT. This ACT Government program with an outlay of over \$1 billion will revitalise and rebuild the ACT Health system to prepare for growing demands in the future. A new Canberra Regional Cancer Centre on the Canberra Hospital campus opened to patients in August 2014. This modern facility will provide integrated, multi-disciplinary cancer services, making treatments more efficient for patients. Work on the construction of the Belconnen Community Health Centre and refurbishment of the Tuggeranong Community Health Centre has been completed. These Centres will provide expanded health services to assist people manage acute and chronic conditions in the community. Nurse-led Walk-in-Centres (WiCs) have been opened at the two Health Centres providing free, extended hours primary health care treatments for minor illnesses in the community. The WiC at the Canberra Hospital was closed in June 2014.

Stage 2 of the Centenary Hospital for Women and Children has also been completed, bringing a range of services for women and children under one roof. Canberra Hospital ED and Intensive Care Unit extension work has also been completed. Work has commenced on a multi-storey 700+ capacity car park at Calvary Hospital while construction of the new University of Canberra Public Hospital which will provide sub-acute services is expected to begin in 2015.

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Northern Territory Government comments

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During 2013-14, the NT Department of Health services continued to provide primary health care in a range of settings, including 45 remote health centres; and acute health care in five hospitals.

The geography of the NT and a population widely distributed across remote and very remote areas creates challenges for service delivery. These challenges contribute to significant socioeconomic disadvantage within the population which often results in limited life and health choices and poorer wellbeing.

Changes to service delivery within the NT made in 2013-14 are designed to improve responses to local needs and conditions through integration, local decision making, regional perspectives and accountability through Service Delivery Agreements backed by an NT-wide safety and quality system. Operational services are now mostly being delivered by two organisations: the Top End and Central Australia Health Services, combining the delivery of primary, community and acute health care services.

This change to a New Services Framework also implements national health reforms. A more streamlined contemporary Department of Health was established on 1 July 2014 as the overall health system manager, with responsibility for: planning and managing the NT public health system; setting Territory wide policy and frameworks; and monitoring the performance of health services. The Department still delivers a number of Territory-wide services (some of which will move into the Health Services) and provides corporate services for the whole public health system.

Other major initiatives in 2013-14 included:

- the passing of the *Health Services Act* and appointment of the Health Service Boards
- the establishment of the Office of Disability and the Ministerial Advisory Council on Disability
- preparations for the National Disability Insurance Scheme trial in Tennant Creek commencing 1 July 2014
- the continued implementation of Alcohol Mandatory Treatment across the NT along with the review of the *Alcohol Mandatory Treatment Act*
- progress towards the development and construction of the Palmerston Regional Public Hospital
- continued work towards full implementation of activity based funding for commencement on 1 July 2014
- implementation of enhanced cardiac and cardiac outreach services including low risk angioplasty services in the Top End.

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Australian Government comments

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Australia's health system is world class, supporting universal and affordable access to high quality medical, pharmaceutical and hospital services, while helping people to stay healthy through health promotion and disease prevention activities.

Australia has one of the most efficient and effective health care systems in the world. According to the most recent Global Burden of Disease Study, Australia achieves strong health outcomes with lower than average spending on health per capita. However, advances in medical technologies and treatments, new pharmaceuticals, the rising incidence of chronic disease in the community and an ageing population, have meant that the cost of maintaining the health care system continues to rise. Ensuring Australia's current world class health care system is sustainable into the future is one of the Government's highest priorities.

One of the key elements of this strategy is a continued investment in health promotion, keeping people healthy and out of hospital. To achieve this, the Government delivers a comprehensive immunisation programme to protect people against harmful communicable diseases. It also continues to invest in public health programmes aimed at reducing Australia's growing rate of chronic disease caused by smoking, obesity, dietary risks, physical inactivity, and alcohol misuse. About one-third of Australia's burden of disease is due to these 'lifestyle' health risks, therefore continued investment in preventive health is vital to ensuring not only the health and wellbeing of Australian citizens, but also the long term sustainability of the health system.

Complementing this investment in preventive health is the Government's strengthening of the primary care system. Through Medicare, the Government provides subsidised access to GP, specialists, optometrical services and certain allied health services. And through the Pharmaceutical Benefits Scheme (PBS), Australians have access to subsidised medicines at affordable prices.

While state governments have primary responsibility for acute care services, the Australian Government provides vital funding to the system through Medicare and block funding for hospitals. The Government is introducing reforms to the system to increase the autonomy of state governments to manage their hospitals and health systems more effectively.

The Government is also investing innovation to improve the efficiency and effectiveness of health services and the health system. The Personally Controlled Electronic Health Record system will continue to be rolled out to improve the coordination of health care services. The Government is also making record investments in medical research to set Australia's health system up for the future. Properly funded and coordinated research, including clinical trials, is critical to finding new treatments and better systems of care.

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E.6 List of attachment tables

Attachment tables are identified in references throughout this appendix by an 'EA' prefix (for example, table EA.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

Table EA.1	Total health expenditure, by broad source of funds (2012-13 dollars)
Table EA.2	Government recurrent health expenditure, by area of expenditure (2012-13 dollars)
Table EA.3	Non-government recurrent health expenditure by area of expenditure (2012-13 dollars)
Table EA.4	Recurrent health expenditure, by source of funds and area of expenditure, 2012-13
Table EA.5	Total health expenditure per person (2012-13 dollars)
Table EA.6	Recurrent health expenditure per person by source of funds (2012-13 dollars)
Table EA.7	Total health price index and industry-wide indexes (reference year 2012-13 = 100)
Table EA.8	Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status
Table EA.9	Birthweights, live births, all mothers, 2012
Table EA.10	Birthweights, live births, Aboriginal and Torres Strait Islander mothers, 2012
Table EA.11	Proportion of live-born singleton babies of low birthweight, by remoteness and SEIFA quintiles, and SEIFA deciles, National, 2012
Table EA.12	Proportion of adults and children in BMI categories
Table EA.13	Rate of overweight and obesity for adults and children, by remoteness
Table EA.14	Rates of overweight and obesity for adults and children, by SEIFA IRSD quintiles
Table EA.15	Rates of overweight and obesity for adults, by sex and age
Table EA.16	Rates of overweight and obesity for adults, by Indigenous status, 2011–13
Table EA.17	Rates of overweight and obesity for adults, by Indigenous status, 2004-05
Table EA.18	Rate of overweight and obesity for children by Indigenous status, 2011–13
Table EA.19	Proportion of adults who are daily smokers, by remoteness
Table EA.20	Proportion of adults who are daily smokers, by SEIFA IRSD quintiles
Table EA.21	Proportion of adults who are daily smokers, by Indigenous status
Table EA.22	Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by remoteness
Table EA.23	Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by SEIFA IRSD quintiles
Table EA.24	Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by Indigenous status
Table EA.25	Proportion of adult abstainers from alcohol, by Indigenous status
Table EA.26	Incidence of selected cancers
Table EA.27	Incidence of selected cancers, by remoteness area, 2011
Table EA.28	Incidence of selected cancers, by SEIFA IRSD quintiles, 2011
Table EA.29	Incidence of selected cancers, by Indigenous status (per 100 000 population)

Table EA.30	Incidence of heart attacks (acute coronary events), by age and sex, people aged 25 years and over (per 100 000 people)
Table EA.31	Incidence of heart attacks (acute coronary events), people 25 years or over, by Indigenous status (per 100 000 people)
Table EA.32	Incidence of heart attacks (acute coronary events), people 25 years or over, NSW (per 100 000 people)
Table EA.33	Incidence of heart attacks (acute coronary events), people 25 years or over, Victoria (per 100 000 people)
Table EA.34	Incidence of heart attacks (acute coronary events), people 25 years or over, Queensland (per 100 000 people)
Table EA.35	Incidence of heart attacks (acute coronary events), people 25 years or over, WA (per 100 000 people)
Table EA.36	Incidence of heart attacks (acute coronary events), people 25 years or over, SA (per 100 000 people)
Table EA.37	Incidence of heart attacks (acute coronary events), people 25 years or over, Tasmania (per 100 000 people)
Table EA.38	Incidence of heart attacks (acute coronary events), people 25 years or over, ACT (per 100 000 people)
Table EA.39	Incidence of heart attacks (acute coronary events), people 25 years or over, NT (per 100 000 people)
Table EA.40	Proportion of people with type 2 diabetes (based on fasting blood glucose test), by sex, 2011-12 (per cent)
Table EA.41	Proportion of people aged 18 years or over with type 2 diabetes (based on fasting blood glucose test), by Indigenous status, by sex, 2011-13 (per cent)
Table EA.42	Proportion of people aged 25 years or over with type 2 diabetes (based on fasting blood glucose test), by Indigenous status, by sex, 2011-13 (per cent)
Table EA.43	Age-standardised mortality rates of potentially avoidable deaths, under 75 years
Table EA.44	Age standardised mortality rates of potentially avoidable deaths, under 75 years, by Indigenous status, NSW, Queensland, WA, SA, NT, 2007-2011
Table EA.45	All Australians average life expectancy at birth (years)
Table EA.46	Estimated life expectancies at birth, by Indigenous status and sex (years)
Table EA.47	Median age at death (years)
Table EA.48	Median age at death, by Indigenous status (years)
Table EA.49	Age standardised mortality rate (all causes), by State and Territory
Table EA.50	Age standardised all-cause mortality rate, rate ratios and rate differences, by Indigenous status, NSW, Qld, WA, SA, NT, five year aggregate, 2008-2012 (per 100 000 people)
Table EA.51	Age standardised all-cause mortality rate, rate ratios and rate differences, by Indigenous status, NSW, Qld, WA, SA, NT, 2013 (per 100 000 people)
Table EA.52	Infant mortality
Table EA.53	Infant mortality rate by Indigenous status, three year average (per 1000 live births)
Table EA.54	All causes infant and child mortality, by age group
Table EA.55	All causes infant and child mortality, by Indigenous status, NSW, Queensland, WA, SA, NT
Table EA.56	Age standardised mortality rates by cause of death (with variability bands), by State and Territory
Table EA.57	Age standardised mortality rates by major cause of death, by Indigenous status, 2008-2012

Table EA.58	Employed medical practitioners
Table EA.59	Employed nurses
Table EA.60	FTE employed allied health practitioners by age, 2012 (per 100 000 people)
Table EA.61	Net growth in health workforce, selected professions
Table EA.62	Employed health workforce, by Indigenous status and state and territory of principal practice
Table EA.63	Indigenous health workforce, by State/Territory, 2011
Table EA.64	Indigenous health workforce, by sex, 2011
Table EA.65	Indigenous persons employed in selected health-related occupations, 2011
Table EA.66	Proportion of people who accessed health services by health status, 2011-12
Table EA.67	Proportion of people who accessed health services by health status, 2004-05
Table EA.68	Proportion of Aboriginal and Torres Strait Islander people who accessed health services by health status, 2012-13
Table EA.69	Proportion of people who accessed health services by health status, by Indigenous status, 2004-05
Table EA.70	Proportion of people who accessed health services by health status, by remoteness of residence, 2011-12
Table EA.71	Proportion of people who accessed health services by health status, by remoteness of residence, 2004-05
Table EA.72	Proportion of people who accessed health services by health status, by SEIFA, 2011-12
Table EA.73	Proportion of people who accessed health services by health status, by SEIFA, 2004-05

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EA Health sector overview — attachment

Un sourced information was obtained from the Australian, State and Territory governments.

Data in this Report are examined by the Health Working Group, but have not been formally audited by the Secretariat.

Data reported in the attachment tables are the most accurate available at the time of data collection. Historical data may have been updated since the last edition of RoGS.

This file is available in Adobe PDF format on the Review web page (www.pc.gov.au/gsp).

Attachment contents

Table EA.1	Total health expenditure, by broad source of funds (2012-13 dollars)
Table EA.2	Government recurrent health expenditure, by area of expenditure (2012-13 dollars)
Table EA.3	Non-government recurrent health expenditure by area of expenditure (2012-13 dollars)
Table EA.4	Recurrent health expenditure, by source of funds and area of expenditure, 2012-13
Table EA.5	Total health expenditure per person (2012-13 dollars)
Table EA.6	Recurrent health expenditure per person by source of funds (2012-13 dollars)
Table EA.7	Total health price index and industry-wide indexes (reference year 2012-13 = 100)
Table EA.8	Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status
Table EA.9	Birthweights, live births, all mothers, 2012
Table EA.10	Birthweights, live births, Aboriginal and Torres Strait Islander mothers, 2012
Table EA.11	Proportion of live-born singleton babies of low birthweight, by remoteness and SEIFA quintiles, and SEIFA deciles, National, 2012
Table EA.12	Proportion of adults and children in BMI categories
Table EA.13	Rate of overweight and obesity for adults and children, by remoteness
Table EA.14	Rates of overweight and obesity for adults and children, by SEIFA IRSD quintiles
Table EA.15	Rates of overweight and obesity for adults, by sex and age
Table EA.16	Rates of overweight and obesity for adults, by Indigenous status, 2011–13
Table EA.17	Rates of overweight and obesity for adults, by Indigenous status, 2004-05
Table EA.18	Rate of overweight and obesity for children by Indigenous status, 2011–13
Table EA.19	Proportion of adults who are daily smokers, by remoteness
Table EA.20	Proportion of adults who are daily smokers, by SEIFA IRSD quintiles
Table EA.21	Proportion of adults who are daily smokers, by Indigenous status
Table EA.22	Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by remoteness
Table EA.23	Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by SEIFA IRSD quintiles
Table EA.24	Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by Indigenous status
Table EA.25	Adult abstainers from alcohol, by Indigenous status (per cent)
Table EA.26	Incidence of selected cancers
Table EA.27	Incidence of selected cancers, by remoteness area, 2011
Table EA.28	Incidence of selected cancers, by SEIFA IRSD quintiles, 2011
Table EA.29	Incidence of selected cancers, by Indigenous status (per 100 000 population)
Table EA.30	Incidence of heart attacks (acute coronary events), by age and sex, people aged 25 years and over (per 100 000 people)
Table EA.31	Incidence of heart attacks (acute coronary events), people 25 years or over, by Indigenous status (per 100 000 people)
Table EA.32	Incidence of heart attacks (acute coronary events), people 25 years or over, NSW (per 100 000 people)
Table EA.33	Incidence of heart attacks (acute coronary events), people 25 years or over, Victoria (per 100 000 people)
Table EA.34	Incidence of heart attacks (acute coronary events), people 25 years or over, Queensland (per 100 000 people)
Table EA.35	Incidence of heart attacks (acute coronary events), people 25 years or over, WA (per 100 000 people)
Table EA.36	Incidence of heart attacks (acute coronary events), people 25 years or over, SA (per 100 000 people)

Attachment contents

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- Table EA.37** Incidence of heart attacks (acute coronary events), people 25 years or over, Tasmania (per 100 000 people)
- Table EA.38** Incidence of heart attacks (acute coronary events), people 25 years or over, ACT (per 100 000 people)
- Table EA.39** Incidence of heart attacks (acute coronary events), people 25 years or over, NT (per 100 000 people)
- Table EA.40** Proportion of people with type 2 diabetes (based on fasting blood glucose test), by sex, 2011-12 (per cent)
- Table EA.41** Proportion of people aged 18 years or over with type 2 diabetes (based on fasting blood glucose test), by Indigenous status, by sex, 2011-13 (per cent)
- Table EA.42** Proportion of people aged 25 years or over with type 2 diabetes (based on fasting blood glucose test), by Indigenous status, by sex, 2011-13 (per cent)
- Table EA.43** Age-standardised mortality rates of potentially avoidable deaths, under 75 years
- Table EA.44** Age standardised mortality rates of potentially avoidable deaths, under 75 years, by Indigenous status, NSW, Queensland, WA, SA, NT, 2007-2011
- Table EA.45** All Australians average life expectancy at birth (years)
- Table EA.46** Estimated life expectancies at birth, by Indigenous status and sex (years)
- Table EA.47** Median age at death (years)
- Table EA.48** Median age at death, by Indigenous status (years)
- Table EA.49** Age standardised mortality rate (all causes), by State and Territory
- Table EA.50** Age standardised all-cause mortality rates and rate ratios, by Indigenous status, NSW, Qld, WA, SA, NT, five year aggregate, 2008-2012 (per 100 000 people)
- Table EA.51** Age standardised all-cause mortality rate and rate ratios, by Indigenous status, NSW, Qld, WA, SA, NT, 2013 (per 100 000 people)
- Table EA.52** Infant mortality
- Table EA.53** Infant mortality rate by Indigenous status, three year average (per 1000 live births)
- Table EA.54** All causes infant and child mortality, by age group
- Table EA.55** All causes infant and child mortality, by Indigenous status, NSW, Queensland, WA, SA, NT
- Table EA.56** Age standardised mortality rates by cause of death (with variability bands), by State and Territory
- Table EA.57** Age standardised mortality rates by major cause of death, by Indigenous status, 2008-2012
- Table EA.58** Employed medical practitioners
- Table EA.59** Employed nurses
- Table EA.60** FTE employed allied health practitioners by age, 2012 (per 100 000 people)
- Table EA.61** Net growth in health workforce, selected professions
- Table EA.62** Employed health workforce, by Indigenous status and state or territory of principal practice
- Table EA.63** Aboriginal and Torres Strait Islander health workforce, by State/Territory, 2011
- Table EA.64** Aboriginal and Torres Strait Islander health workforce, by sex, 2011
- Table EA.65** Aboriginal and Torres Strait Islander persons employed in selected health-related occupations, 2011
- Table EA.66** Proportion of people who accessed health services by health status, 2011-12
- Table EA.67** Proportion of people who accessed health services by health status, 2004-05
- Table EA.68** Proportion of Aboriginal and Torres Strait Islander people who accessed health services by health status, 2012-13
- Table EA.69** Proportion of people who accessed health services by health status, by Indigenous status, 2004-05
- Table EA.70** Proportion of people who accessed health services by health status, by remoteness of residence, 2011-12

Attachment contents

-
- Table EA.71** Proportion of people who accessed health services by health status, by remoteness of residence, 2004-05
- Table EA.72** Proportion of people who accessed health services by health status, by SEIFA, 2011-12
- Table EA.73** Proportion of people who accessed health services by health status, by SEIFA, 2004-05

**Table EA.1 Total health expenditure, by broad source of funds (2012-13 dollars)
(a), (b), (c)**

	<i>Unit</i>	<i>Australian Government</i> (d)	<i>State, Territory and local governments</i>	<i>Total government</i>	<i>Non-government</i> (d)	<i>Total</i>
Expenditure						
2003-04	\$m	40 647	23 090	63 737	29 222	92 960
2004-05	\$m	43 300	25 092	68 393	30 528	98 921
2005-06	\$m	43 440	26 775	70 215	31 263	101 478
2006-07	\$m	45 325	28 881	74 207	33 307	107 513
2007-08	\$m	49 976	30 011	79 987	34 609	114 596
2008-09	\$m	54 292	31 303	85 596	37 507	123 103
2009-10	\$m	56 009	33 946	89 955	38 353	128 308
2010-11	\$m	59 076	36 188	95 264	41 610	136 874
2011-12	\$m	62 513	39 208	101 721	43 454	145 175
2012-13	\$m	61 022	39 767	100 789	46 594	147 384
Shares (e)						
2003-04	%	43.7	24.8	68.6	31.4	100.0
2004-05	%	43.8	25.4	69.1	30.9	100.0
2005-06	%	42.8	26.4	69.2	30.8	100.0
2006-07	%	42.2	26.9	69.0	31.0	100.0
2007-08	%	43.6	26.2	69.8	30.2	100.0
2008-09	%	44.1	25.4	69.5	30.5	100.0
2009-10	%	43.7	26.5	70.1	29.9	100.0
2010-11	%	43.2	26.4	69.6	30.4	100.0
2011-12	%	43.1	27.0	70.1	29.9	100.0
2012-13	%	41.4	27.0	68.4	31.6	100.0

(a) Constant price health expenditure for 2003-04 to 2012-13 is expressed in terms of 2012-13 prices using a combination of deflators (see table EA.7).

(b) Components may not add to totals due to rounding.

(c) Data exclude expenditure on high level residential aged care.

(d) Funding of expenditure has been adjusted for medical expenses tax rebate.

(e) Data are derived.

Source: Australian Institute of Health and Welfare (AIHW) 2014, *Health Expenditure Australia 2012-13*, Health and Welfare Expenditure Series no. 52, Cat. no. HWE 61, Canberra.

TABLE EA.2

Table EA.2 Government recurrent health expenditure, by area of expenditure (2012-13 dollars) (a), (b), (c), (d)

	Unit	Hospitals		Primary health care					Other	Total
		Public hospitals (e)	Private hospitals	Unreferred Medical services	Dental services	Other health practitioners	Community health and other(f)	Medications	Other health (g)	Total government recurrent expenditure
Expenditure										
2003-04	\$m	26 192	3 032	5 586	1 093	881	4 340	5 862	14 944	61 929
2004-05	\$m	27 690	3 168	6 115	1 131	810	4 603	6 218	16 168	65 903
2005-06	\$m	28 837	3 217	5 910	1 157	849	4 777	6 288	16 471	67 505
2006-07	\$m	30 594	3 253	6 079	1 146	992	5 255	6 662	17 287	71 268
2007-08	\$m	32 589	3 524	6 727	1 330	1 252	5 806	7 230	18 915	77 373
2008-09	\$m	34 152	3 615	6 803	1 725	1 366	5 894	7 956	20 798	82 309
2009-10	\$m	35 716	3 957	7 291	1 969	1 510	6 024	8 574	21 357	86 397
2010-11	\$m	37 658	4 146	7 860	2 199	1 562	6 331	8 889	21 815	90 461
2011-12	\$m	39 686	4 436	8 015	2 433	1 645	7 034	9 152	23 454	95 855
2012-13	\$m	39 897	4 092	8 257	2 207	1 701	7 092	8 952	23 000	95 197
Shares (h)										
2003-04	%	42.3	4.9	9.0	1.8	1.4	7.0	9.5	24.1	100.0
2004-05	%	42.0	4.8	9.3	1.7	1.2	7.0	9.4	24.5	100.0
2005-06	%	42.7	4.8	8.8	1.7	1.3	7.1	9.3	24.4	100.0
2006-07	%	42.9	4.6	8.5	1.6	1.4	7.4	9.3	24.3	100.0
2007-08	%	42.1	4.6	8.7	1.7	1.6	7.5	9.3	24.4	100.0
2008-09	%	41.5	4.4	8.3	2.1	1.7	7.2	9.7	25.3	100.0
2009-10	%	41.3	4.6	8.4	2.3	1.7	7.0	9.9	24.7	100.0
2010-11	%	41.6	4.6	8.7	2.4	1.7	7.0	9.8	24.1	100.0
2011-12	%	41.4	4.6	8.4	2.5	1.7	7.3	9.5	24.5	100.0
2012-13	%	41.9	4.3	8.7	2.3	1.8	7.4	9.4	24.2	100.0

(a) Constant price health expenditure for 2003-04 to 2012-13 is expressed in terms of 2012-13 prices using a combination of deflators (see table EA.7).

Table EA.2 **Government recurrent health expenditure, by area of expenditure (2012-13 dollars) (a), (b), (c), (d)**

<i>Unit</i>	<i>Hospitals</i>		<i>Primary health care</i>				<i>Other</i>	<i>Total</i>
	<i>Public hospitals (e)</i>	<i>Private hospitals</i>	<i>Unreferred Medical services</i>	<i>Dental services</i>	<i>Other health practitioners</i>	<i>Community health and other(f) Medications</i>	<i>Other health (g)</i>	<i>Total government recurrent expenditure</i>

(b) Includes funding provided by the Australian Government, State and Territory governments and local government authorities.

(c) Components may not add to totals due to rounding.

(d) Data exclude expenditure on high level residential aged care.

(e) Public hospital services exclude any dental services, community health services, patient transport services, public health and health research undertaken by the hospital. Can include services provided off the hospital site such as hospital in the home, dialysis or other services.

(f) 'Other' denotes 'other recurrent health services not elsewhere classified'.

(g) Other health data are derived and comprise patient transport services, referred medical services, public health, aids and appliances, other non-institutional health not elsewhere classified, administration and research.

Source: AIHW online health expenditure data cubes.

TABLE EA.3

Table EA.3 Non-government recurrent health expenditure by area of expenditure (2012-13 dollars) (a), (b), (c), (d), (e)

	Unit	Hospitals		Primary health care					Other	Total
		Public hospitals (f)	Private hospitals	Unreferred Medical services	Dental services	Other health practitioners	Community health and other (g)	Medications	Other health (h)	Total non-government recurrent expenditure
Expenditure										
2003-04	\$m	1 699	4 822	1 635	5 066	2 623	398	4 609	5 954	26 806
2004-05	\$m	2 043	4 958	1 533	5 188	2 786	396	5 145	6 036	28 084
2005-06	\$m	2 143	5 004	1 474	5 252	2 872	401	5 379	6 238	28 764
2006-07	\$m	2 336	5 203	1 537	5 353	2 939	344	5 943	6 710	30 366
2007-08	\$m	2 525	5 353	1 673	5 305	2 803	373	6 436	7 063	31 531
2008-09	\$m	2 957	6 603	1 671	5 447	2 587	198	7 260	7 646	34 371
2009-10	\$m	3 024	6 797	1 698	5 939	2 698	273	7 704	7 945	36 078
2010-11	\$m	3 450	7 215	1 753	5 811	3 180	322	8 841	8 339	38 911
2011-12	\$m	3 602	7 382	1 808	6 044	3 263	273	9 556	8 578	40 506
2012-13	\$m	3 963	7 991	1 909	6 500	3 508	352	10 328	9 029	43 580
Shares (h)										
2003-04	%	6.3	18.0	6.1	18.9	9.8	1.5	17.2	22.2	100.0
2004-05	%	7.3	17.7	5.5	18.5	9.9	1.4	18.3	21.5	100.0
2005-06	%	7.5	17.4	5.1	18.3	10.0	1.4	18.7	21.7	100.0
2006-07	%	7.7	17.1	5.1	17.6	9.7	1.1	19.6	22.1	100.0
2007-08	%	8.0	17.0	5.3	16.8	8.9	1.2	20.4	22.4	100.0
2008-09	%	8.6	19.2	4.9	15.8	7.5	0.6	21.1	22.2	100.0
2009-10	%	8.4	18.8	4.7	16.5	7.5	0.8	21.4	22.0	100.0
2010-11	%	8.9	18.5	4.5	14.9	8.2	0.8	22.7	21.4	100.0
2011-12	%	8.9	18.2	4.5	14.9	8.1	0.7	23.6	21.2	100.0
2012-13	%	9.1	18.3	4.4	14.9	8.1	0.8	23.7	20.7	100.0

Table EA.3 **Non-government recurrent health expenditure by area of expenditure (2012-13 dollars) (a), (b), (c), (d), (e)**

<i>Unit</i>	<i>Hospitals</i>		<i>Primary health care</i>				<i>Other</i>	<i>Total</i>
	<i>Public hospitals (f)</i>	<i>Private hospitals</i>	<i>Unreferred Medical services</i>	<i>Dental services</i>	<i>Other health practitioners</i>	<i>Community health and other (g) Medications</i>	<i>Other health (h)</i>	<i>Total non-government recurrent expenditure</i>

(a) Total health funding has not been adjusted to include medical expenses tax rebate funded by the Australian Government.

(b) Constant price health expenditure for 2003-04 to 2012-13 is expressed in terms of 2012-13 prices using a combination of deflators (see table EA.7).

(c) Tables show funding by the major non-government sources of funding for health care.

(d) Components may not add to totals due to rounding.

(e) Data exclude expenditure on high level residential aged care.

(f) Public hospital services exclude any dental services, community health services, patient transport services, public health and health research undertaken by the hospital. Can include services provided off the hospital site such as hospital in the home, dialysis or other services.

(g) 'Other' denotes 'other recurrent health services not elsewhere classified'.

(h) Other health data are derived and comprise patient transport services, referred medical services, public health, aids and appliances, other non-institutional health not elsewhere classified, administration and research.

Source: AIHW online health expenditure data cubes.

TABLE EA.4

Table EA.4 Recurrent health expenditure, by source of funds and area of expenditure, 2012-13 (a), (b), (c), (d)

Area of expenditure	Unit	Government						Non-government				
		Australian Government						Private health insurance funds				
		DVA	Health and other	Health insurance premium rebates (e)	Total	State, Territory and local government	Total government	Individuals	Other (f)	Total non-government	Total	
Expenditure												
Hospitals	\$m	1 664	15 331	2 882	19 876	24 112	43 989	6 637	2 803	2 514	11 954	55 943
Public hospital services (g)	\$m	785	15 065	393	16 242	23 655	39 897	904	1 305	1 754	3 963	43 860
Private hospitals	\$m	879	266	2 489	3 635	457	4 092	5 733	1 497	760	7 991	12 083
Primary health care	\$m	1 608	20 255	915	22 779	7 463	30 242	2 108	18 517	2 080	22 706	52 948
Unreferred medical services	\$m	838	7 419	..	8 257	..	8 257	..	661	1 248	1 909	10 166
Dental services	\$m	100	843	606	1 550	657	2 207	1 396	5 066	37	6 500	8 706
Other health practitioners	\$m	241	1 160	287	1 688	13	1 701	661	2 426	422	3 508	5 209
Community health and other (h)	\$m	1	1 181	–	1 182	5 909	7 092	1	153	198	352	7 444
Public health	\$m	..	1 150	..	1 150	884	2 034	..	13	96	109	2 143
Benefit-paid pharmaceuticals	\$m	429	7 994	..	8 423	..	8 423	..	1 547	..	1 547	9 970
All other medications	\$m	..	507	22	529	..	529	50	8 651	80	8 781	9 309
Other	\$m	201	16 325	1 347	17 873	3 092	20 966	3 103	5 373	444	8 920	29 886
Patient transport services	\$m	157	56	85	298	2 067	2 364	195	353	100	648	3 012
Referred medical services	\$m	..	10 892	556	11 448	..	11 448	1 280	2 428	..	3 709	15 157
Aids and appliances	\$m	2	440	229	671	..	671	529	2 585	59	3 172	3 844
Administration	\$m	41	1 101	477	1 619	235	1 855	1 099	3	1	1 103	2 958
Research	\$m	1	3 836	..	3 837	790	4 627	..	4	284	288	4 915
Total recurrent funding	\$m	3 474	51 911	5 144	60 529	34 668	95 197	11 849	26 693	5 039	43 580	138 777

TABLE EA.4

Table EA.4 Recurrent health expenditure, by source of funds and area of expenditure, 2012-13 (a), (b), (c), (d)

Area of expenditure	Unit	Government						Non-government				
		DVA	Australian Government			State, Territory and local government	Private health insurance funds				Total non-government	
			Health and other	Health insurance premium rebates (e)	Total		Individuals	Other (f)	Total			
Share of expenditure (i)												
Hospitals	%	3.0	27.4	5.2	35.5	43.1	78.6	11.9	5.0	4.5	21.4	100.0
Public hospital services (g)	%	1.8	34.3	0.9	37.0	53.9	91.0	2.1	3.0	4.0	9.0	100.0
Private hospitals	%	7.3	2.2	20.6	30.1	3.8	33.9	47.4	12.4	6.3	66.1	100.0
Primary health care	%	3.0	38.3	1.7	43.0	14.1	57.1	4.0	35.0	3.9	42.9	100.0
Unreferred medical services	%	8.2	73.0	..	81.2	..	81.2	..	6.5	12.3	18.8	100.0
Dental services	%	1.1	9.7	7.0	17.8	7.5	25.4	16.0	58.2	0.4	74.7	100.0
Other health practitioners	%	4.6	22.3	5.5	32.4	0.2	32.7	12.7	46.6	8.1	67.3	100.0
Community health and other (h)	%	–	15.9	–	15.9	79.4	95.3	–	2.1	2.7	4.7	100.0
Public health	%	..	53.7	..	53.7	41.3	94.9	..	0.6	4.5	5.1	100.0
Benefit-paid pharmaceuticals	%	4.3	80.2	..	84.5	..	84.5	..	15.5	..	15.5	100.0
All other medications	%	..	5.4	0.2	5.7	..	5.7	0.5	92.9	0.9	94.3	100.0
Other	%	0.7	54.6	4.5	59.8	10.3	70.2	10.4	18.0	1.5	29.8	100.0
Patient transport services	%	5.2	1.9	2.8	9.9	68.6	78.5	6.5	11.7	3.3	21.5	100.0
Referred medical services	%	..	71.9	3.7	75.5	..	75.5	8.4	16.0	..	24.5	100.0
Aids and appliances	%	0.1	11.4	6.0	17.5	..	17.5	13.8	67.2	1.5	82.5	100.0
Administration	%	1.4	37.2	16.1	54.7	7.9	62.7	37.2	0.1	–	37.3	100.0
Research	%	–	78.0	..	78.1	16.1	94.1	..	0.1	5.8	5.9	100.0
Total recurrent funding	%	2.5	37.4	3.7	43.6	25.0	68.6	8.5	19.2	3.6	31.4	100.0

(a) Total health funding has not been adjusted to include medical expenses tax rebate as funding by the Australian Government.

Table EA.4 Recurrent health expenditure, by source of funds and area of expenditure, 2012-13 (a), (b), (c), (d)

Area of expenditure	Unit	Government					Non-government				Total
		DVA	Australian Government			Total government	Non-government				
			Health and other	Health insurance premium rebates (e)	State, Territory and local government		Private health insurance funds	Individuals	Other (f)	Total non- government	

(b) Tables show funding provided by the Australian Government, State and Territory governments and local government authorities and by the major non-government sources of funding for health care. They do not show total expenditure on health goods and services.

(c) Data exclude expenditure on high level residential aged care.

(d) Components may not add to totals due to rounding.

(e) Includes the 30-40 per cent rebate on health insurance premiums that can be claimed either directly from the Australian Government through the taxation system or it may involve a reduced premium being charged by the private health insurance fund.

(f) Expenditure on health goods and services by workers compensation and compulsory third-party motor vehicle insurers, as well as other sources of income (for example, rent, interest earned) for service providers.

(g) Public hospital services exclude certain services undertaken in hospitals. Can include services provided off-site, such as hospital in the home, dialysis or other services.

(h) 'Other' denotes 'other recurrent health services not elsewhere classified'.

(i) Data are derived.

.. Not applicable. – Nil or rounded to zero.

Source: AIHW 2014, *Health Expenditure Australia 2012-13*, Health and Welfare Expenditure Series no. 52, Cat. no. HWE 61, Canberra.

Table EA.5 **Total recurrent health expenditure per person (2012-13 dollars) (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (c)</i>	<i>NT</i>	<i>Aust</i>
2003-04	4 522	4 446	4 231	4 605	4 583	4 140	5 366	5 559	4 476
2004-05	4 793	4 606	4 389	4 815	4 879	4 269	5 677	5 777	4 689
2005-06	4 757	4 678	4 582	4 789	4 929	4 433	5 661	6 102	4 740
2006-07	4 917	4 826	4 867	5 014	5 042	4 629	5 937	6 278	4 928
2007-08	5 124	5 025	5 153	5 322	5 448	5 114	6 103	6 785	5 183
2008-09	5 368	5 285	5 433	5 499	5 720	5 339	6 303	7 156	5 434
2009-10	5 534	5 544	5 639	5 467	5 901	5 390	6 322	6 935	5 602
2010-11	5 707	5 810	5 804	5 813	6 160	5 801	6 686	7 741	5 836
2011-12	5 918	5 979	6 095	5 925	6 427	5 979	7 018	8 757	6 056
2012-13	5 977	5 985	6 101	5 909	6 302	5 912	6 761	8 202	6 055

(a) Constant price health expenditure for 2003-04 to 2012-13 is expressed in terms of 2012-13 prices using a combination of deflators (see table EA.7).

(b) Data exclude expenditure on high level residential aged care.

(c) ACT expenditure includes substantial expenditure for NSW residents which may inflate expenditure per person data.

np Not published.

Source: AIHW online health expenditure data cubes.

Table EA.6 **Recurrent health expenditure per person by source of funds (2012-13 dollars) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT</i>	<i>Aust</i>
Government recurrent health expenditure									
2003-04	3 157	2 944	3 039	3 241	3 314	2 943	3 861	4 627	3 124
2004-05	3 381	3 049	3 134	3 393	3 596	3 080	4 107	4 813	3 288
2005-06	3 366	3 094	3 288	3 328	3 609	3 197	4 152	5 028	3 324
2006-07	3 459	3 178	3 497	3 509	3 761	3 348	4 388	5 204	3 455
2007-08	3 626	3 420	3 750	3 705	4 077	3 763	4 617	5 668	3 682
2008-09	3 774	3 559	3 926	3 783	4 280	3 870	4 851	6 008	3 833
2009-10	3 880	3 720	4 094	3 757	4 430	4 042	4 901	5 841	3 952
2010-11	3 969	3 867	4 169	3 969	4 565	4 280	5 110	6 581	4 081
2011-12	4 140	3 955	4 393	4 183	4 803	4 220	5 449	7 535	4 257
2012-13	4 077	3 909	4 304	4 012	4 561	4 041	5 016	6 903	4 153
Non-government recurrent health expenditure									
2003-04	1 364	1 502	1 192	1 364	1 269	1 197	1 506	932	1 352
2004-05	1 412	1 557	1 255	1 422	1 283	1 189	1 570	964	1 401
2005-06	1 391	1 584	1 294	1 460	1 319	1 236	1 509	1 075	1 416
2006-07	1 458	1 648	1 369	1 504	1 281	1 280	1 549	1 074	1 472
2007-08	1 497	1 605	1 403	1 618	1 371	1 352	1 487	1 117	1 501
2008-09	1 594	1 726	1 507	1 716	1 440	1 468	1 452	1 149	1 601
2009-10	1 654	1 825	1 546	1 710	1 472	1 348	1 421	1 094	1 650
2010-11	1 738	1 943	1 635	1 844	1 595	1 521	1 576	1 160	1 755
2011-12	1 778	2 024	1 701	1 742	1 624	1 759	1 569	1 222	1 799
2012-13	1 900	2 075	1 797	1 896	1 741	1 871	1 745	1 299	1 901
Total recurrent health expenditure									
2003-04	4 522	4 446	4 231	4 605	4 583	4 139	5 366	5 559	4 476
2004-05	4 793	4 606	4 389	4 815	4 879	4 268	5 677	5 775	4 689
2005-06	4 757	4 678	4 582	4 789	4 929	4 432	5 661	6 101	4 740
2006-07	4 917	4 826	4 867	5 013	5 042	4 628	5 937	6 280	4 928
2007-08	5 123	5 025	5 153	5 322	5 448	5 115	6 103	6 783	5 183
2008-09	5 368	5 285	5 433	5 499	5 720	5 339	6 303	7 157	5 434
2009-10	5 534	5 544	5 639	5 466	5 901	5 389	6 322	6 934	5 602
2010-11	5 707	5 809	5 804	5 813	6 160	5 802	6 686	7 743	5 836
2011-12	5 918	5 979	6 095	5 925	6 427	5 979	7 018	8 755	6 056
2012-13	5 977	5 985	6 101	5 908	6 303	5 912	6 761	8 201	6 055

(a) Tables show funding provided by the Australian Government, State and Territory governments and local government authorities and by the major non-government sources of funding for health goods and services. They do not show total expenditure on health services by the different service provider sectors.

(b) Constant price health expenditure for 2003-04 to 2012-13 is expressed in terms of 2012-13 prices using a combination of deflators (see table EA.7).

(c) Data exclude expenditure on high level residential aged care.

(d) ACT expenditure includes substantial expenditure for NSW residents which may inflate expenditure per person data.

np Not published.

Source: AIHW online health expenditure data cubes.

TABLE EA.7

Table EA.7 **Total health price index and industry-wide indexes (reference year 2012-13 = 100)**

	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
Total health price index (a)	79.1	81.9	85.4	88.3	90.4	93.0	95.2	96.2	97.8	100.0
Government final consumption expenditure on hospitals and nursing homes	76.0	78.0	81.6	84.8	87.4	90.2	93.6	94.9	97.2	100.0
Medicare medical services fees charged (b)	75.5	81.4	85.9	88.6	89.4	92.9	94.7	96.1	97.7	100.0
Dental services (a)	75.7	80.5	83.8	88.5	92.0	95.2	97.6	98.5	98.5	100.0
Other health practitioners (a)	75.7	77.9	81.6	83.3	83.2	86.7	88.9	91.8	96.8	100.0
Professional health workers wage rates	71.5	74.2	77.5	81.0	84.0	87.2	90.7	94.0	96.7	100.0
PBS pharmaceuticals (a)	99.6	99.7	99.7	99.7	99.7	100.0	100.1	100.1	100.1	100.0
HFCE on chemist goods	97.1	97.8	98.9	101.8	102.2	100.6	101.7	99.7	98.6	100.0
Aids and appliances (a)	104.5	107.2	110.1	112.4	115.5	113.6	108.1	102.1	100.1	100.0
Australian Government gross fixed capital formation	87.4	87.8	98.2	96.6	102.9	106.4	103.5	101.5	100.4	100.0
State, territory and local government gross fixed capital formation	76.4	78.9	88.3	89.4	97.5	101.4	98.8	99.6	100.4	100.0
Private gross fixed capital formation	89.2	91.2	92.8	95.3	97.0	99.0	98.8	99.6	99.2	100.0
Gross domestic product	73.0	75.7	79.5	83.5	87.3	91.6	92.5	98.2	100.1	100.0

(a) Implicit Price Deflator, constructed by AIHW

(b) Chain price index, constructed by the AIHW

Source: AIHW 2014, *Health Expenditure Australia 2012-13*, Health and Welfare Expenditure Series no. 52, Cat. no. HWE 61, Canberra.

TABLE EA.8

Table EA.8 **Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status (a), (b), (c), (d), (e), (f)**

	<i>unit</i>	<i>NSW</i>	<i>Vic (g)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas(h)</i>	<i>ACT(h)</i>	<i>NT</i>	<i>Aust</i>
2008										
Proportion low birthweight babies born to										
Aboriginal and Torres Strait Islander mothers	%	10.4	13.1	8.9	14.0	12.4	9.2	10.0	13.7	11.2
Non-Indigenous mothers	%	4.3	4.5	4.4	4.3	4.6	5.0	3.7	4.1	4.4
Total (i)	%	4.5	4.6	4.6	4.9	4.8	5.2	3.8	7.6	4.7
Number of low birthweight babies born to										
Aboriginal and Torres Strait Islander mothers	no.	314	85	294	233	75	26	7	184	1 218
Non-Indigenous mothers	no.	3 947	3 067	2 445	1 213	849	298	166	98	12 083
Total (i)	no.	4 280	3 155	2 742	1 446	924	324	174	282	13 327
Variability bands for rate										
Aboriginal and Torres Strait Islander mothers	no.	1.1	2.6	1.0	1.7	2.6	3.4	7.0	1.8	0.6
Non-Indigenous mothers	no.	0.1	0.2	0.2	0.2	0.3	0.6	0.5	0.8	0.1
Total (i)	no.	0.1	0.2	0.2	0.2	0.3	0.6	0.5	0.8	0.1
2009										
Proportion low birthweight babies born to										
Aboriginal and Torres Strait Islander mothers	%	10.0	12.2	9.8	13.0	10.4	8.3	13.9	12.5	10.9
Non-Indigenous mothers	%	4.2	4.6	4.7	4.3	5.0	5.0	3.7	5.0	4.5
Total (i)	%	4.4	4.7	4.9	4.8	5.1	5.1	3.8	7.7	4.7
Number of low birthweight babies born to										
Aboriginal and Torres Strait Islander mothers	no.	294	91	320	223	63	23	11	174	1 199
Non-Indigenous mothers	no.	3 813	3 076	2 637	1 221	921	290	172	117	12 247
Total (i)	no.	4 124	3 231	2 961	1 444	984	313	184	291	13 532
Variability bands for rate										
Aboriginal and Torres Strait Islander mothers	no.	1.1	2.4	1.0	1.6	2.4	3.3	7.6	1.7	0.6
Non-Indigenous mothers	no.	0.1	0.2	0.2	0.2	0.3	0.6	0.5	0.9	0.1
Total (i)	no.	0.1	0.2	0.2	0.2	0.3	0.6	0.5	0.9	0.1
2010										
Proportion low birthweight babies born to										
Aboriginal and Torres Strait Islander mothers	%	10.0	10.0	10.1	12.3	12.7	6.6	12.7	12.4	10.7
Non-Indigenous mothers	%	4.2	4.8	4.6	4.3	4.8	5.5	4.3	4.4	4.5
Total (i)	%	4.4	4.8	4.9	4.7	5.0	5.5	4.4	7.3	4.8
Number of low birthweight babies born to										
Aboriginal and Torres Strait Islander mothers	no.	312	78	344	204	81	15	8	163	1 205
Non-Indigenous mothers	no.	3 841	3 255	2 585	1 227	881	309	205	104	12 407
Total (i)	no.	4 172	3 359	2 929	1 431	962	326	213	271	13 663

TABLE EA.8

Table EA.8 **Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status (a), (b), (c), (d), (e), (f)**

	<i>unit</i>	<i>NSW</i>	<i>Vic (g)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas(h)</i>	<i>ACT(h)</i>	<i>NT</i>	<i>Aust</i>
Variability bands for rate										
Aboriginal and Torres Strait Islander mothers	no.	1.0	2.1	1.0	1.6	2.6	3.2	8.2	1.8	0.6
Non-Indigenous mothers	no.	0.1	0.2	0.2	0.2	0.3	0.6	0.6	0.8	0.1
Total (i)	no.	0.1	0.2	0.2	0.2	0.3	0.6	0.6	0.8	0.1
2011										
Proportion low birthweight babies born to										
Aboriginal and Torres Strait Islander mothers	%	10.7	10.9	10.0	11.9	11.5	10.8	13.5	14.5	11.2
Non-Indigenous mothers	%	4.4	4.7	4.4	4.3	5.2	5.8	4.6	4.8	4.6
Total (i)	%	4.6	4.8	4.7	4.7	5.5	6.0	4.8	8.2	4.8
Number of low birthweight babies born to										
Aboriginal and Torres Strait Islander mothers	no.	322	89	354	198	78	31	10	193	1 275
Non-Indigenous mothers	no.	4 038	3 212	2 492	1 266	989	328	216	116	12 657
Total (i)	no.	4 379	3 322	2 849	1 464	1 067	368	227	309	13 985
Variability bands for rate										
Aboriginal and Torres Strait Islander mothers	no.	1.1	2.1	1.0	1.6	2.4	3.6	7.8	1.9	0.6
Non-Indigenous mothers	no.	0.1	0.2	0.2	0.2	0.3	0.6	0.6	0.8	0.1
Total (i)	no.	0.1	0.2	0.2	0.2	0.3	0.6	0.6	0.9	0.1
2012										
Proportion low birthweight babies born to										
Aboriginal and Torres Strait Islander mothers	%	9.4	9.3	9.6	13.2	11.9	9.2	6.7	12.9	10.5
Non-Indigenous mothers	%	4.4	4.5	4.6	4.3	5.2	5.6	4.4	4.2	4.5
Total (i)	%	4.5	4.6	4.9	4.8	5.4	5.7	4.5	7.2	4.8
Number of low birthweight babies born to										
Aboriginal and Torres Strait Islander mothers	no.	316	81	358	211	79	27	6	174	1 252
Non-Indigenous mothers	no.	4 121	3 267	2 685	1 347	998	297	221	108	13 044
Total (i)	no.	4 445	3 372	3 045	1 558	1 077	330	228	282	14 337
Variability bands for rate										
Aboriginal and Torres Strait Islander mothers	no.	1.0	2.0	1.0	1.8	2.6	3.5	5.3	1.9	0.6
Non-Indigenous mothers	no.	0.1	0.2	0.2	0.2	0.3	0.6	0.6	0.8	0.1
Total (i)	no.	0.1	0.2	0.2	0.2	0.3	0.6	0.6	0.8	0.1

(a) Low birthweight is defined as less than 2500 grams.

(b) Data do not include babies born to non-Indigenous mothers and Aboriginal and Torres Strait Islander fathers. Therefore, the number of babies born to Aboriginal and Torres Strait Islander mothers is not necessarily the total number of Aboriginal and Torres Strait Islander babies born.

(c) Allocation to State/Territory is by place of usual residence of the mother.

Table EA.8 Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status (a), (b), (c), (d), (e), (f)

	<i>unit</i>	<i>NSW</i>	<i>Vic (g)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas(h)</i>	<i>ACT(h)</i>	<i>NT</i>	<i>Aust</i>
(d)	Data excludes Australian non-residents, residents of external territories and where State/Territory of residence was not stated.									
(e)	Data relate to live births. Excludes stillbirths and multiple births. Births were included if they were at least 20 weeks gestation or at least 400 grams birthweight.									
(f)	Data quality information for some data in this table can be found at www.pc.gov.au/rogs/2015 .									
(g)	Data for Victoria are provisional and subject to vary with data quality activities. Further minor changes to the data are not foreseen to produce any detectable change to the indicator.									
(h)	Birthweight data on babies born to Aboriginal and Torres Strait Islander mothers residing in the ACT and Tasmania should be viewed with caution as they are based on small numbers of births.									
(i)	Includes births to mothers whose Aboriginal and Torres Strait Islander status was not stated.									
<i>Source:</i> AIHW unpublished, National Perinatal Data Collection.										

TABLE EA.9

Table EA.9 **Birthweights, live births, all mothers, 2012 (a), (b)**

	Unit	NSW	Vic (c)	Qld	WA	SA	Tas	ACT (d)	NT	Aust
Mean birthweight	grams	3 369	3 369	3 380	3 352	3 338	3 382	3 352	3 303	3 367
Number of babies by birthweight										
Less than 1000g	no.	370	336	290	122	95	29	34	23	1 299
1000–1499g	no.	486	437	396	185	141	47	51	29	1 772
1500–1999g	no.	1 120	967	855	390	317	69	92	64	3 874
2000–2499g	no.	3 668	2 993	2 610	1 344	927	276	266	214	12 298
2500–2999g	no.	15 309	11 971	9 168	5 324	3 176	827	860	710	47 345
3000–3499g	no.	36 580	28 032	22 172	12 597	7 499	1 995	2 211	1 442	112 528
3500–3999g	no.	30 139	23 726	19 926	10 241	6 151	1 891	1 766	1 095	94 935
4000–4499g	no.	9 565	7 851	6 561	2 957	1 908	630	604	357	30 433
4500g and over	no.	1 615	1 287	1 266	465	314	131	110	69	5 257
Not stated	no.	20	94	6	–	–	–	–	–	120
All births	no.	98 872	77 694	63 250	33 625	20 528	5 895	5 994	4 003	309 861
<i>Less than 1500g</i>	<i>no.</i>	<i>856</i>	<i>773</i>	<i>686</i>	<i>307</i>	<i>236</i>	<i>76</i>	<i>85</i>	<i>52</i>	<i>3 071</i>
<i>Less than 2500g</i>	<i>no.</i>	<i>5 644</i>	<i>4 733</i>	<i>4 151</i>	<i>2 041</i>	<i>1 480</i>	<i>421</i>	<i>443</i>	<i>330</i>	<i>19 243</i>
Proportion of babies by birthweight										
Less than 1000g	%	0.4	0.4	0.5	0.4	0.5	0.5	0.6	0.6	0.4
1000–1499g	%	0.5	0.6	0.6	0.6	0.7	0.8	0.9	0.7	0.6
1500–1999g	%	1.1	1.2	1.4	1.2	1.5	1.2	1.5	1.6	1.3
2000–2499g	%	3.7	3.9	4.1	4.0	4.5	4.7	4.4	5.3	4.0
2500–2999g	%	15.5	15.4	14.5	15.8	15.5	14.0	14.3	17.7	15.3
3000–3499g	%	37.0	36.1	35.1	37.5	36.5	33.8	36.9	36.0	36.3
3500–3999g	%	30.5	30.5	31.5	30.5	30.0	32.1	29.5	27.4	30.6
4000–4499g	%	9.7	10.1	10.4	8.8	9.3	10.7	10.1	8.9	9.8
4500g and over	%	1.6	1.7	2.0	1.4	1.5	2.2	1.8	1.7	1.7
Not stated	%	–	0.1	–	–	–	–	–	–	–
All births	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>Less than 1500g (c)</i>	<i>%</i>	<i>0.9</i>	<i>1.0</i>	<i>1.1</i>	<i>0.9</i>	<i>1.1</i>	<i>1.3</i>	<i>1.4</i>	<i>1.3</i>	<i>1.0</i>
<i>Less than 2500g (c)</i>	<i>%</i>	<i>5.7</i>	<i>6.1</i>	<i>6.6</i>	<i>6.1</i>	<i>7.2</i>	<i>7.1</i>	<i>7.4</i>	<i>8.2</i>	<i>6.2</i>

(a) This table cannot be compared with birthweight for all births in previous reports.

(b) Allocation to State/Territory is by birthplace of the baby.

(c) Data for Victoria are provisional data.

(d) Non-ACT residents made up 14.2 per cent of women who gave birth in the ACT in 2012. Care must be taken when interpreting percentages for the ACT. For example, the proportion of live births of ACT residents who gave birth in the ACT where the birthweight was less than 1500 grams was 1.1 per cent, and where the birthweight was less than 2500 grams the proportion was 5.9 per cent.

– Nil or rounded to zero.

Source: Hilder L., Zhichao Z., Parker M., Jahan S. and Chambers G.M., 2014, *Australia's mothers and babies 2012*, Perinatal statistics series no. 30, Cat. no. PER 69, Sydney: AIHW National Perinatal Epidemiology and Statistics Unit.

Table EA.10 **Birthweights, live births, Aboriginal and Torres Strait Islander mothers, 2012 (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT</i>	<i>Aust</i>
Mean birthweight	grams	3 245	3 298	3 233	3 128	3 131	3 313	3 133	3 128	3 211
Number of babies by birthweight										
Less than 1500g	no.	56	10	76	43	26	n.p.	<5	36	257
1500–2499g	no.	297	81	351	193	72	n.p.	n.p.	158	1 193
2500–2999g	no.	674	168	765	362	139	45	27	357	2 537
3000–3499g	no.	1 134	322	1 307	562	225	103	39	469	4 161
3500–3999g	no.	858	267	986	352	141	86	30	301	3 021
4000–4499g	no.	282	91	308	96	53	29	7	82	948
4500g and over	no.	66	12	65	21	7	5	–	21	197
Not stated	no.	–	–	–	–	–	–	–	–	–
All births	no.	3 367	951	3 858	1 629	663	301	121	1 424	12 314
<i>Less than 2500g</i>	<i>no.</i>	<i>353</i>	<i>91</i>	<i>427</i>	<i>236</i>	<i>98</i>	<i>33</i>	<i>18</i>	<i>194</i>	<i>1 450</i>
Proportion of babies by birthweight										
Less than 1500g	%	1.7	1.1	2.0	2.6	3.9	n.p.	n.p.	2.5	2.1
1500–2499g	%	8.8	8.5	9.1	11.8	10.9	n.p.	n.p.	11.1	9.7
2500–2999g	%	20.0	17.7	19.8	22.2	21.0	15.0	22.3	25.1	20.6
3000–3499g	%	33.7	33.9	33.9	34.5	33.9	34.2	32.2	32.9	33.8
3500–3999g	%	25.5	28.1	25.6	21.6	21.3	28.6	24.8	21.1	24.5
4000–4499g	%	8.4	9.6	8.0	5.9	8.0	9.6	5.8	5.8	7.7
4500g and over	%	2.0	1.3	1.7	1.3	1.1	1.7	–	1.5	1.6
Not stated	%	–	–	–	–	–	–	–	–	–
All births	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>Less than 2500g (c)</i>	<i>%</i>	<i>10.5</i>	<i>9.6</i>	<i>11.1</i>	<i>14.5</i>	<i>14.8</i>	<i>11.0</i>	<i>14.9</i>	<i>13.6</i>	<i>11.8</i>

(a) This table cannot be compared with birthweight for all births to Aboriginal and Torres Strait Islander women in previous reports.

(b) Allocation to State/Territory is by birthplace of the baby.

(c) Data for Victoria are provisional data.

(d) Of Aboriginal and Torres Strait Islander women who gave birth in the ACT in 2012, 24.2 per cent were non-ACT residents. Care must be taken when interpreting percentages for the ACT. For example, the proportion of liveborn babies born in the ACT in 2012 to Aboriginal and Torres Strait Islander women resident in the ACT where the birthweight was less than 2500 grams was 6.5 per cent.

– Nil or rounded to zero. **np** Not published.

Source: Hilder L., Zhichao Z., Parker M., Jahan S. and Chambers G.M., 2014, *Australia's mothers and babies 2012*, Perinatal statistics series no. 30, Cat. no. PER 69, Sydney: AIHW National Perinatal Epidemiology and Statistics Unit.

Table EA.11 Proportion of live-born singleton babies of low birthweight, by remoteness and SEIFA quintiles, and SEIFA deciles, National, 2012 (a), (b), (c), (d)

	<i>Aust %</i>	<i>Variability band +</i>	<i>Aust no.</i>
Remoteness of residence (e)			
Major cities	4.6	0.1	9 726
Inner regional	5.0	0.2	2 550
Outer regional	5.2	0.3	1 262
Remote	6.3	0.8	258
Very remote	7.7	1.0	222
SEIFA of residence (f)			
Decile 1	6.3	0.3	2 148
Decile 2	5.5	0.3	1 536
Decile 3	5.4	0.3	1 553
Decile 4	5.0	0.3	1 429
Decile 5	4.8	0.3	1 374
Decile 6	4.4	0.2	1 303
Decile 7	4.1	0.2	1 210
Decile 8	4.4	0.2	1 289
Decile 9	4.0	0.2	1 218
Decile 10	3.8	0.2	957
Total (g)	4.8	0.1	14 337

- (a) Low birthweight is defined as less than 2500 grams.
- (b) Excludes multiple births, stillbirths and births with unknown birthweight. Births were included if they were at least 20 weeks gestation or, if gestation was not known, at least 400 grams birthweight.
- (c) Data excludes Australian non-residents, residents of external territories and where State/Territory of residence was not stated.
- (d) Data quality information for some data in this table can be found at www.pc.gov.au/rogs/2015.
- (e) Disaggregation by remoteness area is by place of usual residence of the mother, not by place of birth.
- (f) SEIFA (Socio-Economic Indexes for Areas) deciles are based on the ABS (Australian Bureau of Statistics) IRSD (Index of Relative Socio-economic Disadvantage), with decile 1 being the most disadvantaged and decile 10 being the least disadvantaged. Disaggregation by SEIFA is based on the place of usual residence of the mother, not the place of birth.
- (g) Total includes number of babies for which remoteness areas and/or SEIFA categories for the mothers could not be assigned.

Source: AIHW (unpublished) National Perinatal Data Collection.

TABLE EA.12

Table EA.12 **Proportion of adults and children in BMI categories (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT(g), (h)</i>	<i>Aust</i>
Adults										
2007-08										
Underweight	%	1.8	1.5	3.1	1.4	2.3	2.1	1.1	–	2.0
Conf. Inter.	±	0.7	0.6	1.4	0.6	0.9	1.2	0.7	–	0.4
Normal weight	%	37.6	37.5	35.7	35.6	36.9	35.2	39.8	36.8	36.9
Conf. Inter.	±	2.4	2.6	2.5	3.2	2.5	3.3	3.0	19.4	1.2
Overweight	%	37.1	36.5	36.1	37.4	37.1	36.2	34.2	30.4	36.7
Conf. Inter.	±	2.4	2.3	2.5	3.0	2.6	3.1	2.8	11.2	1.2
Obese	%	23.4	24.5	25.0	25.6	23.7	26.5	24.8	32.8	24.4
Conf. Inter.	±	2.2	2.4	2.4	3.2	2.2	3.2	2.5	17.9	1.1
2011-12 (h)										
Underweight	%	1.9	1.5	1.8	1.3	1.3	1.0	0.6	2.3	1.6
Conf. Inter.	±	0.5	0.6	0.5	0.5	0.5	0.6	0.4	1.1	0.2
Normal weight	%	36.9	37.5	33.6	33.1	33.1	35.7	36.4	34.9	35.7
Conf. Inter.	±	1.6	1.8	2.0	1.8	1.8	2.1	2.8	3.0	0.9
Overweight	%	35.0	35.5	34.7	37.3	36.5	36.0	37.8	34.9	35.5
Conf. Inter.	±	1.5	1.8	1.7	1.9	1.8	1.9	2.2	3.4	0.7
Obese	%	26.2	25.6	30.0	28.2	29.2	27.2	25.2	27.9	27.2
Conf. Inter.	±	1.6	1.8	1.6	2.0	1.8	2.3	2.2	2.7	0.8
Children										
2007-08										
Underweight	%	7.8	6.3	10.2	6.9	6.2	4.1	3.3	np	7.5
Conf. Inter.	±	2.6	2.8	3.5	3.3	3.3	3.5	1.8	np	1.4
Normal weight	%	68.8	68.5	62.9	68.1	68.1	77.2	75.8	88.4	67.7
Conf. Inter.	±	4.7	5.1	6.4	6.1	8.2	7.1	5.1	52.1	2.9
Overweight	%	15.0	18.9	18.0	19.6	18.4	12.1	np	np	17.2
Conf. Inter.	±	3.7	4.4	5.3	5.4	6.4	5.4	np	np	2.1
Obese	%	8.5	6.3	8.9	5.4	7.3	6.6	np	np	7.5
Conf. Inter.	±	3.3	2.5	4.0	2.8	4.5	3.9	np	np	1.7
2011-12 (h)										
Underweight	%	4.2	4.6	6.9	5.5	4.4	5.0	4.6	9.9	5.1
Conf. Inter.	±	1.3	1.3	1.9	1.8	1.7	2.1	2.0	4.0	0.6
Normal weight	%	70.6	71.8	67.2	66.8	72.0	69.7	70.0	64.9	69.8
Conf. Inter.	±	3.6	3.2	3.5	3.4	4.2	5.0	4.4	6.1	1.7
Overweight	%	18.5	17.8	17.4	21.1	16.6	16.9	19.5	17.4	18.2
Conf. Inter.	±	2.8	3.1	2.6	2.8	3.5	3.5	4.1	4.5	1.3
Obese	%	6.7	5.8	8.5	6.6	7.0	8.5	5.9	7.8	6.9
Conf. Inter.	±	1.6	1.6	2.0	2.0	2.2	3.1	1.9	3.5	0.9
Relative standard error for adults										
2007-08										
Underweight	%	19.5	21.2	22.5	22.1	20.9	29.0	30.1	–	11.3
Normal weight	%	3.2	3.5	3.6	4.6	3.4	4.8	3.8	26.9	1.7

Table EA.12 **Proportion of adults and children in BMI categories (a), (b), (c), (d), (e), (f)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT(g), (h)	Aust
Overweight	%	3.3	3.3	3.5	4.1	3.6	4.4	4.2	18.9	1.6
Obese	%	4.8	5.0	4.9	6.3	4.8	6.2	5.1	27.8	2.3
2011-12 (h)										
Underweight	%	13.6	20.9	14.3	19.5	19.7	28.3	33.9	24.1	7.7
Normal weight	%	2.2	2.5	3.0	2.8	2.7	3.0	3.9	4.3	1.3
Overweight	%	2.2	2.6	2.5	2.5	2.5	2.7	3.0	5.0	1.0
Obese	%	3.0	3.5	2.7	3.6	3.2	4.3	4.5	4.9	1.6
Relative standard error for children										
2007-08										
Underweight	%	17.0	22.7	17.3	24.2	26.6	43.2	27.1	np	9.5
Normal weight	%	3.5	3.8	5.2	4.6	6.1	4.7	3.4	30.1	2.2
Overweight	%	12.5	11.9	14.9	14.2	17.9	22.7	np	np	6.2
Obese	%	19.7	20.7	22.9	26.0	31.2	29.8	np	np	11.5
2011-12 (h)										
Underweight	%	15.2	13.8	13.8	16.7	19.0	21.2	22.4	20.5	5.8
Normal weight	%	2.6	2.3	2.6	2.6	2.9	3.7	3.2	4.8	1.2
Overweight	%	7.7	8.7	7.5	6.8	10.6	10.6	10.6	13.1	3.6
Obese	%	12.4	14.0	12.1	15.4	16.2	19.0	16.2	22.7	6.4

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution.

- (a) Adults are defined as persons aged 18 years or over. Children are defined as persons aged 5–17 years.
- (b) Body mass index (BMI) categories for adults are defined as: Underweight (BMI less than 18.5); Normal weight (BMI 18.5–24.9); Overweight (BMI 25.0–29.9); Obese (BMI 30.0 or over).
- (c) BMI categories for children are defined as BMI (appropriate for age and sex) that is likely to be equal to the BMI for the same adult category at age 18 years.
- (d) Data are calculated from measured height and weight. Data exclude those for whom measured height and weight were not available. Data are not comparable with data for 2004-05 that are based on self-reported height and weight.
- (e) Rates are age standardised by State and Territory, to the 2001 ERP (5 year ranges from 18 years for adults, selected ranges from 5–17 years for children).
- (f) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.
- (g) Data for the NT should be used with care as very remote areas were excluded from the Australian Health Survey, which translates to exclusion of around 23 per cent of the NT population.
- (h) Data for the NT for 2011-12 are not comparable with data for previous years due to the increase in sample size.

– Nil or rounded to zero. **np** Not published.

Source: Australian Bureau of Statistics (ABS) unpublished, *Australian Health Survey 2011–13* (2011-12 Core component), Cat. no. 4364.0; ABS unpublished, *National Health Survey 2007-08*, Cat. no. 4364.0.

TABLE EA.13

Table EA.13 **Rate of overweight and obesity for adults and children, by remoteness (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT</i>	<i>NT (f), (g), (h)</i>	<i>Aust</i>
Adults										
2007-08										
Major cities	%	58.4	58.7	57.5	59.6	61.6	..	59.1	..	58.8
Conf. Inter.	±	2.7	3.0	3.9	3.8	2.8	..	3.0	..	1.4
Inner regional	%	64.4	66.8	66.4	72.7	51.1	60.8	np	..	66.2
Conf. Inter.	±	5.3	5.6	4.6	8.4	9.2	4.6	np	..	2.3
Outer regional	%	69.2	77.1	60.5	65.1	59.6	66.3	..	53.8	65.0
Conf. Inter.	±	10.0	14.5	8.1	13.4	22.8	6.2	..	17.6	4.5
Remote	%	53.0	np	64.2	73.3	61.7	81.3	..	52.9	64.0
Conf. Inter.	±	55.3	np	27.7	12.7	18.3	48.5	..	38.2	12.2
Very remote	%	na	..	na	na	na	na	..	na	na
Conf. Inter.	±	na	..	na	na	na	na	..	na	na
2011-12 (h)										
Major cities	%	59.4	59.1	62.4	64.2	64.2	..	63.0	..	60.9
Conf. Inter.	±	2.1	2.3	2.0	2.2	2.1	..	2.8	..	1.2
Inner regional	%	68.2	68.9	67.4	70.0	71.0	61.9	–	..	67.8
Conf. Inter.	±	4.1	4.1	3.7	6.1	7.5	2.6	–	..	1.8
Outer regional	%	64.0	59.8	70.8	72.3	69.3	66.3	..	62.3	67.8
Conf. Inter.	±	6.5	14.2	5.1	6.3	8.2	4.0	..	3.7	3.0
Remote	%	np	–	67.3	68.7	65.8	70.9	..	64.4	70.1
Conf. Inter.	±	np	–	35.4	13.2	15.9	24.3	..	6.9	6.1
Very remote	%	na	..	na	na	na	na	..	na	na
Conf. Inter.	±	na	..	na	na	na	na	..	na	na
Children										
2007-08										
Major cities	%	21.5	23.6	24.6	23.0	23.5	..	20.9	..	22.8
Conf. Inter.	±	5.2	5.2	7.3	6.1	8.3	..	4.7	..	3.1
Inner regional	%	27.3	28.5	30.6	24.7	38.3	19.8	np	..	28.7
Conf. Inter.	±	11.5	11.3	11.2	12.4	28.5	9.1	np	..	5.3
Outer regional	%	28.4	np	22.8	24.3	np	16.8	..	np	25.5
Conf. Inter.	±	26.1	np	14.8	19.2	np	9.0	..	np	10.7
Remote	%	np	np	35.4	30.6	np	np	..	np	21.3
Conf. Inter.	±	np	np	67.1	28.5	np	np	..	np	16.7
Very remote	%	na	..	na	na	na	na	..	na	na
Conf. Inter.	±	na	..	na	na	na	na	..	na	na
2011-12 (h)										
Major cities	%	24.2	24.8	25.3	26.9	21.1	..	25.4	..	24.6
Conf. Inter.	±	3.6	3.9	3.9	3.8	3.9	..	4.5	..	1.8
Inner regional	%	27.6	21.5	26.2	27.4	28.6	26.0	–	..	25.6
Conf. Inter.	±	8.7	7.7	6.3	13.8	14.1	5.3	–	..	4.3
Outer regional	%	30.1	12.4	28.0	32.6	32.0	25.3	..	22.6	27.4

Table EA.13 **Rate of overweight and obesity for adults and children, by remoteness (a), (b), (c), (d), (e), (f)**

	Unit	NSW	Vic (f)	Qld	WA	SA	Tas (f)	ACT	NT (f), (g), (h)	Aust
Conf. Inter.	±	16.1	7.5	10.2	11.0	12.6	10.9	..	5.9	4.7
Remote	%	–	–	27.0	31.0	21.1	np	..	33.6	27.6
Conf. Inter.	±	–	–	43.8	42.3	29.5	np	..	10.8	14.7
Very remote	%	na	..	na	na	na	na	..	na	na
Conf. Inter.	±	na	..	na	na	na	na	..	na	na
Relative standard error for adults										
2007-08										
Major cities	%	2.4	2.6	3.4	3.2	2.4	..	2.6	..	1.3
Inner regional	%	4.2	4.3	3.5	5.9	9.2	3.8	np	..	1.8
Outer regional	%	7.4	9.6	6.9	10.5	19.5	4.8	..	16.7	3.6
Remote	%	53.3	np	22.0	8.9	15.1	30.5	..	36.9	9.7
Very remote	%	na	..	na	na	na	na	..	na	na
2011-12 (h)										
Major cities	%	1.8	2.0	1.6	1.7	1.7	..	2.3	..	1.0
Inner regional	%	3.1	3.1	2.8	4.4	5.4	2.1	np	..	1.4
Outer regional	%	5.2	12.1	3.6	4.4	6.1	3.0	..	3.0	2.3
Remote	%	np	np	26.8	9.8	12.3	17.5	..	5.5	4.5
Very remote	%	na	..	na	na	na	na	..	na	na
Relative standard error for children										
2007-08										
Major cities	%	21.5	23.6	24.6	23.0	23.5	..	20.9	..	22.8
Inner regional	%	27.3	28.5	30.6	24.7	38.3	19.8	np	..	28.7
Outer regional	%	28.4	np	22.8	24.3	np	16.8	..	np	25.5
Remote	%	np	np	35.4	30.6	np	np	..	np	21.3
Very remote	%	na	..	na	na	na	na	..	na	na
2011-12 (h)										
Major cities	%	7.7	8.1	7.8	7.1	9.4	..	9.0	..	3.7
Inner regional	%	16.1	18.3	12.4	25.7	25.1	10.5	–	..	8.5
Outer regional	%	27.2	30.9	18.6	17.1	20.1	22.0	..	13.3	8.8
Remote	%	–	–	82.6	69.7	71.4	np	..	16.5	27.2
Very remote	%	na	..	na	na	na	na	..	na	na

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(a) Adults are defined as persons aged 18 years or over. Children are defined as persons aged 5–17 years.

(b) Overweight for adults is defined as BMI equal to 25 but less than 30. Overweight for children is defined as BMI (appropriate for age and sex) that is likely to be equal to 25 but less than 30 at age 18 years. Obesity for adults is defined as BMI equal to or greater than 30. Obesity for children is defined as BMI (appropriate for age and sex) that is likely to be 30 or more at age 18 years.

Table EA.13 Rate of overweight and obesity for adults and children, by remoteness (a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT</i>	<i>NT (f), (g), (h)</i>	<i>Aust</i>
(c)	Data are calculated from measured height and weight. Data exclude those for whom measured height and weight were not available. Data are not comparable with data for 2004-05 that are based on self-reported height and weight.									
(d)	Rates are age standardised by State and Territory, to the 2001 ERP.									
(e)	Data quality information for some data in this table is at www.pc.gov.au/rogs/2015 .									
(f)	There are no very remote areas in Victoria; no major cities in Tasmania; no outer regional or remote areas in the ACT; and no inner regional or major cities in the NT.									
(g)	Data for the NT should be used with care as very remote areas were excluded from the Australian Health Survey, which translates to exclusion of around 23 per cent of the NT population.									
(h)	Data for the NT for 2011-12 are not comparable to data for previous years due to the increase in sample size.									
	.. Not applicable. – Nil or rounded to zero. np Not published.									
	<i>Source:</i> ABS unpublished, <i>Australian Health Survey 2011–13</i> (2011-12 Core component), Cat. no. 4364.0; ABS unpublished, <i>National Health Survey 2007-08</i> , Cat. no. 4364.0.									

Table EA.14 **Rates of overweight and obesity for adults and children, by SEIFA IRSD quintiles (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT(g), (h)</i>	<i>Aust</i>
Adults										
2007-08										
Quintile 1	%	66.0	67.4	63.5	72.7	67.3	69.1	55.3	55.9	65.9
Conf. Inter.	±	6.0	7.3	5.8	5.2	6.0	6.2	7.1	37.4	3.2
Quintile 2	%	59.7	60.5	65.9	63.5	55.1	63.5	65.0	80.1	61.9
Conf. Inter.	±	3.9	6.4	5.9	6.8	6.6	7.7	35.7	38.8	2.7
Quintile 3	%	63.6	63.2	63.9	63.5	64.0	59.5	60.7	40.5	63.3
Conf. Inter.	±	5.7	6.7	6.1	6.0	5.4	9.1	11.2	32.8	2.3
Quintile 4	%	62.6	60.7	53.4	64.3	63.6	59.1	56.7	45.0	60.5
Conf. Inter.	±	6.0	5.0	6.6	7.9	5.6	7.6	5.7	43.7	2.4
Quintile 5	%	54.7	56.7	55.5	53.9	59.5	58.4	59.8	60.4	55.3
Conf. Inter.	±	4.6	5.7	8.5	7.4	7.8	24.2	3.4	8.5	2.7
2011-12 (h)										
Quintile 1	%	63.4	65.6	68.0	71.7	69.3	65.3	61.7	67.2	65.8
Conf. Inter.	±	4.6	4.5	5.4	7.1	5.7	3.9	14.3	7.1	2.8
Quintile 2	%	65.7	66.9	65.1	67.5	67.3	65.7	52.5	66.0	66.2
Conf. Inter.	±	4.1	3.7	4.4	3.7	3.6	4.7	11.8	5.8	1.8
Quintile 3	%	60.9	61.3	64.2	64.4	65.5	61.1	63.6	68.8	62.8
Conf. Inter.	±	3.5	4.9	3.8	4.8	4.4	5.0	8.2	6.2	1.8
Quintile 4	%	58.3	60.5	64.0	67.3	61.4	64.7	65.8	59.5	61.6
Conf. Inter.	±	3.9	4.8	3.3	3.7	5.5	6.4	5.5	7.4	2.3
Quintile 5	%	57.7	52.3	61.9	60.6	60.2	52.2	61.8	55.7	57.5
Conf. Inter.	±	3.4	4.6	4.7	5.4	6.1	11.0	4.0	10.1	2.3
Children										
2007-08										
Quintile 1	%	31.9	41.7	44.1	44.6	35.9	26.3	np	np	36.2
Conf. Inter.	±	5.5	4.6	7.8	6.3	5.1	4.1	34.4	9.3	2.2
Quintile 2	%	23.8	29.5	31.8	37.1	24.3	10.6	np	np	28.3
Conf. Inter.	±	5.1	4.6	5.2	6.2	4.4	4.8	17.6	8.7	2.5
Quintile 3	%	28.8	23.8	22.7	14.9	23.9	np	11.3	np	23.9
Conf. Inter.	±	5.7	5.7	5.9	6.0	6.1	7.5	9.0	10.8	2.8
Quintile 4	%	24.1	19.9	22.4	16.9	19.3	28.0	16.7	np	21.0
Conf. Inter.	±	3.5	4.6	4.5	5.7	6.2	7.1	6.3	9.6	2.0
Quintile 5	%	10.5	21.9	11.5	22.4	24.2	np	25.6	np	17.2
Conf. Inter.	±	4.8	5.6	5.2	5.5	8.5	21.1	5.8	17.1	2.4
2011-12 (h)										
Quintile 1	%	35.4	26.9	28.0	29.7	35.2	29.9	21.2	35.8	31.4
Conf. Inter.	±	7.9	8.8	9.3	11.5	10.3	9.9	27.3	16.8	4.1
Quintile 2	%	32.5	34.0	27.9	35.9	23.5	17.6	44.4	34.3	31.0
Conf. Inter.	±	10.2	7.4	7.5	6.6	7.2	6.9	41.1	7.9	4.4
Quintile 3	%	17.6	20.5	31.1	23.0	22.0	35.7	18.9	22.8	23.3
Conf. Inter.	±	7.4	6.8	7.2	7.8	9.8	13.2	10.0	12.1	2.8

Table EA.14 **Rates of overweight and obesity for adults and children, by SEIFA IRSD quintiles (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT(g), (h)</i>	<i>Aust</i>
Quintile 4	%	22.0	18.3	21.0	28.7	20.2	17.1	26.7	17.0	21.3
Conf. Inter.	±	7.4	7.4	6.9	6.7	7.0	11.1	10.1	8.5	3.1
Quintile 5	%	20.5	21.0	20.4	23.4	14.3	15.7	26.1	16.4	20.7
Conf. Inter.	±	5.5	6.6	7.1	7.2	6.6	16.8	6.0	15.5	2.8
Relative standard error for adults										
2007-08										
Quintile 1	%	4.6	5.5	4.6	3.6	4.5	4.6	6.5	34.1	2.5
Quintile 2	%	3.4	5.4	4.5	5.4	6.1	6.2	28.1	24.7	2.2
Quintile 3	%	4.6	5.4	4.8	4.8	4.3	7.8	9.4	41.3	1.8
Quintile 4	%	4.9	4.2	6.3	6.3	4.5	6.6	5.2	49.6	2.0
Quintile 5	%	4.3	5.1	7.8	7.0	6.7	21.2	2.9	7.1	2.5
2011-12 (h)										
Quintile 1	%	3.7	3.5	4.0	5.1	4.2	3.1	11.8	5.4	2.2
Quintile 2	%	3.2	2.8	3.4	2.8	2.8	3.6	11.5	4.5	1.4
Quintile 3	%	2.9	4.1	3.0	3.8	3.5	4.2	6.5	4.6	1.5
Quintile 4	%	3.4	4.0	2.7	2.8	4.6	5.1	4.3	6.4	1.9
Quintile 5	%	3.0	4.5	3.8	4.6	5.2	10.8	3.3	9.3	2.1
Relative standard error for children										
2007-08										
Quintile 1	%	21.2	21.2	17.8	39.4	37.0	20.8	np	np	10.7
Quintile 2	%	28.9	20.1	20.6	16.0	32.3	46.3	np	np	12.2
Quintile 3	%	23.4	22.2	22.1	30.4	32.0	np	96.0	np	12.6
Quintile 4	%	21.9	29.7	29.3	33.0	36.2	38.8	20.7	np	12.5
Quintile 5	%	36.1	19.4	47.5	22.1	33.0	np	12.0	np	11.8
2011-12 (h)										
Quintile 1	%	11.4	16.7	16.9	19.8	14.9	16.9	65.8	23.9	6.6
Quintile 2	%	15.9	11.1	13.7	9.4	15.6	19.9	47.2	11.8	7.3
Quintile 3	%	21.3	16.9	11.8	17.3	22.7	18.8	27.0	27.2	6.2
Quintile 4	%	17.2	20.6	16.7	11.9	17.6	33.0	19.4	25.3	7.4
Quintile 5	%	13.7	16.0	17.6	15.7	23.5	54.6	11.8	48.2	6.8

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

- (a) Adults are defined as persons aged 18 years or over. Children are defined as persons aged 5–17 years.
- (b) Overweight for adults is defined as BMI equal to 25 but less than 30. Overweight for children is defined as BMI (appropriate for age and sex) that is likely to be equal to 25 but less than 30 at age 18 years. Obesity for adults is defined as BMI equal to or greater than 30. Obesity for children is defined as BMI (appropriate for age and sex) that is likely to be 30 or more at age 18 years.
- (c) Data are calculated from measured height and weight. Data exclude those for whom measured height and weight were not available. Data are not comparable with data for 2004-05 that are based on self-reported height and weight.
- (d) Rates are age standardised by State and Territory, to the 2001 ERP (5 year ranges from 18 for adults, selected ranges from 5–17 for children).

Table EA.14 Rates of overweight and obesity for adults and children, by SEIFA IRSD quintiles (a), (b), (c), (d), (e), (f)

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT(g), (h)</i>	<i>Aust</i>
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(e) A lower SEIFA quintile indicates relatively greater disadvantage and a lack of advantage in general. A higher SEIFA quintile indicates a relative lack of disadvantage and greater advantage in general.

(f) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.

(g) Data for the NT should be used with care as very remote areas were excluded from the Australian Health Survey, which translates to exclusion of around 23 per cent of the NT population.

(h) Data for the NT for 2011-12 are not comparable to previous years due to the increase in sample size.

Source: ABS unpublished, *Australian Health Survey 2011–13* (2011-12 Core component), Cat. no. 4364.0; ABS unpublished, *National Health Survey 2007-08*, Cat. no. 4364.0.

TABLE EA.15

Table EA.15 **Rates of overweight and obesity for adults, by sex and age (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT(f), (g)</i>	<i>Aust</i>
Overweight and obese adults										
Males										
2007-08										
18-24	%	40.5	36.8	42.2	42.2	34.9	41.4	np	np	39.8
25-34	%	69.9	52.3	62.9	64.2	56.7	43.1	54.4	40.3	62.0
35-44	%	68.8	69.7	71.7	77.0	71.5	78.2	72.1	47.9	70.7
45-54	%	74.9	77.9	74.7	83.7	78.7	66.8	76.0	81.5	76.7
55-64	%	72.8	76.2	75.1	72.4	79.3	77.6	np	np	74.9
65-69	%	74.2	82.1	85.1	79.8	78.6	91.8	np	np	79.4
70-74	%	79.0	89.2	75.7	64.2	63.8	78.9	np	np	78.3
75 and over	%	80.4	70.1	77.7	71.4	58.7	65.1	np	np	74.3
Total	%	68.6	66.1	68.5	70.0	65.7	64.1	66.8	73.1	67.8
Total	000	1 332.5	925.4	726.6	417.8	252.2	79.6	61.6	32.9	3 828.6
2011-12 (g)										
18-24	%	41.2	37.8	39.4	46.8	40.8	39.3	51.5	50.4	40.8
25-34	%	62.2	64.4	67.2	67.0	68.6	65.0	57.6	59.6	64.6
35-44	%	75.9	72.1	76.7	78.8	71.4	66.2	75.1	72.6	74.9
45-54	%	76.9	78.4	80.8	77.0	81.4	75.2	84.7	78.6	78.5
55-64	%	74.5	77.8	84.2	78.8	80.8	85.6	74.6	71.8	78.5
65-69	%	75.1	78.0	83.2	76.1	85.4	78.0	72.0	74.3	78.3
70-74	%	82.8	78.8	89.3	90.0	83.0	83.1	77.2	85.8	83.8
75 and over	%	68.2	63.4	77.8	71.0	78.6	78.1	81.3	74.5	70.3
Total	%	68.5	68.0	72.7	72.0	71.6	68.7	70.7	69.3	69.9
Total	000	1 665.6	1 182.2	1 059.1	560.3	386.0	114.3	83.1	35.4	5 086.2
Females										
2007-08										
18-24	%	35.7	36.1	33.2	37.8	26.1	43.8	np	np	34.8
25-34	%	43.2	40.8	49.0	48.1	39.4	52.6	48.5	45.8	44.4
35-44	%	48.4	59.7	57.1	59.8	59.8	58.1	52.0	51.3	55.1
45-54	%	55.1	62.3	56.2	61.2	67.7	70.0	47.8	53.6	58.7
55-64	%	65.0	78.2	63.8	64.9	64.3	69.0	np	np	67.9
65-69	%	65.8	67.4	84.9	65.9	87.0	81.2	np	np	71.9
70-74	%	77.3	67.2	67.7	59.9	72.5	72.7	np	np	70.6
75 and over	%	60.7	50.2	53.5	58.1	61.1	68.5	np	np	56.9
Total	%	52.1	55.8	54.5	55.9	55.5	61.5	51.3	39.4	54.3
Total	000	982.2	762.7	626.9	328.7	206.1	79.5	46.1	22.2	3 054.3
2011-12 (g)										
18-24	%	31.6	21.6	36.4	38.9	41.7	42.8	29.1	37.2	31.8
25-34	%	37.3	43.8	44.7	52.0	49.8	51.8	47.7	45.5	43.2
35-44	%	51.7	53.4	57.3	59.2	58.4	57.1	52.0	55.0	54.7
45-54	%	64.5	62.7	61.8	63.6	69.7	59.5	58.9	69.6	63.6
55-64	%	70.4	68.6	70.4	63.2	69.4	72.2	68.8	66.0	69.1

Table EA.15 **Rates of overweight and obesity for adults, by sex and age (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT(f), (g)</i>	<i>Aust</i>
65–69	%	63.3	65.8	67.0	66.1	68.5	73.0	61.8	78.4	65.7
70–74	%	75.6	73.5	70.3	75.4	74.9	74.2	86.5	57.4	74.0
75 and over	%	61.3	69.9	68.3	70.7	62.7	58.2	69.9	np	65.7
Total	%	53.3	53.8	56.5	58.6	59.6	58.1	54.9	56.0	55.2
Total	000	1 259.0	929.8	812.9	426.5	317.8	97.8	62.2	27.1	3 933.3
All adults										
2007-08										
18–24	%	38.1	36.5	37.4	40.1	31.0	42.6	np	np	37.3
25–34	%	57.6	46.9	56.1	56.5	48.1	48.0	51.7	43.8	53.6
35–44	%	58.4	64.9	64.2	68.3	65.9	67.4	61.7	50.1	62.9
45–54	%	65.3	70.4	65.1	72.9	73.5	68.4	61.6	65.4	67.9
55–64	%	70.0	75.0	85.0	72.5	83.5	86.8	np	np	75.7
65–69	%	69.1	77.2	69.3	68.7	72.4	73.2	71.8	88.8	71.5
70–74	%	78.2	77.6	71.4	61.9	68.1	76.1	np	np	74.3
75 and over	%	69.6	59.6	63.3	64.1	60.0	67.0	np	np	64.8
Total	%	60.6	61.0	61.2	62.9	60.9	62.8	59.0	63.2	61.1
Total	000	2 314.8	1 688.0	1 353.5	746.5	458.2	159.1	107.7	55.1	6 882.9
2011-12 (g)										
18–24	%	36.4	30.1	38.0	42.9	41.2	41.0	40.9	44.4	36.4
25–34	%	50.4	54.7	56.5	60.2	59.7	58.2	53.1	52.3	54.5
35–44	%	64.1	62.7	67.1	69.3	65.1	61.7	63.9	64.0	64.9
45–54	%	70.9	70.5	71.2	70.5	75.6	67.2	71.9	74.3	71.1
55–64	%	72.5	73.1	77.2	71.4	75.4	79.1	71.5	69.0	73.9
65–69	%	69.3	72.1	75.3	71.2	76.5	75.5	67.0	76.2	72.1
70–74	%	79.1	76.2	79.4	82.7	78.5	78.9	81.8	74.6	78.8
75 and over	%	64.5	66.9	72.9	70.8	69.9	66.5	75.2	62.9	67.8
Total adults	%	61.1	61.0	64.7	65.6	65.7	63.3	63.0	62.9	62.7
Total adults	000	2 924.7	2 112.0	1 872.1	986.8	703.8	212.2	145.3	62.5	9 019.4
Relative standard errors										
Males										
2007-08										
18–24	%	15.1	16.4	14.7	15.2	24.1	19.0	np	np	6.1
25–34	%	4.9	9.0	7.4	7.1	8.4	17.1	7.6	58.6	3.6
35–44	%	5.6	5.5	6.7	4.7	6.4	7.6	5.6	70.0	2.7
45–54	%	5.2	5.1	5.4	4.4	5.0	8.1	5.5	30.2	2.2
55–64	%	5.6	7.8	5.7	6.8	5.4	5.9	np	np	3.0
65–69	%	7.8	9.0	7.0	9.3	9.4	4.8	np	np	3.9
70–74	%	6.5	6.6	9.5	19.5	16.2	13.3	np	np	3.9
75 and over	%	6.0	8.3	8.5	8.8	13.0	8.5	np	np	3.5
Total	%	2.5	2.6	3.0	2.7	2.8	3.8	2.8	23.8	1.3
2011-12 (g)										
18–24	%	10.8	10.9	11.8	8.7	14.8	14.0	9.6	14.2	4.6

TABLE EA.15

Table EA.15 Rates of overweight and obesity for adults, by sex and age (a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT(f), (g)</i>	<i>Aust</i>
25-34	%	5.1	4.2	3.7	5.2	5.1	6.4	6.4	8.4	2.1
35-44	%	3.1	3.7	3.4	3.7	4.7	5.4	4.9	5.3	1.7
45-54	%	3.3	3.4	3.7	3.5	3.6	4.7	4.2	5.4	1.6
55-64	%	4.3	4.1	2.9	3.4	3.7	3.3	5.8	7.2	1.8
65-69	%	6.1	4.9	3.8	6.0	4.7	5.3	11.3	10.9	2.5
70-74	%	4.9	6.3	3.3	4.5	6.1	7.2	9.2	9.6	2.3
75 and over	%	5.4	8.5	5.5	6.3	4.9	5.8	8.9	15.1	2.9
Total	%	1.7	1.9	1.5	1.6	1.7	2.3	2.6	3.3	0.9
Females										
2007-08										
18-24	%	18.1	18.2	16.2	19.6	25.9	23.4	np	np	7.0
25-34	%	7.9	9.8	9.3	10.1	11.0	11.4	9.8	30.9	4.1
35-44	%	7.0	6.6	7.0	7.9	9.2	11.3	8.4	49.2	2.9
45-54	%	7.3	8.1	8.7	10.2	8.5	8.0	11.0	37.5	3.7
55-64	%	6.8	5.0	6.7	8.9	7.9	8.8	np	np	3.2
65-69	%	8.9	12.5	6.2	11.7	5.2	11.6	np	np	3.7
70-74	%	6.5	12.0	10.5	16.2	10.3	10.2	np	np	4.7
75 and over	%	10.1	13.4	11.7	13.3	9.4	8.6	np	np	5.0
Total females	%	3.2	3.4	2.9	4.4	3.7	4.1	4.4	20.4	1.5
2011-12 (g)										
18-24	%	10.6	20.5	11.9	11.0	13.4	13.2	22.0	17.7	5.7
25-34	%	7.6	8.3	7.8	5.9	8.2	8.1	6.9	7.9	3.5
35-44	%	5.4	5.6	5.0	5.2	5.7	6.1	9.0	8.8	2.6
45-54	%	3.9	5.1	5.1	5.6	5.9	6.2	7.5	6.9	2.2
55-64	%	4.2	5.4	4.1	4.6	5.2	4.9	5.3	7.1	2.3
65-69	%	7.2	7.3	6.6	8.1	6.7	6.9	9.5	7.3	3.6
70-74	%	6.0	8.0	8.1	6.6	5.6	7.5	7.2	21.9	3.4
75 and over	%	6.6	4.5	5.6	6.1	6.9	8.3	8.8	np	2.9
Total	%	2.3	2.7	2.6	2.7	2.6	2.8	3.5	4.4	1.2
All adults										
2007-08										
18-24	%	10.1	12.1	11.8	11.6	17.1	13.9	np	np	4.3
25-34	%	4.5	6.5	6.2	5.9	7.2	9.9	6.1	30.3	3.0
35-44	%	4.3	4.7	4.5	4.4	5.0	6.9	4.4	40.6	1.8
45-54	%	4.2	4.8	5.2	5.5	4.6	5.9	5.9	29.7	2.2
55-64	%	4.3	4.4	4.6	4.9	4.4	4.8	4.9	11.3	2.1
65-69	%	5.9	7.4	4.4	6.8	5.0	5.7	np	np	2.6
70-74	%	4.9	7.8	6.8	12.6	9.6	8.2	np	np	3.5
75 and over	%	5.8	8.0	6.6	8.0	8.5	5.9	np	np	2.9
Total	%	2.0	2.2	2.2	2.6	2.0	2.7	2.6	17.2	1.0
2011-12 (g)										
18-24	%	7.4	11.3	7.5	7.6	9.1	8.8	8.9	10.8	3.4

Table EA.15 Rates of overweight and obesity for adults, by sex and age (a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT(f), (g)</i>	<i>Aust</i>
25-34	%	4.5	3.9	3.8	3.6	4.4	4.8	4.9	6.1	2.0
35-44	%	3.1	3.0	3.1	3.3	3.5	3.3	4.9	4.7	1.5
45-54	%	2.4	3.2	3.2	2.6	3.3	3.9	4.4	4.2	1.3
55-64	%	3.0	3.6	2.7	2.7	3.1	3.0	4.0	5.0	1.5
65-69	%	4.3	4.5	3.7	4.2	4.0	4.2	7.2	6.5	2.1
70-74	%	4.1	4.5	3.4	4.2	4.7	4.8	6.1	10.0	1.9
75 and over	%	4.0	4.3	4.0	3.9	4.4	4.7	6.3	14.3	2.0
Total	%	1.5	1.6	1.5	1.4	1.3	1.6	2.3	2.7	0.8

95 per cent confidence intervals

Males

2007-08

18-24	±	11.9	11.8	12.2	12.6	16.5	15.4	np	np	4.8
25-34	±	6.8	9.2	9.1	8.9	9.4	14.5	8.1	46.3	4.3
35-44	±	7.6	7.5	9.4	7.1	8.9	11.7	8.0	65.7	3.7
45-54	±	7.6	7.8	7.9	7.2	7.7	10.6	8.2	48.2	3.2
55-64	±	8.0	11.7	8.3	9.6	8.4	9.0	np	np	4.4
65-69	±	11.3	14.5	11.7	14.6	14.5	8.7	np	np	6.1
70-74	±	10.0	11.6	14.1	24.5	20.3	20.5	np	np	6.0
75 and over	±	9.4	11.3	13.0	12.3	14.9	10.8	np	np	5.2
Total	±	3.3	3.4	4.0	3.8	3.6	4.8	3.7	34.0	1.7

2011-12 (g)

18-24	±	8.7	8.1	9.1	8.0	11.8	10.8	9.7	14.0	3.7
25-34	±	6.2	5.3	4.9	6.8	6.9	8.2	7.2	9.8	2.7
35-44	±	4.6	5.2	5.1	5.8	6.6	7.0	7.2	7.5	2.6
45-54	±	5.0	5.2	5.9	5.3	5.8	6.9	6.9	8.3	2.4
55-64	±	6.3	6.3	4.7	5.3	5.9	5.6	8.5	10.1	2.7
65-69	±	9.0	7.4	6.3	9.0	7.9	8.1	16.0	15.9	3.9
70-74	±	7.9	9.7	5.8	8.0	10.0	11.7	14.0	16.1	3.8
75 and over	±	7.2	10.6	8.4	8.8	7.5	8.8	14.1	22.0	3.9
Total	±	2.2	2.5	2.2	2.3	2.4	3.1	3.6	4.5	1.2

Females

2007-08

18-24	±	12.6	12.9	10.6	14.5	13.3	20.1	np	np	4.8
25-34	±	6.7	7.8	9.0	9.6	8.5	11.7	9.3	27.8	3.5
35-44	±	6.7	7.8	7.8	9.2	10.7	12.8	8.5	49.4	3.1
45-54	±	7.9	9.9	9.6	12.3	11.3	11.0	10.3	39.3	4.3
55-64	±	8.7	7.6	8.3	11.3	10.0	11.9	np	np	4.2
65-69	±	11.5	16.5	10.2	15.1	9.0	18.5	np	np	5.2
70-74	±	9.9	15.8	13.9	19.0	14.7	14.5	np	np	6.6
75 and over	±	12.0	13.2	12.2	15.1	11.2	11.5	np	np	5.6
Total	±	3.3	3.7	3.1	4.8	4.0	5.0	4.4	15.7	1.6

2011-12 (g)

Table EA.15 **Rates of overweight and obesity for adults, by sex and age (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT(f), (g)</i>	<i>Aust</i>
18–24	±	6.5	8.7	8.5	8.4	10.9	11.1	12.5	12.9	3.5
25–34	±	5.6	7.1	6.9	6.0	8.0	8.2	6.5	7.1	2.9
35–44	±	5.4	5.9	5.7	6.0	6.5	6.8	9.2	9.5	2.8
45–54	±	4.9	6.2	6.2	7.0	8.1	7.3	8.6	9.4	2.7
55–64	±	5.7	7.3	5.7	5.7	7.1	7.0	7.2	9.2	3.1
65–69	±	9.0	9.5	8.6	10.5	9.0	9.9	11.5	11.2	4.6
70–74	±	8.9	11.5	11.1	9.7	8.2	10.9	12.2	24.6	4.9
75 and over	±	7.9	6.2	7.5	8.5	8.4	9.4	12.1	np	3.8
Total	±	2.4	2.8	2.9	3.1	3.0	3.2	3.8	4.8	1.3
All adults										
2007-08										
18–24	±	7.6	8.6	8.7	9.1	10.4	11.6	np	np	3.2
25–34	±	5.1	6.0	6.8	6.5	6.8	9.4	6.2	26.0	3.1
35–44	±	5.0	6.0	5.7	5.8	6.5	9.1	5.4	39.8	2.2
45–54	±	5.4	6.6	6.7	7.8	6.7	7.9	7.1	38.1	3.0
55–64	±	5.8	6.7	6.3	6.6	6.2	6.8	6.9	19.6	2.9
65–69	±	8.1	10.9	7.4	9.7	8.1	9.8	np	np	3.8
70–74	±	7.5	11.8	9.5	15.3	12.8	12.3	np	np	5.0
75 and over	±	7.9	9.3	8.2	10.1	10.0	7.8	np	np	3.7
Total	±	2.3	2.6	2.6	3.2	2.4	3.3	3.0	21.4	1.2
2011-12 (g)										
18–24	±	5.3	6.7	5.6	6.4	7.4	7.1	7.2	9.4	2.5
25–34	±	4.4	4.1	4.2	4.3	5.2	5.4	5.1	6.3	2.1
35–44	±	3.9	3.6	4.1	4.5	4.5	4.0	6.1	5.9	2.0
45–54	±	3.4	4.4	4.4	3.6	4.9	5.1	6.2	6.0	1.9
55–64	±	4.3	5.1	4.1	3.8	4.6	4.6	5.6	6.7	2.2
65–69	±	5.9	6.3	5.5	5.9	6.0	6.2	9.5	9.7	3.0
70–74	±	6.4	6.7	5.3	6.8	7.2	7.4	9.7	14.7	2.9
75 and over	±	5.0	5.7	5.7	5.4	6.0	6.1	9.3	17.6	2.7
Total	±	1.8	1.9	1.9	1.9	1.7	2.0	2.8	3.3	0.9

RSE = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

- (a) Adults are defined as persons aged 18 years or over.
- (b) Overweight for adults is defined as BMI equal to 25 but less than 30. Obesity for adults is defined as BMI equal to or greater than 30.
- (c) Data are calculated from measured height and weight. Data exclude those for whom measured height and weight were not available. Data are not comparable with data for 2004-05 that are based on self-reported height and weight.
- (d) Rates for total are age standardised by State and Territory, to the 2001 ERP (5 year ranges from 18 for adults).
- (e) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.
- (f) Data for the NT should be used with care as very remote areas were excluded from the Australian Health Survey, which translates to exclusion of around 23 per cent of the NT population.

Table EA.15 **Rates of overweight and obesity for adults, by sex and age (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT(f), (g)</i>	<i>Aust</i>
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(g) Data for the NT for 2011-12 are not comparable to previous years due to the increase in sample size.

np Not published.

Source: ABS unpublished, *Australian Health Survey 2011-13* (2011-12 Core component), Cat. no. 4364.0;
ABS unpublished, *National Health Survey 2007-08*, Cat. no. 4364.0.

Table EA.16 **Rates of overweight and obesity for adults, by Indigenous status, 2011–13 (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust</i>
Rates										
Aboriginal and Torres Strait Islander people	%	76.4	71.0	72.4	73.7	71.9	69.2	72.8	61.5	72.4
Conf. Inter.	±	3.1	5.5	3.0	3.6	4.7	4.9	8.4	5.6	1.5
Other Australians	%	61.0	61.1	64.5	65.3	65.5	63.8	62.5	62.1	62.6
Conf. Inter.	±	1.8	1.9	1.8	2.0	1.7	2.0	2.9	2.9	1.0
Relative standard errors										
Aboriginal and Torres Strait Islander people	%	2.1	4.0	2.1	2.5	3.3	3.6	5.9	4.6	1.0
Other Australians	%	1.5	1.6	1.4	1.5	1.4	1.6	2.4	2.4	0.8
Rate ratio (h)	no.	1.3	1.2	1.1	1.1	1.1	1.1	1.2	1.0	1.2

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(a) Adults are defined as persons aged 18 years or over.

(b) Overweight for adults is defined as BMI equal to 25 but less than 30. Obesity for adults is defined as BMI equal to or greater than 30.

(c) BMI calculated from measured height and weight. Data are not comparable with 2004-05 data that are calculated from self-reported height and weight.

(d) Rates are age standardised by State and Territory to the 2001 ERP (10 year ranges from 18).

(e) Data have been revised and are based on the full sample of the Australian Aboriginal and Torres Strait Islander Health Survey. They differ from data published in the 2014 Report (based on a subset of the full sample).

(f) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.

(g) Data for other Australians for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(h) Rate ratio is computed by dividing the age standardised rate for Aboriginal and Torres Strait Islander people by the age standardised rate for other Australians.

Source: ABS unpublished, *Australian Health Survey 2011–13* (2011-12 Core component), Cat. no. 4364.0; ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (Core component), Cat. no. 4727.0.

Table EA.17 **Rates of overweight and obesity for adults, by Indigenous status, 2004-05 (a), (b), (c), (d), (e)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (f)	Aust
Rates										
Aboriginal and Torres Strait Islander people	%	66.9	55.7	66.1	65.4	71.9	60.1	63.7	53.9	64.1
Conf. Inter.	±	6.4	13.1	6.8	6.8	8.5	9.5	10.6	9.1	3.3
Other Australians	%	53.6	53.3	52.5	52.2	54.5	54.7	53.2	51.2	53.2
Conf. Inter.	±	1.8	1.7	2.2	2.8	1.6	2.6	3.4	11.5	0.9
Relative standard errors										
Aboriginal and Torres Strait Islander people	%	4.9	12.0	5.3	5.3	6.0	8.0	8.5	8.6	2.6
Other Australians	%	1.7	1.6	2.1	2.7	1.5	2.4	3.3	11.5	0.9

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(a) Adults are defined as persons aged 18 years or over.

(b) Overweight for adults is defined as BMI equal to 25 but less than 30. Obesity for adults is defined as BMI equal to or greater than 30.

(c) BMI calculated from self-reported height and weight. Data excludes persons for whom height or weight was not reported. Data are not comparable with data for 2011–13 that are calculated from measured height and weight.

(d) Rates are age standardised by State and Territory, to the 2001 ERP.

(e) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.

(f) Data for other Australians for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(g) 95 per cent confidence interval.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no. 4715.0; ABS unpublished, *National Health Survey, 2004-05*, Cat. No. 4364.0.

Table EA.18 Rate of overweight and obesity for children by Indigenous status, 2011–13 (a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust</i>
Rates										
Aboriginal and Torres Strait Islander people	%	36.7	34.5	30.4	31.6	37.6	32.1	41.9	24.2	32.8
Conf. Inter.	±	5.1	7.8	5.1	6.2	7.9	7.9	15.2	5.3	2.5
Other Australians	%	24.5	23.9	25.5	27.8	23.0	24.8	24.7	23.8	24.8
Conf. Inter.	±	3.3	3.3	3.5	3.3	3.4	4.5	4.3	5.3	1.6
Relative standard errors										
Aboriginal and Torres Strait Islander people	%	7.2	11.6	8.6	10.0	10.7	12.5	18.5	11.1	4.0
Other Australians	%	6.9	7.0	6.9	6.1	7.6	9.2	8.8	11.3	3.2

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(a) Children are defined as persons aged 5-17 years.

(b) Overweight for children is defined as BMI (appropriate for age and sex) that is likely to be equal to 25 but less than 30 at age 18 years. Obesity for children is defined as BMI (appropriate for age and sex) that is likely to be 30 or more at age 18 years.

(c) BMI calculated from measured height and weight.

(d) Rates are age standardised by State and Territory to the 2001 ERP (selected age ranges from 5-17

(e) Data have been revised and are based on the full sample of the Australian Aboriginal and Torres Strait Islander Health Survey. They differ from data published in the 2014 Report (based on a subset of the full sample).

(f) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.

(g) Data for other Australians for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

Source: ABS unpublished, *Australian Health Survey 2011–13* (2011-12 Core component), Cat. no. 4364.0; ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey 2012-13* (Core component), Cat. no. 4727.0.

Table EA.19 **Proportion of adults who are daily smokers, by remoteness (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT (c)</i>	<i>NT (c), (e), (f)</i>	<i>Aust</i>
Remoteness of residence (age standardised rate)										
2007-08										
Major cities	%	17.9	17.0	18.5	16.7	18.1	..	15.8	..	17.6
Conf. Inter.	±	2.1	1.7	2.6	2.3	2.1	..	2.0	..	1.0
Inner regional	%	20.8	17.5	22.0	13.2	25.5	23.2	–	..	20.1
Conf. Inter.	±	4.6	3.5	4.0	5.1	10.2	4.2	–	..	2.1
Outer regional	%	23.7	21.3	28.4	23.9	28.5	27.4	..	21.7	25.7
Conf. Inter.	±	6.1	14.5	5.3	5.6	7.0	5.2	..	12.1	3.1
Remote	%	27.9	–	33.4	32.8	21.7	11.3	..	19.6	27.3
Conf. Inter.	±	32.2	–	16.1	17.0	10.5	6.4	..	11.7	7.3
Very remote (d)	%	na	..	na	na	na	na	..	na	na
Conf. Inter.	±	na	..	na	na	na	na	..	na	na
Total	%	19.0	17.3	21.6	17.3	20.2	24.3	15.7	21.1	19.1
Conf. Inter.	±	1.9	1.6	2.0	2.1	2.3	3.0	2.0	10.5	0.9
Daily smokers	'000	975.4	682.5	665.2	268.6	232.9	85.1	41.9	28.8	2 980.3
2011-12 (f)										
Major cities	%	13.5	14.8	15.9	16.4	15.6	..	12.5	..	14.7
Conf. Inter.	±	1.4	1.6	1.6	1.6	1.6	..	1.9	..	0.7
Inner regional	%	17.2	22.2	20.6	21.2	14.5	18.8	–	..	19.5
Conf. Inter.	±	3.3	3.9	4.3	5.7	5.4	2.2	–	..	1.8
Outer regional	%	21.6	24.1	20.6	24.2	26.4	28.4	..	21.5	22.6
Conf. Inter.	±	7.4	18.6	4.1	6.8	5.5	3.7	..	2.9	2.2
Remote	%	31.1	np	48.6	20.1	23.4	42.1	..	25.2	26.1
Conf. Inter.	±	43.6	np	40.8	10.1	20.3	26.5	..	4.2	7.2
Very remote (d)	%	na	–	na	na	na	na	..	na	na
Conf. Inter.	±	na	–	na	na	na	na	..	na	na
Total	%	14.4	16.5	17.9	17.6	16.8	21.9	12.5	22.5	16.3
Conf. Inter.	±	1.1	1.3	1.3	1.6	1.4	1.9	1.9	2.5	0.6
Daily smokers	'000	807.8	702.9	601.6	308.4	203.3	78.7	35.0	29.4	2 751.4
Relative standard error										
2007-08										
Major cities	%	6.1	5.2	7.2	7.1	5.8	..	6.4	..	2.9
Inner regional	%	11.3	10.1	9.2	19.7	20.5	9.3	–	..	5.3
Outer regional	%	13.2	34.7	9.6	12.0	12.6	9.7	..	28.5	6.1
Remote	%	58.7	–	24.6	26.5	24.8	29.1	..	30.5	13.7
Very remote (d)	%	na	..	na	na	na	na	..	na	na
Total	%	5.2	4.6	4.7	6.3	5.7	6.2	6.4	25.4	2.4
2011-12 (f)										
Major cities	%	5.3	5.4	5.0	5.0	5.3	..	7.6	..	2.5
Inner regional	%	9.8	8.9	10.7	13.8	18.9	5.9	–	..	4.8
Outer regional	%	17.4	39.4	10.2	14.4	10.7	6.6	..	6.8	5.0
Remote	%	71.4	–	42.9	25.6	44.4	32.1	..	8.5	14.2

Table EA.19 **Proportion of adults who are daily smokers, by remoteness (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT (c)</i>	<i>NT (c), (e), (f)</i>	<i>Aust</i>
Very remote (d)	%	na	..	na	na	na	na	..	na	na
Total	%	4.0	4.1	3.8	4.6	4.2	4.5	7.6	5.8	2.0

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

- (a) Rates for total are age standardised by State and Territory, to the 2001 ERP.
- (b) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.
- (c) There are no very remote areas in Victoria; no major cities in Tasmania; no outer regional or remote areas in the ACT; and no inner regional or major cities in the NT.
- (d) Data were not collected for Very remote areas.
- (e) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.
- (f) Data for 2011-12 for the NT are not comparable to data for previous years due to the increased sample size.
- .. Not applicable. – Nil or rounded to zero. **np** Not published.

Source: ABS unpublished, *Australian Health Survey 2011–13* (2011-12 Core component), Cat. no. 4364.0; ABS unpublished, *National Health Survey 2007-08*, Cat. no. 4364.0.

Table EA.20 **Proportion of adults who are daily smokers, by SEIFA IRSD quintiles (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d), (e)</i>	<i>Aust</i>
SEIFA IRSD quintile (age standardised)										
2007-08										
Quintile 1	%	28.8	29.0	28.1	30.2	27.4	33.4	17.9	13.5	28.7
Conf. Inter.	±	4.2	5.4	5.5	6.5	4.4	6.0	14.7	18.5	2.4
Quintile 2	%	19.3	17.8	28.0	23.1	24.2	24.4	26.7	18.7	21.6
Conf. Inter.	±	4.6	4.0	5.2	4.8	4.4	6.5	17.0	12.9	2.1
Quintile 3	%	19.3	16.7	23.8	19.1	18.3	17.1	18.5	26.5	19.6
Conf. Inter.	±	4.4	3.2	4.2	4.0	4.8	4.6	5.4	20.8	1.8
Quintile 4	%	15.6	17.4	16.2	16.2	14.1	18.9	16.6	13.7	16.2
Conf. Inter.	±	3.2	4.0	3.5	5.1	3.5	8.2	4.4	36.6	1.7
Quintile 5	%	12.3	10.0	11.7	8.2	13.5	18.1	np	np	11.2
Conf. Inter.	±	3.0	2.7	3.4	2.7	4.8	13.3	np	np	1.6
Total (f)	%	19.0	17.3	21.6	17.3	20.2	24.3	15.7	21.1	19.1
Conf. Inter.	±	1.9	1.6	2.0	2.1	2.3	3.0	2.0	9.3	0.9
Daily smokers	'000	975.4	682.5	665.2	268.6	232.9	85.1	41.9	28.8	2 980.3
2011-12 (d), (e)										
Quintile 1	%	20.4	26.4	28.1	26.9	25.4	28.7	12.5	27.5	24.3
Conf. Inter.	±	3.0	4.2	3.3	5.0	3.8	3.3	15.5	6.3	2.0
Quintile 2	%	16.4	22.7	21.5	21.5	17.6	22.7	14.5	29.3	19.9
Conf. Inter.	±	2.4	3.1	3.6	3.1	2.7	4.0	9.6	8.0	1.5
Quintile 3	%	15.4	15.6	17.9	22.4	16.8	17.9	19.8	25.6	17.0
Conf. Inter.	±	2.3	2.9	2.4	3.2	4.0	5.1	5.7	5.0	1.1
Quintile 4	%	11.1	12.1	14.5	15.2	13.5	15.4	15.3	18.7	12.9
Conf. Inter.	±	1.8	2.8	2.9	2.6	3.2	3.7	2.6	4.2	1.1
Quintile 5	%	9.7	7.4	9.5	8.6	9.2	15.9	8.8	12.2	9.0
Conf. Inter.	±	2.4	2.7	2.4	2.2	2.9	5.6	2.2	6.5	1.2
Total (f)	%	14.4	16.5	17.9	17.6	16.8	21.9	12.5	22.5	16.3
Conf. Inter.	±	1.1	1.3	1.3	1.6	1.4	1.9	1.9	2.5	0.6
Daily smokers	'000	792.1	702.9	601.6	308.4	203.3	78.7	35.0	29.4	2 751.4
Relative standard error										
2007-08										
Quintile 1	%	7.4	9.6	10.0	11.1	8.2	9.2	41.9	69.9	4.2
Quintile 2	%	12.3	11.4	9.4	10.6	9.2	13.6	32.5	35.2	4.9
Quintile 3	%	11.7	9.9	9.0	10.8	13.3	13.9	14.8	40.2	4.8
Quintile 4	%	10.6	11.7	11.1	16.0	12.5	22.3	13.5	136.5	5.5
Quintile 5	%	12.4	13.9	14.7	16.6	18.2	37.6	np	np	7.3
Total (f)	%	5.2	4.6	4.7	6.3	5.7	6.2	6.4	22.4	2.4
2011-12 (d), (e)										
Quintile 1	%	7.6	8.2	6.0	9.5	7.7	5.9	63.0	11.7	4.3
Quintile 2	%	7.4	6.9	8.5	7.4	7.7	9.0	33.9	14.0	3.9
Quintile 3	%	7.5	9.6	6.9	7.4	12.0	14.6	14.8	9.9	3.3
Quintile 4	%	8.2	11.8	10.3	8.8	11.9	12.2	8.7	11.3	4.5

Table EA.20 **Proportion of adults who are daily smokers, by SEIFA IRSD quintiles (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d), (e)</i>	<i>Aust</i>
Quintile 5	%	12.8	18.5	12.9	12.8	15.9	18.1	12.8	27.3	7.0
Total (f)	%	4.0	4.1	3.8	4.6	4.2	4.5	7.6	5.8	2.0

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

- (a) Rates for total are age standardised by State and Territory, to the 2001 ERP.
- (b) A lower SEIFA quintile indicates relatively greater disadvantage and a lack of advantage in general. A higher SEIFA quintile indicates a relative lack of disadvantage and greater advantage in general.
- (c) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.
- (d) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.
- (e) Data for 2011-12 for the NT are not comparable to data for previous years due to the increased sample
- (f) Total includes those who could not be allocated to a SEIFA quintile.

np Not published.

Source: ABS unpublished, *Australian Health Survey 2011–13* (2011-12 Core component), Cat. no. 4364.0; ABS unpublished, *National Health Survey 2007-08*, Cat. no. 4364.0.

Table EA.21 **Proportion of adults who are daily smokers, by Indigenous status (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e), (f)</i>	<i>Aust</i>
2007-08										
Rate of adult daily smokers (age standardised)										
Aboriginal and Torres Strait Islander people	%	47.6	46.6	42.8	39.6	47.0	44.2	29.8	46.6	44.8
Conf. Inter.	±	4.6	3.8	4.2	4.4	5.4	5.9	6.5	4.9	2.0
Other Australians	%	18.8	17.3	21.5	16.9	20.0	23.5	16.0	22.2	18.9
Conf. Inter.	±	1.9	1.6	2.0	2.0	2.3	3.1	2.0	12.3	0.9
Relative standard errors										
Aboriginal and Torres Strait Islander people	%	5.0	4.1	5.0	5.7	5.9	6.8	11.2	5.4	2.3
Other Australians	%	5.1	4.8	4.6	6.2	5.8	6.7	6.4	28.2	2.4
Rate ratio (g)		2.5	2.7	2.0	2.3	2.4	1.9	1.9	2.1	2.4
2011–13 (f)										
Rate of adult daily smokers (age standardised)										
Aboriginal and Torres Strait Islander people	%	41.6	41.7	41.9	39.7	41.8	39.5	28.3	49.0	42.0
Conf. Inter.	±	3.6	5.3	3.2	3.4	4.8	5.0	7.5	4.7	1.8
Other Australians	%	14.0	16.5	17.1	17.4	16.3	21.2	12.6	22.1	16.0
Conf. Inter.	±	1.1	1.3	1.2	1.5	1.4	1.9	1.9	2.7	0.7
Total		14.5	16.5	18.0	17.8	16.8	22.0	12.6	23.3	16.4
Conf. Inter.		1.1	1.3	1.4	1.6	1.4	2.0	1.9	2.6	0.7
Relative standard errors										
Aboriginal and Torres Strait Islander people	%	4.4	6.4	3.9	4.4	5.9	6.5	13.5	4.9	2.2
Other Australians	%	4.2	4.1	3.7	4.5	4.4	4.5	7.8	6.3	2.1
Total		4.0	4.1	3.8	4.6	4.2	4.6	7.7	5.8	2.0
Rate ratio (g)		3.0	2.5	2.5	2.3	2.6	1.9	2.2	2.2	2.6

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(a) Adults are defined as persons aged 18 years and over.

(b) Rates are age standardised by State and Territory to the 2001 ERP (5 year age ranges from 18 years).

(c) Data for 2011–13 have been revised and are based on the full sample of the Australian Aboriginal and Torres Strait Islander Health Survey. They differ from data published in the 2014 Report (based on a subset of the full sample).

(d) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.

(e) Data for other Australians for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(f) Data for 2011–13 for other Australians for the NT are not comparable to data for previous years due to the increased sample size.

(g) Rate ratio is computed by dividing the age standardised rate for Aboriginal and Torres Strait Islander people by the age standardised rate for other Australians.

Table EA.21 Proportion of adults who are daily smokers, by Indigenous status (a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e), (f)</i>	<i>Aust</i>
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Source: ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey 2012-13* (Core component) Cat. no. 4727.0; ABS unpublished, *National Aboriginal and Torres Strait Islander Social Survey, 2008*, Cat. no. 4714.0; ABS unpublished, *Australian Health Survey 2011-13* (2011-12 Core component), Cat. no. 4364.0; ABS unpublished, *National Health Survey, 2007-08*, Cat. no. 4364.0.

Table EA.22 **Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by remoteness (a), (b), (c), (d), (e), (f)**

	Unit	NSW	Vic (e)	Qld	WA	SA	Tas (e)	ACT (e)	NT (g), (h)	Aust
Remoteness of residence (age standardised rate)										
2007-08										
Major cities	%	18.9	17.7	20.3	22.9	18.6	..	21.3	..	19.2
Conf. Inter.	±	1.8	1.9	2.2	2.7	2.1	..	2.1	..	0.8
Inner regional	%	25.5	23.5	23.3	28.4	20.9	21.3	np	..	24.3
Conf. Inter.	±	4.0	5.0	4.2	6.5	10.9	3.6	np	..	2.5
Outer regional	%	np	21.7	25.6	40.8	12.2	np	..	23.8	24.2
Conf. Inter.	±	np	14.3	4.0	11.2	5.5	np	..	16.8	2.9
Remote	%	np	np	39.5	23.8	24.6	np	..	52.1	32.1
Conf. Inter.	±	np	np	24.8	20.3	12.8	np	..	30.9	11.1
Very remote (e)	%	na	..	na	na	na	na	..	na	na
Conf. Inter.	±	na	..	na	na	na	na	..	na	na
Total	%	na	na	na	na	na	na	..	na	na
Conf. Inter.	±	1.7	1.8	2.0	2.5	1.8	2.9	2.1	14.6	0.9
Adults at risk	'000	1 063.2	749.3	694.6	395.4	220.0	77.8	55.2	38.5	3 294.0
2011-12 (e)										
Major cities	%	17.5	16.7	20.5	22.9	17.6	..	21.0	..	18.5
Conf. Inter.	±	1.9	1.9	2.1	2.1	2.0	..	2.4	..	1.0
Inner regional	%	20.4	19.7	17.8	33.7	18.8	21.7	np	..	20.6
Conf. Inter.	±	5.2	3.9	4.3	7.0	6.7	2.7	np	..	2.4
Outer regional	%	np	17.0	np	28.5	20.7	23.6	..	24.5	22.1
Conf. Inter.	±	np	9.8	np	8.8	5.9	5.2	..	4.2	2.9
Remote	%	np	np	np	36.7	27.3	37.6	..	22.9	31.4
Conf. Inter.	±	np	np	np	12.7	32.6	50.6	..	8.1	7.4
Very remote (e)	%	na	..	na	na	na	na	..	na	na
Conf. Inter.	±	na	..	na	na	na	na	..	na	na
Total	%	18.5	17.5	19.9	25.3	18.2	22.8	21.0	24.2	19.4
Conf. Inter.	±	1.5	1.6	1.8	2.1	1.8	2.4	2.4	3.5	0.8
Adults at risk	'000	1 027.5	760.4	682.8	443.1	228.3	86.9	58.5	30.7	3 318.2
Relative standard error										
2007-08										
Major cities	%	4.8	5.6	5.5	5.9	5.6	..	5.0	..	2.1
Inner regional	%	8.0	10.9	9.3	11.7	26.7	8.7	np	..	5.3
Outer regional	%	np	33.5	8.0	14.0	22.8	np	..	35.9	6.0
Remote	%	np	np	32.1	43.5	26.5	np	..	30.2	17.7
Very remote (e)	%	na	..	na	na	na	na	..	na	na
Total	%	4.2	5.0	4.5	5.0	5.1	7.0	5.0	22.3	2.1
2011-12 (g)										
Major cities	%	5.4	5.8	5.3	4.6	5.7	..	5.8	..	2.9
Inner regional	%	13.0	10.1	12.2	10.6	18.1	6.4	np	..	5.9
Outer regional	%	np	29.3	np	15.7	14.5	11.3	..	8.8	6.8
Remote	%	np	np	np	17.6	60.8	68.7	..	18.1	12.1

Table EA.22 **Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by remoteness (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (e)</i>	<i>NT (g), (h)</i>	<i>Aust</i>
Very remote (e)	%	na	..	na	na	na	na	..	na	na
Total	%	4.2	4.7	4.7	4.3	4.9	5.5	5.8	7.4	2.2

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

- (a) Rates are based on the 2009 NHMRC guidelines and can be used for the purposes of comparisons over time.
- (b) Rates are age standardised by State and Territory, to the 2001 ERP.
- (c) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.
- (d) Individuals are defined as at risk of long term harm if they consume more than 2 standard drinks a day (2009 NHMRC alcohol guidelines). Data based on consumption in week before the interview – does not take into account whether consumption in that week was more, less than or the same as usual.
- (e) There are no very remote areas in Victoria; no major cities in Tasmania; no outer regional or remote areas in the ACT; and no inner regional or major cities in the NT.
- (f) Data were not collected for Very remote areas.
- (g) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.
- (h) Data for 2011-12 for the NT are not comparable to data for previous years due to the increased sample size.
- .. Not applicable. **np** Not published.

Source: ABS unpublished, *Australian Health Survey 2011–13* (2011-12 National Health Survey (NHS) component), Cat. no. 4364.0; ABS unpublished, *National Health Survey 2007-08*, Cat. no. 4364.0.

Table EA.23 **Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by SEIFA IRSD quintiles (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f), (g)</i>	<i>Aust</i>
SEIFA IRSD quintile (age standardised)										
2007-08										
Quintile 1	%	11.7	16.2	26.1	19.8	14.3	23.3	23.9	22.7	17.3
Conf. Inter.	±	2.8	5.3	5.2	6.1	3.0	6.0	12.4	36.9	1.8
Quintile 2	%	19.4	16.1	23.0	27.4	19.0	20.3	24.0	35.7	20.7
Conf. Inter.	±	4.3	4.2	3.6	5.3	4.4	7.6	20.0	22.9	1.7
Quintile 3	%	23.9	24.3	24.0	23.4	20.5	17.9	27.5	27.9	23.6
Conf. Inter.	±	4.8	4.9	4.2	6.5	5.8	4.7	11.3	24.1	2.2
Quintile 4	%	22.3	16.6	17.6	26.8	16.1	22.3	18.7	23.2	19.8
Conf. Inter.	±	4.2	3.8	4.3	5.9	3.9	6.8	3.9	26.6	1.9
Quintile 5	%	24.2	20.9	20.0	26.5	22.8	21.5	21.3	28.1	22.6
Conf. Inter.	±	3.5	4.0	5.4	5.5	5.9	8.5	2.5	17.0	1.9
Total (h)	%	20.4	18.8	22.3	25.3	18.5	21.5	21.3	33.4	20.9
Conf. Inter.	±	1.7	1.8	2.0	2.5	1.8	2.9	2.1	14.6	0.9
Adults at risk	'000	1 063.2	749.3	694.6	395.4	220.0	77.8	55.2	38.5	3 294.0
2011-12 (f)										
Quintile 1	%	14.1	16.7	20.2	22.7	14.4	21.0	10.4	22.1	16.7
Conf. Inter.	±	3.6	3.5	5.0	6.7	3.9	4.3	10.2	8.1	1.9
Quintile 2	%	18.3	15.5	18.5	25.5	16.7	22.6	20.3	23.8	18.3
Conf. Inter.	±	3.8	4.0	4.0	5.8	3.3	6.4	10.9	6.9	1.8
Quintile 3	%	19.1	15.1	21.5	24.9	18.1	20.7	21.1	21.5	19.2
Conf. Inter.	±	3.8	3.8	3.7	4.6	5.9	6.1	6.8	6.6	2.0
Quintile 4	%	19.6	20.0	21.3	21.1	20.1	26.5	17.0	26.7	20.2
Conf. Inter.	±	3.2	4.6	4.1	5.0	5.7	7.3	4.6	7.2	2.1
Quintile 5	%	20.6	21.2	18.3	29.8	21.2	23.7	23.6	31.9	21.7
Conf. Inter.	±	4.7	3.4	4.2	4.6	4.5	8.3	4.1	13.7	2.1
Total (h)	%	18.5	17.5	19.9	25.3	18.2	22.8	21.0	24.2	19.4
Conf. Inter.	±	1.5	1.6	1.8	2.1	1.8	2.4	2.4	3.5	0.8
Adults at risk	'000	1 027.5	760.4	682.8	443.1	228.3	86.9	58.5	30.7	3 318.2
Relative standard error										
2007-08										
Quintile 1	%	12.2	16.6	10.1	15.7	10.6	13.2	26.4	83.1	5.4
Quintile 2	%	11.4	13.4	8.0	9.8	11.9	19.2	42.6	32.8	4.2
Quintile 3	%	10.3	10.4	9.0	14.1	14.4	13.4	20.9	44.0	4.7
Quintile 4	%	9.6	11.7	12.6	11.2	12.3	15.7	10.6	58.5	4.8
Quintile 5	%	7.3	9.7	13.7	10.7	13.2	20.1	6.0	30.9	4.2
Total (h)	%	4.2	5.0	4.5	5.0	5.1	7.0	5.0	22.3	2.1
2011-12 (f)										
Quintile 1	%	13.1	10.6	12.7	15.1	13.8	10.5	50.3	18.6	5.7
Quintile 2	%	10.7	13.1	11.2	11.7	10.2	14.4	27.4	14.8	5.0
Quintile 3	%	10.1	12.7	8.8	9.5	16.5	15.1	16.4	15.7	5.2
Quintile 4	%	8.4	11.7	9.8	12.0	14.5	14.1	13.8	13.7	5.3

Table EA.23 **Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by SEIFA IRSD quintiles (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i> (f), (g)	<i>Aust</i>
Quintile 5	%	11.5	8.2	11.8	7.8	10.7	17.8	8.9	22.0	4.8
Total (h)	%	4.2	5.0	4.5	5.0	5.1	7.0	5.0	22.3	2.1

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

- (a) Rates are based on the 2009 NHMRC guidelines and can be used for the purposes of comparisons over time.
- (b) Rates for total are age standardised by State and Territory to the 2001 ERP.
- (c) A lower SEIFA quintile indicates relatively greater disadvantage and a lack of advantage in general. A higher SEIFA quintile indicates a relative lack of disadvantage and greater advantage in general.
- (d) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.
- (e) Individuals are defined as at risk of long term harm if they consume more than 2 standard drinks a day (2009 NHMRC alcohol guidelines). Data based on consumption in week before the interview — does not take into account whether consumption in that week was more, less than or the same as usual.
- (f) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.
- (g) Data for 2011-12 for the NT are not comparable to data for previous years due to the increased sample size.
- (h) Total includes those who could not be allocated to a SEIFA quintile.

Source: ABS unpublished, *Australian Health Survey 2011–13* (2011-12 NHS component), Cat. no. 4364.0; ABS unpublished, *National Health Survey 2007-08*, Cat. no. 4364.0.

Table EA.24 **Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by Indigenous status (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e), (f)</i>	<i>Aust</i>
2004-05 (g)										
Number of adults at risk										
Aboriginal and Torres Strait Islander people	'000	16.6	3.8	17.4	8.6	3.4	1.9	0.5	3.8	56.0
Other Australians	'000	1 085.9	764.0	623.8	349.1	257.5	65.8	52.3	28.2	3 226.6
Rate of adults at risk of long term harm from alcohol (age standardised)										
Aboriginal and Torres Strait Islander people	%	21.4	22.1	23.0	20.4	21.2	19.1	21.0	10.3	20.3
Conf. Inter.	±	3.9	7.7	4.4	3.9	7.1	4.3	7.2	3.1	1.9
Other Australians	%	21.9	20.4	22.4	24.6	23.0	19.2	21.6	29.6	21.9
Conf. Inter.	±	1.3	1.6	1.5	2.3	1.6	2.0	2.5	11.7	0.7
Relative standard errors										
Aboriginal and Torres Strait Islander people	%									
Other Australians	%	9.3	17.8	9.7	9.8	17.0	11.4	17.4	15.5	4.9
	%	3.1	3.9	3.4	4.8	3.6	5.2	5.8	20.1	1.6
Rate ratio (h)		1.0	1.1	1.0	0.8	0.9	1.0	1.0	0.3	0.9
2011-13 (f)										
Number of adults at risk										
Aboriginal and Torres Strait Islander people	'000	22.1	5.6	19.5	11.3	4.7	2.6	0.6	5.8	72.3
Other Australians	'000	1 003.9	757.3	663.8	434.2	227.1	83.8	57.6	28.3	3 256.0
Rate of adults at risk of long term harm from alcohol (age standardised)										
Aboriginal and Torres Strait Islander people	%	19.7	19.9	18.2	23.0	22.1	18.1	15.5	14.2	19.2
Conf. Inter.	±	3.3	4.1	3.7	3.8	5.1	4.2	6.2	4.0	1.6
Other Australians	%	18.4	17.7	20.1	25.4	18.5	23.0	20.9	24.9	19.5
Conf. Inter.	±	1.5	1.7	1.9	2.1	1.8	2.4	2.3	3.9	0.9
Relative standard errors										
Aboriginal and Torres Strait Islander people	%	8.4	10.5	10.4	8.3	11.7	11.9	20.3	14.5	4.3
Other Australians	%	4.3	4.8	4.8	4.3	4.9	5.4	5.7	7.9	2.3
Rate ratio (h)		1.1	1.1	0.9	0.9	1.2	0.8	0.7	0.6	1.0

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(a) Individuals are defined as at risk of long term harm if they consume more than 2 standard drinks a day (2009 NHMRC alcohol guidelines). Data based on consumption in week before the interview – does not take into account whether consumption in that week was more, less than or the same as usual.

(b) Adults are defined as people aged 18 years or over.

Table EA.24 Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by Indigenous status (a), (b), (c), (d)

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e), (f)</i>	<i>Aust</i>
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(c) Rates are age standardised by State and Territory to the 2001 ERP.

(d) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.

(e) Data for other Australians for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey in 2011-12 and the National Health Survey in 2004-05 translates to exclusion of around 23 per cent of the NT population.

(f) Data for 2011-13 for other Australians for the NT are not comparable to data for previous years due to the increased sample size.

(g) Data for 2004-05 are based on the 2009 NHMRC alcohol guidelines and differ from previously reported data that were based on 2001 NHMRC guidelines.

(h) Rate ratio is computed by dividing the age standardised rate for Aboriginal and Torres Strait Islander people by the age standardised rate for other Australians.

Source: 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; ABS unpublished, *Australian Health Survey 2011-13* (2011-12 Core component), Cat. no. 4364.0; ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no. 4715.0; ABS unpublished, *National Health Survey, 2004-05*, Cat. no. 4364.0.

Table EA.25 **Proportion of adult abstainers from alcohol, by Indigenous status (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e), (f)</i>	<i>Aust</i>
2004-05 (g)										
Abstainers (age standardised)										
Aboriginal and Torres Strait Islander people										
	%	22.8	19.3	28.0	33.6	30.0	14.3	11.4	50.6	29.0
Conf. Inter.	±	4.2	6.5	4.5	4.5	7.1	5.3	4.9	6.3	2.0
Other Australians										
	%	17.1	16.3	13.2	12.8	13.8	10.5	11.3	15.7	15.2
Conf. Inter.	±	1.5	1.3	1.2	1.8	1.3	1.6	1.7	11.1	0.7
Relative standard errors										
Aboriginal and Torres Strait Islander people										
	%	9.5	17.3	8.3	6.8	12.0	18.8	21.7	6.4	3.5
Other Australians										
	%	4.4	4.1	4.6	7.3	4.9	7.9	7.5	36.1	2.2
Rate ratio (g)		1.3	1.2	2.1	2.6	2.2	1.4	1.0	3.2	1.9
2011–13 (f)										
Abstainers (age standardised)										
Aboriginal and Torres Strait Islander people										
	%	20.8	19.9	25.2	26.8	27.8	18.1	13.0	50.5	26.1
Conf. Inter.	±	3.9	4.0	3.7	4.6	5.5	4.2	6.7	6.3	1.9
Other Australians										
	%	18.0	16.3	15.5	13.9	16.2	12.5	11.4	15.4	16.3
Conf. Inter.	±	1.5	1.8	1.4	1.8	1.6	2.0	1.6	3.0	0.7
Relative standard errors										
Aboriginal and Torres Strait Islander people										
	%	9.6	10.3	7.5	8.8	10.2	11.8	26.4	6.4	3.8
Other Australians										
	%	4.3	5.7	4.8	6.5	4.9	8.1	7.0	9.9	2.2
Rate ratio (g)		1.2	1.2	1.6	1.9	1.7	1.4	1.1	3.3	1.6

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

- (a) Abstainers have consumed no alcohol in the previous 12 months (includes those who have never consumed alcohol).
- (b) Adults are defined as people aged 18 years or over.
- (c) Rates are age standardised by State and Territory to the 2001 ERP.
- (d) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.
- (e) Data for other Australians for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey in 2011-12 and the National Health Survey in 2004-05 translates to exclusion of around 23 per cent of the NT population.
- (f) Data for 2011–13 for other Australians for the NT are not comparable to data for previous years due to the increased sample size.
- (g) Rate ratio is computed by dividing the age standardised rate for Aboriginal and Torres Strait Islander people by the age standardised rate for other Australians.

Table EA.25 **Proportion of adult abstainers from alcohol, by Indigenous status
(a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e), (f)</i>	<i>Aust</i>
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Source: 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; ABS unpublished, *Australian Health Survey 2011-13* (2011-12 Core component), Cat. no. 4364.0; ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no. 4715.0; ABS unpublished, *National Health Survey, 2004-05*, Cat. no. 4364.0.

TABLE EA.26

Table EA.26 Incidence of selected cancers (a), (b), (c)

	<i>Unit</i>	<i>NSW (d)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT</i>	<i>Aust</i>
Incidence of selected cancers		<i>Age standardised rate per 100 000 population</i>								
2011 (d)										
Bowel cancer (e)	rate	61.9	60.7	62.6	58.0	60.3	73.3	63.0	45.3	61.5
Lung cancer (e)	rate	43.6	41.0	44.3	42.7	37.1	48.0	33.2	62.6	42.5
Melanoma (e)	rate	49.8	34.1	70.1	46.6	35.1	45.7	41.3	32.0	48.0
Female breast cancer (f)	rate	114.0	119.5	118.6	114.0	109.6	119.4	130.0	105.3	116.0
Cervical cancer (f)	rate	7.0	6.3	7.6	6.0	7.0	9.2	6.1	13.8	6.9
2010 (d)										
Bowel cancer (e)	rate	61.5	61.7	63.2	58.5	57.6	80.7	62.9	52.0	61.8
Lung cancer (e)	rate	43.5	39.2	46.3	45.1	40.7	45.6	33.2	53.1	42.8
Melanoma (e)	rate	49.5	38.2	68.2	44.5	36.0	49.3	41.3	39.3	48.5
Female breast cancer (f)	rate	113.9	114.0	121.6	121.5	118.1	108.2	129.8	91.7	116.4
Cervical cancer (f)	rate	7.0	6.3	7.9	7.6	7.4	7.3	6.1	7.8	7.1
2009										
Bowel cancer (e)	rate	59.5	60.8	63.6	58.4	60.6	71.6	62.9	54.7	60.9
Lung cancer (e)	rate	43.6	41.5	47.2	45.9	43.6	39.5	31.3	57.7	43.8
Melanoma (e)	rate	48.2	41.4	69.3	46.0	36.3	47.7	34.9	37.0	49.1
Female breast cancer (f)	rate	116.7	109.4	120.8	113.5	112.7	117.0	149.0	83.0	115.2
Cervical cancer (f)	rate	6.8	5.7	7.6	8.4	5.1	6.0	6.5	14.1	6.7
2008										
Bowel cancer (e)	rate	60.6	62.1	66.4	58.1	66.1	77.4	63.2	49.3	62.7
Lung cancer (e)	rate	43.4	42.6	47.9	44.3	44.0	47.9	35.4	79.2	44.4
Melanoma (e)	rate	48.1	39.7	68.9	49.5	39.9	49.1	44.6	35.3	49.3
Female breast cancer (f)	rate	114.0	116.7	123.1	118.8	119.0	103.1	117.6	97.4	116.9
Cervical cancer (f)	rate	6.7	6.6	7.1	8.7	8.1	6.9	3.8	14.1	7.1
2007										
Bowel cancer (e)	rate	63.8	64.3	66.6	57.3	65.7	81.8	60.6	69.7	64.5

TABLE EA.26

Table EA.26 Incidence of selected cancers (a), (b), (c)

	<i>Unit</i>	<i>NSW (d)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT</i>	<i>Aust</i>
Lung cancer (e)	rate	43.6	45.6	46.5	42.9	41.1	49.8	38.0	56.0	44.6
Melanoma (e)	rate	48.3	39.6	64.7	46.2	34.6	42.0	32.7	25.4	47.5
Female breast cancer (f)	rate	111.0	112.3	113.2	102.5	117.4	97.4	115.1	82.8	110.9
Cervical cancer (f)	rate	7.7	6.0	6.9	7.8	5.0	7.9	4.4	10.4	6.9
Number of new cases						<i>Number</i>				
2011 (d)										
Bowel cancer	no.	5 135	3 746	2 905	1 382	1 235	468	211	69	15 151
Lung cancer	no.	3 613	2 543	2 088	1 010	760	310	109	78	10 511
Melanoma	no.	3 975	2 059	3 263	1 117	685	274	145	52	11 570
Female breast cancer	no.	4 677	3 718	2 857	1 413	1 097	379	241	83	14 465
Cervical cancer	no.	269	184	172	70	58	22	11	15	801
2010 (d)										
Bowel cancer	no.	4 976	3 728	2 862	1 345	1 158	506	204	80	14 860
Lung cancer	no.	3 506	2 375	2 108	1 022	821	287	105	71	10 296
Melanoma	no.	3 861	2 245	3 089	1 031	684	291	141	63	11 405
Female breast cancer	no.	4 582	3 475	2 848	1 463	1 155	334	236	88	14 181
Cervical cancer	no.	265	182	177	90	65	19	11	9	818
2009										
Bowel cancer	no.	4 668	3 565	2 780	1 294	1 202	440	195	70	14 214
Lung cancer	no.	3 438	2 441	2 086	1 008	860	247	96	65	10 241
Melanoma	no.	3 695	2 376	3 041	1 036	671	274	117	54	11 264
Female breast cancer	no.	4 609	3 266	2 766	1 324	1 086	355	265	71	13 742
Cervical cancer	no.	251	164	165	93	45	15	12	11	756
2008										
Bowel cancer	no.	4 656	3 545	2 844	1 254	1 273	467	191	61	14 291
Lung cancer	no.	3 319	2 441	2 053	948	855	289	107	89	10 101

Table EA.26 Incidence of selected cancers (a), (b), (c)

	<i>Unit</i>	<i>NSW (d)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT</i>	<i>Aust</i>
Melanoma	no.	3 617	2 216	2 951	1 080	734	276	144	50	11 068
Female breast cancer	no.	4 392	3 413	2 739	1 343	1 121	306	207	75	13 596
Cervical cancer	no.	248	182	149	96	66	17	7	12	777
2007										
Bowel cancer	no.	4785	3584	2774	1200	1240	481	178	80	14322
Lung cancer	no.	3 279	2 548	1 925	887	777	288	110	70	9 884
Melanoma	no.	3 542	2 163	2 698	977	619	237	104	50	10 390
Female breast cancer	no.	4 203	3 199	2 449	1 127	1 108	286	200	61	12 633
Cervical cancer	no.	278	164	145	82	40	21	8	10	748

(a) Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.

(b) Due to the low incidence of cancers in some jurisdictions, rates may fluctuate widely from year to year. Comparisons across time and between jurisdictions should be made with caution.

(c) Data quality information (DQI) for some data in this table is at www.pc.gov.au/rogs/2015.

(d) Data for NSW and the ACT for 2010 and 2011 are estimated as incidence data are not available. See DQI for more information.

(e) Age-standardised to the 2001 ERP, using five-year age groups to 85+ years, and expressed per 100 000 persons.

(f) Age-standardised to the 2001 ERP, using five-year age groups to 85+ years, and expressed per 100 000 females.

Source: AIHW unpublished, Australian Cancer Database, various years; ABS various years, *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE EA.27

Table EA.27 Incidence of selected cancers, by remoteness area, 2011 (a), (b), (c), (d), (e)

	NSW (f)	Vic	Qld	WA	SA	Tas	ACT (f)	NT	Total excluding NSW/ACT (g)	Total excluding NSW/ACT (g) no.
<i>Age standardised rate per 100 000 population</i>										
Bowel cancer (h)										
Major cities	na	57.2	60.7	57.8	60.0	..	na	..	58.6	6,183
Inner regional	na	69.0	66.3	57.7	56.6	71.4	na	..	66.7	2,222
Outer regional	na	74.2	63.8	62.7	62.5	77.5	na	52.7	67.2	1,182
Remote	na	45.3	61.7	56.2	71.3	91.2	na	35.5	60.5	153
Very remote	na	..	32.3	40.9	66.8	np	na	27.1	37.8	50
Lung cancer (h)										
Major cities	na	39.6	42.2	41.8	37.6	..	na	..	40.4	4,271
Inner regional	na	44.8	44.6	40.6	33.3	43.4	na	..	43.5	1,475
Outer regional	na	42.5	48.1	46.2	36.4	55.3	na	57.5	46.0	832
Remote	na	np	46.9	55.2	31.3	67.5	na	71.7	46.9	118
Very remote	na	..	49.1	55.0	60.6	np	na	72.2	55.8	70
Melanoma (h)										
Major cities	na	30.8	72.2	44.3	33.4	..	na	..	44.8	4,687
Inner regional	na	43.5	71.7	66.0	39.5	46.6	na	..	54.6	1,710
Outer regional	na	43.8	65.4	50.1	43.2	42.6	na	39.1	51.9	904
Remote	na	np	52.5	50.0	26.7	54.6	na	20.6	41.1	112
Very remote	na	..	32.2	15.6	np	np	na	np	23.9	33
Female breast cancer (i)										
Major cities	na	118.1	119.6	114.0	115.7	..	na	..	117.5	6,394
Inner regional	na	124.2	119.5	116.8	85.0	131.0	na	..	120.2	1,969
Outer regional	na	118.9	108.6	119.4	102.2	101.7	na	129.5	110.3	977
Remote	na	np	135.3	91.4	79.2	np	na	86.6	97.1	124
Very remote	na	..	112.6	135.8	100.9	np	na	46.8	102.6	67

Table EA.27 Incidence of selected cancers, by remoteness area, 2011 (a), (b), (c), (d), (e)

	NSW (f)	Vic	Qld	WA	SA	Tas	ACT (f)	Total excluding NT	Total excluding NSW/ACT (g)	Total excluding NSW/ACT (g) no.
<i>Age standardised rate per 100 000 population</i>										
Cervical cancer (i)										
Major cities	na	6.0	7.6	5.8	6.6	..	na	..	6.4	334
Inner regional	na	7.8	8.6	np	6.2	6.4	na	..	7.3	100
Outer regional	na	4.6	8.0	11.3	10.8	15.6	na	18.0	9.6	75
Remote	na	–	np	9.6	np	np	na	np	6.4	9
Very remote	na	..	–	–	–	–	na	np	np	np

(a) Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.

(b) Remoteness areas are classified according to the Australian Statistical Geographical Standard (ASGS) Remoteness Area. Disaggregation by remoteness area is based on Statistical Area Level 2 (SA2) of usual residence at time of diagnosis. Not all remoteness areas are represented in all states and territories.

(c) Due to the low incidence of cancers in some jurisdictions, rates may fluctuate widely from year to year. Comparisons across time and between jurisdictions should be made with caution.

(d) Incidence rates based on counts of between 1 and 4 persons are not published because of statistical unreliability.

(e) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.

(f) 2011 incidence data for NSW and the ACT are not available and were not estimated for data disaggregated by remoteness area. See DQI for more information.

(g) Totals exclude NSW and the ACT as data disaggregated by remoteness area were not available. Therefore totals should not be compared to previous years.

(h) Age-standardised to the 2001 ERP, using five-year age groups to 85+ years, and expressed per 100 000 persons.

(i) Age-standardised to the 2001 ERP, using five-year age groups to 85+ years, and expressed per 100 000 females.

na Not available. **..** Not applicable. **–** Nil or rounded to zero. **np** Not published.

Source: AIHW unpublished, 2011 Australian Cancer Database; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE EA.28

Table EA.28 Incidence of selected cancers, by SEIFA IRSD quintiles, 2011 (a), (b), (c), (d), (e)

	NSW (f)	Vic	Qld	WA	SA	Tas	ACT (f)	Total excluding NT	Total excluding NSW/ACT (g)	Total excluding NSW/ACT (g) no.
<i>Age standardised rate per 100 000 population</i>										
Bowel cancer (h)										
Quintile 1	na	64.0	62.6	62.9	64.2	78.4	na	44.3	64.5	2,004
Quintile 2	na	68.6	74.5	58.5	62.8	69.5	na	43.7	67.9	2,277
Quintile 3	na	62.0	56.8	57.7	60.3	59.4	na	42.8	59.1	2,093
Quintile 4	na	56.3	57.7	64.6	54.5	84.4	na	43.6	58.3	1,927
Quintile 5	na	52.9	59.1	51.6	56.8	np	na	52.0	54.3	1,480
Lung cancer (h)										
Quintile 1	na	50.8	50.6	64.6	49.1	60.3	na	84.6	52.8	1,659
Quintile 2	na	45.6	54.0	44.7	36.7	51.5	na	85.9	46.6	1,573
Quintile 3	na	41.1	38.5	45.8	33.9	38.4	na	np	40.0	1,424
Quintile 4	na	38.9	38.4	41.5	31.3	27.2	na	63.8	37.9	1,251
Quintile 5	na	29.9	34.7	32.2	28.7	np	na	35.4	31.4	853
Melanoma (h)										
Quintile 1	na	25.8	61.5	45.5	34.7	41.8	na	18.9	41.3	1,218
Quintile 2	na	37.8	86.5	48.5	30.4	46.3	na	34.5	52.3	1,671
Quintile 3	na	34.3	63.0	46.3	36.6	46.3	na	33.3	46.6	1,627
Quintile 4	na	33.4	68.6	43.1	39.2	46.6	na	32.6	45.7	1,539
Quintile 5	na	38.2	75.2	48.6	39.4	110.5	na	56.7	50.3	1,390
Female breast cancer (i)										
Quintile 1	na	103.3	113.2	95.1	98.7	117.2	na	76.6	105.9	1,597
Quintile 2	na	120.2	140.4	118.3	104.2	122.8	na	104.8	122.9	2,003
Quintile 3	na	117.1	104.1	113.3	96.0	108.2	na	124.9	109.4	1,975
Quintile 4	na	125.7	114.0	101.9	130.6	133.6	na	109.6	119.5	2,107
Quintile 5	na	126.1	123.9	125.5	128.0	121.3	na	121.9	125.6	1,848

Table EA.28 Incidence of selected cancers, by SEIFA IRSD quintiles, 2011 (a), (b), (c), (d), (e)

	NSW (f)	Vic	Qld	WA	SA	Tas	ACT (f)	NT	Total excluding NSW/ACT (g)	Total excluding NSW/ACT (g)
	Age standardised rate per 100 000 population									
Cervical cancer (i)										
Quintile 1	na	6.6	8.5	8.0	7.5	14.3	na	np	8.0	109
Quintile 2	na	7.8	10.1	8.0	8.5	np	na	np	8.5	124
Quintile 3	na	5.7	6.2	7.6	6.5	np	na	np	6.3	106
Quintile 4	na	5.7	7.0	4.1	6.6	np	na	18.0	6.1	105
Quintile 5	na	5.9	5.9	4.2	np	np	na	np	5.5	75

(a) Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.

(b) Socio-Economic Indexes for Areas (SEIFA) quintiles are based on the ABS IRSD, with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. The SEIFA quintiles represent approximately 20 per cent of the national population, but do not necessarily represent 20 per cent of the population in each State or Territory. Disaggregation by SEIFA is based on Statistical Area Level 2 (SA2) of usual residence at time of diagnosis. Not all quintiles are represented in every jurisdiction.

(c) Due to the low incidence of cancers in some jurisdictions, rates may fluctuate widely from year to year. Comparisons across time and between jurisdictions should be made with caution.

(d) Incidence rates based on counts of between 1 and 4 persons are not published because of statistical unreliability.

(e) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.

(f) 2011 incidence data for NSW and the ACT are not available and were not estimated for data disaggregated by SEIFA IRSD. See DQI for more information.

(g) Totals exclude NSW and the ACT as data disaggregated by SEIFA IRSD were not available. Therefore totals should not be compared to previous years.

(h) Age-standardised to the Australian population as at 30 June 2001, using five-year age groups to 85+ years, and expressed per 100 000 persons.

(i) Age-standardised to the Australian population as at 30 June 2001, using five-year age groups to 85+ years, and expressed per 100 000 females.

na Not available. **..** Not applicable. **–** Nil or rounded to zero. **np** Not published.

Source: AIHW unpublished, 2011 Australian Cancer Database; ABS 2013, *Populations by Age and Sex, Regions of Australia, 2012*, Cat. no. 3235.0.

TABLE EA.29

Table EA.29	Incidence of selected cancers, by Indigenous status (per 100 000 population) (a), (b), (c), (d), (e), (f), (g)										
	NSW (h), (i), (j)	Vic	Qld	WA	SA	Tas	ACT	NT	Total (k)	Total (no.) (k)	
2007											
Bowel cancer (l)											
Aboriginal and Torres Strait Islander people	43.3	np	46.8	33.7	np	np	np	38.1	42.4	78	
Other Australians (m)	64.3	np	66.8	57.4	np	np	np	75.5	64.1	8 763	
Lung cancer (l)											
Aboriginal and Torres Strait Islander people	83.1	np	87.0	92.4	np	np	np	44.7	80.8	146	
Other Australians (m)	43.4	np	45.8	42.1	np	np	np	60.8	44.0	6 021	
Melanoma of the skin (l)											
Aboriginal and Torres Strait Islander people	14.1	np	9.1	np	np	np	np	np	10.9	19	
Other Australians (m)	49.0	np	65.9	47.0	np	np	np	32.6	53.8	7 255	
Female breast cancer (n)											
Aboriginal and Torres Strait Islander people	77.0	np	66.2	115.2	np	np	np	54.7	77.0	90	
Other Australians (m)	111.5	np	114.2	103.1	np	np	np	87.8	110.7	7 753	
Cervical cancer (n)											
Aboriginal and Torres Strait Islander people	15.1	np	11.3	23.3	np	np	np	np	15.7	25	
Other Australians (m)	7.5	np	6.8	7.5	np	np	np	8.9	7.3	490	
2008											
Bowel cancer (l)											
Aboriginal and Torres Strait Islander people	53.5	np	34.8	27.7	np	np	np	np	39.2	77	
Other Australians (m)	61.0	np	66.7	58.5	np	np	np	58.4	62.2	8 742	
Lung cancer (l)											

TABLE EA.29

Table EA.29	Incidence of selected cancers, by Indigenous status (per 100 000 population) (a), (b), (c), (d), (e), (f), (g)										
	NSW (h), (i), (j)	Vic	Qld	WA	SA	Tas	ACT	NT	Total (k)	Total (no.) (k)	
Aboriginal and Torres Strait Islander people	62.8	np	46.0	62.8	np	np	np	130.6	66.0	131	
Other Australians (m)	43.1	np	47.7	43.8	np	np	np	57.9	44.7	6 288	
Melanoma of the skin (l)											
Aboriginal and Torres Strait Islander people	6.8	np	np	24.6	np	np	np	–	7.9	15	
Other Australians (m)	48.9	np	70.2	50.2	np	np	np	40.7	55.6	7 687	
Female breast cancer (n)											
Aboriginal and Torres Strait Islander people	84.3	np	79.5	93.8	np	np	np	66.2	81.6	104	
Other Australians (m)	114.1	np	124.4	119.9	np	np	np	113.3	118.0	8 451	
Cervical cancer (n)											
Aboriginal and Torres Strait Islander people	8.1	np	17.1	26.5	np	np	np	np	14.6	26	
Other Australians (m)	6.7	np	7.0	8.3	np	np	np	13.7	7.1	480	
2009											
Bowel cancer (l)											
Aboriginal and Torres Strait Islander people	35.8	np	59.4	56.8	np	np	np	40.4	46.5	100	
Other Australians (m)	59.8	np	63.0	58.1	np	np	np	55.7	60.5	8 714	
Lung cancer (l)											
Aboriginal and Torres Strait Islander people	71.4	np	78.2	98.3	np	np	np	68.7	76.9	142	
Other Australians (m)	43.3	np	46.6	44.9	np	np	np	47.5	44.5	6 456	
Melanoma of the skin (l)											
Aboriginal and Torres Strait Islander people	4.4	np	9.2	15.9	np	np	np	np	8.2	22	

TABLE EA.29

Table EA.29 Incidence of selected cancers, by Indigenous status (per 100 000 population) (a), (b), (c), (d), (e), (f), (g)

	NSW (h), (i), (j)	Vic	Qld	WA	SA	Tas	ACT	NT	Total (k)	Total (no.) (k)
Other Australians (m)	48.9	np	70.2	46.5	np	np	np	41.9	55.0	7 809
Female breast cancer (n)										
Aboriginal and Torres Strait Islander people	80.5	np	63.2	116.6	np	np	np	107.9	83.4	109
Other Australians (m)	116.9	np	122.2	114.3	np	np	np	74.8	117.9	8 664
Cervical cancer (n)										
Aboriginal and Torres Strait Islander people	9.9	np	18.2	np	np	np	np	np	13.6	21
Other Australians (m)	6.8	np	7.3	8.1	np	np	np	11.2	7.2	496
2010 (h), (k)										
Bowel cancer (l)										
Aboriginal and Torres Strait Islander people	na	np	54.1	43.2	np	np	na	13.9	43.1	56
Other Australians (m)	na	np	63.3	58.5	np	np	na	61.3	61.7	4 262
Lung cancer (l)										
Aboriginal and Torres Strait Islander people	na	np	85.6	45.2	np	np	na	99.4	78.3	93
Other Australians (m)	na	np	46.1	44.7	np	np	na	43.7	45.5	3 155
Melanoma of the skin (l)										
Aboriginal and Torres Strait Islander people	na	np	9.1	np	np	np	na	np	8.2	10
Other Australians (m)	na	np	69.5	45.2	np	np	na	42.7	60.9	4 193
Female breast cancer (n)										
Aboriginal and Torres Strait Islander people	na	np	81.4	101.2	np	np	na	92.8	88.5	77
Other Australians (m)	na	np	124.1	122.3	np	np	na	94.7	123.1	4 369
Cervical cancer (n)										

TABLE EA.29

Table EA.29 **Incidence of selected cancers, by Indigenous status (per 100 000 population) (a), (b), (c), (d), (e), (f), (g)**

	NSW (h), (i), (j)	Vic	Qld	WA	SA	Tas	ACT	NT	Total (k)	Total (no.) (k)
Aboriginal and Torres Strait Islander people	na	np	25.3	19.9	np	np	na	np	20.7	19
Other Australians (m)	na	np	7.8	7.3	np	np	na	8.0	7.7	261
2011 (h), (k)										
Bowel cancer (l)										
Aboriginal and Torres Strait Islander people	na	np	33.1	35.1	np	np	na	np	29.9	40
Other Australians (m)	na	np	61.9	57.9	np	np	na	52.0	60.5	4 316
Lung cancer (l)										
Aboriginal and Torres Strait Islander people	na	np	69.9	85.3	np	np	na	76.6	75.1	98
Other Australians (m)	na	np	43.4	41.6	np	np	na	51.2	42.9	3 078
Melanoma of the skin (l)										
Aboriginal and Torres Strait Islander people	na	np	np	np	np	np	na	np	4.3	8
Other Australians (m)	na	np	71.3	47.2	np	np	na	38.3	62.5	4 424
Female breast cancer (n)										
Aboriginal and Torres Strait Islander people	na	np	94.2	146.7	np	np	na	99.8	108.2	94
Other Australians (m)	na	np	119.0	113.9	np	np	na	97.5	116.9	4 259
Cervical cancer (n)										
Aboriginal and Torres Strait Islander people	na	np	14.9	np	np	np	na	25.3	15.4	17
Other Australians (m)	na	np	7.4	5.9	np	np	na	11.7	7.0	240

(a) Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.

(b) Rates may differ from previous Report editions as population estimates have been revised based on the 2011 Census.

Table EA.29 **Incidence of selected cancers, by Indigenous status (per 100 000 population) (a), (b), (c), (d), (e), (f), (g)**

	NSW (h), (i), (j)	Vic	Qld	WA	SA	Tas	ACT	NT	Total (k)	Total (no.) (k)
(c)	The completeness of identification of Aboriginal and Torres Strait Islander people in cancer registry data varies between jurisdictions. Those with sufficiently complete identification to enable reliable reporting of cancer incidence rates are NSW, Qld, WA and NT. Data are not published by Indigenous status for the other jurisdictions.									
(d)	Due to the low incidence of cancers in some jurisdictions, rates may fluctuate widely from year to year. Comparisons across time and between jurisdictions should be made with caution.									
(e)	Incidence rates based on counts of between 1 and 4 persons are not published because of statistical unreliability.									
(f)	The incidence rate in Aboriginal and Torres Strait Islander people may fluctuate widely from year to year due to the behaviour of rare events in small populations.									
(g)	Data quality information (DQI) for some data in this table is at www.pc.gov.au/rogs/2015 .									
(h)	Incidence data for NSW are not available for 2010 or 2011 and were not estimated for data disaggregated by Indigenous status. See DQI for more information.									
(i)	Incidence rates for Aboriginal and Torres Strait Islander people in NSW are substantially lower than previously reported by the Cancer Institute NSW (CINSW). This is largely due to the 2011 census based population revisions. In addition, the CINSW estimates Indigenous status for cases with Indigenous status not stated, whereas those cases are counted in data for other Australians in this Report. See DQI for more information.									
(j)	Information on the death certificate is used to supplement the cancer registry's information about Indigenous status. Death certificate data for 2009 were not available for NSW by the time 2009 cancer data were being processed and this may impact on NSW data reported here for 2009.									
(k)	Totals include only those jurisdictions with sufficiently complete identification of Aboriginal and Torres Strait Islander people with cancer to enable reliable reporting of incidence rates — NSW, Queensland, WA and the NT. For 2010 and 2011, totals exclude NSW (see footnote (g)). This constitutes a break in time series — totals for 2010 and 2011 are not comparable with totals for previous years.									
(l)	Age-standardised to the Australian population as at 30 June 2001, using five-year age groups to 64+ years, and expressed per 100 000 persons.									
(m)	Other Australians includes non-Indigenous people and those for whom Indigenous status was not stated.									
(n)	Age-standardised to the Australian population as at 30 June 2001, using five-year age groups to 64+ years, and expressed per 100 000 females.									
	na Not available. – Nil or rounded to zero. np Not published.									

Source: AIHW unpublished, Australian Cancer Database 2011; ABS 2013, *Australian Demographic Statistics, December 2012*, Cat. no. 3101.0; ABS 2014, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*, Series B, Cat. no. 3238.0, Canberra.

Table EA.30 **Incidence of heart attacks (acute coronary events), by age and sex, people aged 25 years and over (per 100 000 people) (a), (b), (c), (d)**

	<i>Unit</i>	<i>25-34</i>	<i>35-44</i>	<i>45-54</i>	<i>55-64</i>	<i>65-74</i>	<i>75-84</i>	<i>85+</i>	<i>Aust (e)</i>
2007									
Males	rate	22.3	149.3	492.7	979.0	1 650.8	2 710.5	4 586.1	729.0
Females	rate	6.4	44.1	148.1	350.7	785.8	1 683.5	3 475.5	358.2
Total	rate	14.4	96.3	319.0	664.7	1 209.3	2 135.1	3 840.9	534.2
2008									
Males	rate	18.8	142.0	457.1	907.6	1 556.2	2 519.7	4 408.5	682.7
Females	rate	5.3	40.9	144.0	314.1	721.0	1 599.7	3 402.9	337.4
Total	rate	12.1	91.1	299.2	610.4	1 130.7	2 006.3	3 737.6	501.7
2009									
Males	rate	18.4	140.4	438.5	882.3	1 399.8	2 334.5	4 104.6	639.9
Females	rate	5.1	46.3	139.6	296.9	641.1	1 442.7	3 102.1	310.2
Total	rate	11.8	93.0	287.8	588.7	1 014.1	1 838.7	3 439.7	467.2
2010									
Males	rate	17.3	131.3	437.3	823.5	1 325.2	2 225.4	3 979.2	611.3
Females	rate	5.2	43.3	139.9	283.6	620.5	1 395.3	2 943.8	299.2
Total	rate	11.3	87.0	287.3	552.3	967.9	1 765.5	3 296.2	447.8
2011									
Males	rate	15.8	125.7	416.8	784.4	1 265.0	2 127.5	3 834.8	584.0
Females	rate	6.4	40.6	134.3	274.1	578.4	1 287.7	2 901.3	283.9
Total	rate	11.1	82.8	274.2	527.7	917.9	1 663.9	3 222.9	427.1
2012									
Males	rate	15.2	132.9	399.8	752.1	1 194.6	2 019.1	3 610.7	558.3
Females	rate	5.3	40.9	135.6	256.5	521.0	1 220.8	2 677.2	266.4
Total	rate	10.3	86.6	266.5	502.2	854.0	1 581.2	3 005.4	405.9

- (a) Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.
- (b) The estimated number of heart attacks (acute coronary events) in a given year is derived from hospitalisations with principal diagnoses of acute myocardial infarction or unstable angina that did not end in a transfer to another acute hospital or death in hospital, plus deaths from acute coronary heart disease.
- (c) Deaths registered in 2010 and earlier are based on the final version of cause of death data; deaths registered in 2011 and 2012 are based on revised and preliminary versions, respectively and are subject to further revision by the ABS.
- (d) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.
- (e) The Australian total is directly age-standardised to the 2001 Australian standard population.

Source: AIHW unpublished, National Hospital Morbidity Database; AIHW unpublished, National Mortality Database; ABS 2012, *Australian Demographic Statistics, September 2011*, Cat. no. 3101.0; ABS 2013, *Australian Demographic Statistics, December 2012*, Cat. no. 3101.0.

Table EA.31 **Incidence of heart attacks (acute coronary events), people 25 years or over, by Indigenous status (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (f)</i>
Incidence of heart attacks										
2007										
Aboriginal and Torres Strait Islander people	rate	na	na	na	na	na	na	na	na	1 048.0
Other Australians (h)	rate	na	na	na	na	na	na	na	na	527.6
2008										
Aboriginal and Torres Strait Islander people	rate	na	na	na	na	na	na	na	na	1 034.8
Other Australians (h)	rate	na	na	na	na	na	na	na	na	491.5
2009										
Aboriginal and Torres Strait Islander people	rate	na	na	na	na	na	na	na	na	1 024.8
Other Australians (h)	rate	na	na	na	na	na	na	na	na	456.1
2010										
Aboriginal and Torres Strait Islander people	rate	na	na	na	na	na	na	na	na	954.7
Other Australians (h)	rate	na	na	na	na	na	na	na	na	440.0
2011										
Aboriginal and Torres Strait Islander people	rate	na	na	na	na	na	na	na	na	936.6
Other Australians (h)	rate	na	na	na	na	na	na	na	na	425.1
2012										
Aboriginal and Torres Strait Islander people	rate	na	na	na	na	na	na	na	na	994.5
Other Australians (h)	rate	na	na	na	na	na	na	na	na	407.5

- (a) Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.
- (b) The estimated number of heart attacks (acute coronary events) in a given year is derived from hospitalisations with principal diagnoses of acute myocardial infarction or unstable angina that did not end in a transfer to another acute hospital or death in hospital, plus deaths from acute coronary heart disease.
- (c) Data are directly age standardised to the 2001 Australian standard population.
- (d) Deaths registered in 2010 and earlier are based on the final version of cause of death data; deaths registered in 2011 and 2012 are based on revised and preliminary versions, respectively and are subject to further revision by the ABS.
- (e) Rates may differ from previous reports as population estimates have been revised based on the 2011 Census.
- (f) Australian estimates are based on data from the five jurisdictions where the quality of identification of Indigenous status is considered to be reasonable in both the NHMD and the NMD (NSW, QLD, WA, SA and the NT).
- (g) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.
- (h) Other Australians includes non-Indigenous people and cases where Indigenous status was not stated or inadequately described. For the NT, all non-fatal events treated in the private hospital are included in the incidence counts for other Australians.

Table EA.31 **Incidence of heart attacks (acute coronary events), people 25 years or over, by Indigenous status (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i> (f)
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Source: AIHW unpublished, National Hospital Morbidity Database; AIHW unpublished, National Mortality Database; ABS 2012, *Australian Demographic Statistics, September 2011*, Cat. no. 3101.0; ABS 2013, *Australian Demographic Statistics, December 2012*, Cat. no. 3101.0; ABS 2014, *Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*, Cat. no. 3238.0.

Table EA.32 **Incidence of heart attacks (acute coronary events), people 25 years or over, NSW (per 100 000 people) (a), (b), (c), (d)**

	<i>NSW</i>	<i>Aust</i>
2012	365.7	405.9
2011	379.2	427.1
2010	409.8	447.8
2009	428.2	467.2
2008	466.1	501.7
2007	496.6	534.2

- (a) Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.
- (b) Directly age standardised to the 2001 Australian standard population.
- (c) Comparisons between jurisdictions **should not** be made as differences in treatment and referral patterns across states/territories are likely to have an impact on administrative records and affect jurisdictional comparability. These data are estimated from national hospital and deaths data. The accuracy of the estimates rely on the accuracy of coding of principal diagnosis, transfers and deaths in hospital in the National Hospital Morbidity Database (NHMD) and the underlying cause of death in the National Mortality Database (NMD). See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (d) Deaths registered in 2010 and earlier are based on the final version of cause of death data; deaths registered in 2011 and 2012 are based on revised and preliminary versions, respectively and are subject to further revision by the ABS.

Source: AIHW unpublished, National Hospital Morbidity Database; AIHW unpublished, National Mortality Database; ABS 2012, *Australian Demographic Statistics, September 2011*, Cat. no. 3101.0; ABS 2013, *Australian Demographic Statistics, December 2012*, Cat. no. 3101.0.

Table EA.33 **Incidence of heart attacks (acute coronary events), people 25 years or over, Victoria (per 100 000 people) (a), (b), (c), (d)**

	<i>Vic</i>	<i>Aust</i>
2012	380.3	405.9
2011	416.7	427.1
2010	444.6	447.8
2009	469.5	467.2
2008	503.8	501.7
2007	525.8	534.2

- (a) Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.
- (b) Directly age standardised to the 2001 Australian standard population.
- (c) Comparisons between jurisdictions **should not** be made as differences in treatment and referral patterns across states/territories are likely to have an impact on administrative records and affect jurisdictional comparability. These data are estimated from national hospital and deaths data. The accuracy of the estimates rely on the accuracy of coding of principal diagnosis, transfers and deaths in hospital in the National Hospital Morbidity Database (NHMD) and the underlying cause of death in the National Mortality Database (NMD). See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (d) Deaths registered in 2010 and earlier are based on the final version of cause of death data; deaths registered in 2011 and 2012 are based on revised and preliminary versions, respectively and are subject to further revision by the ABS.

Source: AIHW unpublished, National Hospital Morbidity Database; AIHW unpublished, National Mortality Database; ABS 2012, *Australian Demographic Statistics, September 2011*, Cat. no. 3101.0; ABS 2013, *Australian Demographic Statistics, December 2012*, Cat. no. 3101.0.

Table EA.34 **Incidence of heart attacks (acute coronary events), people 25 years or over, Queensland (per 100 000 people) (a), (b), (c), (d)**

	<i>Qld</i>	<i>Aust</i>
2012	495.7	405.9
2011	515.7	427.1
2010	513.3	447.8
2009	535.8	467.2
2008	599.4	501.7
2007	631.6	534.2

- (a) Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.
- (b) Directly age standardised to the 2001 Australian standard population.
- (b) Comparisons between jurisdictions **should not** be made as differences in treatment and referral patterns across states/territories are likely to have an impact on administrative records and affect jurisdictional comparability. These data are estimated from national hospital and deaths data. The accuracy of the estimates rely on the accuracy of coding of principal diagnosis, transfers and deaths in hospital in the National Hospital Morbidity Database (NHMD) and the underlying cause of death in the National Mortality Database (NMD). See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (d) Deaths registered in 2010 and earlier are based on the final version of cause of death data; deaths registered in 2011 and 2012 are based on revised and preliminary versions, respectively and are subject to further revision by the ABS.

Source: AIHW unpublished, National Hospital Morbidity Database; AIHW unpublished, National Mortality Database; ABS 2012, *Australian Demographic Statistics, September 2011*, Cat. no. 3101.0; ABS 2013, *Australian Demographic Statistics, December 2012*, Cat. no. 3101.0.

Table EA.35 **Incidence of heart attacks (acute coronary events), people 25 years or over, WA (per 100 000 people) (a), (b), (c), (d)**

	WA	Aust
2012	427.9	405.9
2011	441.5	427.1
2010	446.3	447.8
2009	443.4	467.2
2008	439.7	501.7
2007	500.9	534.2

- (a) Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.
- (b) Directly age standardised to the 2001 Australian standard population.
- (c) Comparisons between jurisdictions **should not** be made as differences in treatment and referral patterns across states/territories are likely to have an impact on administrative records and affect jurisdictional comparability. These data are estimated from national hospital and deaths data. The accuracy of the estimates rely on the accuracy of coding of principal diagnosis, transfers and deaths in hospital in the National Hospital Morbidity Database (NHMD) and the underlying cause of death in the National Mortality Database (NMD). See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (d) Deaths registered in 2010 and earlier are based on the final version of cause of death data; deaths registered in 2011 and 2012 are based on revised and preliminary versions, respectively and are subject to further revision by the ABS.

Source: AIHW unpublished, National Hospital Morbidity Database; AIHW unpublished, National Mortality Database; ABS 2012, *Australian Demographic Statistics, September 2011*, Cat. no. 3101.0; ABS 2013, *Australian Demographic Statistics, December 2012*, Cat. no. 3101.0.

Table EA.36 **Incidence of heart attacks (acute coronary events), people 25 years or over, SA (per 100 000 people) (a), (b), (c), (d)**

	SA	Aust
2012	375.0	405.9
2011	400.9	427.1
2010	412.1	447.8
2009	438.9	467.2
2008	448.2	501.7
2007	497.3	534.2

- (a) Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.
- (b) Directly age standardised to the 2001 Australian standard population.
- (c) Comparisons between jurisdictions **should not** be made as differences in treatment and referral patterns across states/territories are likely to have an impact on administrative records and affect jurisdictional comparability. These data are estimated from national hospital and deaths data. The accuracy of the estimates rely on the accuracy of coding of principal diagnosis, transfers and deaths in hospital in the National Hospital Morbidity Database (NHMD) and the underlying cause of death in the National Mortality Database (NMD). See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (d) Deaths registered in 2010 and earlier are based on the final version of cause of death data; deaths registered in 2011 and 2012 are based on revised and preliminary versions, respectively and are subject to further revision by the ABS.

Source: AIHW unpublished, National Hospital Morbidity Database; AIHW unpublished, National Mortality Database; ABS 2012, *Australian Demographic Statistics, September 2011*, Cat. no. 3101.0; ABS 2013, *Australian Demographic Statistics, December 2012*, Cat. no. 3101.0.

Table EA.37 **Incidence of heart attacks (acute coronary events), people 25 years or over, Tasmania (per 100 000 people) (a), (b), (c), (d)**

	<i>Tas</i>	<i>Aust</i>
2012	395.9	405.9
2011	390.3	427.1
2010	457.8	447.8
2009	478.4	467.2
2008	528.3	501.7
2007	565.9	534.2

- (a) Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.
- (b) Directly age standardised to the 2001 Australian standard population.
- (b) Comparisons between jurisdictions **should not** be made as differences in treatment and referral patterns across states/territories are likely to have an impact on administrative records and affect jurisdictional comparability. These data are estimated from national hospital and deaths data. The accuracy of the estimates rely on the accuracy of coding of principal diagnosis, transfers and deaths in hospital in the National Hospital Morbidity Database (NHMD) and the underlying cause of death in the National Mortality Database (NMD). See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (d) Deaths registered in 2010 and earlier are based on the final version of cause of death data; deaths registered in 2011 and 2012 are based on revised and preliminary versions, respectively and are subject to further revision by the ABS.

Source: AIHW unpublished, National Hospital Morbidity Database; AIHW unpublished, National Mortality Database; ABS 2012, *Australian Demographic Statistics, September 2011*, Cat. no. 3101.0; ABS 2013, *Australian Demographic Statistics, December 2012*, Cat. no. 3101.0.

Table EA.38 **Incidence of heart attacks (acute coronary events), people 25 years or over, ACT (per 100 000 people) (a), (b), (c), (d)**

	<i>ACT</i>	<i>Aust</i>
2012	369.5	405.9
2011	366.5	427.1
2010	407.7	447.8
2009	423.6	467.2
2008	380.3	501.7
2007	379.8	534.2

- (a) Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.
- (b) Directly age standardised to the 2001 Australian standard population.
- (c) Comparisons between jurisdictions **should not** be made as differences in treatment and referral patterns across states/territories are likely to have an impact on administrative records and affect jurisdictional comparability. These data are estimated from national hospital and deaths data. The accuracy of the estimates rely on the accuracy of coding of principal diagnosis, transfers and deaths in hospital in the National Hospital Morbidity Database (NHMD) and the underlying cause of death in the National Mortality Database (NMD). See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (d) Deaths registered in 2010 and earlier are based on the final version of cause of death data; deaths registered in 2011 and 2012 are based on revised and preliminary versions, respectively and are subject to further revision by the ABS.

Source: AIHW unpublished, National Hospital Morbidity Database; AIHW unpublished, National Mortality Database; ABS 2012, *Australian Demographic Statistics, September 2011*, Cat. no. 3101.0; ABS 2013, *Australian Demographic Statistics, December 2012*, Cat. no. 3101.0.

Table EA.39 **Incidence of heart attacks (acute coronary events), people 25 years or over, NT (per 100 000 people) (a), (b), (c), (d)**

	<i>NT</i>	<i>Aust</i>
2012	647.1	405.9
2011	729.2	427.1
2010	716.8	447.8
2009	767.6	467.2
2008	707.3	501.7
2007	696.4	534.2

- (a) Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.
- (b) Directly age standardised to the 2001 Australian standard population.
- (c) Comparisons between jurisdictions **should not** be made as differences in treatment and referral patterns across states/territories are likely to have an impact on administrative records and affect jurisdictional comparability. These data are estimated from national hospital and deaths data. The accuracy of the estimates rely on the accuracy of coding of principal diagnosis, transfers and deaths in hospital in the National Hospital Morbidity Database (NHMD) and the underlying cause of death in the National Mortality Database (NMD). See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (d) Deaths registered in 2010 and earlier are based on the final version of cause of death data; deaths registered in 2011 and 2012 are based on revised and preliminary versions, respectively and are subject to further revision by the ABS.

Source: AIHW unpublished, National Hospital Morbidity Database; AIHW unpublished, National Mortality Database; ABS 2012, *Australian Demographic Statistics, September 2011*, Cat. no. 3101.0; ABS 2013, *Australian Demographic Statistics, December 2012*, Cat. no. 3101.0.

TABLE EA.40

Table EA.40 **Proportion of people with type 2 diabetes (based on fasting blood glucose test), by sex, 2011-12 (per cent)**
(a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
People aged 18 years or over										
Proportion										
Males	%	5.4	5.1	5.8	5.4	6.4	5.1	4.4	8.6	5.5
95 per cent confidence interval	±	1.9	2.4	1.9	1.7	2.2	1.6	2.3	5.1	0.9
Females	%	3.1	2.3	3.3	3.9	4.4	3.0	4.8	6.3	3.2
95 per cent confidence interval	±	1.1	1.7	1.3	1.7	1.7	1.2	2.2	5.0	0.7
Total (g)	%	4.2	3.6	4.6	4.6	5.4	4.0	4.6	7.4	4.3
95 per cent confidence interval	±	1.1	1.3	1.1	1.2	1.3	1.0	1.8	3.1	0.5
Relative standard error										
Males	%	17.6	24.0	16.4	16.3	17.8	16.4	27.3	30.4	8.5
Females	%	18.9	37.4	20.1	22.0	19.2	20.0	24.1	40.7	10.7
Total (g)	%	13.0	18.4	12.8	13.6	12.3	13.0	19.3	21.8	6.4
People aged 25 years or over										
Proportion										
Males	%	6.2	5.8	6.7	6.2	7.4	5.9	5.0	9.9	6.3
95 per cent confidence interval	±	2.1	2.7	2.1	2.0	2.6	1.9	2.7	5.9	1.0
Females	%	3.5	2.7	3.7	4.4	5.1	3.5	5.5	4.0	3.6
95 per cent confidence interval	±	1.3	2.0	1.5	1.9	1.9	1.4	2.6	3.9	0.8
Total (g)	%	4.8	4.1	5.2	5.2	6.1	4.6	5.3	7.0	4.9
95 per cent confidence interval	±	1.2	1.5	1.3	1.4	1.5	1.2	2.0	2.9	0.6

Table EA.40 **Proportion of people with type 2 diabetes (based on fasting blood glucose test), by sex, 2011-12 (per cent)**
(a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
Relative standard error										
Males	%	17.6	24.0	16.4	16.3	17.8	16.4	27.3	30.4	8.5
Females	%	18.9	37.4	20.1	22.0	19.2	20.0	24.1	49.4	10.7
Total (g)	%	13.0	18.4	12.8	13.6	12.3	13.0	19.3	21.2	6.4

RSE = Relative Standard Error. Estimates with RSEs between 25 percent and 50 per cent should be used with caution.

(a) Data include pregnant women.

(b) Data include those with known type 2 diabetes and all persons with newly diagnosed diabetes. Diabetes prevalence is derived using a combination of fasting plasma glucose test results and self-reported information on diabetes diagnosis and medication use. The type of diabetes for newly diagnosed cases cannot be determined from a fasting plasma glucose test alone. However, as it is assumed that the vast majority of newly diagnosed cases would be Type 2, all newly diagnosed cases of diabetes have been included in this measure. See data quality information (DQI) for more information.

(c) Fasting plasma glucose is a fasting blood test. Data include only people who fasted for 8 hours or more prior to their blood test. For Australia in 2011-12, approximately 79% of people aged 18 years or over and people aged 25 years or over who participated in the National Health Measures Survey (NHMS) had

(d) Rates are age standardised to the 2001 Australian standard population using 5 year ranges from 18 years.

(e) DQI for some data in this table is at www.pc.gov.au/rogs/2015.

(f) Data for the NT should be used with care as the exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(g) Denominator includes a small number of persons for whom test results were not reported.

Source: ABS unpublished, *Australian Health Survey 2011-13*, (2011-12 NHMS component), Cat. No. 4364.0.

TABLE EA.41

Table EA.41 **Proportion of people aged 18 years or over with type 2 diabetes (based on fasting blood glucose test), by Indigenous status, by sex, 2011–13 (per cent) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
Aboriginal and Torres Strait Islander people										
Proportion										
Males	%	13.1	na	7.5	23.7	9.1	na	na	22.7	13.6
95 per cent confidence interval	±	5.4	na	4.3	10.4	10.0	na	na	12.4	3.3
Females	%	12.9	na	10.9	16.9	15.0	na	na	17.1	12.5
95 per cent confidence interval	±	5.6	na	6.8	8.7	11.6	na	na	7.6	3.0
Total (g)	%	12.6	na	9.1	20.3	12.8	na	na	20.0	12.9
95 per cent confidence interval	±	3.7	na	3.7	6.6	7.9	na	na	7.3	2.2
Relative standard error										
Males	%	21.2	na	29.2	22.3	55.9	na	na	27.9	12.4
Females	%	22.0	na	31.8	26.2	39.3	na	na	22.8	12.2
Total (g)	%	15.1	na	21.1	16.6	31.4	na	na	18.6	8.8
Other Australians										
Proportion										
Males	%	5.4	5.0	5.9	5.3	5.9	4.8	4.4	7.6	5.5
95 per cent confidence interval	±	1.8	2.3	1.9	1.7	2.0	1.6	2.3	4.4	0.9
Females	%	3.0	2.2	3.1	3.9	4.2	3.2	4.2	5.0	3.1
95 per cent confidence interval	±	1.1	1.5	1.3	1.6	1.6	1.3	2.0	4.3	0.6
Total (g)	%	4.2	3.5	4.5	4.6	5.1	4.0	4.3	6.4	4.2
95 per cent confidence interval	±	1.0	1.2	1.2	1.2	1.2	1.0	1.6	2.9	0.5

TABLE EA.41

Table EA.41 **Proportion of people aged 18 years or over with type 2 diabetes (based on fasting blood glucose test), by Indigenous status, by sex, 2011–13 (per cent) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
Relative standard error										
Males	%	17.2	23.6	16.7	16.1	16.8	17.2	27.5	29.8	8.3
Females	%	18.5	35.9	20.3	21.6	19.2	20.1	24.6	43.7	10.5
Total (g)	%	12.8	17.9	13.2	13.1	12.1	13.1	19.4	23.5	6.4

RSE = Relative Standard Error. Estimates with RSEs between 25 percent and 50 per cent should be used with caution.

(a) Data include pregnant women.

(b) Data include those with known type 2 diabetes and all persons with newly diagnosed diabetes. Diabetes prevalence is derived using a combination of fasting plasma glucose test results and self-reported information on diabetes diagnosis and medication use. The type of diabetes for newly diagnosed cases cannot be determined from a fasting plasma glucose test alone. However, as it is assumed that the vast majority of newly diagnosed cases would be Type 2, all newly diagnosed cases of diabetes have been included in this measure. See data quality information (DQI) for more information.

(c) Fasting plasma glucose is a fasting blood test. Data include only people who fasted for 8 hours or more prior to their blood test. For Australia in 2011-12, approximately 79 per cent of people aged 18 years or over who participated in the NHMS had fasted. Approximately 78 per cent of people aged 18 years or over who participated in the National Aboriginal and Torres Strait Islander Health Measures Survey had fasted.

(d) Rates are age standardised to the 2001 ERP (10 year age ranges from 18–24 years to 55 years or over).

(e) DQI for some data in this table is at www.pc.gov.au/rogs/2015.

(f) Data for other Australians for the NT should be used with care as the exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(g) Denominator includes a small number of persons for whom test results were not reported.

na Not available.

Source: ABS unpublished, *Australian Health Survey 2011–13*, (2011-12 NHMS component), Cat. No. 4364.0; ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Measures Survey component), Cat. No. 4727.0.

TABLE EA.42

Table EA.42 **Proportion of people aged 25 years or over with type 2 diabetes (based on fasting blood glucose test), by Indigenous status, by sex, 2011–13 (per cent) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
Aboriginal and Torres Strait Islander people										
Proportion										
Males	%	15.0	na	8.6	27.2	10.3	na	na	25.7	15.5
95 per cent confidence interval	±	6.2	na	4.9	11.9	11.4	na	na	14.2	3.8
Females	%	14.8	na	12.4	19.4	17.2	na	na	19.2	14.3
95 per cent confidence interval	±	6.4	na	7.7	9.9	13.2	na	na	8.7	3.4
Total (g)	%	14.4	na	10.4	23.2	14.6	na	na	22.6	14.8
95 per cent confidence interval	±	4.3	na	4.3	7.6	9.0	na	na	8.3	2.6
Relative standard error										
Males	%	21.2	na	29.2	22.3	56.6	na	na	28.2	12.4
Females	%	22.0	na	31.8	26.2	39.3	na	na	23.2	12.3
Total (g)	%	15.1	na	21.1	16.6	31.5	na	na	18.6	8.8
Other Australians										
Proportion										
Males	%	6.2	5.8	6.8	6.1	6.8	5.5	5.0	8.7	6.3
95 per cent confidence interval	±	2.1	2.7	2.2	1.9	2.2	1.9	2.7	5.1	1.0
Females	%	3.4	2.5	3.6	4.4	4.8	3.7	4.8	2.6	3.5
95 per cent confidence interval	±	1.3	1.8	1.4	1.9	1.8	1.4	2.3	2.1	0.7
Total (g)	%	4.8	4.1	5.2	5.2	5.8	4.6	4.9	5.8	4.8
95 per cent confidence interval	±	1.2	1.4	1.3	1.3	1.4	1.2	1.9	2.5	0.6

TABLE EA.42

Table EA.42 **Proportion of people aged 25 years or over with type 2 diabetes (based on fasting blood glucose test), by Indigenous status, by sex, 2011–13 (per cent) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
Relative standard error										
Males	%	17.2	23.6	16.7	16.1	16.8	17.2	27.5	29.8	8.3
Females	%	18.5	35.9	20.3	21.6	19.2	20.1	24.6	41.0	10.5
Total (g)	%	12.8	17.9	13.2	13.1	12.1	13.1	19.4	22.5	6.4

RSE = Relative Standard Error. Estimates with RSEs between 25 percent and 50 per cent should be used with caution.

(a) Data include pregnant women.

(b) Data include those with known type 2 diabetes and all persons with newly diagnosed diabetes. Diabetes prevalence is derived using a combination of fasting plasma glucose test results and self-reported information on diabetes diagnosis and medication use. The type of diabetes for newly diagnosed cases cannot be determined from a fasting plasma glucose test alone. However, as it is assumed that the vast majority of newly diagnosed cases would be Type 2, all newly diagnosed cases of diabetes have been included in this measure. See data quality information (DQI) for more information.

(c) Fasting plasma glucose is a fasting blood test. Data include only people who fasted for 8 hours or more prior to their blood test. For Australia in 2011-12, approximately 79 per cent of people aged 18 years or over who participated in the NHMS had fasted. Approximately 78 per cent of people aged 18 years or over who participated in the National Aboriginal and Torres Strait Islander Health Measures Survey had fasted.

(d) Rates are age standardised to the 2001 ERP (10-year age ranges from 25 years to 55 years or over).

(e) DQI for some data in this table is at www.pc.gov.au/rogs/2015.

(f) Data for other Australians for the NT should be used with care as the exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(g) Denominator includes a small number of persons for whom test results were not reported.

na Not available.

Source: ABS unpublished, *Australian Health Survey 2011–13*, (2011-12 NHMS component), Cat. No. 4364.0; ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Health Measures Survey component), Cat. No. 4727.0.

Table EA.43 **Age-standardised mortality rates of potentially avoidable deaths, under 75 years (a), (b), (c), (d), (e), (f)**

	NSW	Vic	Qld (g)	WA	SA	Tas	ACT	NT	Aust (g) (h)
2007									
Number of deaths	8 313	5 604	5 229	2 533	2 101	756	312	477	25 327
Rate per 100 000 persons	123.8	111.9	133.6	126.8	131.8	147.0	103.1	298.0	125.4
variability band (±)	2.7	2.9	3.6	5.0	5.7	10.6	11.6	29.9	1.6
2008									
Number of deaths	8 381	5 853	5 465	2 629	1 987	774	339	464	25 892
Rate per 100 000 persons	122.2	114.0	135.1	127.4	121.4	147.1	110.2	267.9	124.9
variability band (±)	2.6	2.9	3.6	4.9	5.4	10.5	11.9	26.5	1.5
2009									
Number of deaths	8 259	6 127	5 412	2 530	2 121	834	306	424	26 016
Rate per 100 000 persons	117.4	116.2	129.1	118.4	127.6	154.7	95.1	240.8	122.0
variability band (±)	2.5	2.9	3.5	4.6	5.5	10.7	10.8	24.8	1.5
2010									
Number of deaths	8 051	5 769	5 520	2 603	2 072	746	333	449	25 547
Rate per 100 000 persons	111.4	106.6	128.0	118.3	122.1	133.9	101.5	236.5	116.7
variability band (±)	2.4	2.8	3.4	4.6	5.3	9.8	11.1	23.5	1.4
2011									
Number of deaths	8 403	5 821	5 510	2 547	1 985	719	278	414	25 680
Rate per 100 000 persons	113.3	104.8	123.8	112.1	114.5	126.1	82.0	217.7	114.1
variability band (±)	2.4	2.7	3.3	4.4	5.1	9.4	9.8	22.3	1.4
2012									
Number of deaths	7 992	5 343	5 564	2 558	1 914	768	291	478	24 908
Rate per 100 000 persons	105.6	93.5	121.1	108.0	108.8	131.8	83.4	240.5	107.8
variability band (±)	2.3	2.5	3.2	4.2	4.9	9.6	9.7	22.6	1.3

(a) Age-standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 1000 or 100 000 persons. SDRs in this table have been calculated using the direct method, age-standardised by 5 year age groups to less than 75 years.

(b) Data based on reference year. See data quality information (DQI) at www.pc.gov.au/rogs/2015 for further detail.

(c) Potentially avoidable deaths refer to deaths from certain conditions that are considered avoidable given timely and effective health care. Avoidable mortality measures premature deaths (for those aged 0-74 years) for specific conditions defined and agreed to nationally by NHISSC and endorsed by NHIPPC (August 2014).

(d) Causes of death data are subject to a two-year revisions process. Data for 2007 to 2010 are final; data for 2011 are revised and subject to further revision; data for 2012 are preliminary and subject to revision. See Causes of Death, Australia, 2012 (Cat. no. 3303.0) Technical Note: Causes of Death Revisions 2010 and 2011 for further information.

(e) Historical data may differ from previous reports as a nationally agreed revisions to the definition of potentially avoidable deaths in 2014 have been applied. See DQI for more information.

(f) Some totals and figures may not compute due to the effects of rounding.

Table EA.43 Age-standardised mortality rates of potentially avoidable deaths, under 75 years (a), (b), (c), (d), (e), (f)

	NSW	Vic	Qld (g)	WA	SA	Tas	ACT	NT	Aust (g) (h)
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(g) Care should be taken when interpreting deaths data for Queensland for 2010 as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See DQI for a more detailed explanation.

(h) All states and territories including other territories.

Source: ABS unpublished, *Causes of Death, Australia*, Cat. no. 3303.0.

Table EA.44 **Age standardised mortality rates of potentially avoidable deaths, under 75 years, by Indigenous status, NSW, Queensland, WA, SA, NT (a), (b), (c), (d), (e), (f), (g), (h), (i), (j)**

	<i>unit</i>	<i>NSW</i>	<i>Qld (k)</i>	<i>WA (l)</i>	<i>SA</i>	<i>NT</i>	<i>Total (m)</i>
2003–2007							
Aboriginal and Torres Strait Islander people							
Number of deaths	no.	1 219	1 488	1 012	389	1 248	5 356
Rate (a)	per 100 000	256.0	380.4	504.6	405.8	701.9	391.1
Other Australians (i)							
Number of deaths	no.	41 400	24 263	10 812	10 215	962	87 652
Rate (a)	per 100 000	130.1	135.1	118.1	133.4	181.6	130.5
2004–2008							
Aboriginal and Torres Strait Islander people							
Number of deaths	no.	1 220	1 447	1 109	378	1 269	5 423
Rate (a)	per 100 000	246.9	350.7	524.1	386.5	696.5	379.9
Other Australians (i)							
Number of deaths	no.	40 660	24 329	10 885	9 870	991	86 735
Rate (a)	per 100 000	126.3	131.7	115.8	127.2	175.1	126.8
2005–2009							
Aboriginal and Torres Strait Islander people							
Number of deaths	no.	1 244	1 477	1 155	390	1 253	5 519
Rate (a)	per 100 000	241.3	342.9	527.2	378.2	672.2	371.8
Other Australians (i)							
Number of deaths	no.	39 909	24 216	11 027	9 879	991	86 022
Rate (a)	per 100 000	121.1	126.6	113.3	124.8	168.4	122.3
2006–2010							
Aboriginal and Torres Strait Islander people							
Number of deaths	no.	1 310	1 506	1 199	372	1 261	5 648
Rate (a)	per 100 000	246.6	338.3	529.8	357.6	661.4	370.1
Other Australians (i)							
Number of deaths	no.	39 534	24 344	11 254	9 782	981	85 895
Rate (a)	per 100 000	117.1	123.2	111.8	121.2	158.2	118.8
2007–2011							
Aboriginal and Torres Strait Islander people							
Number of deaths	no.	1 371	1 501	1 213	387	1 241	5 713
Rate (a)	per 100 000	245.3	316.8	525.6	357.0	637.0	359.0
Other Australians (i)							
Number of deaths	no.	39 614	24 695	11 309	9 753	976	86 347
Rate (a)	per 100 000	114.2	120.7	108.2	118.3	149.7	115.9
2008–2012							

Table EA.44 **Age standardised mortality rates of potentially avoidable deaths, under 75 years, by Indigenous status, NSW, Queensland, WA, SA, NT (a), (b), (c), (d), (e), (f), (g), (h), (i), (j)**

	<i>unit</i>	<i>NSW</i>	<i>Qld (k)</i>	<i>WA (l)</i>	<i>SA</i>	<i>NT</i>	<i>Total (m)</i>
Aboriginal and Torres Strait Islander people							
Number of deaths	no.	1 377	1 541	1 231	377	1 275	5 801
Rate (a)	per 100 000	236.2	313.3	515.3	342.0	630.0	351.3
Other Australians (i)							
Number of deaths	no.	39 289	24 945	11 298	9 595	944	86 071
Rate (a)	per 100 000	110.5	118.2	104.9	114.0	138.8	112.5

- (a) Age-standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 1000 or 100 000 persons. SDRs in this table have been calculated using the direct method, age-standardised by 5 year age groups to less than 75 years.
- (b) Potentially avoidable deaths refer to deaths from certain conditions that are considered avoidable given timely and effective health care. Avoidable mortality measures premature deaths (for those aged 0-74 years) for specific conditions defined and agreed to nationally by NHISSC and endorsed by NHIPPC (August 2014).
- (c) Historical data may differ from previous reports as a nationally agreed revisions to the definition of potentially avoidable deaths in 2014 have been applied. data quality information (DQI) at www.pc.gov.au/rogs/2015 for further detail.
- (d) Non-Indigenous estimates are available for census years only. In the intervening years, Aboriginal and Torres Strait Islander population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the projected Indigenous population from the total population. Non-Indigenous population estimates have been derived for these data by subtracting the 2011 Census-based Indigenous population projections from the 2011 Census based total persons estimated resident population (ERP). Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.
- (e) Data based on reference year. See DQI for further information.
- (f) Some totals and figures may not compute due to the effects of rounding.
- (g) Data are presented in five-year groupings due to the volatility of small numbers each year.
- (h) Data are reported by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. Only these five states and territories have evidence of a sufficient level of Indigenous identification and sufficient numbers of Indigenous deaths to support mortality analysis.
- (i) Causes of death data are subject to a two-year revisions process. Data for 2007 to 2010 are final; data for 2011 are revised and subject to further revision; data for 2012 are preliminary and subject to revision. See Causes of Death, Australia, 2012 (Cat. no. 3303.0) Technical Note: Causes of Death Revisions 2010 and 2011 for further information.
- (j) Deaths where the Indigenous status of the deceased was not stated are excluded from analysis.
- (k) Care should be taken when interpreting deaths data for Queensland for 2010 as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See DQI for a more detailed explanation.
- (l) For WA, Indigenous deaths data for 2007, 2008 and 2009 have been corrected. The data differ from previous reports in which they were over-reported. Please see DQI for more information.

Table EA.44 **Age standardised mortality rates of potentially avoidable deaths, under 75 years, by Indigenous status, NSW, Queensland, WA, SA, NT (a), (b), (c), (d), (e), (f), (g), (h), (i), (j)**

	<i>unit</i>	<i>NSW</i>	<i>Qld (k)</i>	<i>WA (l)</i>	<i>SA</i>	<i>NT</i>	<i>Total (m)</i>
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(m) Total includes data for NSW, Queensland, WA, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.

Source: ABS unpublished, *Causes of Death, Australia*, Cat. no. 3303.0; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0; ABS 2014, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*, Series B, Cat. no. 3238.0.

Table EA.45 **All Australians average life expectancy at birth (years) (a), (b)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (c)
Males									
2002–2004	78.0	78.5	77.8	78.6	78.0	76.7	79.7	72.3	78.1
2003–2005	76.3	76.8	75.6	75.6	77.5	75.8	74.3	57.1	76.3
2004–2006	76.9	77.3	75.9	75.6	77.4	76.6	74.9	55.0	76.6
2005–2007	77.0	77.4	76.0	76.0	77.7	76.3	76.0	56.8	76.8
2006–2008	77.7	77.9	76.4	76.4	78.2	76.9	75.9	57.1	77.3
2007–2009	77.9	78.2	76.7	76.2	78.6	76.6	76.7	59.2	77.5
2008–2010	78.3	78.5	77.0	76.4	78.9	78.2	78.3	61.4	77.9
2009–2011	79.8	80.3	79.5	80.1	79.7	78.3	81.0	74.9	79.7
2010–2012	79.9	80.5	79.5	80.1	79.8	78.7	81.2	74.7	79.9
2011–2013	80.0	80.7	79.6	80.3	80.0	78.8	81.7	74.9	80.1
Females									
2002–2004	83.3	83.3	82.9	83.3	83.1	81.8	83.9	78.0	83.0
2003–2005	83.3	83.6	83.2	83.8	83.4	82.1	84.0	78.2	83.3
2004–2006	83.4	83.7	83.4	83.8	83.6	82.3	83.9	78.1	83.5
2005–2007	83.8	83.8	83.6	84.0	83.9	82.4	84.0	78.4	83.7
2006–2008	83.9	83.9	83.7	84.0	83.8	82.3	84.0	78.4	83.7
2007–2009	84.3	84.1	83.8	84.1	83.9	82.2	84.3	79.0	83.9
2008–2010	84.1	84.3	83.9	84.3	83.8	82.3	84.7	79.2	84.0
2009–2011	84.2	84.4	84.1	84.6	84.0	82.5	84.8	80.5	84.2
2010–2012	84.2	84.5	84.0	84.8	84.2	82.6	85.1	80.0	84.3
2011–2013	84.3	84.7	84.1	84.8	84.3	82.6	85.0	79.2	84.3
Difference between male and female life expectancies at birth (d)									
2002–2004	5.3	4.8	5.1	4.7	5.1	5.1	4.2	5.7	4.9
2003–2005	7.0	6.8	7.6	8.2	5.9	6.3	9.7	21.1	7.0
2004–2006	6.5	6.4	7.5	8.2	6.2	5.7	9.0	23.1	6.9
2005–2007	6.8	6.4	7.6	8.0	6.2	6.1	8.0	21.6	6.9
2006–2008	6.2	6.0	7.3	7.6	5.6	5.4	8.1	21.3	6.4
2007–2009	6.4	5.9	7.1	7.9	5.3	5.6	7.6	19.8	6.4
2008–2010	5.8	5.8	6.9	7.9	4.9	4.1	6.4	17.8	6.1
2009–2011	4.4	4.1	4.6	4.5	4.3	4.2	3.8	5.6	4.5
2010–2012	4.3	4.0	4.5	4.7	4.4	3.9	3.9	5.3	4.4
2011–2013	4.3	4.0	4.5	4.5	4.3	3.8	3.3	4.3	4.2

(a) Life expectancy is calculated using three years of data.

(b) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.

(c) Data for Australia include Other territories.

(d) Differences are based on unrounded estimates.

Source: ABS 2014, *Life Tables, Australia, States and Territories, 2011-2013* (Cat. no. 3302.0.55.001).

Table EA.46 **Estimated life expectancies at birth, by Indigenous status and sex (years) (a), (b), (c), (d)**

	NSW	Qld	WA	NT	Australia — for comparison (e), (f)	Australia — Headline estimates (e), (g)
2005–2007						
Aboriginal and Torres Strait Islander people						
Life expectancy at birth						
Males	68.3	67.1	64.5	61.5	65.7	67.5
Females	74.0	72.7	70.0	69.4	71.7	73.1
Persons (c)	71.1	69.8	67.2	65.3	68.6	70.2
Upper and lower 95 per cent confidence intervals						
Males	66.3–70.3	65.6–68.6	62.9–66.1	60.1–62.9	64.3–67.1	66.1–68.9
Females	72.3–75.7	71.4–74.0	68.5–71.5	68.1–70.7	70.5–72.9	71.9–74.3
Persons	na	na	na	na	na	na
Other Australians						
Life expectancy at birth						
Males	78.8	78.8	79.2	75.5	78.9	78.9
Females	82.6	82.7	82.9	81.0	82.7	82.6
Persons (c)	80.7	80.7	81.0	78.1	80.7	80.7
Difference between Aboriginal and Torres Strait Islander and other Australians (h)						
Males	10.5	11.8	14.7	14.0	13.2	11.4
Females	8.6	10.0	12.9	11.6	11.0	9.6
Persons (c)	9.6	10.9	13.8	12.8	12.1	10.5
2010–2012						
Aboriginal and Torres Strait Islander people						
Life expectancy at birth						
Males	70.5	68.7	65.0	63.4	67.4	69.1
Females	74.6	74.4	70.2	68.7	72.3	73.7
Persons (c)	72.5	71.5	67.5	66.0	69.8	71.3
Upper and lower 95 per cent confidence intervals						
Males	69.0–72.0	67.3–70.1	63.4–66.6	61.3–65.5	66.1–68.7	67.8–70.4
Females	73.3–75.9	73.2–75.6	68.8–71.6	66.8–70.6	71.2–73.4	72.5–74.9
Persons	na	na	na	na	na	na
Other Australians						
Life expectancy at birth						
Males	79.8	79.4	80.1	77.8	79.8	79.7
Females	83.1	83.0	83.7	83.1	83.2	83.1
Persons (c)	81.4	81.2	81.9	80.4	81.5	81.4
Difference between Aboriginal and Torres Strait Islander and other Australians (h)						
Males	9.3	10.8	15.1	14.4	12.4	10.6
Females	8.5	8.6	13.5	14.4	10.9	9.5
Persons (c)	8.9	9.7	14.3	14.4	11.7	10.1

(a) Estimates of life expectancy for Aboriginal and Torres Strait Islander people are not available for Victoria, SA, Tasmania or the ACT as numbers are insufficiently large to support valid estimation.

Table EA.46 **Estimated life expectancies at birth, by Indigenous status and sex (years) (a), (b), (c), (d)**

	<i>NSW</i>	<i>Qld</i>	<i>WA</i>	<i>NT</i>	<i>Australia — for comparison (e), (f)</i>	<i>Australia — Headline estimates (e), (g)</i>
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- (b) Care should be taken in comparing life expectancy data by Indigenous status over time as Indigenous status is determined by self-identification and can vary from one Census to another.
- (c) Life tables are constructed separately for males and females. Life expectancy estimates for Persons are a weighted combination of male and female life expectancies.
- (d) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.
- (e) Australian totals include all states and territories.
- (f) These estimates, calculated without an age-adjustment, are not the headline estimates for Australia but are provided to enable effective comparison with the state and territory estimates.
- (g) Headline estimates for Australia for 2010–2012 are calculated using an improved methodology (taking into account age-specific identification rates) that could not be applied at state/territory level. Therefore, these data should not be compared with data for any State or Territory. The statistical impact of the improved methodology as well as the improved collection of Indigenous status in the 2011 Post Enumeration Survey were also applied to provide 'Headline estimates' for Australia for 2005--2007 data, to enable comparison over time.
- (h) Differences are based on unrounded estimates.

na Not available.

Source: ABS 2013, *Life Tables for Aboriginal and Torres Strait Islander Australians, 2010–2012*, Cat. no. 3302.0.55.003; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

Table EA.47 **Median age at death (years) (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (c)</i>
All Australians									
Males									
2004	76.9	77.3	75.9	75.6	77.4	76.6	74.9	55.0	76.6
2005	77.0	77.4	76.0	76.0	77.7	76.3	76.0	56.8	76.8
2006	77.7	77.9	76.4	76.4	78.2	76.9	75.9	57.1	77.3
2007	77.9	78.2	76.7	76.2	78.6	76.6	76.7	59.2	77.5
2008	78.3	78.5	77.0	76.4	78.9	78.2	78.3	61.4	77.9
2009	78.2	78.5	76.7	76.5	79.1	77.3	76.7	59.3	77.8
2010	78.5	79.1	76.9	77.0	79.5	78.0	77.4	61.3	78.2
2011 (d)	78.8	79.3	77.0	76.8	79.4	78.0	77.9	60.1	78.3
2012	79.1	79.7	77.3	77.0	80.2	78.0	78.3	59.6	78.7
2013	78.8	79.9	77.0	77.3	79.8	78.1	76.7	64.7	78.6
Females									
2004	82.7	82.9	82.1	82.0	83.2	82.6	81.0	61.4	82.6
2005	83.1	83.2	82.4	82.8	83.7	82.7	82.4	57.1	83.0
2006	83.4	83.6	82.8	82.6	84.0	83.1	82.6	65.0	83.3
2007	83.6	83.9	83.1	83.1	84.2	83.6	82.5	60.3	83.5
2008	84.0	84.2	83.4	83.7	84.5	83.4	83.0	61.8	83.9
2009	84.0	84.5	83.2	83.2	84.4	83.4	83.1	64.5	83.9
2010	84.2	84.7	83.6	83.7	84.8	83.5	84.4	64.1	84.2
2011 (d)	84.6	84.8	83.9	84.1	85.3	83.8	84.3	62.0	84.5
2012	84.7	85.2	83.9	84.0	85.5	83.7	84.6	63.7	84.6
2013	84.9	85.3	83.6	83.9	85.4	84.1	83.8	65.0	84.7

(a) Median age at death does not adjust for the age structure of the populations involved.

(b) Based on year of registration of death (also called 'reference year').

(c) Figures for Australia include 'Other Territories'.

(d) Data for 2011 include delayed notifications of registered deaths to the Australian Bureau of Statistics.

Source: ABS 2014, *Deaths Australia, 2013*, Cat. no. 3302.0, Canberra.

Table EA.48 **Median age at death, by Indigenous status (years) (a), (b), (c), (d)**

	NSW	Vic (e)	Qld	WA	SA	Tas (e)	ACT (e)	NT	Total (e), (f)
Aboriginal and Torres Strait Islander people (c), (d)									
Males									
2004	55.8	np	53.7	50.0	49.5	np	np	43.8	51.2
2005	54.3	np	51.1	52.8	42.4	np	np	45.8	50.4
2006	59.3	np	55.6	47.9	50.4	np	np	45.4	52.4
2007	58.1	np	54.7	51.3	50.5	np	np	45.9	52.7
2008	59.9	np	53.2	48.7	49.0	np	np	52.1	53.1
2009	57.2	np	53.2	50.2	48.0	np	np	48.3	52.3
2010	58.3	np	55.0	52.0	54.0	np	np	50.8	54.3
2011	58.5	np	57.3	52.2	50.3	np	np	51.8	55.4
2012	60.6	np	56.1	54.8	53.0	np	np	49.9	55.0
2013	58.5	np	53.6	53.9	48.8	np	np	52.5	54.6
Females									
2004	62.7	np	57.9	63.6	53.5	np	np	54.0	60.1
2005	65.8	np	59.5	57.8	47.5	np	np	50.4	57.9
2006	64.8	np	57.0	57.0	59.3	np	np	55.3	59.0
2007	63.0	np	59.5	58.1	58.3	np	np	55.7	59.2
2008	63.8	np	62.3	57.7	53.5	np	np	56.0	59.3
2009	65.9	np	62.6	56.8	53.0	np	np	55.4	61.0
2010	67.1	np	59.5	56.3	59.3	np	np	55.4	60.7
2011	66.2	np	59.0	54.2	50.3	np	np	55.0	58.5
2012	63.9	np	63.9	61.1	61.3	np	np	52.8	61.3
2013	66.2	np	62.9	57.8	55.3	np	np	58.0	61.6
Other Australians (c), (d)									
Males									
2004	77.0	np	76.2	76.3	77.6	np	np	63.0	76.8
2005	77.2	np	76.4	76.6	77.9	np	np	63.7	76.9
2006	77.8	np	76.7	76.9	78.3	np	np	64.7	77.4
2007	78.1	np	77.1	76.9	78.7	np	np	64.6	77.7
2008	78.5	np	77.3	77.0	79.2	np	np	66.3	78.0
2009	78.4	np	77.2	77.3	79.3	np	np	66.6	78.0
2010	78.6	np	77.5	77.8	79.6	np	np	64.9	78.3
2011	79.1	np	77.5	77.4	79.7	np	np	66.6	78.5
2012	79.3	np	77.6	77.9	80.2	np	np	67.1	78.7
2013	78.9	np	77.4	77.8	80.0	np	np	69.9	78.5
Females									
2004	82.8	np	82.5	82.3	83.3	np	np	71.3	82.7
2005	83.1	np	82.6	83.2	83.7	np	np	70.5	83.1
2006	83.5	np	83.1	83.1	84.1	np	np	75.0	83.4
2007	83.7	np	83.3	83.4	84.3	np	np	69.3	83.6
2008	84.2	np	83.7	84.1	84.6	np	np	75.7	84.1

Table EA.48 **Median age at death, by Indigenous status (years) (a), (b), (c), (d)**

	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (e)</i>	<i>NT</i>	<i>Total (e), (f)</i>
2009	84.1	np	83.4	83.6	84.6	np	np	71.8	83.9
2010	84.3	np	83.9	84.2	84.9	np	np	75.2	84.3
2011	84.7	np	84.2	84.4	85.3	np	np	73.5	84.6
2012	84.9	np	84.2	84.4	85.6	np	np	74.0	84.7
2013	85.0	np	83.9	84.2	85.5	np	np	71.4	84.7

(a) Median age at death does not adjust for the age structure of the populations involved.

(b) Based on year of registration of death (also called 'reference year').

(c) Excludes deaths not identified as Aboriginal and Torres Strait Islander people or other Australians. As a result, deaths may be underestimated for both populations.

(d) Care should be exercised when comparing median age at death between Aboriginal and Torres Strait Islander and other Australians. For example, a lower median age at death can result from better identification of Aboriginal and Torres Strait Islander people for infant deaths than for older age groups.

(e) Victoria, Tasmania and the ACT are excluded due to small numbers of registered Aboriginal and Torres Strait Islander deaths.

(f) Figures for Australia include 'Other Territories'.

np Not published.

Source: ABS 2014, *Deaths Australia, 2013*, Cat. no. 3302.0, Canberra.

Table EA.49 **Age standardised mortality rate (all causes), by State and Territory (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (d)</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d) (e)</i>
2007										
Rate	per 100 000 persons	600.4	583.4	621.2	594.7	611.5	693.2	560.1	902.2	604.4
	variability band \pm	5.5	6.2	7.6	10.6	10.9	21.3	27.8	68.5	3.2
2008										
Rate	per 100 000 persons	607.9	592.6	638.0	596.8	606.8	688.5	578.0	950.3	612.4
	variability band \pm	5.4	6.2	7.6	10.4	10.8	21.0	27.8	70.5	3.2
2009										
Rate	per 100 000 persons	569.7	577.4	595.9	568.9	587.9	671.0	540.2	824.6	582.0
	variability band \pm	5.2	6.0	7.2	10.0	10.5	20.5	26.4	64.3	3.1
2010										
Rate	per 100 000 persons	562.6	557.8	589.8	556.0	593.9	664.6	528.8	818.4	572.5
	variability band \pm	5.1	5.8	7.1	9.7	10.4	20.2	25.6	63.2	3.0
2011										
Rate	per 100 000 persons	576.4	555.8	581.0	535.6	566.6	642.4	513.1	795.0	570.0
	variability band \pm	5.1	5.8	6.9	9.4	10.1	19.6	24.7	62.1	2.9
2012										
Rate	per 100 000 persons	544.5	524.7	580.7	538.9	572.4	658.3	494.9	769.2	552.3
	variability band \pm	4.9	5.5	6.8	9.2	10.0	19.6	23.8	56.7	2.9
2013										
Rate	per 100 000 persons	543.6	512.1	554.9	522.6	547.8	649.0	474.8	831.9	540.0
	variability band \pm	4.8	5.4	6.6	8.9	9.7	19.4	22.8	58.1	2.8

(a) Age standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 100 000 standard population. SDRs in this table have been calculated using the direct method, age standardised by 5 year age groups to 95 years or over. Rates calculated using the direct method are not comparable to rates calculated using the indirect method.

(b) Rates may differ from previous Report editions as population estimates are revised based on the 2011 Census.

(c) Data based on year of registration of death (also called 'reference year'). See data quality information (DQI) for more detail.

(d) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See DQI for more information.

Table EA.49 **Age standardised mortality rate (all causes), by State and Territory (a), (b), (c)**

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (d)</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d) (e)</i>
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(e) Includes Other Territories.

Source: ABS unpublished, *Deaths, Australia*, Cat. no. 3302.0; ABS 2013, 2014, *Australian Demographic Statistics*, Cat. no. 3101.0.

Table EA.50 **Age standardised all-cause mortality rate and rate ratios, by Indigenous status, NSW, Qld, WA, SA, NT, five year aggregate, 2009–2013 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g), (h)**

<i>Unit</i>	<i>NSW</i>	<i>Qld (i)</i>	<i>WA</i>	<i>SA</i>	<i>NT</i>	<i>Total (j), (k)</i>
Aboriginal and Torres Strait Islander people						
Rate per 100 000 persons	804.0	964.4	1 232.4	818.0	1 461.3	985.0
Variability bands (l)	± 72.3	± 91.0	± 144.1	± 150.3	± 163.9	± 48.1
Other Australians						
Rate per 100 000 persons	584.9	589.6	552.1	611.0	611.6	585.2
Variability bands (l)	± 5.2	± 7.2	± 9.8	± 10.7	± 59.7	± 3.6
Rate ratio (m)	no. 1.4	no. 1.6	no. 2.2	no. 1.3	no. 2.4	no. 1.7

- (a) Age standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 100 000 standard population. SDRs in this table have been calculated using the direct method, age standardised by 5 year age groups to 75 years and over. Rates calculated using the direct method are not comparable to rates calculated using the indirect method.
- (b) Although most deaths are registered, it is likely that some are not accurately identified as of Aboriginal and Torres Strait Islander people. Therefore, data are likely to underestimate the mortality rate for Aboriginal and Torres Strait Islander people.
- (c) Data are reported individually by jurisdiction of usual residence for NSW, Qld, WA, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification for Aboriginal and Torres Strait Islander people and sufficient numbers of deaths to support mortality analysis.
- (d) Data based on year of registration of death (also called 'reference year').
- (e) Data are presented in five-year groupings due to volatility of the small numbers involved.
- (f) Rates are derived using population estimates and projections based on the 2011 Census. Non-Indigenous population estimates are available for Census years only. In the intervening years, non-Indigenous rates are derived using Aboriginal and Torres Strait Islander population estimates and projections — derived from assumptions about past and future levels of fertility, mortality and migration — subtracted from the total ERP to provide non-Indigenous population estimates. Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base Census year of the projection series increases. ERPs used from 2012 onwards are first release preliminary estimates. See DQI for further information.
- (g) Age at death unknown has been prorated across all age groups.
- (h) Excludes deaths where Indigenous status is recorded as 'not stated'.

Table EA.50 **Age standardised all-cause mortality rate and rate ratios, by Indigenous status, NSW, Qld, WA, SA, NT, five year aggregate, 2009–2013 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g), (h)**

	<i>Unit</i>	<i>NSW</i>	<i>Qld (i)</i>	<i>WA</i>	<i>SA</i>	<i>NT</i>	<i>Total (j), (k)</i>
(i)	Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See data quality information (DQI) for further information.						
(j)	Some totals and figures may not compute due to the effects of using different denominators and of rounding.						
(k)	Total includes data for NSW, Qld, WA, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.						
(l)	Variability bands can be used for comparisons within jurisdictions (for cause of death or over time), but not between jurisdictions or between jurisdictions and totals. See DQI for further information.						
(m)	Rate ratio is the age standardised rate for Aboriginal and Torres Strait Islander people divided by the non-Indigenous rate.						

Source: ABS unpublished, *Deaths, Australia*, Cat. no. 3302.0; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0; ABS 2014, *Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001–2026*, B Series, Cat. no. 3238.0.

Table EA.51 **Age standardised all-cause mortality rate and rate ratios, by Indigenous status, NSW, Qld, WA, SA, NT, 2013 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>NT</i>	<i>Total (h), (i)</i>
2013							
Aboriginal and Torres Strait Islander people	rate	832.0	1 003.1	1 121.3	827.7	1 490.1	995.7
Variability bands (j)	±	69.9	89.2	130.1	142.1	161.2	46.2
Other Australians	rate	574.4	565.6	532.4	587.6	632.4	568.5
Variability bands (j)	±	5.1	6.8	9.3	10.3	56.6	3.5
Rate ratio (k)	no.	1.4	1.8	2.1	1.4	2.4	1.8

- (a) Age standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 100 000 standard population. SDRs in this table have been calculated using the direct method, age standardised by 5 year age groups to 75 years and over. Rates calculated using the direct method are not comparable to rates calculated using the indirect method.
- (b) Although most deaths of Aboriginal and Torres Strait Islander people are registered, it is likely that some are not accurately identified as Indigenous. Therefore, these data are likely to underestimate the Aboriginal and Torres Strait Islander all causes mortality rate.
- (c) Data are reported individually by jurisdiction of usual residence for NSW, Qld, WA, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.
- (d) Data based on year of registration of death (also called 'reference year').
- (e) Rates are derived using population estimates and projections based on the 2011 Census. Non-Indigenous population estimates are available for Census years only. In the intervening years, non-Indigenous rates are derived using Aboriginal and Torres Strait Islander population estimates and projections — derived from assumptions about past and future levels of fertility, mortality and migration — subtracted from the total ERP to provide non-Indigenous population estimates. Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base Census year of the projection series increases. ERPs used from 2012 onwards are first release preliminary estimates. See DQI for more information.
- (f) Age at death unknown has been prorated across all age groups.
- (g) Excludes deaths where Indigenous status is recorded as 'not stated'.
- (h) Some totals and figures may not compute due to the effects of rounding.
- (i) Total includes data for NSW, Qld, WA, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.

Table EA.51 **Age standardised all-cause mortality rate and rate ratios, by Indigenous status, NSW, Qld, WA, SA, NT, 2013 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)**

<i>Unit</i>	<i>NSW</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>NT</i>	<i>Total (h), (i)</i>
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(j) Variability bands can be used for comparisons within jurisdictions (for cause of death or over time), but not between jurisdictions or between jurisdictions and totals. See DQI for more information.

(k) Rate ratio is the age standardised rate for Aboriginal and Torres Strait Islander people divided by the non-Indigenous rate.

Source: ABS unpublished, *Deaths, Australia, 2013*, Cat. no. 3302.0; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0; ABS 2014, *Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001–2026*, B Series, Cat. no. 3238.0.

Table EA.52 **Infant mortality (a), (b), (c), (d)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (e)</i>
2004									
Number of deaths	399	282	262	99	54	21	29	38	1 184
Rate per 1000 live births	4.6	4.5	5.2	3.9	3.2	3.6	6.9	10.7	4.7
2005									
Number of deaths	425	321	264	120	91	22	24	35	1 302
Rate per 1000 live births	4.7	5.1	5.1	4.6	5.1	3.5	5.7	9.6	4.9
2006									
Number of deaths	424	283	279	136	59	25	23	33	1 262
Rate per 1000 live births	4.6	4.3	5.3	4.9	3.2	3.9	5.1	8.9	4.7
2007									
Number of deaths	387	270	308	71	88	28	18	33	1 203
Rate per 1000 live births	4.0	3.8	5.0	2.4	4.5	4.2	3.8	8.5	4.1
2008									
Number of deaths	412	264	308	108	59	26	24	24	1 226
Rate per 1000 live births	4.1	3.7	4.9	3.4	2.9	3.8	5.0	6.1	4.1
2009									
Number of deaths	387	278	356	99	73	24	17	27	1 261
Rate per 1000 live births	3.9	3.9	5.4	3.2	3.7	3.6	3.5	7.1	4.2
2010									
Number of deaths	390	230	347	113	76	26	19	28	1 229
Rate per 1000 live births	3.9	3.3	5.4	3.6	3.8	4.1	3.7	7.2	4.1
2011									
Number of deaths	372	251	294	96	52	30	15	30	1 140
Rate per 1000 live births	3.8	3.5	4.6	3.0	2.6	4.5	2.9	7.6	3.8
2012									
Number of deaths	312	219	281	83	65	22	16	33	1 031
Rate per 1000 live births	3.2	2.8	4.4	2.5	3.2	3.6	2.9	8.0	3.3
2013									
Number of deaths	372	216	289	84	65	22	16	30	1 094
Rate per 1000 live births	3.7	2.9	4.6	2.4	3.2	3.6	2.9	7.4	3.6

(a) Includes all deaths within the first year of life.

(b) Data are based on year of registration. Note that the terms 'registration year' in the Deaths collection and 'reference year' in the Causes of Death collection have the same meaning.

(c) Some totals and figures may not compute due to rounding.

(d) Small numbers of registered deaths can lead to volatility in death rates.

(e) Includes other territories.

Source: ABS 2014, *Deaths, Australia, 2013*, Cat. no. 3302.0, Canberra.

Table EA.53 **Infant mortality rate by Indigenous status, three year average (per 1000 live births) (a), (b), (c), (d), (e), (f)**

	NSW (g)	Vic (e)	Qld (h)	WA	SA	Tas (e)	ACT (e)	NT	Aust
Aboriginal and Torres Strait Islander infants									
2004–2006	6.6	na	11.1	11.9	6.7	na	na	16.7	na
2005–2007	7.2	na	9.1	10.2	8.9	na	na	15.7	na
2006–2008	6.2	na	7.9	9.5	6.4	na	na	13.6	na
2007–2009	5.3	na	7.6	7.1	6.7	na	na	12.2	na
2008–2010	4.1	na	8.8	7.7	4.6	na	na	11.4	na
2009–2011	3.9	na	8.4	7.0	5.4	na	na	13.0	na
2010–2012	3.8	na	6.9	6.5	6.5	na	na	13.7	na
2011–2013	3.9	na	6.5	5.1	7.9	na	na	13.6	na
Other infants									
2004–2006	4.5	na	4.7	3.9	3.6	na	na	4.7	na
2005–2007	4.2	na	4.8	3.4	4.0	na	na	4.2	na
2006–2008	4.1	na	4.7	3.1	3.4	na	na	3.8	na
2007–2009	3.9	na	4.7	2.8	3.5	na	na	3.9	na
2008–2010	3.9	na	4.7	3.1	3.4	na	na	3.7	na
2009–2011	3.8	na	4.7	2.9	3.3	na	na	3.6	na
2010–2012	3.5	na	4.4	2.6	3.0	na	na	3.7	na
2011–2013	3.5	na	4.2	2.3	2.7	na	na	4.1	na

(a) Includes deaths within the first year of life.

(b) Deaths where Indigenous status was not stated are excluded. As a result, infant death rates by Indigenous status may be underestimated.

(c) Data based on year of registration of death (also called 'reference year').

(d) Data are presented in three-year groupings to reduce volatility stemming from the small numbers of registered Aboriginal and Torres Strait Islander infant deaths.

(e) Data are not available for Victoria, Tasmania or the ACT due to small numbers of registered Aboriginal and Torres Strait Islander infant deaths.

(f) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.

(g) NSW data have been revised to include previously unprocessed NSW Birth Registrations for the period 2005 to 2010.

(h) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registrations of deaths on mortality indicators. See data quality statements for more information.

na Not available.

Source: ABS 2014, *Deaths, Australia, 2013*, Cat. no. 3302.0, Canberra.

Table EA.54 **All causes infant and child mortality, by age group (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (f)</i>	<i>WA (g)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i> <i>(f), (g), (h)</i>
Infants (<1 year) (i)										
<i>2007–2009</i>										
Number of deaths	no.	1 186	812	972	278	220	78	59	84	3 690
Rate per 1000 live births		4.3	3.8	5.1	3.0	3.7	3.9	4.1	7.2	4.2
<i>2008–2010</i>										
Number of deaths	no.	1 189	772	1 011	320	208	76	60	79	3 716
Rate per 1000 live births		4.0	3.6	5.1	3.5	3.5	3.8	4.1	6.9	4.1
<i>2009–2011</i>										
Number of deaths	no.	1 149	759	997	308	201	80	51	85	3 630
Rate per 1000 live births		3.8	3.6	5.2	3.3	3.3	4.2	3.3	7.3	4.0
<i>2010–2012</i>										
Number of deaths	no.	1074	700	903	292	193	78	50	91	3381
Rate per 1000 live births		3.6	3.3	4.8	3.0	3.2	3.9	3.3	7.7	3.7
<i>2011–2013</i>										
Number of deaths	no.	1056	686	864	263	182	74	47	93	3265
Rate per 100 000 population		3.6	3.0	4.5	2.6	3.0	4.0	2.9	7.6	3.5
Child (0–4 years) (j)										
<i>2007–2009</i>										
Number of deaths	no.	204	955	1 146	346	271	94	71	104	4 378
Rate per 100 000 population		104.1	95.0	132.1	80.9	96.3	97.7	105.9	191.9	105.9
<i>2008–2010</i>										
Number of deaths	no.	1 386	919	1 150	398	258	94	71	100	4 377
Rate per 100 000 population		101.9	88.7	126.2	88.9	89.4	94.4	102.8	180.5	102.6
<i>2009–2011</i>										
Number of deaths	no.	1 346	901	1 124	383	249	96	58	103	4 260
Rate per 100 000 population		97.7	85.4	120.8	82.9	84.3	95.6	80.6	184.0	97.9
<i>2010–2012</i>										
Number of deaths	no.	1 254	834	1 046	370	238	91	60	110	4 003
Rate per 100 000 population		88.3	79.0	114.6	78.9	81.4	95.3	82.9	198.3	91.5
<i>2011–2013</i>										
Number of deaths	no.	1234	809	1013	341	234	83	57	115	3886
Rate per 100 000 population		86.0	74.9	108.9	70.0	78.9	87.5	75.8	204.5	87.2

(a) State or Territory of usual residence.

(b) Data are presented in three-year groupings due to volatility of the small numbers involved.

(c) Data based on year of registration of death (also called 'reference year').

(d) Some totals and figures may not compute due to the effects of using different denominators and of rounding.

(e) Data quality information for some data in this table is at www.pc.gov.au/rogs/2015.

(f) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registrations of deaths on mortality indicators. See data quality statements for more information.

Table EA.54 **All causes infant and child mortality, by age group (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i> (f)	<i>WA</i> (g)	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i> (f), (g), (h)
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(g) Due to potential over-reporting of WA Indigenous deaths for 2007, 2008 and 2009, WA mortality data were not previously supplied in 2011. Corrected WA Indigenous mortality data for these years are now available. See data quality statements for more information.

(h) All states and territories including other territories.

(i) Includes all deaths within the first year of life. Historical data have been revised and differ from previous reports. Rates represent the number of deaths per 1000 live births.

(j) For child deaths (0–4 years), rates represent the number of deaths per 100 000 ERP (0–4 years) at 30 June of the mid point year of the reference period. Rates for data to 2010–2012 are derived using ERPs based on the 2006 Census. Rates for data from 2011–2013 are derived using ERPs based on the 2011 Census. Rates derived using estimates based on different Censuses are not comparable.

Source: ABS unpublished, *Deaths, Australia*; ABS unpublished, *Births, Australia*; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

Table EA.55 **All causes infant and child mortality, by Indigenous status, NSW, Queensland, WA, SA, NT (a), (b), (c), (d), (e), (f), (g)**

<i>Unit</i>	<i>NSW</i>	<i>Qld (h)</i>	<i>WA (i)</i>	<i>SA</i>	<i>NT</i>	<i>Total (j)</i>	
2007–2011							
Infants (<1 year) (k)							
Number of deaths							
Aboriginal and Torres Strait Islander infants	no.	128	182	89	28	99	526
Other infants	no.	1 795	1 355	386	311	43	3 890
Rate							
Aboriginal and Torres Strait Islander infants	per 1000 live births	6.2	7.0	7.4	6.3	13.0	7.4
Other infants	per 1000 live births	4.1	4.5	2.8	3.4	3.8	3.9
Rate ratio (l)		1.5	1.6	2.6	1.9	3.4	1.9
Child (0–4 years) (m)							
Number of deaths							
Aboriginal and Torres Strait Islander children	no.	158	218	108	34	120	638
Other children	no.	2 097	1 568	482	384	53	4 584
Rate							
Aboriginal and Torres Strait Islander children	per 100 000 population	156	216	250	197	312	212
Other children	per 100 000 population	96.9	110.6	68.5	82.8	98.5	95.4
Rate ratio (l)		1.6	2.0	3.6	2.4	3.2	2.2
2008–2012							
Infants (<1 year) (k)							
Number of deaths							
Aboriginal and Torres Strait Islander infants	no.	103	182	85	26	97	493
Other infants	no.	1 745	1 320	396	290	45	3 796
Rate							
Aboriginal and Torres Strait Islander infants	per 1000 live births	3.6	6.9	7.3	5.5	12.5	6.2
Other infants	per 1000 live births	3.7	4.5	2.8	3.1	3.8	3.7
Rate ratio (l)		1.0	1.5	2.6	1.8	3.2	1.7
Child (0–4 years) (m)							
Number of deaths							
Aboriginal and Torres Strait Islander children	no.	130	217	110	31	122	627
Other children	no.	2 019	1 537	491	364	55	4 475

Table EA.55 **All causes infant and child mortality, by Indigenous status, NSW, Queensland, WA, SA, NT (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Qld (h)</i>	<i>WA (i)</i>	<i>SA</i>	<i>NT</i>	<i>Total (j)</i>
Rate							
Aboriginal and Torres Strait Islander children	per 100 000 population	124	211	250	175	311	203
Other children	per 100 000 population	92.1	106.1	109.5	48.4	101.7	91.4
Rate ratio (l)		1.4	2.0	2.3	3.6	3.1	2.2
2009–2013							
Infants (<1 year) (k)							
Number of deaths							
Aboriginal and Torres Strait Islander infants	no.	109	189	72	32	100	502
Other infants	no.	1 697	1 300	378	291	48	3 714
Rate							
Aboriginal and Torres Strait Islander infants	per 1000 live births	3.9	7.2	5.7	6.8	13.0	6.3
Other infants	per 1000 live births	3.6	4.5	2.6	3.1	4.0	3.7
Rate ratio (l)		1.1	1.6	2.2	2.2	3.2	1.7
Child (0–4 years) (m)							
Number of deaths							
Aboriginal and Torres Strait Islander children	no.	134	227	98	38	124	621
Other children	no.	1 976	1 506	479	365	58	4 384
Rate							
Aboriginal and Torres Strait Islander children	per 100 000 population	102.9	182.5	186.5	169.8	330.2	169.1
Other children	per 100 000 population	88.0	106.9	65.0	78.1	103.5	89.2
Rate ratio (l)		1.2	1.7	2.9	2.2	3.2	1.9

- (a) Data exclude deaths where Indigenous status was not stated. As a result, death rates by Indigenous status may be underestimated.
- (b) Data are reported individually by jurisdiction of residence for NSW, Queensland, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.
- (c) Data are presented in five-year groupings due to volatility of the small numbers involved.
- (d) A derived ERP is used in the calculation of population rates. Non-Indigenous ERP is derived by subtracting population projections for Aboriginal and Torres Strait Islander people from the total population ERP. The ERP used for data to 2008–2012 is based on the 2006 Census. The ERP used for data from 2009–2013 is based on the 2011 census. Rates derived using estimates based on different Censuses are not comparable. See the data quality information (DQI) for more detail.

Table EA.55 **All causes infant and child mortality, by Indigenous status, NSW, Queensland, WA, SA, NT (a), (b), (c), (d), (e), (f), (g)**

<i>Unit</i>	<i>NSW</i>	<i>Qld (h)</i>	<i>WA (i)</i>	<i>SA</i>	<i>NT</i>	<i>Total (j)</i>
(e) Non-Indigenous estimates are available for census years only. In the intervening years, Aboriginal and Torres Strait Islander population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the projected Aboriginal and Torres Strait Islander population from the total population. Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection						
(f) Data based on year of registration of death (also called 'reference year'). See DQI for more information.						
(g) Some totals and figures may not compute due to the effects of using different denominators and of rounding.						
(h) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and deaths registrations. Queensland deaths data for 2010 have been adjusted to minimise the the impact of late registration of deaths on mortality indicators. See data quality statements for more information.						
(i) Due to potential over-reporting of WA Aboriginal and Torres Strait Islander deaths for 2007, 2008 and 2009, WA mortality data were not previously supplied in 2011. Corrected WA Aboriginal and Torres Strait Islander mortality data for these years are now available. See data quality statements for more						
(j) Total includes data for NSW, Queensland, WA, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.						
(k) For infant deaths (less than one year) rates are per 1000 live births. Includes all deaths within the first year of life. The volatility in infant mortality rates is partially due to the relatively small number of infant deaths registered.						
(l) Rate ratio is the mortality rate for Aboriginal and Torres Strait Islander children/infants mortality rate divided by that for non-Indigenous children/infants.						
(m) For child deaths (0–4 years), the rates represent the number of deaths per 100 000 ERP (0–4 years) at 30 June of the mid point year of the reference period. Data include all deaths of children aged 0–4 years.						
<i>Source:</i> ABS unpublished, <i>Deaths, Australia</i> ; ABS unpublished, <i>Births, Australia</i> ; ABS unpublished, <i>Australian Demographic Statistics</i> , Cat. no. 3101.0; ABS 2009, 2014, <i>Estimates and Projections, Aboriginal and Torres Strait Islander Australians</i> , Cat. no. 3238.0						

TABLE EA.56

Table EA.56 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (f)
<i>2007</i>									
Cause of death	<i>Rate (per 100 000 persons)</i>								
Certain infectious and parasitic diseases (A00-B99)	10.2	6.9	7.7	6.2	7.9	3.7	np	25.1	8.2
Neoplasms (cancer) (C00-D48)	179.8	180.9	173.2	181.3	181.8	202.5	172.5	229.0	179.9
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	2.2	2.0	2.3	1.8	2.1	np	np	np	2.1
Endocrine, nutritional and metabolic diseases (E00-E90)	20.3	25.9	21.8	26.1	24.6	36.4	24.5	63.8	23.6
Mental and behavioural disorders (F00-F99)	25.4	24.8	19.3	21.2	25.5	27.3	31.1	41.3	24.0
Nervous system diseases (G00-G99)	22.0	24.9	22.2	29.8	25.9	25.6	29.8	17.0	24.0
Diseases of the eye and adnexa (H00-H59)	np	np	–	–	–	–	–	–	np
Diseases of the ear and mastoid process (H60-H95)	–	np	–	–	–	np	–	np	np
Circulatory diseases (I00-I99)	205.4	188.7	213.0	188.0	207.5	230.4	177.7	255.4	202.0
Respiratory Diseases (J00-J99)	49.6	47.4	60.1	46.2	45.9	58.8	38.0	69.6	50.6
Digestive diseases (K00-K93)	20.1	20.1	22.5	23.0	20.6	22.3	18.0	39.2	21.1
Diseases of the skin and subcutaneous tissue (L00-L99)	1.8	1.2	np	np	1.9	np	np	np	1.6
Diseases of the musculoskeletal system and connective tissue (M00-M99)	4.4	5.1	3.8	5.5	4.9	7.8	np	np	4.8
Kidney diseases (N00-N99)	13.9	13.9	14.9	13.7	14.6	17.2	9.5	34.6	14.3
Pregnancy, childbirth and the puerperium (O00-O99)	np	–	np	np	np	–	–	–	np
Conditions originating in the perinatal period (P00-P96)	3.0	2.8	3.4	1.3	np	np	np	np	2.9
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	2.6	2.9	3.5	2.2	2.8	np	np	np	2.9
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	4.6	3.2	8.7	2.4	2.8	np	np	np	4.5
External causes of morbidity and mortality (V01-Y98)	34.9	32.5	43.2	45.0	39.8	48.2	36.9	92.9	38.1

TABLE EA.56

Table EA.56 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (f)</i>
External causes of morbidity and mortality (V01-Y98)	±	1.4	1.5	2.0	2.9	3.0	6.1	6.8	16.3	0.8
All causes	±	5.5	6.2	7.6	10.6	10.9	21.3	27.8	68.5	3.2
<i>2008</i>										
Cause of death		<i>Rate (per 100 000 persons)</i>								
Certain infectious and parasitic diseases (A00-B99)		10.6	6.5	7.2	6.7	8.9	6.3	8.5	29.2	8.4
Neoplasms (cancer) (C00-D48)		179.5	184.2	192.7	176.8	186.2	205.0	168.6	235.0	184.2
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)		np	2.3	1.8	2.9	2.8	np	np	np	2.1
Endocrine, nutritional and metabolic diseases (E00-E90)		21.6	26.2	26.9	26.7	24.6	32.3	22.4	86.6	25.1
Mental and behavioural disorders (F00-F99)		25.9	27.2	22.7	25.6	26.6	33.1	28.5	44.7	26.0
Nervous system diseases (G00-G99)		22.6	25.7	25.1	30.4	28.2	26.9	34.9	24.5	25.3
Diseases of the eye and adnexa (H00-H59)		np	np	np	np	np	–	–	–	np
Diseases of the ear and mastoid process (H60-H95)		–	–	np	–	np	–	–	–	np
Circulatory diseases (I00-I99)		209.3	188.3	218.1	187.2	194.2	222.5	186.3	222.5	202.5
Respiratory Diseases (J00-J99)		48.8	45.8	49.0	43.8	46.1	57.5	35.5	93.1	47.7
Digestive diseases (K00-K93)		20.9	20.9	21.1	21.6	20.3	24.7	19.6	43.1	21.1
Diseases of the skin and subcutaneous tissue (L00-L99)		2.2	1.4	1.3	np	1.3	np	np	np	1.6
Diseases of the musculoskeletal system and connective tissue (M00-M99)		4.9	4.4	4.7	5.2	4.3	8.0	9.8	np	4.9
Kidney diseases (N00-N99)		14.1	12.9	13.9	12.1	15.4	12.4	14.4	39.4	13.8
Pregnancy, childbirth and the puerperium (O00-O99)		–	np	np	–	–	–	–	–	np
Conditions originating in the perinatal period (P00-P96)		3.1	2.6	3.2	1.8	2.1	np	np	np	2.8
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)		2.8	2.8	3.8	2.2	2.6	np	np	np	2.9

TABLE EA.56

Table EA.56 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (f)
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)		4.0	3.1	3.4	5.0	2.9	np	np	np	3.7
External causes of morbidity and mortality (V01-Y98)		35.7	38.2	42.9	47.0	40.1	49.7	36.4	101.6	40.1
All causes		607.9	592.6	638.0	596.8	606.8	688.5	578.0	950.3	612.4
Cause of death					<i>variability band ± (g)</i>					
Certain infectious and parasitic diseases (A00-B99)	±	0.7	0.7	0.8	1.1	1.3	2.0	3.4	12.1	0.4
Neoplasms (cancer) (C00-D48)	±	3.0	3.5	4.2	5.7	6.1	11.5	15.0	34.9	1.8
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	±	np	0.4	0.4	0.7	0.7	np	np	np	0.2
Endocrine, nutritional and metabolic diseases (E00-E90)	±	1.0	1.3	1.6	2.2	2.1	4.5	5.5	22.0	0.6
Mental and behavioural disorders (F00-F99)	±	1.1	1.3	1.4	2.2	2.1	4.5	6.2	17.3	0.6
Nervous system diseases (G00-G99)	±	1.0	1.3	1.5	2.4	2.3	4.1	6.9	11.2	0.6
Diseases of the eye and adnexa (H00-H59)	±	np	np	np	np	np	–	–	–	np
Diseases of the ear and mastoid process (H60-H95)	±	–	–	np	–	np	–	–	–	np
Circulatory diseases (I00-I99)	±	3.1	3.4	4.4	5.8	5.9	11.7	15.9	35.8	1.8
Respiratory Diseases (J00-J99)	±	1.5	1.7	2.1	2.8	2.9	6.0	7.0	22.8	0.9
Digestive diseases (K00-K93)	±	1.0	1.2	1.4	2.0	2.0	4.0	5.1	15.1	0.6
Diseases of the skin and subcutaneous tissue (L00-L99)	±	0.3	0.3	0.3	np	0.5	np	np	np	0.2
Diseases of the musculoskeletal system and connective tissue (M00-M99)	±	0.5	0.5	0.6	1.0	0.9	2.2	3.6	np	0.3
Kidney diseases (N00-N99)	±	0.8	0.9	1.1	1.5	1.6	2.8	4.4	14.9	0.5
Pregnancy, childbirth and the puerperium (O00-O99)	±	–	np	np	–	–	–	–	–	np
Conditions originating in the perinatal period (P00-P96)	±	0.4	0.4	0.5	0.6	0.8	np	np	np	0.2

TABLE EA.56

Table EA.56 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (f)
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	±	0.4	0.5	0.6	0.6	0.8	np	np	np	0.2
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	±	0.4	0.5	0.6	1.0	0.8	np	np	np	0.3
External causes of morbidity and mortality (V01-Y98)	±	1.4	1.6	2.0	2.9	3.0	6.2	6.6	18.2	0.8
All causes	±	5.4	6.2	7.6	10.4	10.8	21.0	27.8	70.5	3.2
<i>2009</i>										
Cause of death		<i>Rate (per 100 000 persons)</i>								
Certain infectious and parasitic diseases (A00-B99)		8.2	7.2	6.6	8.0	8.0	6.9	6.6	np	7.6
Neoplasms (cancer) (C00-D48)		173.7	176.3	184.0	177.2	176.3	197.6	155.9	218.9	177.4
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)		1.7	1.6	1.4	2.4	2.4	np	np	np	1.8
Endocrine, nutritional and metabolic diseases (E00-E90)		21.4	26.4	25.0	24.6	23.4	33.2	25.7	67.3	24.4
Mental and behavioural disorders (F00-F99)		24.9	26.0	23.6	26.7	25.9	34.8	29.5	49.3	25.6
Nervous system diseases (G00-G99)		21.6	25.0	24.3	26.8	29.2	28.1	25.7	39.2	24.3
Diseases of the eye and adnexa (H00-H59)		np	np	–	np	–	–	np	–	np
Diseases of the ear and mastoid process (H60-H95)		np	–	np	np	np	–	–	–	np
Circulatory diseases (I00-I99)		187.1	180.0	192.1	173.3	190.2	212.7	185.9	200.6	186.2
Respiratory Diseases (J00-J99)		46.3	44.1	47.6	40.0	44.0	54.4	30.2	73.9	45.3
Digestive diseases (K00-K93)		21.0	21.0	19.6	19.7	21.0	20.9	19.8	41.6	20.7
Diseases of the skin and subcutaneous tissue (L00-L99)		2.0	1.1	1.5	1.8	np	np	np	np	1.5
Diseases of the musculoskeletal system and connective tissue (M00-M99)		4.2	4.2	5.0	4.8	3.5	6.9	np	np	4.4
Kidney diseases (N00-N99)		13.5	15.5	11.4	12.3	14.6	11.6	12.9	20.2	13.7
Pregnancy, childbirth and the puerperium (O00-O99)		np	np	np	np	–	–	–	–	np

TABLE EA.56

Table EA.56 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (f)
Conditions originating in the perinatal period (P00-P96)		3.1	2.8	3.8	2.0	2.4	np	np	np	3.0
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)		2.4	3.1	3.6	2.2	3.2	np	np	np	2.9
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)		3.6	2.3	3.3	3.7	2.7	np	np	np	3.1
External causes of morbidity and mortality (V01-Y98)		34.9	40.7	43.0	43.4	40.0	52.8	36.9	74.9	39.9
All causes		569.7	577.4	595.9	568.9	587.9	671.0	540.2	824.6	582.0
Cause of death					<i>variability band ± (g)</i>					
Certain infectious and parasitic diseases (A00-B99)	±	0.6	0.7	0.8	1.2	1.2	2.1	2.9	np	0.4
Neoplasms (cancer) (C00-D48)	±	2.9	3.4	4.0	5.6	5.8	11.2	14.2	32.4	1.7
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	±	0.3	0.3	0.4	0.7	0.7	np	np	np	0.2
Endocrine, nutritional and metabolic diseases (E00-E90)	±	1.0	1.3	1.5	2.1	2.1	4.6	5.8	18.0	0.6
Mental and behavioural disorders (F00-F99)	±	1.0	1.2	1.4	2.2	2.1	4.5	6.2	18.6	0.6
Nervous system diseases (G00-G99)	±	1.0	1.3	1.5	2.2	2.3	4.2	5.8	16.2	0.6
Diseases of the eye and adnexa (H00-H59)	±	np	np	–	np	–	–	np	–	np
Diseases of the ear and mastoid process (H60-H95)	±	np	–	np	np	np	–	–	–	np
Circulatory diseases (I00-I99)	±	2.9	3.3	4.1	5.5	5.8	11.3	15.6	33.4	1.7
Respiratory Diseases (J00-J99)	±	1.5	1.7	2.1	2.7	2.8	5.8	6.4	20.3	0.9
Digestive diseases (K00-K93)	±	1.0	1.2	1.3	1.9	2.0	3.6	5.0	13.1	0.6
Diseases of the skin and subcutaneous tissue (L00-L99)	±	0.3	0.3	0.4	0.6	np	np	np	np	0.2
Diseases of the musculoskeletal system and connective tissue (M00-M99)	±	0.4	0.5	0.7	0.9	0.8	2.0	np	np	0.3
Kidney diseases (N00-N99)	±	0.8	1.0	1.0	1.5	1.6	2.6	4.1	10.1	0.5

TABLE EA.56

Table EA.56 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (f)
Pregnancy, childbirth and the puerperium (O00-O99)	±	np	np	np	np	–	–	–	–	np
Conditions originating in the perinatal period (P00-P96)	±	0.4	0.5	0.6	0.6	0.8	np	np	np	0.2
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	±	0.4	0.5	0.6	0.6	0.9	np	np	np	0.2
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	±	0.4	0.4	0.5	0.8	0.8	np	np	np	0.2
External causes of morbidity and mortality (V01-Y98)	±	1.3	1.7	2.0	2.7	3.0	6.3	6.5	15.0	0.8
All causes	±	5.2	6.0	7.2	10.0	10.5	20.5	26.4	64.3	3.1

2010

Cause of death

Rate (per 100 000 persons)

Certain infectious and parasitic diseases (A00-B99)	10.0	7.4	7.1	8.8	10.1	7.7	7.5	np	8.7
Neoplasms (cancer) (C00-D48)	175.6	175.5	186.7	172.1	178.3	194.9	157.6	217.1	177.9
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	1.6	1.6	1.6	1.8	1.6	np	np	np	1.6
Endocrine, nutritional and metabolic diseases (E00-E90)	19.3	23.8	23.8	24.1	25.0	35.2	20.0	53.7	22.9
Mental and behavioural disorders (F00-F99)	25.8	26.8	24.8	26.0	29.8	37.6	26.9	48.4	26.6
Nervous system diseases (G00-G99)	22.5	26.3	23.0	28.3	28.7	24.8	24.0	33.5	24.7
Diseases of the eye and adnexa (H00-H59)	np	–	–	np	–	–	–	–	np
Diseases of the ear and mastoid process (H60-H95)	–	np	np	–	–	np	–	–	np
Circulatory diseases (I00-I99)	176.4	166.8	189.1	161.7	186.1	213.0	168.7	198.5	177.0
Respiratory Diseases (J00-J99)	48.6	45.2	48.7	41.6	49.1	53.9	41.4	76.5	47.4
Digestive diseases (K00-K93)	19.8	21.0	21.4	20.3	18.8	23.1	16.2	41.4	20.5
Diseases of the skin and subcutaneous tissue (L00-L99)	1.9	1.5	1.3	1.0	1.5	np	np	np	1.5

TABLE EA.56

Table EA.56 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (f)
Diseases of the musculoskeletal system and connective tissue (M00-M99)	4.3	4.9	5.1	4.1	3.6	7.9	np	np	4.6
Kidney diseases (N00-N99)	12.4	14.0	12.4	12.5	14.5	13.3	12.9	26.8	13.1
Pregnancy, childbirth and the puerperium (O00-O99)	np	np	np	np	np	–	–	np	np
Conditions originating in the perinatal period (P00-P96)	2.9	2.2	3.5	2.1	2.6	np	np	np	2.8
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	2.7	2.7	3.0	2.2	2.2	np	np	np	2.7
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	4.2	1.7	4.2	2.7	3.0	np	np	np	3.3
External causes of morbidity and mortality (V01-Y98)	34.6	36.3	42.6	46.7	38.8	41.0	39.9	78.9	38.8
All causes	562.6	557.8	598.4	556	593.9	664.6	528.8	818.4	574.2
Cause of death									
									<i>variability band ± (g)</i>
Certain infectious and parasitic diseases (A00-B99)	± 0.7	0.7	0.8	1.2	1.4	2.2	3.0	np	0.4
Neoplasms (cancer) (C00-D48)	± 2.9	3.3	4.0	5.4	5.8	11.0	14.1	31.9	1.7
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	± 0.3	0.3	0.4	0.5	0.5	np	np	np	0.2
Endocrine, nutritional and metabolic diseases (E00-E90)	± 0.9	1.2	1.4	2.0	2.1	4.6	5.0	15.5	0.6
Mental and behavioural disorders (F00-F99)	± 1.1	1.2	1.4	2.1	2.2	4.6	5.7	17.7	0.6
Nervous system diseases (G00-G99)	± 1.0	1.3	1.4	2.2	2.3	4.0	5.5	13.7	0.6
Diseases of the eye and adnexa (H00-H59)	± np	–	–	np	–	–	–	–	np
Diseases of the ear and mastoid process (H60-H95)	± –	np	np	–	–	np	–	–	np
Circulatory diseases (I00-I99)	± 2.8	3.1	4.0	5.2	5.7	11.2	14.5	32.9	1.6
Respiratory Diseases (J00-J99)	± 1.5	1.6	2.0	2.7	3.0	5.7	7.3	20.6	0.9
Digestive diseases (K00-K93)	± 1.0	1.1	1.3	1.8	1.9	3.8	4.4	14.2	0.6

TABLE EA.56

Table EA.56 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (f)
Diseases of the skin and subcutaneous tissue (L00-L99)	±	0.3	0.3	0.3	0.4	0.5	np	np	np	0.2
Diseases of the musculoskeletal system and connective tissue (M00-M99)	±	0.4	0.5	0.7	0.8	0.8	2.2	np	np	0.3
Kidney diseases (N00-N99)	±	0.7	0.9	1.0	1.5	1.6	2.8	4.0	12.1	0.4
Pregnancy, childbirth and the puerperium (O00-O99)	±	np	np	np	np	np	–	–	np	np
Conditions originating in the perinatal period (P00-P96)		0.4	0.4	0.5	0.6	0.8	np	np	np	0.2
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	±	0.4	0.4	0.5	0.6	0.7	np	np	np	0.2
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	±	0.4	0.3	0.6	0.7	0.8	np	np	np	0.2
External causes of morbidity and mortality (V01-Y98)	±	1.3	1.6	1.9	2.8	3.0	5.5	6.7	14.1	0.8
All causes	±	5.1	5.8	7.1	9.7	10.4	20.2	25.6	63.2	3.0

2011

Cause of death

Rate (per 100 000 persons)

Certain infectious and parasitic diseases (A00-B99)		11.6	8.5	8.5	6.2	9.0	6.8	8.5	np	9.4
Neoplasms (cancer) (C00-D48)		177.8	173.3	175.1	166.5	170.6	189.5	147.0	220.3	174.5
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)		1.9	1.8	1.8	1.6	2.2	np	np	–	1.8
Endocrine, nutritional and metabolic diseases (E00-E90)		20.9	24.8	23.7	23.5	24.9	34.1	20.3	61.0	23.6
Mental and behavioural disorders (F00-F99)		27.9	27.4	27.4	23.7	30.5	40.8	26.7	51.6	27.9
Nervous system diseases (G00-G99)		23.8	27.8	23.3	30.5	28.5	29.6	32.2	30.9	26.0
Diseases of the eye and adnexa (H00-H59)		np	np	np	np	–	–	–	–	np
Diseases of the ear and mastoid process (H60-H95)		np	np	np	np	np	–	–	–	np
Circulatory diseases (I00-I99)		177.6	161.8	180.7	152.9	171.1	190.3	150.2	201.4	171.6

TABLE EA.56

Table EA.56 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (f)
Respiratory Diseases (J00-J99)		49.5	46.2	49.9	42.1	45.8	53.3	42.8	83.5	47.9
Digestive diseases (K00-K93)		20.2	20.0	20.2	19.9	19.5	21.9	19.7	37.0	20.2
Diseases of the skin and subcutaneous tissue (L00-L99)		2.1	1.4	1.4	1.3	1.6	np	np	np	1.7
Diseases of the musculoskeletal system and connective tissue (M00-M99)		4.7	4.4	4.8	3.7	3.3	5.4	np	np	4.5
Kidney diseases (N00-N99)		12.9	14.1	12.1	11.2	13.2	13.1	14.5	np	13.0
Pregnancy, childbirth and the puerperium (O00-O99)		np	np	np	–	np	–	–	np	np
Conditions originating in the perinatal period (P00-P96)		3.0	2.5	3.3	2.0	1.9	np	np	np	2.8
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)		2.6	2.4	2.7	1.9	2.4	np	np	np	2.4
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)		5.4	3.1	2.8	3.8	4.2	np	6.4	np	4.1
External causes of morbidity and mortality (V01-Y98)		34.4	36.1	43.2	44.8	37.7	45.3	32.4	60.6	38.4
All causes		576.4	555.8	581.0	535.6	566.6	642.4	513.1	795.0	570.0
Cause of death					<i>variability band ± (g)</i>					
Certain infectious and parasitic diseases (A00-B99)	±	0.7	0.7	0.8	1.0	1.3	2.0	3.2	np	0.4
Neoplasms (cancer) (C00-D48)	±	2.9	3.3	3.8	5.2	5.7	10.7	13.3	31.4	1.7
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	±	0.3	0.3	0.4	0.5	0.6	np	np	–	0.2
Endocrine, nutritional and metabolic diseases (E00-E90)	±	1.0	1.2	1.4	2.0	2.1	4.5	4.9	17.9	0.6
Mental and behavioural disorders (F00-F99)	±	1.1	1.2	1.5	2.0	2.2	4.8	5.6	19.4	0.6
Nervous system diseases (G00-G99)	±	1.0	1.3	1.4	2.2	2.2	4.3	6.2	13.7	0.6
Diseases of the eye and adnexa (H00-H59)	±	np	np	np	np	–	–	–	–	np
Diseases of the ear and mastoid process (H60-H95)	±	np	np	np	np	np	–	–	–	np

TABLE EA.56

Table EA.56 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (f)</i>
Circulatory diseases (I00-I99)	±	2.8	3.1	3.8	5.0	5.4	10.4	13.3	32.1	1.6
Respiratory Diseases (J00-J99)	±	1.5	1.6	2.0	2.6	2.8	5.6	7.2	21.4	0.8
Digestive diseases (K00-K93)	±	1.0	1.1	1.3	1.8	1.9	3.6	4.8	13.1	0.6
Diseases of the skin and subcutaneous tissue (L00-L99)	±	0.3	0.3	0.3	0.5	0.5	np	np	np	0.2
Diseases of the musculoskeletal system and connective tissue (M00-M99)	±	0.5	0.5	0.6	0.8	0.8	1.7	np	np	0.3
Kidney diseases (N00-N99)	±	0.7	0.9	1.0	1.4	1.5	2.8	4.2	np	0.4
Pregnancy, childbirth and the puerperium (O00-O99)	±	np	np	np	–	np	–	–	np	np
Conditions originating in the perinatal period (P00-P96)	±	0.4	0.4	0.5	0.6	0.7	np	np	np	0.2
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	±	0.4	0.4	0.5	0.6	0.8	np	np	np	0.2
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	±	0.5	0.4	0.5	0.8	0.9	np	2.7	np	0.3
External causes of morbidity and mortality (V01-Y98)	±	1.3	1.5	1.9	2.7	2.9	5.7	6.0	12.0	0.8
All causes	±	5.1	5.8	6.9	9.4	10.1	19.6	24.7	62.1	2.9
<i>2012</i>										
Cause of death					<i>Rate (per 100 000 persons)</i>					
Certain infectious and parasitic diseases (A00-B99)		10.6	8.4	6.9	7.8	10.9	8.2	6.6	np	9.1
Neoplasms (cancer) (C00-D48)		166.8	162.4	179.2	167.0	166.6	185.7	147.0	211.7	168.4
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)		1.8	1.6	1.7	1.5	1.6	np	np	np	1.7
Endocrine, nutritional and metabolic diseases (E00-E90)		20.2	23.0	23.3	23.6	22.6	33.7	24.6	65.2	22.7
Mental and behavioural disorders (F00-F99)		27.6	27.2	26.7	27.5	34.7	48.3	25.0	30.9	28.5
Nervous system diseases (G00-G99)		23.2	26.8	25.3	30.3	28.5	25.7	24.0	23.7	25.7
Diseases of the eye and adnexa (H00-H59)		np	np	np	np	–	–	–	–	np

TABLE EA.56

Table EA.56 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (f)	
Diseases of the ear and mastoid process (H60-H95)	np	np	np	–	–	–	–	np	np	
Circulatory diseases (I00-I99)	160.1	148.1	175.1	144.5	161.5	195.2	141.4	185.3	159.6	
Respiratory Diseases (J00-J99)	50.7	45.0	50.4	45.9	49.2	62.1	42.0	73.5	49.0	
Digestive diseases (K00-K93)	18.8	19.8	20.8	17.6	21.1	22.2	20.5	26.6	19.7	
Diseases of the skin and subcutaneous tissue (L00-L99)	1.7	1.4	1.4	1.1	1.2	np	np	np	1.4	
Diseases of the musculoskeletal system and connective tissue (M00-M99)	4.0	4.2	5.1	3.3	2.7	8.0	6.6	np	4.3	
Kidney diseases (N00-N99)	13.4	15.5	11.8	13.6	14.0	13.0	13.1	23.5	13.8	
Pregnancy, childbirth and the puerperium (O00-O99)	np	np	np	–	np	–	–	–	np	
Conditions originating in the perinatal period (P00-P96)	2.2	2.0	2.8	1.3	2.6	np	np	np	2.3	
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	2.4	2.2	2.6	2.0	2.6	np	np	np	2.4	
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	7.2	3.5	3.7	5.5	13.3	3.5	np	13.3	5.9	
External causes of morbidity and mortality (V01-Y98)	33.8	33.3	43.7	46.2	39.2	44.0	31.7	79.5	37.9	
All causes	544.5	524.7	580.7	538.9	572.4	658.3	494.9	769.2	552.3	
Cause of death										
									<i>variability band ± (g)</i>	
Certain infectious and parasitic diseases (A00-B99)	±	0.7	0.7	0.7	1.1	1.4	2.3	2.7	np	0.4
Neoplasms (cancer) (C00-D48)	±	2.7	3.1	3.8	5.2	5.5	10.5	13.1	29.8	1.6
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	±	0.3	0.3	0.4	0.5	0.5	np	np	np	0.2
Endocrine, nutritional and metabolic diseases (E00-E90)	±	0.9	1.2	1.4	1.9	2.0	4.4	5.3	16.4	0.6
Mental and behavioural disorders (F00-F99)	±	1.0	1.2	1.4	2.1	2.3	5.1	5.2	12.9	0.6
Nervous system diseases (G00-G99)	±	1.0	1.2	1.4	2.2	2.2	3.8	5.2	11.2	0.6

Table EA.56 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (f)</i>
Diseases of the eye and adnexa (H00-H59)	±	np	np	np	np	–	–	–	–	np
Diseases of the ear and mastoid process (H60-H95)	±	np	np	np	–	–	–	–	np	np
Circulatory diseases (I00-I99)	±	2.6	2.9	3.7	4.7	5.1	10.5	12.7	28.8	1.5
Respiratory Diseases (J00-J99)	±	1.5	1.6	2.0	2.7	2.9	6.0	6.9	19.1	0.8
Digestive diseases (K00-K93)	±	0.9	1.1	1.3	1.7	1.9	3.6	4.9	9.8	0.5
Diseases of the skin and subcutaneous tissue (L00-L99)	±	0.3	0.3	0.3	0.4	0.4	np	np	np	0.1
Diseases of the musculoskeletal system and connective tissue (M00-M99)	±	0.4	0.5	0.6	0.7	0.7	2.1	2.7	np	0.2
Kidney diseases (N00-N99)	±	0.7	0.9	1.0	1.5	1.5	2.6	3.9	10.1	0.4
Pregnancy, childbirth and the puerperium (O00-O99)	±	np	np	np	–	np	–	–	–	np
Conditions originating in the perinatal period (P00-P96)	±	0.3	0.4	0.5	0.5	0.8	np	np	np	0.2
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	±	0.3	0.4	0.5	0.6	0.8	np	np	np	0.2
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	±	0.6	0.5	0.6	0.9	1.7	1.5	np	6.1	0.3
External causes of morbidity and mortality (V01-Y98)	±	1.3	1.4	1.9	2.7	2.9	5.6	5.8	14.3	0.8
All causes	±	4.9	5.5	6.8	9.2	10.0	19.6	23.8	56.7	2.9

(a) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2007-2010 (final), 2011 (revised) and 2012 (preliminary). See Causes of Death, Australia, 2012 (Cat. no. 3303.0) Technical Note: Causes of Death Revisions 2010 and 2011 for further information.

(b) Age standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 100 000 persons. SDRs in this table have been calculated using the direct method, age standardised by 5 year age group to 85 years or over. Rates calculated using the direct method are not comparable to rates calculated using the indirect method.

(c) Based on year of registration of death (also called 'reference year'). See data quality information for a more detailed explanation.

Table EA.56 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i> (f)
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(d) Some totals and figures may not compute due to the effects of rounding.

(e) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See data quality statements for more information.

(f) All states and territories including other territories.

(g) Variability bands can be used for comparisons within jurisdictions (for cause of death or over time), but not between jurisdictions or between jurisdictions and totals. See DQI for more information.

– Nil or rounded to zero. **np** not published.

Source: ABS unpublished, *Causes of Death, Australia, 2012*, Cat. no. 3303.0.

Table EA.57 **Age standardised mortality rates by major cause of death, by Indigenous status, 2008–2012 (a), (b), (c), (d), (e), (f), (g), (h), (i)**

	NSW	Qld (j)	WA (k)	SA	NT	Total (j), (k), (l)
Cause of death — Rate (per 100 000 population)						
Aboriginal and Torres Strait Islander people						
Circulatory diseases (I00-I99)	255.7	276.8	380.9	230.0	330.7	285.7
Neoplasms (cancer) (C00-D48)	194.5	231.2	254.4	156.2	316.2	224.1
External causes of morbidity and mortality (V01-Y98)	51.0	61.0	120.0	83.4	122.8	75.2
Endocrine, metabolic and nutritional disorders (E00-E90)	56.9	106.8	161.7	62.6	210.2	103.3
Respiratory diseases (J00-J99)	88.9	85.1	105.6	78.8	151.8	96.3
Digestive diseases (K00-K93)	30.1	49.9	58.8	55.7	79.5	47.4
Kidney Diseases (N00-N29)	20.5	25.0	39.6	np	63.2	29.6
Conditions originating in the perinatal period (P00-P96)	2.9	4.4	4.1	np	9.3	4.3
Infectious and parasitic diseases (A00-B99)	14.7	18.4	23.4	21.4	31.9	19.4
Nervous system diseases (G00-G99)	17.6	22.8	36.0	34.3	28.0	24.0
Other causes (m)	58.1	69.1	108.8	64.0	125.2	76.4
All causes	791.0	950.6	1 293.3	813.8	1 469.1	985.6
Other Australians						
Circulatory diseases (I00-I99)	193.7	197.8	169.0	196.7	153.9	191.8
Neoplasms (cancer) (C00-D48)	176.6	182.3	173.3	179.4	197.1	177.9
External causes of morbidity and mortality (V01-Y98)	34.6	41.6	41.8	38.3	58.9	38.2
Endocrine, metabolic and nutritional disorders (E00-E90)	21.2	23.5	23.7	25.4	30.6	22.7
Respiratory diseases (J00-J99)	51.0	50.1	43.9	50.1	59.1	49.8
Digestive diseases (K00-K93)	20.8	20.4	19.6	20.8	25.1	20.5
Kidney Diseases (N00-N29)	11.7	9.8	10.2	np	9.8	11.2
Conditions originating in the perinatal period (P00-P96)	2.8	3.0	1.6	np	2.7	2.6
Infectious and parasitic diseases (A00-B99)	10.6	7.0	7.5	9.8	13.3	9.2
Nervous system diseases (G00-G99)	23.9	24.9	30.6	30.6	27.1	25.8
Other causes (m)	48.0	44.2	44.1	51.4	50.7	47.0
All causes	594.9	604.7	565.3	618.3	628.1	596.7
Cause of death — Rate difference						
Circulatory diseases (I00-I99)	62.0	79.0	211.9	33.3	176.8	93.9
Neoplasms (cancer) (C00-D48)	17.9	48.9	81.1	- 23.2	119.1	46.2
External causes of morbidity and mortality (V01-Y98)	16.4	19.4	78.2	45.1	63.9	37.0
Endocrine, metabolic and nutritional disorders (E00-E90)	35.7	83.3	138.0	37.2	179.6	80.6
Respiratory diseases (J00-J99)	37.9	35.0	61.7	28.7	92.7	46.5
Digestive diseases (K00-K93)	9.3	29.5	39.2	34.9	54.4	26.9

Table EA.57 Age standardised mortality rates by major cause of death, by Indigenous status, 2008–2012 (a), (b), (c), (d), (e), (f), (g), (h), (i)

	NSW	Qld (j)	WA (k)	SA	NT	Total (j), (k), (l)
Kidney Diseases (N00-N29)	8.8	15.2	29.4	np	53.4	18.4
Conditions originating in the perinatal period (P00-P96)	0.1	1.4	2.5	np	6.6	1.7
Infectious and parasitic diseases (A00-B99)	4.1	11.4	15.9	11.6	18.6	10.2
Nervous system diseases (G00-G99)	- 6.3	- 2.1	5.4	3.7	0.9	- 1.8
Other causes (m)	10.1	24.9	64.7	12.6	74.5	29.4
All causes	196.1	345.9	728.0	195.5	841.0	388.9
Cause of death — Rate ratio						
Circulatory diseases (I00-I99)	1.3	1.4	2.3	1.2	2.1	1.5
Neoplasms (cancer) (C00-D48)	1.1	1.3	1.5	0.9	1.6	1.3
External causes of morbidity and mortality (V01-Y98)	1.5	1.5	2.9	2.2	2.1	2.0
Endocrine, metabolic and nutritional disorders (E00-E90)	2.7	4.5	6.8	2.5	6.9	4.6
Respiratory diseases (J00-J99)	1.7	1.7	2.4	1.6	2.6	1.9
Digestive diseases (K00-K93)	1.4	2.4	3.0	2.7	3.2	2.3
Kidney Diseases (N00-N29)	1.8	2.6	3.9	np	6.4	2.6
Conditions originating in the perinatal period (P00-P96)	1.0	1.5	2.6	np	3.4	1.7
Infectious and parasitic diseases (A00-B99)	1.4	2.6	3.1	2.2	2.4	2.1
Nervous system diseases (G00-G99)	0.7	0.9	1.2	1.1	1.0	0.9
Other causes (m)	1.2	1.6	2.5	1.2	2.5	1.6
All causes	1.3	1.6	2.3	1.3	2.3	1.7

- (a) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2008-2010 (final), 2011 (revised) and 2012 (preliminary). See *Causes of Death, Australia, 2012* (Cat. no. 3303.0) Technical Note: Causes of Death Revisions 2010 and 2011 for further information.
- (b) Age standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 100 000 persons. SDRs in this table have been calculated using the direct method, age standardised by 5 year age group to 75 years and over. Rates calculated using the direct method are not comparable to rates calculated using the indirect method.
- (c) Non-Indigenous estimates are available for census years only. In the intervening years, Aboriginal and Torres Strait Islander population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the Indigenous population from the total population. Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.
- (d) Data are reported by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. Only these five states and territories have evidence of a sufficient level of Indigenous identification and sufficient numbers of Indigenous deaths to support mortality analysis.
- (e) Deaths where the Indigenous status of the deceased was not stated are excluded from analysis.
- (f) Data are presented in five-year groupings due to the volatility of small numbers each year.
- (g) Data based on reference year. See data quality information (DQI) for a more detailed explanation.

Table EA.57 Age standardised mortality rates by major cause of death, by Indigenous status, 2008–2012 (a), (b), (c), (d), (e), (f), (g), (h), (i)

	NSW	Qld (j)	WA (k)	SA	NT	Total (j), (k), (l)
(h)	A derived ERP based on the 2006 Census is used in the calculation of total population rates. Non-Indigenous ERP was derived by subtracting Aboriginal and Torres Strait Islander projections based on the 2006 Census (3238.0) from the total population ERP. Population estimates from <i>Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021</i> (Cat. no. 3238.0) (based on the 2006 Census) are used to calculate Aboriginal and Torres Strait Islander rates.					
(i)	Some totals and figures may not compute due to the effects of rounding.					
(j)	Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See DQI for a more detailed explanation.					
(k)	For WA, Indigenous deaths data for 2007, 2008 and 2009 have been corrected. The data differ from previous reports in which they were over-reported. Please see DQI for more information.					
(l)	Total includes data for NSW, Queensland, WA, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.					
(m)	Other causes consist of all conditions excluding the selected causes displayed in the table.					
	np Not published.					

Source: ABS unpublished, *Causes of Death, Australia, 2012*, Cat. no. 3303.0.

TABLE EA.58

Table EA.58 **Employed medical practitioners (a), (b), (c), (d), (e), (f)**

	NSW(g)	Vic(h)	Qld(i), (j)	WA(i), (k)	SA	Tas(l)	ACT(m)	NT(n)	Aust
Practitioner rate (per 100 000 people)									
2004	317.9	314.8	225.4	243.2	323.6	288.1	390.0	240.3	292.0
2005	324.7	317.3	238.7	242.7	320.9	295.8	411.3	349.2	298.6
2006	314.1	325.8	243.9	308.0	329.1	275.9	399.8	414.2	305.2
2007	307.6	330.2	296.9	366.2	342.0	312.2	420.8	420.1	322.7
2008	310.7	329.2	315.2	315.7	348.4	300.9	447.5	378.4	322.2
2009	311.8	337.3	342.1	337.3	357.3	365.6	470.7	443.3	335.3
2010	342.0	345.8	na	na	380.4	349.6	420.2	352.1	na
2011	352.8	351.0	349.7	326.0	386.5	354.7	425.3	421.1	353.4
2012	350.2	348.6	348.2	325.0	380.1	346.8	418.5	428.6	350.7
2013	362.4	352.0	347.9	327.8	384.8	360.0	435.4	418.3	356.6
FTE practitioner rate (per 100 000 people) based on 40-hour week									
2004	352.3	343.3	242.9	258.0	347.5	301.2	426.0	263.5	318.1
2005	359.4	342.6	256.4	250.5	340.3	301.5	441.6	379.9	322.8
2006	337.2	355.4	259.8	320.5	347.9	283.1	413.1	452.3	326.5
2007	331.1	353.6	314.1	383.3	355.6	316.9	453.4	451.6	343.7
2008	333.6	352.4	321.8	329.1	359.7	305.0	489.6	400.1	339.9
2009	326.3	355.1	355.6	352.7	363.6	362.7	508.6	472.7	349.6
2010 (d), (m), (n)	373.7	371.4	na	na	409.4	372.4	458.0	378.6	na
2011	385.5	375.3	378.4	349.0	409.0	374.9	468.1	462.8	381.4
2012	378.0	366.5	373.2	343.6	401.1	359.2	454.1	466.1	373.9
2013	390.4	373.0	373.5	349.0	413.0	374.9	478.6	454.1	381.7
FTE employed medical practitioner rate (per 100 000 people), by age group, 2013									
< 25 years	0.7	1.3	1.2	1.0	0.7	1.0	0.3	–	1.0
25–34	90.8	98.9	89.9	92.5	104.5	84.2	119.8	150.1	94.8

Table EA.58 **Employed medical practitioners (a), (b), (c), (d), (e), (f)**

	NSW(g)	Vic(h)	Qld(i), (j)	WA(i), (k)	SA	Tas(l)	ACT(m)	NT(n)	Aust
35–44	100.2	94.7	106.9	96.6	106.7	95.9	125.7	121.4	100.8
45–54	90.5	85.8	93.1	81.9	96.5	93.9	118.2	93.1	90.0
55–64	71.1	64.7	59.1	55.8	73.3	75.4	87.9	62.8	65.9
65 years or over	37.2	27.6	23.3	21.1	31.2	24.5	26.8	26.6	29.3

FTE = Full time equivalent.

- (a) FTE rate (FTE per 100 000 people) is based on a standard full-time working week of 40 hours.
- (b) Includes medical practitioners who are employed in medicine. Excludes medical practitioners on extended leave.
- (c) Due to rounding of average hours worked, the sum of states and territories' FTE rates may not add up to total FTE rate for Australia and the sum of age group FTE rates may not add up to the total FTE rate for each state. Further, data for Australia include employed practitioners where state or territory is unidentified and employed practitioners who are overseas.
- (d) From 2010, state and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are also unavailable, state and territory of residence is used. Records with no information on all three locations are coded to 'Not stated' but are included in data for Australia.
- (e) Introduction of a national data collection tool in 2010 resulted in a slight change in patterns of responses to employment-related questions. Prior to 2010, survey questions were not consistent across jurisdictions. Caution should be used in comparing data over time and, particularly for years prior to 2010, between jurisdictions. See data quality information (DQI) at www.pc.gov.au/rogs/2015 for further detail.
- (f) From 2012, data exclude provisional registrants.
- (g) Prior to 2010, NSW data are based on responses to the AIHW Medical Labour Force Survey weighted to financial registrants holding general, conditional specialist, limited prescribing and referring or non-practising registration.
- (h) In 2009, Victoria surveyed only general, specific and provisional registered medical practitioners in the Medical Labour Force Survey but responses are weighted to all registered medical practitioners.
- (i) 2010 data exclude Qld and WA due to their registration period closing after the national registration deadline of 30 September 2010.
- (j) In 2009, Queensland data are based on responses to the Medical Labour Force Survey weighted to all registrants excluding some conditional registration types. In 2005, responses to annual Medical Labour Force Surveys were weighted to general registrants and conditionally registered specialists only.

Table EA.58 **Employed medical practitioners (a), (b), (c), (d), (e), (f)**

	<i>NSW(g)</i>	<i>Vic(h)</i>	<i>Qld(i), (j)</i>	<i>WA(i), (k)</i>	<i>SA</i>	<i>Tas(l)</i>	<i>ACT(m)</i>	<i>NT(n)</i>	<i>Aust</i>
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(k) For WA, in 2009, the scope was consistent, that is, the survey population and the benchmark figures are based on general and conditional registrants. In 2005, the survey was administered to both general and conditional registrants but benchmark figures were for general registrants only. For WA in 2009, the benchmark data includes a significant number of registered medical practitioners that are no longer active in the workforce. This inflates the perception of the medical labour force in WA. It is also unknown how significantly past years have been affected. Care should be taken when interpreting these figures.

(l) Prior to 2010, Tasmania data are based on responses to the AIHW Medical Labour Force Survey weighted to general registrants, conditionally registered specialists and non-practising registrants only.

(m) Caution should be used in comparing data for the ACT with other jurisdictions. Rates for the ACT are inflated as many services are provided to southern NSW residents not captured in the denominator. In addition, a relatively high proportion of practitioners work in non-clinical roles such as educational facilities, the defence force and other government agencies, compared to other jurisdictions (AIHW 2014d).

(n) Comparisons with NT data should be made with caution due to changes in doctors' registration requirements — in particular, nationally registered doctors providing fly in fly out services are no longer required to register in the NT.

na Not available.

Source: AIHW unpublished, National Health Workforce Data Set; ABS 2013, 2014, *Australian demographic statistics*, Cat. no. 3101.

TABLE EA.59

Table EA.59 **Employed nurses (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic (h)</i>	<i>Qld (i)</i>	<i>WA (j)</i>	<i>SA</i>	<i>Tas (k)</i>	<i>ACT</i>	<i>NT (l)</i>	<i>Aust</i>
Practitioner rate (per 100 000 people)									
2004	1 130	1 369	1 058	1 167	1 500	1 281	1 192	1 162	1 212
2005	1 083	1 367	1 036	1 136	1 523	1 366	1 244	3 468	1 198
2006	na	na	na	na	na	na	na	na	na
2007	1 116	1 438	1 171	1 134	1 508	1 428	1 229	1 385	1 250
2008	1 117	1 391	1 140	1 215	1 625	1 472	1 285	1 827	1 255
2009	1 110	1 386	1 170	1 186	1 712	1 465	1 275	1 814	1 261
2010	na	na	na	na	na	na	na	na	na
2011	1 111	1 429	1 248	1 218	1 670	1 451	1 276	1 514	1 284
2012	1 113	1 413	1 241	1 223	1 666	1 393	1 264	1 596	1 279
2013	1 137	1 395	1 229	1 214	1 669	1 429	1 273	1 572	1 280
FTE nurses rate (per 100 000 people) based on a 38-hour week									
2004	1 014	1 146	916	983	1 259	1 115	1 069	1 149	1 046
2005	975	1 144	913	950	1 279	1 190	1 126	3 468	1 040
2006	na	na	na	na	na	na	na	na	na
2007	1 007	1 224	1 032	972	1 287	1 254	1 106	1 431	1 095
2008	1 014	1 183	1 014	1 042	1 403	1 301	1 170	1 827	1 103
2009	1 005	1 167	1 043	1 008	1 469	1 280	1 168	1 800	1 105
2010 (d), (m), (n)	na	na	na	na	na	na	na	na	na
2011	993	1 182	1 091	1 037	1 388	1 239	1 164	1 504	1 107
2012	1 014	1 189	1 107	1 064	1 416	1 179	1 183	1 615	1 123
2013	1 062	1 210	1 122	1 093	1 443	1 257	1 213	1 643	1 155
FTE employed nurses and midwives, rate per 100 000 people based on 38-hour weeks, by age, 2013 (l)									
< 25 years	50.6	71.8	57.6	61.4	69.8	59.6	59.9	75.2	60.4
25–34	212.5	262.6	207.7	228.8	250.6	185.4	264.3	415.9	230.9

Table EA.59 **Employed nurses (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic (h)</i>	<i>Qld (i)</i>	<i>WA (j)</i>	<i>SA</i>	<i>Tas (k)</i>	<i>ACT</i>	<i>NT (l)</i>	<i>Aust</i>
35–44	231.4	264.7	260.6	241.1	308.2	229.5	277.8	372.6	254.3
45–54	295.7	335.2	344.9	313.4	463.7	442.7	336.9	419.0	334.7
55–64	240.1	246.2	219.7	218.5	321.4	309.5	252.0	318.3	243.6
65 years or over	31.8	29.8	31.1	30.2	29.5	30.2	21.6	41.6	30.7

FTE = Full time equivalent.

(a) Includes registered and enrolled nurses who are employed in nursing.

(b) FTE rate (FTE per 100 000 people) is based on standard full-time working week of 38 hours.

(c) Data for not available for 2006 or 2010.

(d) Due to rounding of average hours worked, the sum of states and territories' FTE rates may not add up to total FTE rate for Australia and the sum of age group FTE rates may not add up to the total FTE rate for each state. Further, data for Australia include employed practitioners where state or territory is unidentified and employed practitioners who are overseas.

(e) From 2010, state and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are also unavailable, state and territory of residence is used. Records with no information on all three locations are coded to 'Not stated' but are included in data for Australia.

(f) Introduction of a national data collection tool in 2010 resulted in a slight change in patterns of responses to employment-related questions. Prior to 2010, survey questions were not consistent across jurisdictions. Caution should be used in comparing data over time and, particularly for years prior to 2010, between jurisdictions. See data quality information (DQI) at www.pc.gov.au/rogs/2015 for further detail.

(g) From 2012, data exclude provisional registrants.

(h) Because survey data for Victoria were not available in 2005, the 2006 Victorian survey responses were weighted to 2005 benchmarks. Therefore, care should be taken when comparing these data for Victoria with earlier years and in making comparisons with other states and territories in 2005. In 2008 Victorian data was affected by large numbers of online survey records not being able to be used for technical reasons. Estimates for Victoria for 2008 and 2009 should be treated with caution due to low response rate (33.3 per cent and 31.7 per cent respectively).

(i) Queensland estimates for 2007, 2008 and 2009 should be treated with caution due to low response rates (33.9, 32.9 and 28.2 per cent, respectively). Benchmark data for Queensland in 2009 was estimated by using the total from a summary table provided to AIHW by Queensland Health prorated to the age distribution of 2008.

(j) Estimates for WA for 2005, 2007, 2008 and 2009 should be treated with caution due to low response rates (26.9, 36.7, 34.4 and 35.4 per cent, respectively). Benchmark data for Western Australia in 2009 was estimated by using the total from the Nursing board annual report prorated to the age distribution of 2008.

Table EA.59 **Employed nurses (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic (h)</i>	<i>Qld (i)</i>	<i>WA (j)</i>	<i>SA</i>	<i>Tas (k)</i>	<i>ACT</i>	<i>NT (l)</i>	<i>Aust</i>
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(k) Estimates for Tasmania for 2009 should be treated with caution due to low response rate (33.2 per cent). Differences between 2008 and 2009 for Tasmanian data in particular may be caused by the large decline in the response rate for that jurisdiction (from 56.9 to 33.2 per cent).

(l) Estimates for the NT for 2004, 2007, 2008 and 2009 should be treated with caution due to low response rates (35.1, 28.7, 34.9 and 32.8 per cent, respectively). Data for NT for 2005 are not published. Benchmark data for the Northern Territory in 2009 was estimated by using the total from the Nursing board quarterly bulletin report prorated to the age distribution of 2008. Data for the NT is affected by the transient nature of the nursing labour force in that jurisdiction. According to the Nursing Board Annual Report, approximately one-third of all nurses do not re-register each year, primarily because they no longer practise in the jurisdiction. There has been some variation across years in the degree to which nurses who are interstate have been removed from the renewal process and hence the survey.

na Not available.

Source: AIHW unpublished, National Health Workforce Data Set; ABS unpublished, ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0 (based on the 2011 ABS Census of Population and Housing).

Table EA.60 **Employed allied health practitioners (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (g)</i>	<i>WA (g)</i>	<i>SA (g)</i>	<i>Tas (g)</i>	<i>ACT (h)</i>	<i>NT</i>	<i>Aust</i>
FTE employed allied health practitioners rate (per 100 000 people) based on a 38-hour week									
2012 (g)	406.2	439.9	302.4	321.0	356.0	311.6	482.9	401.1	379.9
2013	419.4	452.0	406.9	427.9	423.6	360.1	507.0	414.3	426.3
FTE employed allied health practitioners, rate per 100 000 people based on 38-hour weeks, by age, 2013 (l)									
< 25 years	24.9	34.2	32.9	40.0	37.0	19.7	26.7	18.0	31.2
25–34	143.1	171.8	143.3	161.2	154.2	108.8	183.6	155.8	153.1
35–44	97.5	101.5	97.1	93.4	97.3	83.7	113.5	87.1	97.8
45–54	81.2	78.5	77.9	72.6	72.2	79.2	96.3	92.5	78.6
55–64	57.5	51.8	45.5	48.9	51.0	56.8	71.5	51.7	52.4
65 years or over	15.2	14.2	10.2	11.8	11.9	11.9	15.3	9.2	13.2
Total	419.4	452.0	406.9	427.9	423.6	360.1	507.0	414.3	426.3

FTE = Full time equivalent.

(a) FTE rate (FTE per 100 000 people) is based on standard full-time working week of 38 hours.

(b) Due to rounding of average hours worked, the sum of states and territories' FTE rates may not add up to total FTE rate for Australia and the sum of age groups FTE rates may not add up to total FTE rate for each state. The Australian total includes employed practitioners who did not state or adequately describe their state or territory of principal practice and employed practitioners who are overseas.

(c) State and territory is derived, with the exception of medical radiation practitioners and occupational therapists, from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to 'Not stated'. For medical radiation practitioners and occupational therapists, state and territory is derived from principal practice details.

(d) Data exclude provisional registrants.

(e) Allied health workforce data include Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, chiropractors, medical radiation practitioners, occupational therapists, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists. Data are not comparable to allied health workforce data for 2011 as Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists did not join the National Registration and Accreditation Scheme until 2012.

(f) Not all Aboriginal and Torres Strait Islander health workers are registered as Aboriginal and Torres Strait Islander health practitioners.

Table EA.60 **Employed allied health practitioners (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (g)</i>	<i>WA (g)</i>	<i>SA (g)</i>	<i>Tas (g)</i>	<i>ACT (h)</i>	<i>NT</i>	<i>Aust</i>
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(g) For 2012, due to transitional arrangements, many practitioners in some allied health professions were not required to renew their registration in all jurisdictions and so did not complete a workforce survey. Data for those professions are excluded from the affected jurisdictions, as follows:

- data for Queensland and WA exclude medical radiation practitioners and occupational therapists
- data for SA exclude occupational therapists
- data for Tasmania exclude medical radiation practitioners.

(h) Caution should be used in comparing data for the ACT with other jurisdictions. Rates for the ACT are inflated as many services are provided to southern NSW residents not captured in the denominator.

Source: AIHW unpublished, National Health Workforce Data Set; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0 (based on the 2011 ABS Census of Population and Housing).

TABLE EA.61

Table EA.61 **Net growth in health workforce, selected professions (a), (b), (c), (d), (e)**

<i>Unit</i>	<i>NSW (f)</i>	<i>Vic (g)</i>	<i>Qld(f), (g), (h)</i>	<i>WA(f), (g), (h)</i>	<i>SA</i>	<i>Tas (f), (g)</i>	<i>ACT</i>	<i>NT (g), (i)</i>	<i>Aust (j)</i>	
FTE Medical practitioners in the workforce (b), (i)										
2009 (e), (f), (g)	no.	23 017	19 076	15 391	7 901	5 850	1 829	1 804	1 069	75 831
2010 (h)	no.	26 695	20 282	na	na	6 663	1 895	1 657	870	na
2011	no.	27 828	20 781	16 938	8 213	6 705	1 918	1 723	1 070	85 215
2012	no.	27 601	20 628	17 039	8 358	6 644	1 840	1 702	1 096	84 920
2013	no.	28 930	21 407	17 386	8 797	6 900	1 924	1 826	1 095	88 305
Growth in medical workforce from 2009 to 2013										
Net growth	%	25.7	12.2	13.0	11.3	17.9	5.2	1.2	2.5	16.5
Annual average	%	5.9	2.9	3.1	2.7	4.2	1.3	0.3	0.6	3.9
FTE Nurses and midwives in the workforce (b), (k)										
2009 (e), (g)	no.	70 893	62 687	45 164	22 582	23 631	6 454	4 144	4 069	239 648
2010 (j)	no.	na	na	na	na	na	na	na	na	na
2011	no.	71 675	65 460	48 849	24 393	22 756	6 340	4 282	3 478	247 269
2012	no.	74 045	66 933	50 552	25 882	23 454	6 038	4 435	3 797	255 150
2013	no.	78 697	69 457	52 216	27 562	24 113	6 449	4 625	3 962	267 119
Growth in the nursing and midwifery workforce from 2009 to 2013										
Net growth	%	11.0	10.8	15.6	22.1	2.0	- 0.1	11.6	- 2.6	11.5
Annual average	%	2.6	2.6	3.7	5.1	0.5	0.0	2.8	-0.7	2.8

FTE = Full time equivalent.

(a) Net growth measures the change in the full time equivalent (FTE) number in the workforce in the reference year compared to the year prior to the reference year.

(b) FTE is based on a 40 hour standard full-time working week for medical practitioners and a 38 hour standard full-time working week for nurses and midwives.

(c) A national data collection tool was introduced in 2010, resulting in a slight change in patterns of responses to employment-related questions. Prior to 2010, survey questions were not consistent across jurisdictions. Caution should be used in comparing data over time and, particularly for years prior to 2010, between jurisdictions. See data quality information (DQI) at www.pc.gov.au/rogs/2015 for further detail.

Table EA.61 **Net growth in health workforce, selected professions (a), (b), (c), (d), (e)**

<i>Unit</i>	<i>NSW (f)</i>	<i>Vic (g)</i>	<i>Qld(f), (g), (h)</i>	<i>WA(f), (g), (h)</i>	<i>SA</i>	<i>Tas (f), (g)</i>	<i>ACT</i>	<i>NT (g), (i)</i>	<i>Aust (j)</i>
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(d) From 2010, state and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are also unavailable, state and territory of residence is used. Records with no information on all three locations are coded to 'Not stated' but are included in data for Australia.

(e) Data for 2009 are for the workforce, including practitioners who are employed, on extended leave and/or looking for work. From 2010, data are only for those employed in the workforce. Therefore, comparisons should be made with caution.

(f) Data for 2009 for NSW, Queensland and Tasmania are underestimates, as the benchmark figures did not include all registered medical practitioners. For 2009 WA data, the benchmark data were inflated by a significant number of registered medical practitioners that are no longer active in the workforce.

(g) For 2009, state and territory estimates should be treated with caution due to low response rates in some jurisdictions, particularly Victoria, Queensland, WA, Tasmania and the NT.

(h) For medical practitioners, 2010 data for Queensland and Western Australia are not available.

(i) Caution should be used in comparing medical workforce data for the NT with other jurisdictions from 2010 as this was the first year of changed doctors' registration requirements (in particular, doctors providing fly in fly out services are no longer required to register in the NT where they are registered nationally).

(j) Due to rounding of average hours worked, the total FTE for Australia may not add up to the sum of states and territories.

(k) For nurses and midwives, data are not available for 2010.

na Not available.

Source: AIHW unpublished, National Health Workforce Data Set; AIHW unpublished, Medical Labour Force Survey; AIHW unpublished, Nursing and Midwifery Labour Force Survey; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0 (based on the 2011 ABS Census of Population and Housing).

Table EA.62 Employed health workforce, by Indigenous status and state or territory of principal practice (a)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (b)</i>
Medical practitioners employed in medicine (c)									
2010 (d)									
Number									
Aboriginal and Torres Strait Islander practitioners (c)	60	23	na	na	9	3	7	14	117
Non-Indigenous	24 284	18 790	na	na	6 158	1 770	1 508	794	53 330
Not stated	90	73	na	na	24	6	5	1	199
Total	24 434	18 886	na	na	6 191	1 779	1 520	809	53 646
Proportion who are Aboriginal and Torres Strait Islander people (e)	0.2	0.1	na	na	0.1	0.2	0.5	1.7	0.2
2011									
Number									
Aboriginal and Torres Strait Islander practitioners (c)	93	22	59	32	17	4	7	16	249
Non-Indigenous	25 232	19 308	15 509	7 609	6 292	1 795	1 545	950	78 282
Not stated	89	83	61	27	19	14	4	5	302
Total	25 413	19 413	15 628	7 667	6 328	1 813	1 557	972	78 833
Proportion who are Aboriginal and Torres Strait Islander people (e)	0.4	0.1	0.4	0.4	0.3	0.2	0.5	1.7	0.3
2012									
Number									
Aboriginal and Torres Strait Islander practitioners (c)	79	34	49	27	11	3	5	14	221
Non-Indigenous	25 393	19 516	15 792	7 863	6 264	1 767	1 554	994	79 156
Not stated	95	71	56	17	21	6	9	—	276
Total	25 566	19 621	15 897	7 906	6 296	1 777	1 569	1 008	79 653
Proportion who are Aboriginal and Torres Strait Islander people (e)	0.3	0.2	0.3	0.3	0.2	0.2	0.3	1.4	0.3
2013									
Number									
Aboriginal and Torres Strait Islander practitioners (c)	107	51	73	29	20	8	10	10	308
Non-Indigenous	24,522	18,437	14,726	7,222	5,731	1,670	1,458	902	74,689
Not stated	2,225	1,712	1,397	1,012	677	169	193	97	7,501
Total	26,854	20,200	16,196	8,263	6,428	1,847	1,661	1,009	82,498
Proportion who are Aboriginal and Torres Strait Islander people (e)	0.4	0.3	0.5	0.4	0.3	0.5	0.7	1.1	0.4

Table EA.62 Employed health workforce, by Indigenous status and state or territory of principal practice (a)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (b)</i>
Nursing and midwifery practitioners employed (f)									
<i>2010 (g)</i>									
Number									
Aboriginal and Torres Strait Islander practitioners (c)	na	na	na	na	na	na	na	na	na
Non-Indigenous practitioners	na	na	na	na	na	na	na	na	na
Not stated	na	na	na	na	na	na		na	na
Total	na	na	na	na	na	na	na	na	na
Proportion who are Aboriginal and Torres Strait Islander people (e)									
	na	na	na	na	na	na	na	na	na
<i>2011</i>									
Number									
Aboriginal and Torres Strait Islander practitioners (c)	850	310	545	164	167	103	25	47	2 212
Non-Indigenous practitioners	78 160	77 555	54 368	28 127	26 653	7 228	4 652	3 404	280 199
Not stated	341	294	215	139	101	33	24	19	1 166
Total	79 351	78 159	55 128	28 430	26 921	7 364	4 701	3 470	283 577
Proportion who are Aboriginal and Torres Strait Islander people (e)									
	1.1	0.4	1.0	0.6	0.6	1.4	0.5	1.4	0.8
<i>2012</i>									
Number									
Aboriginal and Torres Strait Islander practitioners (c)	865	313	587	159	182	101	38	56	2 301
Non-Indigenous practitioners	80 057	78 957	55 870	29 472	27 297	7 014	4 677	3 683	287 046
Not stated	254	184	150	82	82	17	19	10	797
Total	81 176	79 455	56 607	29 712	27 561	7 132	4 734	3 749	290 144
Proportion who are Aboriginal and Torres Strait Islander people (e)									
	1.1	0.4	1.0	0.5	0.7	1.4	0.8	1.5	0.8
<i>2013</i>									
Number									
Aboriginal and Torres Strait Islander practitioners (c)	994	358	650	179	200	126	30	64	2 601
Non-Indigenous practitioners	81 126	77 358	55 367	28 540	26 737	7 033	4 669	3 592	284 456
Not stated	2 143	2 354	1 184	1 871	953	173	157	136	8 972
Total	84 263	80 070	57 201	30 590	27 890	7 332	4 856	3 792	296 029

Table EA.62 Employed health workforce, by Indigenous status and state or territory of principal practice (a)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (b)</i>
Proportion who are Aboriginal and Torres Strait Islander people (e)	1.2	0.4	1.1	0.6	0.7	1.7	0.6	1.7	0.9

- (a) State and territory is derived from state and territory of main job where available. Otherwise, state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to 'Not stated'.
- (b) Includes employed practitioners who did not state or adequately describe their state or territory and employed practitioners who live overseas. Therefore, state and territory totals may not sum to the national total.
- (c) Due to the small population size, the overall response rate and unexplained variation between years, data for Aboriginal and Torres Strait Islander medical practitioners should be treated with caution.
- (d) For medical practitioners, 2010 data for Queensland and Western Australia are not available.
- (e) Excludes the response category 'Indigenous status—Not stated'.
- (f) Includes people registered as midwives only.
- (g) For nurses and midwives, data are not available for 2010.
- na** Not available.

Source: AIHW various years, *Medical workforce* (various years), *Nursing and midwifery workforce* (various years).

Table EA.63 **Aboriginal and Torres Strait Islander health workforce, by State/Territory, 2011 (a), (b), (c), (d)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Aboriginal and Torres Strait Islander people										
Employed in health related occupation										
15-24 years	no.	260	76	214	94	61	18	8	105	836
25-34 years	no.	670	172	573	199	143	51	13	257	2 078
35-44 years	no.	862	214	782	279	200	60	21	286	2 704
45-54 years	no.	778	180	654	248	186	71	23	245	2 385
55-64 years	no.	336	76	305	141	69	30	7	117	1 084
65 years & over	no.	25	12	39	26	12	4	–	17	135
Total	no.	2 931	730	2 567	987	671	234	72	1 027	9 222
Census population '000		173	38	156	70	30	20	5	57	548
All people										
Employed in health related occupation										
15-24 years	no.	9 610	9 301	6 952	3 677	2 623	647	514	393	33 717
25-34 years	no.	38 545	35 679	26 165	13 372	10 722	2 482	2 146	1 931	131 045
35-44 years	no.	43 155	36 658	29 776	14 314	11 959	3 208	2 173	1 585	142 838
45-54 years	no.	47 276	37 069	30 493	15 002	13 974	4 181	2 331	1 540	151 877
55-64 years	no.	30 772	23 604	17 786	9 361	8 522	2 658	1 480	940	95 140
65 years & over	no.	6 555	4 655	3 313	1 801	1 353	410	251	146	18 484
Total	no.	175 913	146 966	114 485	57 527	49 153	13 586	8 895	6 535	573 101
Census population '000		6 918	5 354	4 333	2 239	1 597	495	357	212	21 508
Aboriginal and Torres Strait Islander health workforce as a proportion of total health workforce										
15-24 years	%	2.7	0.8	3.1	2.6	2.3	2.8	1.6	26.7	2.5
25-34 years	%	1.7	0.5	2.2	1.5	1.3	2.1	0.6	13.3	1.6
35-44 years	%	2.0	0.6	2.6	1.9	1.7	1.9	1.0	18.0	1.9
45-54 years	%	1.6	0.5	2.1	1.7	1.3	1.7	1.0	15.9	1.6
55-64 years	%	1.1	0.3	1.7	1.5	0.8	1.1	0.5	12.4	1.1
65 years & over	%	0.4	0.3	1.2	1.4	0.9	1.0	–	11.6	0.7
Total	%	1.7	0.5	2.2	1.7	1.4	1.7	0.8	15.7	1.6
Aboriginal and Torres Strait Islander people as a proportion of total census population										
Total	%	2.5	0.7	3.6	3.1	1.9	4.0	1.5	26.8	2.5

(a) Aged 15 years and over.

(b) Coded using the Australian and New Zealand Standard Classification of Occupations (ANZSCO), First Edition, Revision 1. The Occupation code assigned to a response is based on the occupation title and tasks of the main job held during the week prior to Census Night.

(c) No reliance should be placed on small cells

(d) Components may not add to total due to perturbation of component data.

Source: ABS 2012, *2011 Census of Population and Housing*, Canberra.

Table EA.64 **Aboriginal and Torres Strait Islander health workforce, by sex, 2011**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Aboriginal and Torres Strait Islander people										
Employed in health related occupation										
Male	no.	783	207	718	308	215	45	25	433	2 734
Female	no.	2 146	523	1 849	679	456	189	46	596	6 487
Total	no.	2 931	730	2 567	987	671	234	72	1 027	9 222
All people										
Employed in health related occupation										
Male	no.	47 025	36 440	31 245	15 021	12 359	3 498	2 368	1 942	149 912
Female	no.	128 885	110 527	83 240	42 506	36 793	10 090	6 527	4 593	423 189
Total	no.	175 913	146 966	114 485	57 527	49 153	13 586	8 895	6 535	573 101
Aboriginal and Torres Strait Islander health workforce as a proportion of total health workforce										
Male	%	1.7	0.6	2.3	2.1	1.7	1.3	1.1	22.3	1.8
Female	%	1.7	0.5	2.2	1.6	1.2	1.9	0.7	13.0	1.5
Total	%	1.7	0.5	2.2	1.7	1.4	1.7	0.8	15.7	1.6

(a) Aged 15 years and over.

(b) Coded using the Australian and New Zealand Standard Classification of Occupations (ANZSCO), First Edition, Revision 1. The Occupation code assigned to a response is based on the occupation title and tasks of the main job held during the week prior to Census Night.

(c) No reliance should be placed on small cells.

(d) Components may not add to total due to perturbation of component data.

Source: ABS 2012, *2011 Census of Population and Housing*, Canberra.

Table EA.65 **Aboriginal and Torres Strait Islander people employed in selected health-related occupations, 2011 (a), (b), (c), (d)**

	<i>Aboriginal and Torres Strait Islander people</i>	<i>All people</i>	<i>Per cent of Aboriginal and Torres Strait Islander people employed in a health- related occupation</i>
Health and welfare services managers	351	17 387	2.0
Health professionals			
Health Professionals nfd	55	2 113	2.6
Health diagnostic and promotion professionals			
Health Diagnostic and Promotion Professionals nfd	7	157	4.5
Dietitians	24	3 705	0.6
Medical Imaging Professionals	22	13 243	0.2
Occupational and Environmental Health Professional	298	18 924	1.6
Optometrists and Orthoptists	6	4 303	0.1
Pharmacists	28	19 936	0.1
Other Health Diagnostic and Promotion Professional:	572	5 595	10.2
Total	954	68 862	1.4
Health therapy professionals			
Health Therapy Professionals nfd	–	171	–
Chiropractors and Osteopaths	11	4 347	0.3
Complementary Health Therapists	19	5 949	0.3
Dental Practitioners	21	10 991	0.2
Occupational Therapists	22	9 251	0.2
Physiotherapists	73	15 928	0.5
Podiatrists	5	2 803	0.2
Speech Professionals and Audiologists	17	6 799	0.3
Total	168	56 231	0.3
Medical practitioners			
Medical Practitioners nfd	4	1 431	0.3
Generalist Medical Practitioners	129	43 429	0.3
Anaesthetists	6	3 765	0.2
Specialist Physicians	–	5 468	–
Psychiatrists	6	2 586	0.2
Surgeons	11	4 926	0.2
Other Medical Practitioners	17	8 619	0.2
Total	173	70 229	0.2
Midwifery and nursing professionals			
Midwifery and Nursing Professionals nfd	3	354	0.8
Midwives	70	14 105	0.5
Nurse Educators and Researchers	21	5 288	0.4
Nurse Managers	81	12 631	0.6
Registered Nurses	1 710	206 916	0.8
Total	1 890	239 292	0.8

Table EA.65 **Aboriginal and Torres Strait Islander people employed in selected health-related occupations, 2011 (a), (b), (c), (d)**

	<i>Aboriginal and Torres Strait Islander people</i>	<i>All people</i>	<i>Per cent of Aboriginal and Torres Strait Islander people employed in a health- related occupation</i>
Total Health professionals	3 240	433 726	0.7
Health and welfare support workers			
Health and Welfare Support Workers nfd	65	777	8.4
Ambulance Officers and Paramedics	215	11 939	1.8
Dental Hygienists, Technicians and Therapists	32	6 333	0.5
Diversional Therapists	42	4 256	1.0
Enrolled and Mothercraft Nurses	285	17 891	1.6
Indigenous Health Workers	1 257	1 373	91.6
Massage Therapists	73	10 604	0.7
Welfare Support Workers	3 572	50 205	7.1
Total	5 548	103 383	5.4
Psychologists	81	18 522	0.4
Total aged 15 years and over (n)	9 221	573 101	1.6

(a) Aged 15 years and over.

(b) Coded using the Australian and New Zealand Standard Classification of Occupations (ANZSCO), First Edition, Revision 1. The Occupation code assigned to a response is based on the occupation title and tasks of the main job held during the week prior to Census Night.

(c) No reliance should be placed on small cells

(d) Components may not add to total due to perturbation of component data.

Source: ABS 2012, *2011 Census of Population and Housing*, Canberra.

Table EA.66 **Proportion of people who accessed health services by health status, 2011-12 (a), (b), (c)**

		<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
Health status (excellent/very good/good)											
Admitted to hospital	%		10.9	11.2	11.0	12.2	12.0	10.8	12.4	12.9	11.3
Casualty/outpatients/day clinic	%		1.7	2.1	2.5	2.8	2.9	1.5	2.1	2.7	2.2
Doctor consultation (GP and/or specialist)	%		22.5	21.6	24.4	21.2	21.2	21.9	21.0	22.9	22.3
Dental consultation	%		16.7	18.9	17.5	18.4	20.3	15.7	17.7	15.0	17.8
Consultation with other health professional	%		6.6	8.2	6.6	5.7	8.5	5.1	8.5	5.3	7.0
Total accessing health care (e)	%		26.9	27.0	28.6	25.4	26.9	25.1	26.9	26.5	27.1
Health status (fair/poor)											
Admitted to hospital	%		21.7	21.9	26.1	24.5	26.3	22.9	21.5	25.0	23.3
Casualty/outpatients/day clinic	%		2.3	7.3	8.6	5.9	9.1	6.3	8.0	10.1	6.1
Doctor consultation (GP and/or specialist)	%		40.5	52.8	43.3	36.7	40.7	40.1	37.7	36.0	43.4
Dental consultation	%		19.5	15.6	16.2	14.8	18.3	13.8	13.4	22.1	17.4
Consultation with other health professional	%		11.9	14.7	11.9	15.9	12.0	11.3	23.1	8.8	13.2
Total accessing health care (e)	%		43.8	55.8	50.2	44.8	48.3	44.4	47.7	42.4	48.5
95 per cent confidence interval for Health status (excellent/very good/good)											
Admitted to hospital	± %		1.4	1.2	1.6	1.6	1.7	1.9	2.2	3.1	0.6
Casualty/outpatients/day clinic	± %		0.5	0.7	0.7	0.8	0.9	0.8	0.9	1.2	0.3
Doctor consultation (GP and/or specialist)	± %		1.8	1.7	1.9	2.0	2.2	2.6	2.4	2.9	0.8
Dental consultation	± %		1.9	1.8	1.8	2.1	2.4	2.3	2.1	2.8	0.8
Consultation with other health professional	± %		1.1	1.1	1.0	1.0	1.9	1.4	2.0	1.9	0.5
Total accessing health care (e)	± %		2.1	2.0	2.0	2.2	2.3	2.6	3.0	3.3	0.9
95 per cent confidence interval for Health status (fair/poor)											
Admitted to hospital	± %		4.8	5.6	6.1	5.4	6.8	5.8	7.4	7.2	2.5
Casualty/outpatients/day clinic	± %		1.3	3.3	3.2	2.7	4.8	2.9	6.2	4.5	1.2
Doctor consultation (GP and/or specialist)	± %		6.9	8.3	6.2	7.5	6.4	6.8	9.4	9.6	3.6
Dental consultation	± %		5.0	4.6	5.2	4.4	5.3	4.9	7.0	8.4	2.5
Consultation with other health professional	± %		3.1	5.1	3.7	5.3	3.8	4.1	7.5	5.7	1.8
Total accessing health care (e)	± %		6.9	8.0	6.0	8.0	5.9	6.3	10.1	8.3	3.5

(a) Rates are age standardised by State/Territory to the 2001 estimated resident population (10 year age ranges from 15 years).

(b) People aged 15 years or over who: were admitted to hospital in the last 12 months; consulted a dentist in the last 3 months; visited casualty, an outpatient clinic or a day clinic in the last 2 weeks; or, consulted a GP, specialist or other health professional in the last 2 weeks.

Table EA.66 **Proportion of people who accessed health services by health status, 2011-12 (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
(c)	Data are not comparable to data for 2004-05 (table EA.67) or to 2012-13 data for Aboriginal and Torres Strait Islander people (table EA.68) due to differences in survey methodology.									
(d)	Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.									
(e)	Total accessing casualty/outpatients/day clinic, or consulting a doctor or other health professional, in the last 2 weeks. Data are not comparable to data for 2004-05 or to 2012-13 data for Aboriginal and Torres Strait Islander people due to differences in survey methodology.									
	np Not published.									

Source: ABS unpublished *Australian Health Survey, 2011-13* (2011-12 NHS component), Cat. no. 4364.0.

Table EA.67 **Proportion of people who accessed health services by health status, 2004-05 (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
Health status (excellent/very good/good)										
Admitted to hospital	%	14.2	13.5	13.5	15.8	13.5	13.5	13.4	13.7	14.0
Casualty/outpatients/day clinic	%	3.4	5.5	3.7	4.8	4.5	4.7	np	np	4.2
Doctor consultation (GP and/or specialist)	%	21.1	21.5	20.5	22.4	21.8	21.6	19.9	21.5	21.3
Dental consultation	%	5.5	5.9	5.2	6.3	6.4	5.6	5.8	4.4	5.7
Consultation with other health professional	%	11.8	14.3	14.0	13.5	14.2	11.9	12.5	12.6	13.2
Total accessing health care (e)	%	41.8	41.7	41.1	43.4	42.9	40.5	37.7	38.8	41.8
Health status (fair/poor)										
Admitted to hospital	%	27.6	24.6	25.8	28.1	26.5	27.0	23.8	37.2	26.5
Casualty/outpatients/day clinic	%	7.9	10.0	10.3	12.5	11.4	11.9	5.5	13.0	9.7
Doctor consultation (GP and/or specialist)	%	41.8	44.1	42.3	39.7	41.1	44.1	30.4	38.7	42.0
Dental consultation	%	5.8	6.8	5.8	5.6	9.0	3.5	np	np	6.3
Consultation with other health professional	%	19.7	22.1	24.2	23.9	23.8	19.4	27.4	30.3	22.0
Total accessing health care (e)	%	60.6	65.2	63.3	63.0	64.2	58.6	58.5	66.5	62.6
95 per cent confidence interval for Health status (excellent/very good/good)										
Admitted to hospital	± %	1.2	1.5	1.3	1.4	1.1	1.9	2.1	10.7	0.6
Casualty/outpatients/day clinic	± %	0.7	1.0	0.7	1.2	0.8	1.0	np	np	0.4
Doctor consultation (GP and/or specialist)	± %	1.3	1.6	1.6	2.1	1.8	2.2	3.0	15.0	0.8
Dental consultation	± %	0.8	1.0	0.7	1.2	1.0	1.1	1.4	4.1	0.5
Consultation with other health professional	± %	1.3	1.6	1.5	1.6	1.3	1.7	1.7	13.6	0.7
Total accessing health care (e)	± %	1.9	2.3	2.0	2.2	2.2	2.7	16.7	3.3	1.1
95 per cent confidence interval for Health status (fair/poor)										
Admitted to hospital	± %	4.7	4.0	3.7	5.9	4.4	6.0	7.3	34.1	2.2
Casualty/outpatients/day clinic	± %	2.8	2.8	3.5	4.1	3.6	4.4	2.6	16.9	1.3
Doctor consultation (GP and/or specialist)	± %	5.4	5.1	5.4	6.1	5.9	7.5	7.1	26.6	2.7
Dental consultation	± %	2.9	3.2	2.3	3.0	3.9	2.5	np	np	1.3
Consultation with other health professional	± %	3.8	4.6	4.2	6.0	4.3	5.4	7.9	20.1	2.1
Total accessing health care (e)	± %	5.7	5.5	5.5	6.9	5.0	7.6	8.2	32.1	3.0

(a) Rates are age standardised by State/Territory to the 2001 estimated resident population (5 year ranges from 15 years).

(b) People aged 15 years or over who accessed at least one of the health services noted in the table in the last two weeks or were admitted to hospital in the last 12 months.

Table EA.67 Proportion of people who accessed health services by health status, 2004-05 (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
(c)	Data are not comparable to data for 2011-12 (table EA.66) due to methodological differences between the surveys.									
(d)	Data for the NT should be used with care as exclusion of very remote areas from the National Health Survey translates to exclusion of around 23 per cent of the NT population.									
(e)	Total persons accessing any of the selected health services noted above. Components may not add to total because persons may have accessed more than one type of health service. Data for 2004-05 are not comparable with data for 2011-12 due to methodological differences between the surveys.									
	np Not published.									

Source: ABS (unpublished) *National Health Survey, 2004-05*, Cat. No. 4364.0.

TABLE EA.68

Table EA.68 **Proportion of Aboriginal and Torres Strait Islander people who accessed health services by health status, 2012-13 (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Health status (excellent/very good/good)										
Admitted to hospital (d)	%	17.3	21.6	17.5	22.4	18.6	17.7	23.9	22.1	19.0
Casualty/outpatients/day clinic (e)	%	5.6	5.2	6.1	5.2	6.7	3.1	10.5	4.4	5.5
Doctor consultation (GP and/or specialist) (e)	%	22.3	28.6	19.8	22.0	29.6	23.4	37.1	24.1	22.8
Dental consultation (f)	%	12.6	13.5	11.2	13.6	17.4	10.6	21.0	18.1	13.3
Consultation with other health professional (e)	%	16.9	23.4	18.5	22.2	23.2	20.6	32.2	26.0	20.1
Total accessing health care (g)	%	33.0	42.0	34.1	37.2	43.4	35.6	50.3	37.7	35.8
Health status (fair/poor)										
Admitted to hospital (d)	%	33.6	31.5	27.2	36.8	34.4	23.1	34.0	27.1	31.2
Casualty/outpatients/day clinic (e)	%	7.8	18.0	12.4	16.9	7.5	10.2	9.7	7.5	11.1
Doctor consultation (GP and/or specialist) (e)	%	38.8	43.6	40.4	41.8	42.9	43.1	48.7	36.3	40.1
Dental consultation (f)	%	15.6	14.0	11.2	13.5	20.2	16.6	19.3	15.5	14.5
Consultation with other health professional (e)	%	31.3	35.9	26.8	31.4	36.7	22.7	25.2	29.6	30.6
Total accessing health care (g)	%	54.5	55.4	52.4	56.9	58.2	51.6	55.5	45.2	53.9
95 per cent confidence interval for Health status (excellent/very good/good)										
Admitted to hospital (d)	± %	4.5	5.5	3.7	3.8	5.5	5.1	9.8	5.8	2.0
Casualty/outpatients/day clinic (e)	± %	2.6	2.6	2.2	1.6	3.9	1.7	9.1	3.4	1.2
Doctor consultation (GP and/or specialist) (e)	± %	4.8	5.6	4.2	4.7	6.4	4.8	9.7	5.4	2.0
Dental consultation (f)	± %	3.5	4.5	3.0	3.8	5.7	4.6	9.7	4.8	1.6
Consultation with other health professional (e)	± %	4.1	5.3	4.1	4.9	5.2	5.0	11.5	6.1	1.9
Total accessing health care (g)	± %	5.6	6.1	4.6	5.2	6.2	5.1	8.6	5.9	2.2
95 per cent confidence interval for Health status (fair/poor)										
Admitted to hospital (d)	± %	7.5	9.4	6.7	6.7	8.8	7.1	17.2	8.9	3.4
Casualty/outpatients/day clinic (e)	± %	4.1	7.3	6.2	6.1	4.5	5.8	9.7	4.3	2.5
Doctor consultation (GP and/or specialist) (e)	± %	7.3	9.4	8.3	9.6	7.9	9.0	20.2	10.3	3.8
Dental consultation (f)	± %	6.0	7.0	4.7	6.0	8.4	7.3	18.0	8.5	2.7
Consultation with other health professional (e)	± %	7.1	10.0	6.8	7.3	10.9	7.6	20.4	7.7	3.4
Total accessing health care (g)	± %	8.8	9.4	8.3	8.7	9.5	8.2	17.5	8.7	4.1

Table EA.68 Proportion of Aboriginal and Torres Strait Islander people who accessed health services by health status, 2012-13 (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(a)	Rates are age standardised by State/Territory to the 2001 estimated resident population (10 year age ranges from 15 years).									
(b)	Limited to people aged 15 years or over.									
(c)	Data are not comparable to 2011-12 data for all Australians (table EA.66) due to differences in survey methodology.									
(d)	People who were admitted to hospital in the last 12 months.									
(e)	People who accessed the specified health service in the last two weeks.									
(f)	People who visited the dentist in the last 3 months. Data are not comparable to data for 2004-05 (table EA.69) for which the reference period was 2 weeks.									
(g)	Total accessing casualty/outpatients/day clinic, or consulting a doctor or other health professional, in the last 2 weeks. Components may not add to total because people may have accessed more than one type of health service. Data are not comparable to data for 2004-05 (table EA.69) or to 2011-12 data for all Australians (table EA.66) due to differences in survey methodology.									

np Not published.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2012-13*, Cat. no. 4727.0.

Table EA.69 **Proportion of people who accessed health services by health status, by Indigenous status, 2004-05 (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
Health status (excellent/very good/good)										
Aboriginal and Torres Strait Islander people										
Admitted to hospital	%	14.7	17.1	16.0	19.1	19.2	10.7	9.9	23.3	17.0
Casualty/outpatients/day clinic	%	3.0	1.7	5.0	5.0	6.7	3.3	np	4.4	4.0
Doctor consultation (GP and/or specialist)	%	20.9	24.0	21.2	23.1	25.4	18.4	12.9	23.8	21.9
Dental consultation	%	3.3	np	3.4	np	np	np	np	2.6	3.3
Consultation with other health professional	%	14.5	15.6	18.7	20.7	20.5	9.0	14.1	37.2	19.7
Total accessing health care (e)	%	40.4	47.9	43.4	47.1	46.1	34.3	30.0	55.3	44.3
Other Australians										
Admitted to hospital	%	14.2	13.4	13.2	15.6	13.4	13.3	13.1	10.8	13.8
Casualty/outpatients/day clinic	%	1.6	2.5	1.5	2.0	2.8	2.1	1.8	–	1.9
Doctor consultation (GP and/or specialist)	%	21.0	21.3	20.3	21.9	21.5	21.0	19.4	12.4	21.0
Dental consultation	%	5.5	5.9	5.2	6.4	6.6	5.8	5.6	8.2	5.7
Consultation with other health professional	%	11.6	14.4	14.0	13.3	14.2	12.1	12.1	12.5	13.2
Total accessing health care (e)	%	41.1	41.2	40.4	42.0	43.1	39.9	37.5	35.9	41.1
Health status (fair/poor)										
Aboriginal and Torres Strait Islander people										
Admitted to hospital	%	29.9	34.8	26.1	28.3	27.7	31.9	20.5	39.2	29.7
Casualty/outpatients/day clinic	%	5.0	10.9	14.6	16.3	10.7	7.2	np	10.9	10.8
Doctor consultation (GP and/or specialist)	%	40.6	45.4	34.6	41.1	39.4	52.2	27.4	43.0	39.8
Dental consultation	%	3.0	np	7.0	np	np	np	np	4.6	4.3
Consultation with other health professional	%	24.6	33.7	28.1	21.3	24.1	24.9	30.5	47.5	27.8
Total accessing health care (e)	%	61.3	71.7	65.8	59.1	61.7	66.6	48.2	70.6	64.1
Other Australians										
Admitted to hospital	%	28.6	25.1	26.3	28.6	26.1	26.5	23.1	49.4	27.1
Casualty/outpatients/day clinic	%	4.9	4.9	5.4	6.4	9.3	6.8	np	np	5.5
Doctor consultation (GP and/or specialist)	%	41.7	44.2	42.7	40.5	41.2	44.0	30.9	20.8	42.1
Dental consultation	%	5.7	6.9	5.7	5.5	8.8	3.6	6.9	–	6.1
Consultation with other health professional	%	19.2	22.2	24.2	23.7	23.7	18.9	27.8	18.0	21.7
Total accessing health care (e)	%	60.7	64.8	62.5	62.2	64.3	58.3	58.5	58.9	62.3
95 per cent confidence interval for Health status (excellent/very good/good)										
Aboriginal and Torres Strait Islander people										
Admitted to hospital	± %	4.6	6.2	4.4	4.6	6.2	5.7	6.8	6.8	2.2
Casualty/outpatients/day clinic	± %	1.5	1.9	2.9	3.5	4.4	2.5	3.4	2.9	1.1

Table EA.69 **Proportion of people who accessed health services by health status, by Indigenous status, 2004-05 (a), (b), (c)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (d)	Aust
Doctor consultation (GP and/or specialist)	± %	5.2	9.2	5.9	7.3	7.4	5.9	8.2	8.5	2.8
Dental consultation	± %	2.1	4.6	2.1	2.5	3.4	3.3	2.8	1.7	0.9
Consultation with other health professional	± %	5.8	6.5	6.1	8.5	7.4	5.3	6.3	7.5	2.9
Total accessing health care (e)	± %	6.9	11.2	6.6	8.5	8.5	6.7	12.4	7.7	3.3
Other Australians										
Admitted to hospital	± %	1.2	1.5	1.3	1.4	1.1	1.8	2.0	9.4	0.7
Casualty/outpatients/day clinic	± %	0.4	0.7	0.5	0.7	0.7	0.8	0.8	–	0.3
Doctor consultation (GP and/or specialist)	± %	1.3	1.6	1.7	2.1	1.8	2.1	2.9	7.4	0.8
Dental consultation	± %	0.8	1.0	0.8	1.2	1.0	1.2	1.4	7.2	0.5
Consultation with other health professional	± %	1.3	1.6	1.5	1.6	1.3	1.7	1.7	13.8	0.7
Total accessing health care (e)	± %	1.8	2.3	2.0	2.3	2.2	2.6	3.2	13.1	1.1
95 per cent confidence interval for Health status (fair/poor)										
Aboriginal and Torres Strait Islander people										
Admitted to hospital	± %	7.9	12.9	7.7	7.5	10.1	10.2	11.9	9.1	3.5
Casualty/outpatients/day clinic	± %	2.5	8.2	6.9	7.8	9.8	4.6	2.5	6.3	2.5
Doctor consultation (GP and/or specialist)	± %	8.1	14.0	8.2	8.0	11.0	11.7	15.2	9.6	3.8
Dental consultation	± %	2.6	3.0	6.8	1.1	6.3	6.8	9.9	4.1	2.2
Consultation with other health professional	± %	7.6	13.7	7.7	6.0	8.0	8.9	15.3	10.6	3.4
Total accessing health care (e)	± %	10.1	9.8	7.6	8.2	11.7	10.6	18.8	8.7	4.1
Other Australians										
Admitted to hospital	± %	4.9	4.0	3.7	6.2	4.2	5.6	7.0	39.7	2.1
Casualty/outpatients/day clinic	± %	2.1	1.9	2.3	2.9	4.1	2.9	np	np	1.0
Doctor consultation (GP and/or specialist)	± %	5.1	5.1	5.2	6.3	6.1	7.6	7.3	30.0	2.5
Dental consultation	± %	2.6	3.1	2.3	2.9	4.4	2.5	3.7	–	1.2
Consultation with other health professional	± %	3.8	4.5	4.5	6.0	4.4	5.2	7.9	14.9	2.1
Total accessing health care (e)	± %	5.7	6.1	5.5	6.9	5.2	7.9	8.2	41.1	2.9

(a) Rates are age standardised by State/Territory to the 2001 estimated resident population (5 year ranges from 15 years).

(b) People aged 15 years or over who accessed at least one of the health services noted in the table in the last two weeks or were admitted to hospital in the last 12 months.

(c) Data are not comparable to 2011-12 data for all Australians (table EA.66) or to 2012-13 data for Aboriginal and Torres Strait Islander people (table EA.68) due to differences in survey methodology.

(d) Data for other Australians for the NT should be used with care as exclusion of very remote areas from the National Health Survey translates to exclusion of around 23 per cent of the NT population.

Table EA.69 **Proportion of people who accessed health services by health status, by Indigenous status, 2004-05 (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
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(e) Total people accessing at least one of the health services noted in the table. Components may not add to total because persons may have accessed more than one type of health service. Data are not comparable to 2011-12 data for all Australians or to 2012-13 data for Aboriginal and Torres Strait Islander people, due to differences in survey methodology.

– Nil or rounded to zero. **np** Not published.

Source: ABS unpublished, *National Health Survey, 2004-05*, Cat. no. 4364.0; ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no 4715.0.

TABLE EA.70

Table EA.70 **Proportion of people who accessed health services by health status, by remoteness of residence, 2011-12 (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Health status (excellent/very good/good)										
Major cities										
Admitted to hospital	%	10.7	10.4	11.1	12.0	13.3	..	12.4	..	11.1
Casualty/outpatients/day clinic	%	1.6	2.0	2.5	2.6	2.9	..	2.1	..	2.1
Doctor consultation (GP and/or specialist)	%	23.3	21.5	24.4	21.2	22.5	..	21.0	..	22.7
Dental consultation	%	17.5	20.0	18.6	19.9	20.5	..	17.7	..	18.8
Consultation with other health professional	%	6.6	7.8	6.8	5.5	8.8	..	8.5	..	7.1
Total accessing health care (f)	%	27.4	26.4	28.6	25.3	28.2	..	26.9	..	27.2
Inner regional										
Admitted to hospital	%	12.3	13.9	13.3	11.4	7.2	11.4	..	..	12.7
Casualty/outpatients/day clinic	%	np	1.8	1.8	np	np	1.2	..	..	1.8
Doctor consultation (GP and/or specialist)	%	19.6	20.2	24.1	22.3	14.7	21.2	..	..	20.8
Dental consultation	%	15.1	17.7	14.3	10.2	24.6	17.8	..	..	16.1
Consultation with other health professional	%	7.2	9.3	6.1	np	9.0	6.3	..	..	7.7
Total accessing health care (f)	%	25.3	27.6	28.1	29.4	23.3	24.9	..	..	26.6
Outer regional										
Admitted to hospital	%	11.1	15.2	7.7	15.2	9.2	8.2	..	11.4	10.3
Casualty/outpatients/day clinic	%	np	np	np	np	np	np	..	2.4	3.3
Doctor consultation (GP and/or specialist)	%	24.3	26.7	25.6	20.7	19.6	22.7	..	24.0	23.7
Dental consultation	%	13.5	np	16.8	16.4	17.7	11.9	..	15.4	14.7
Consultation with other health professional	%	np	np	5.3	5.9	7.2	2.4	..	5.3	5.5
Total accessing health care (f)	%	30.8	34.5	30.0	24.4	24.1	25.8	..	27.5	28.4
Remote										
Admitted to hospital	%	np	..	np	13.0	np	np	..	18.9	13.0
Casualty/outpatients/day clinic	%	–	..	np	np	np	–	..	np	3.8
Doctor consultation (GP and/or specialist)	%	–	..	np	21.7	np	np	..	18.5	20.3
Dental consultation	%	np	..	np	10.4	np	–	..	14.7	11.9
Consultation with other health professional	%	–	..	np	np	np	np	..	np	5.6
Total accessing health care (f)	%	–	..	34.3	27.6	23.6	np	..	22.4	25.8
Health status (fair/poor)										
Major cities										
Admitted to hospital	%	19.1	19.5	30.2	21.2	29.4	..	21.5	..	22.2
Casualty/outpatients/day clinic	%	2.0	7.1	7.3	4.1	7.8	..	8.0	..	5.3

TABLE EA.70

Table EA.70 **Proportion of people who accessed health services by health status, by remoteness of residence, 2011-12 (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Doctor consultation (GP and/or specialist)	%	41.2	53.3	43.9	38.9	44.0	..	37.7	..	44.3
Dental consultation	%	21.6	18.9	18.9	14.4	19.8	..	13.4	..	19.9
Consultation with other health professional	%	11.0	17.3	12.2	14.0	10.8	..	23.1	..	13.5
Total accessing health care (f)	%	44.6	56.2	50.9	45.4	50.8	..	47.7	..	49.4
Inner regional										
Admitted to hospital	%	29.7	26.5	28.2	29.9	np	20.3	..	..	26.3
Casualty/outpatients/day clinic	%	np	np	np	np	np	5.7	..	..	5.3
Doctor consultation (GP and/or specialist)	%	44.6	50.6	41.3	37.5	np	45.5	..	..	44.8
Dental consultation	%	19.5	7.7	12.3	np	np	10.9	..	..	13.4
Consultation with other health professional	%	16.3	7.2	13.3	np	np	13.7	..	..	13.0
Total accessing health care (f)	%	47.7	54.7	49.4	43.8	np	48.4	..	..	49.7
Outer regional										
Admitted to hospital	%	np	np	17.9	37.6	26.5	33.6	..	23.0	25.7
Casualty/outpatients/day clinic	%	np	np	np	np	np	np	..	5.3	11.9
Doctor consultation (GP and/or specialist)	%	np	35.5	42.2	np	37.8	35.3	..	34.0	34.4
Dental consultation	%	–	np	np	np	np	22.4	..	20.0	8.5
Consultation with other health professional	%	np	np	np	np	np	12.7	..	4.8	11.2
Total accessing health care (f)	%	np	35.5	55.0	35.3	46.9	45.2	..	38.7	40.2
Remote										
Admitted to hospital	%	–	..	np	np	np	–	..	24.9	16.6
Casualty/outpatients/day clinic	%	–	..	np	np	np	–	..	np	21.0
Doctor consultation (GP and/or specialist)	%	–	..	np	np	np	np	..	42.5	46.0
Dental consultation	%	–	..	np	np	np	np	..	np	35.4
Consultation with other health professional	%	–	..	–	np	np	–	..	np	16.6
Total accessing health care (f)	%	–	..	np	np	np	np	..	56.4	58.2

95 per cent confidence interval for Health status (excellent/very good/good)

Major cities										
Admitted to hospital	± %	1.7	1.4	1.8	1.9	1.8	..	2.2	..	0.8
Casualty/outpatients/day clinic	± %	0.7	0.8	0.9	0.9	1.0	..	0.9	..	0.4
Doctor consultation (GP and/or specialist)	± %	2.2	2.2	2.3	2.6	2.4	..	2.4	..	1.0
Dental consultation (e)	± %	2.4	1.9	2.2	2.3	2.5	..	2.1	..	1.0
Consultation with other health professional	± %	1.2	1.3	1.3	1.1	2.1	..	2.0	..	0.6
Total accessing health care (f)	± %	2.4	2.3	2.4	2.6	2.4	..	3.0	..	1.1

TABLE EA.70

Table EA.70 **Proportion of people who accessed health services by health status, by remoteness of residence, 2011-12 (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Inner regional										
Admitted to hospital	± %	2.9	3.0	3.9	7.1	5.0	2.2	..	..	1.4
Casualty/outpatients/day clinic	± %	np	1.1	1.2	np	np	0.9	..	..	0.7
Doctor consultation (GP and/or specialist)	± %	3.9	3.2	4.7	10.1	5.5	2.9	..	..	1.8
Dental consultation	± %	3.2	3.9	3.7	4.5	7.9	2.6	..	..	1.8
Consultation with other health professional	± %	2.7	3.3	2.3	np	7.9	1.9	..	..	1.3
Total accessing health care (f)	± %	5.3	5.0	4.6	10.8	9.9	3.1	..	..	2.3
Outer regional										
Admitted to hospital	± %	9.5	9.2	2.9	6.1	5.6	3.1	..	3.3	2.2
Casualty/outpatients/day clinic	± %	np	np	np	np	np	np	..	1.4	1.2
Doctor consultation (GP and/or specialist)	± %	9.9	9.3	5.4	6.1	6.8	5.2	..	3.3	3.1
Dental consultation	± %	7.5	np	4.8	5.7	7.6	4.4	..	3.3	2.2
Consultation with other health professional	± %	np	np	2.3	5.1	5.0	1.9	..	2.0	1.8
Total accessing health care (f)	± %	9.9	8.6	5.6	6.2	7.1	4.9	..	3.6	2.9
Remote										
Admitted to hospital	± %	np	..	np	6.5	np	np	..	11.7	3.9
Casualty/outpatients/day clinic	± %	–	..	np	np	np	–	..	np	2.4
Doctor consultation (GP and/or specialist)	± %	–	..	np	8.6	np	np	..	5.6	5.8
Dental consultation	± %	np	..	np	7.0	np	–	..	8.2	3.9
Consultation with other health professional	± %	–	..	np	np	np	np	..	np	3.3
Total accessing health care (f)	± %	–	..	20.4	8.3	25.9	np	..	7.1	6.7

95 per cent confidence interval for Health status (fair/poor)

Major cities										
Admitted to hospital	± %	5.3	7.7	9.1	5.0	8.6	..	7.4	..	3.0
Casualty/outpatients/day clinic	± %	1.5	4.2	3.7	2.3	4.0	..	6.2	..	1.4
Doctor consultation (GP and/or specialist)	± %	7.5	8.5	8.9	8.7	7.7	..	9.4	..	4.1
Dental consultation	± %	5.7	5.9	6.4	4.8	6.2	..	7.0	..	2.7
Consultation with other health professional	± %	3.4	6.5	4.4	5.9	3.8	..	7.5	..	2.1
Total accessing health care (f)	± %	7.4	8.2	8.5	9.0	7.5	..	10.1	..	4.0
Inner regional										
Admitted to hospital	± %	13.7	9.4	14.9	23.3	17.9	np	..	..	5.7
Casualty/outpatients/day clinic	± %	np	np	np	np	np	np	..	..	2.2
Doctor consultation (GP and/or specialist)	± %	13.7	15.8	14.2	16.6	15.7	np	..	..	6.5
Dental consultation	± %	13.3	6.7	10.3	16.9	np	np	..	..	5.2

Table EA.70 **Proportion of people who accessed health services by health status, by remoteness of residence, 2011-12 (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Consultation with other health professional	± %	8.0	5.1	8.7	19.9	np	np	..	..	4.1
Total accessing health care (f)	± %	13.9	15.9	13.1	17.3	np	10.1	..	..	6.0
Outer regional										
Admitted to hospital	± %	np	np	10.9	24.4	26.0	19.6	..	8.1	6.7
Casualty/outpatients/day clinic	± %	np	np	np	np	np	np	..	2.6	5.8
Doctor consultation (GP and/or specialist)	± %	np	21.3	32.8	np	25.2	10.3	..	9.5	8.7
Dental consultation	± %	–	np	np	np	np	15.1	..	8.3	4.1
Consultation with other health professional	± %	np	np	np	np	np	7.6	..	3.8	4.7
Total accessing health care (f)	± %	19.3	21.3	16.1	31.2	33.9	18.3	..	9.2	9.0
Remote										
Admitted to hospital	± %	–	..	np	np	np	–	..	21.7	10.4
Casualty/outpatients/day clinic	± %	–	..	np	np	np	–	..	np	22.4
Doctor consultation (GP and/or specialist)	± %	–	..	np	np	np	np	..	31.0	22.6
Dental consultation	± %	–	..	np	np	np	np	..	np	38.7
Consultation with other health professional	± %	–	..	–	np	np	–	..	np	20.1
Total accessing health care (f)	± %	–	..	np	np	np	np	..	12.0	13.1

- (a) Rates are age standardised by State/Territory to the 2001 estimated resident population (10 year age ranges from 15 years).
- (b) People aged 15 years or over who were admitted to hospital in the last 12 months, consulted a dentist in the last 3 months or who visited casualty, an outpatient clinic, day clinic or consulted a GP, specialist or other health professional in the last 2 weeks.
- (c) Data are not comparable to data for 2004-05 (table EA.71) or to 2012-13 data for Aboriginal and Torres Strait Islander people (table EA.68) due to differences in survey methodology.
- (d) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which are based on a different classification.
- (e) Very remote areas are excluded from the Australian Health Survey.
- (f) Total accessing casualty/outpatients/day clinic, or consulting a doctor or other health professional, in the last 2 weeks. Data are not comparable to data for 2004-05 or to 2012-13 data for Aboriginal and Torres Strait Islander people due to differences in survey methodology.

.. Not applicable. – Nil or rounded to zero. **np** Not published.

Source: ABS unpublished, *Australian Health Survey, 2011-13* (2011-12 NHS component), Cat. no. 4364.0.

TABLE EA.71

Table EA.71 **Proportion of people who accessed health services by health status, by remoteness of residence, 2004-05 (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Health status (excellent/very good/good)										
Major cities										
Admitted to hospital	%	13.7	13.2	14.3	14.3	12.8	..	13.4	..	13.6
Casualty/outpatients/day clinic	%	3.4	5.5	3.7	4.9	4.3	..	3.8	..	4.3
Doctor consultation (GP and/or specialist)	%	22.3	22.9	21.0	24.1	22.1	..	19.9	..	22.4
Dental consultation	%	5.7	5.7	5.3	6.8	6.5	..	5.8	..	5.8
Consultation with other health professional	%	12.1	13.6	13.8	13.2	14.4	..	12.5	..	13.1
Total accessing health care (f)	%	42.8	42.5	42.0	42.8	44.0	..	38.8	..	42.6
Inner regional										
Admitted to hospital	%	16.6	15.0	11.5	19.2	14.9	14.5	..	..	14.8
Casualty/outpatients/day clinic	%	3.1	4.9	3.2	3.4	3.3	4.7	..	..	3.8
Doctor consultation (GP and/or specialist)	%	18.4	16.1	20.9	18.3	18.4	21.3	..	..	18.6
Dental consultation	%	5.2	6.5	6.2	5.9	7.8	5.7	..	..	6.0
Consultation with other health professional	%	11.1	14.4	15.1	15.0	14.4	12.1	..	..	13.4
Total accessing health care (f)	%	39.3	38.2	40.5	44.0	42.1	41.4	..	..	39.9
Outer regional										
Admitted to hospital	%	13.9	10.9	14.4	18.7	16.1	12.1	..	13.8	14.2
Casualty/outpatients/day clinic	%	4.3	8.8	4.1	3.8	7.3	np	..	np	4.8
Doctor consultation (GP and/or specialist)	%	15.4	22.7	18.3	18.0	22.3	21.9	..	26.2	19.1
Dental consultation	%	5.1	4.9	3.9	3.1	4.6	5.9	..	2.1	4.4
Consultation with other health professional	%	10.9	25.5	13.2	14.5	11.9	12.2	..	13.2	14.1
Total accessing health care (f)	%	37.5	45.4	39.4	44.1	40.8	39.7	..	39.4	40.3
Remote										
Admitted to hospital	%	np	..	8.0	26.3	16.9	5.7	..	np	16.2
Casualty/outpatients/day clinic	%	np	..	6.5	9.6	3.8	np	..	np	5.9
Doctor consultation (GP and/or specialist)	%	36.3	..	22.6	15.5	24.9	np	..	np	20.0
Dental consultation	%	–	..	np	5.4	4.7	np	..	12.3	4.5
Consultation with other health professional	%	–	..	12.4	11.5	17.3	4.9	..	10.3	11.4
Total accessing health care (f)	%	47.3	..	37.4	40.2	45.8	28.8	..	32.0	39.4
Health status (fair/poor)										
Major cities										
Admitted to hospital	%	27.3	22.2	25.8	30.6	28.4	..	23.8	..	26.2
Casualty/outpatients/day clinic	%	7.9	9.6	10.7	13.9	10.9	..	5.5	..	9.6

TABLE EA.71

Table EA.71 **Proportion of people who accessed health services by health status, by remoteness of residence, 2004-05 (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Doctor consultation (GP and/or specialist)	%	42.2	43.8	42.6	40.9	45.9	..	30.4	..	42.6
Dental consultation	%	7.1	8.2	7.2	6.0	9.7	..	7.0	..	7.5
Consultation with other health professional	%	17.0	19.0	24.5	25.1	24.1	..	27.4	..	20.3
Total accessing health care (f)	%	61.2	63.4	64.0	63.8	67.4	..	58.5	..	62.9
Inner regional										
Admitted to hospital	%	27.8	28.0	23.4	20.0	20.8	32.1	..	..	26.2
Casualty/outpatients/day clinic	%	10.4	10.5	12.4	9.6	17.5	15.2	..	..	11.7
Doctor consultation (GP and/or specialist)	%	42.3	44.9	43.7	35.7	25.8	53.1	..	..	43.0
Dental consultation	%	2.3	4.2	5.4	np	np	4.6	..	..	4.1
Consultation with other health professional	%	30.5	29.1	20.8	24.4	13.9	22.9	..	..	25.7
Total accessing health care (f)	%	61.5	71.4	63.8	65.1	53.6	67.9	..	..	64.9
Outer regional										
Admitted to hospital	%	30.0	36.3	30.3	30.0	20.1	21.5	..	53.9	30.2
Casualty/outpatients/day clinic	%	4.0	12.4	6.0	np	10.3	8.2	..	np	6.8
Doctor consultation (GP and/or specialist)	%	38.3	44.1	40.0	36.2	34.5	32.8	..	34.1	38.4
Dental consultation	%	3.7	np	2.5	4.1	8.8	2.4	..	np	3.7
Consultation with other health professional	%	19.0	27.8	30.1	np	26.1	14.0	..	np	23.4
Total accessing health care (f)	%	56.0	59.9	60.2	55.9	56.0	45.4	..	53.9	56.7
Remote										
Admitted to hospital	%	np	..	20.6	np	np	10.9	..	np	16.1
Casualty/outpatients/day clinic	%	np	..	np	np	np	np	..	np	10.5
Doctor consultation (GP and/or specialist)	%	np	..	29.6	38.1	12.8	25.9	..	44.3	32.8
Dental consultation	%	–	..	np	np	np	–	..	np	6.6
Consultation with other health professional	%	np	..	np	–	52.2	19.4	..	57.7	27.3
Total accessing health care (f)	%	43.7	..	71.8	61.1	65.0	49.5	..	82.3	66.4

95 per cent confidence interval for Health status (excellent/very good/good)

Major cities

Admitted to hospital	± %	1.4	1.8	1.8	1.8	1.3	..	2.1	..	0.8
Casualty/outpatients/day clinic	± %	0.8	1.1	1.1	1.3	1.0	..	1.3	..	0.5
Doctor consultation (GP and/or specialist)	± %	1.7	1.8	2.8	2.6	2.2	..	3.0	..	1.0
Dental consultation	± %	0.9	1.2	1.1	1.4	1.1	..	1.4	..	0.5
Consultation with other health professional	± %	1.4	1.5	2.3	2.0	1.6	..	1.7	..	0.8
Total accessing health care (f)	± %	2.1	2.3	3.0	2.8	2.7	..	3.3	..	1.2

TABLE EA.71

Table EA.71 **Proportion of people who accessed health services by health status, by remoteness of residence, 2004-05 (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Inner regional										
Admitted to hospital	± %	3.3	3.1	2.7	5.8	3.4	2.2	..	..	1.4
Casualty/outpatients/day clinic	± %	1.7	1.7	1.4	1.9	2.3	1.1	..	..	0.8
Doctor consultation (GP and/or specialist)	± %	3.1	3.4	3.0	5.7	5.2	2.4	..	..	1.4
Dental consultation	± %	1.9	2.4	2.2	3.5	3.2	1.3	..	..	1.0
Consultation with other health professional	± %	2.6	3.3	2.8	4.3	4.6	2.0	..	..	1.5
Total accessing health care (f)	± %	4.6	5.5	4.0	8.4	6.5	3.1	..	..	2.2
Outer regional										
Admitted to hospital	± %	4.6	4.9	3.4	6.0	4.9	3.4	..	12.0	2.0
Casualty/outpatients/day clinic	± %	2.7	5.2	1.7	2.0	3.1	np	..	np	1.2
Doctor consultation (GP and/or specialist)	± %	5.4	7.6	3.1	6.6	5.5	3.9	..	18.3	2.4
Dental consultation	± %	2.9	3.4	1.6	2.0	2.5	2.4	..	3.4	1.1
Consultation with other health professional	± %	3.9	11.0	3.4	4.3	3.9	3.6	..	17.3	2.4
Total accessing health care (f)	± %	6.8	10.3	4.2	7.7	7.2	5.3	..	19.6	3.4
Remote										
Admitted to hospital	± %	np	..	6.4	11.4	8.5	8.4	..	np	4.4
Casualty/outpatients/day clinic	± %	np	..	7.1	10.6	4.0	np	..	np	3.7
Doctor consultation (GP and/or specialist)	± %	54.9	..	11.7	9.9	8.4	np	..	np	6.5
Dental consultation	± %	–	..	np	7.2	4.4	np	..	8.8	2.6
Consultation with other health professional	± %	–	..	9.6	8.2	4.9	5.0	..	12.2	3.7
Total accessing health care (f)	± %	39.6	..	11.9	13.6	11.3	23.6	..	34.2	7.4

95 per cent confidence interval for Health status (fair/poor)

Major cities										
Admitted to hospital	±	6.2	4.3	6.0	7.9	5.8	..	7.3	..	2.8
Casualty/outpatients/day clinic	±	3.4	3.3	5.4	5.2	3.4	..	2.6	..	1.6
Doctor consultation (GP and/or specialist)	±	6.3	6.1	8.6	7.3	7.5	..	7.1	..	3.0
Dental consultation	±	4.0	4.2	3.4	4.0	5.4	..	3.7	..	2.0
Consultation with other health professional	±	3.9	5.2	7.3	7.4	5.3	..	7.9	..	2.3
Total accessing health care (f)	±	7.2	7.0	8.5	8.7	6.3	..	8.2	..	3.6
Inner regional										
Admitted to hospital	±	8.0	11.6	6.6	12.5	11.3	6.7	..	..	4.0
Casualty/outpatients/day clinic	±	6.7	7.1	6.8	8.7	17.0	6.2	..	..	3.0
Doctor consultation (GP and/or specialist)	±	10.7	13.0	9.3	16.0	11.8	9.7	..	..	4.7
Dental consultation	±	3.1	4.9	4.4	np	np	3.6	..	..	1.9

TABLE EA.71

Table EA.71 **Proportion of people who accessed health services by health status, by remoteness of residence, 2004-05 (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Consultation with other health professional	±	13.6	14.6	6.6	21.3	11.1	7.0	..	..	6.1
Total accessing health care (f)	±	10.6	9.9	9.2	16.7	12.7	8.1	..	..	4.8
Outer regional										
Admitted to hospital	±	12.3	16.5	9.3	17.5	10.1	10.0	..	59.1	6.2
Casualty/outpatients/day clinic	±	3.5	5.8	5.1	np	7.3	7.0	..	np	2.5
Doctor consultation (GP and/or specialist)	±	12.5	15.1	11.6	23.1	16.0	12.4	..	44.7	6.1
Dental consultation	±	3.1	np	3.1	5.2	9.6	2.7	..	np	1.8
Consultation with other health professional	±	10.5	16.1	11.0	np	14.2	8.3	..	np	6.8
Total accessing health care (f)	±	12.7	17.0	11.1	21.2	17.2	15.1	..	59.1	6.6
Remote										
Admitted to hospital	±	np	..	23.3	np	np	12.3	..	np	12.0
Casualty/outpatients/day clinic	±	np	..	np	np	np	np	..	np	9.7
Doctor consultation (GP and/or specialist)	±	np	..	38.0	21.5	13.0	18.2	..	49.7	16.3
Dental consultation	±	–	..	np	np	np	–	..	np	8.1
Consultation with other health professional	±	np	..	np	–	56.7	26.9	..	29.4	16.8
Total accessing health care (f)	±	118.5	..	30.2	55.6	45.8	22.4	..	25.2	16.8

(a) Rates are age standardised by State/Territory to the 2001 estimated resident population (5 year ranges from 15 years).

(b) People aged 15 years or over who accessed at least one of the health services noted in the table in the last two weeks or were admitted to hospital in the last 12 months.

(c) Data are not comparable to data for 2011-12 (table EA.70) due to differences in survey methodology.

(d) Remoteness areas are based on the Australian Standard Geographical Classification 2001 (ASGC) and are not comparable with data for later years, which are based on a different classification.

(e) Very remote areas are excluded from the National Health Survey.

(f) Total persons accessing any of the selected health services noted above. Components may not add to total because persons may have accessed more than one type of health service. Data are not comparable with data for 2011-12 due to methodological differences between the surveys.

.. Not applicable. – Nil or rounded to zero. **np** Not published.

Source: ABS unpublished, *National Health Survey, 2004-05*, Cat. no. 4364.0.

TABLE EA.72

Table EA.72 **Proportion of people who accessed health services by health status, by SEIFA, 2011-12 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
Health status (excellent/very good/good)										
Quintile 1										
Admitted to hospital	%	12.7	13.0	8.4	16.3	8.3	14.6	np	16.5	12.0
Casualty/outpatients/day clinic	%	2.3	3.7	np	4.0	3.5	np	np	–	2.8
Doctor consultation (GP and/or specialist)	%	26.4	20.2	22.4	22.4	26.1	23.1	np	17.4	23.6
Dental consultation	%	15.3	13.0	12.2	11.6	15.3	12.6	np	16.0	14.0
Consultation with other health professional	%	6.3	4.2	5.2	5.1	7.6	3.2	np	np	5.6
Total accessing health care (f)	%	31.8	23.8	26.8	25.0	30.2	26.3	18.7	18.8	28.1
Quintile 2										
Admitted to hospital	%	11.9	13.3	9.3	11.4	12.0	7.5	np	12.3	11.6
Casualty/outpatients/day clinic	%	3.4	2.3	2.5	3.4	3.1	np	–	np	2.8
Doctor consultation (GP and/or specialist)	%	23.9	21.6	25.6	22.0	21.5	16.5	25.0	22.6	23.1
Dental consultation	%	15.3	16.5	15.7	14.7	19.3	18.4	19.8	10.3	16.1
Consultation with other health professional	%	5.6	6.9	5.9	4.6	8.7	5.4	np	np	6.2
Total accessing health care (f)	%	27.0	25.7	30.6	26.8	26.7	20.1	26.8	26.0	27.4
Quintile 3										
Admitted to hospital	%	7.5	11.3	10.4	9.9	13.8	7.9	10.9	12.1	10.0
Casualty/outpatients/day clinic	%	np	2.0	3.1	np	np	np	np	np	2.1
Doctor consultation (GP and/or specialist)	%	21.1	25.9	21.9	19.9	16.9	24.0	23.6	24.2	22.4
Dental consultation	%	14.8	19.2	17.2	16.8	21.3	12.6	13.4	13.6	16.9
Consultation with other health professional	%	4.8	9.9	5.9	5.4	5.9	4.2	4.3	3.9	6.5
Total accessing health care (f)	%	24.5	32.4	25.6	24.2	22.3	26.4	26.1	27.3	26.9
Quintile 4										
Admitted to hospital	%	10.2	10.2	12.2	12.4	10.7	13.6	15.1	15.6	11.2
Casualty/outpatients/day clinic	%	np	np	2.4	3.9	2.7	–	np	np	2.0
Doctor consultation (GP and/or specialist)	%	22.8	21.7	25.8	19.8	19.4	26.3	21.9	27.8	22.5
Dental consultation	%	18.2	21.1	16.9	19.9	24.3	20.9	16.3	17.6	19.2
Consultation with other health professional	%	8.8	11.2	8.7	6.7	7.3	8.4	12.7	11.3	9.0
Total accessing health care (f)	%	28.4	28.2	29.9	25.4	24.8	29.7	29.5	34.0	27.9
Quintile 5										
Admitted to hospital	%	12.1	9.1	14.6	13.4	13.9	np	11.9	np	11.9
Casualty/outpatients/day clinic	%	np	np	np	np	np	np	3.2	np	1.3
Doctor consultation (GP and/or specialist)	%	19.3	18.6	26.1	21.4	23.3	13.2	20.5	19.5	20.6
Dental consultation	%	19.3	23.4	23.8	23.0	20.5	17.9	19.9	19.0	21.6

TABLE EA.72

Table EA.72 **Proportion of people who accessed health services by health status, by SEIFA, 2011-12 (a), (b), (c), (d)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (e)	Aust
Consultation with other health professional	%	7.1	8.1	6.5	6.5	13.6	np	8.4	np	7.5
Total accessing health care (f)	%	23.5	25.0	30.2	25.3	33.1	19.3	26.9	21.3	25.6
Health status (fair/poor)										
Quintile 1										
Admitted to hospital	%	24.7	29.4	23.5	33.3	22.7	18.7	np	np	25.6
Casualty/outpatients/day clinic	%	np	13.9	10.8	np	18.5	6.5	np	np	8.2
Doctor consultation (GP and/or specialist)	%	39.5	55.5	48.8	42.8	32.3	35.4	np	37.2	44.4
Dental consultation	%	18.8	7.5	13.3	np	13.5	15.0	np	np	13.5
Consultation with other health professional	%	6.4	13.9	10.4	np	11.6	11.3	np	np	10.4
Total accessing health care (f)	%	40.4	56.5	59.8	47.4	49.3	39.5	47.1	42.6	48.9
Quintile 2										
Admitted to hospital	%	27.0	15.2	25.3	16.4	23.5	32.0	np	np	23.1
Casualty/outpatients/day clinic	%	np	np	11.0	np	6.0	np	np	np	6.8
Doctor consultation (GP and/or specialist)	%	45.7	53.4	50.6	41.2	42.0	38.6	np	27.3	47.6
Dental consultation	%	23.9	20.9	22.4	np	18.1	18.2	np	np	20.9
Consultation with other health professional	%	12.9	14.0	13.5	np	12.1	10.4	np	np	13.1
Total accessing health care (f)	%	50.0	56.1	58.2	45.5	46.9	47.2	np	37.4	52.4
Quintile 3										
Admitted to hospital	%	18.9	22.8	32.8	24.2	11.6	18.7	np	31.8	24.1
Casualty/outpatients/day clinic	%	np	np	np	np	np	np	np	np	4.2
Doctor consultation (GP and/or specialist)	%	40.0	50.9	37.7	34.0	38.8	53.4	37.8	np	42.6
Dental consultation	%	19.6	15.6	6.4	17.5	21.9	np	np	31.0	15.5
Consultation with other health professional	%	13.8	np	12.8	14.1	np	np	np	np	13.3
Total accessing health care (f)	%	43.9	57.2	44.4	35.7	40.3	55.0	45.2	37.7	47.2
Quintile 4										
Admitted to hospital	%	13.2	15.5	37.6	27.1	38.4	np	24.9	31.3	20.2
Casualty/outpatients/day clinic	%	–	np	np	np	np	np	np	np	5.5
Doctor consultation (GP and/or specialist)	%	36.1	55.5	31.1	29.1	43.8	35.5	32.7	42.2	40.0
Dental consultation	%	np	np	22.3	18.4	17.8	np	np	np	15.5
Consultation with other health professional	%	14.2	np	np	21.5	np	np	21.8	np	14.6
Total accessing health care (f)	%	39.5	57.3	33.1	50.9	46.0	35.5	45.2	48.5	46.6
Quintile 5										
Admitted to hospital	%	15.0	24.7	np	17.6	33.8	np	20.9	34.7	20.6

Table EA.72 **Proportion of people who accessed health services by health status, by SEIFA, 2011-12 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
Casualty/outpatients/day clinic	%	np	np	np	–	np	np	np	np	6.1
Doctor consultation (GP and/or specialist)	%	37.6	44.2	29.7	32.0	38.9	np	34.0	54.4	40.0
Dental consultation	%	25.0	25.0	np	22.6	23.9	np	15.1	np	25.2
Consultation with other health professional	%	np	30.0	np	np	np	np	22.9	np	18.2
Total accessing health care (f)	%	44.8	48.0	32.5	37.6	56.9	np	43.4	57.8	46.0
95 per cent confidence interval for Health status (excellent/very good/good)										
Quintile 1										
Admitted to hospital	± %	2.9	3.4	3.6	7.0	3.3	4.2	np	11.5	1.6
Casualty/outpatients/day clinic	± %	1.3	2.0	np	2.4	2.3	np	np	–	0.8
Doctor consultation (GP and/or specialist)	± %	4.3	3.8	5.4	5.1	4.6	4.5	np	9.1	2.4
Dental consultation	± %	3.5	3.8	4.7	5.1	4.2	3.9	np	7.2	1.8
Consultation with other health professional	± %	2.3	2.5	2.9	3.0	3.7	1.8	np	np	1.1
Total accessing health care (f)	± %	4.5	4.1	6.4	4.8	4.6	4.3	8.4	8.4	2.6
Quintile 2										
Admitted to hospital	± %	3.8	3.5	2.5	3.7	3.2	3.0	np	7.4	1.8
Casualty/outpatients/day clinic	± %	1.9	1.5	1.7	2.0	1.6	np	–	np	0.7
Doctor consultation (GP and/or specialist)	± %	4.8	5.1	3.7	4.8	3.7	4.4	12.3	13.0	2.2
Dental consultation	± %	3.4	4.2	3.2	4.2	4.6	5.3	14.9	6.1	1.5
Consultation with other health professional	± %	2.4	2.8	2.1	1.9	3.0	3.3	np	np	1.2
Total accessing health care (f)	± %	4.8	4.8	4.1	4.9	4.5	4.9	14.3	12.8	2.3
Quintile 3										
Admitted to hospital	± %	2.7	2.7	2.8	3.5	4.6	3.7	4.6	4.8	1.5
Casualty/outpatients/day clinic	± %	np	1.4	1.8	np	np	np	np	np	0.6
Doctor consultation (GP and/or specialist)	± %	4.6	4.1	4.3	4.1	4.7	5.5	6.6	7.8	2.1
Dental consultation	± %	3.7	4.2	4.1	3.9	6.0	3.7	6.1	4.6	2.2
Consultation with other health professional	± %	1.6	2.9	1.8	3.1	3.1	2.5	2.9	2.1	1.1
Total accessing health care (f)	± %	4.6	4.5	4.2	5.0	4.6	5.4	6.6	7.8	2.2
Quintile 4										
Admitted to hospital	± %	3.5	2.5	3.4	2.9	3.4	5.1	4.3	8.7	1.3
Casualty/outpatients/day clinic	± %	np	np	1.3	2.4	1.8	–	np	np	0.9
Doctor consultation (GP and/or specialist)	± %	4.3	4.1	4.6	4.3	5.2	8.7	4.5	7.5	1.9
Dental consultation	± %	4.7	4.8	4.0	4.6	5.3	7.4	5.8	6.7	2.4

TABLE EA.72

Table EA.72 **Proportion of people who accessed health services by health status, by SEIFA, 2011-12 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
Consultation with other health professional	± %	2.2	3.7	2.8	2.5	3.1	5.1	4.6	5.3	1.3
Total accessing health care (f)	± %	3.9	4.7	4.7	5.3	5.5	9.8	5.6	7.9	1.9
Quintile 5										
Admitted to hospital	± %	3.5	2.8	4.4	3.3	5.8	np	3.2	np	1.7
Casualty/outpatients/day clinic	± %	np	np	np	np	np	np	1.3	np	0.7
Doctor consultation (GP and/or specialist)	± %	3.5	3.5	4.9	4.3	5.7	7.5	2.9	10.2	1.9
Dental consultation	± %	3.2	3.9	4.5	5.3	6.4	8.0	2.8	8.5	1.6
Consultation with other health professional	± %	2.2	2.2	3.0	2.5	6.4	np	2.5	np	1.2
Total accessing health care (f)	± %	3.9	3.7	5.4	5.0	7.4	11.3	3.4	10.5	2.0
95 per cent confidence interval for Health status (fair/poor)										
Quintile 1										
Admitted to hospital	± %	10.6	19.7	11.9	17.4	9.9	6.4	np	np	6.0
Casualty/outpatients/day clinic	± %	np	17.9	6.7	np	21.8	6.0	np	np	2.6
Doctor consultation (GP and/or specialist)	± %	9.5	19.0	12.8	20.4	10.2	10.5	np	13.4	5.0
Dental consultation	± %	8.6	5.1	7.8	np	9.8	9.8	np	np	3.9
Consultation with other health professional	± %	3.8	17.6	6.1	np	8.3	5.9	np	np	3.0
Total accessing health care (f)	± %	9.4	18.9	12.6	15.9	20.8	9.6	23.0	12.2	5.2
Quintile 2										
Admitted to hospital	± %	12.4	8.4	9.7	14.3	8.7	18.0	np	np	5.1
Casualty/outpatients/day clinic	± %	np	np	8.1	np	4.5	np	np	np	2.3
Doctor consultation (GP and/or specialist)	± %	21.0	13.6	11.9	18.8	10.8	16.1	np	25.6	6.7
Dental consultation	± %	17.5	11.8	14.7	np	8.3	14.1	np	np	5.3
Consultation with other health professional	± %	7.8	8.0	9.3	np	5.9	7.4	np	np	4.2
Total accessing health care (f)	± %	21.2	13.8	10.7	17.0	10.7	18.1	np	36.5	6.7
Quintile 3										
Admitted to hospital	± %	7.1	12.1	9.0	9.0	12.7	11.9	np	24.0	4.5
Casualty/outpatients/day clinic	± %	np	np	np	np	np	np	np	np	2.2
Doctor consultation (GP and/or specialist)	± %	12.5	17.6	11.7	14.0	23.4	17.4	21.9	np	7.4
Dental consultation	± %	9.5	11.9	4.8	12.3	19.3	np	np	24.6	4.1
Consultation with other health professional	± %	7.5	np	7.9	10.5	np	np	np	np	4.1
Total accessing health care (f)	± %	12.6	16.0	8.6	13.9	23.4	17.4	15.5	33.6	6.9
Quintile 4										
Admitted to hospital	± %	7.5	14.2	35.6	12.9	27.3	np	15.5	34.2	5.0

Table EA.72 Proportion of people who accessed health services by health status, by SEIFA, 2011-12 (a), (b), (c), (d)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (e)	Aust
Casualty/outpatients/day clinic	± %	–	np	np	np	np	np	np	np	3.4
Doctor consultation (GP and/or specialist)	± %	18.7	37.2	9.2	12.4	19.2	29.4	24.0	29.6	7.8
Dental consultation	± %	np	np	11.8	13.2	12.8	np	np	np	5.6
Consultation with other health professional	± %	15.4	np	np	13.1	np	np	20.0	np	5.1
Total accessing health care (f)	± %	19.0	36.7	8.3	18.2	20.8	29.4	24.9	29.6	7.9
Quintile 5										
Admitted to hospital	± %	9.5	24.2	np	10.6	28.7	np	13.6	25.4	6.7
Casualty/outpatients/day clinic	± %	np	np	np	–	np	np	np	np	4.9
Doctor consultation (GP and/or specialist)	± %	17.7	23.3	19.4	17.8	40.8	np	13.1	30.4	8.4
Dental consultation	± %	19.1	17.6	np	19.4	27.0	np	12.0	np	7.2
Consultation with other health professional	± %	np	26.8	np	np	np	np	11.7	np	7.0
Total accessing health care (f)	± %	20.9	24.9	19.2	15.8	20.4	np	14.8	36.0	8.5

- (a) Rates are age standardised by State/Territory to the 2001 estimated resident population (10 year age ranges from 15 years).
- (b) People aged 15 years or over who: were admitted to hospital in the last 12 months; consulted a dentist in the last 3 months; visited casualty, an outpatient clinic or a day clinic, or consulted a GP, specialist or other health professional, in the last 2 weeks.
- (c) Data are not comparable to data for 2004-05 (table EA.73) or to 2012-13 data for Aboriginal and Torres Strait Islander people (table EA.68) due to differences in survey methodology.
- (d) Socio-Economic Indexes for Areas (SEIFA) quintiles are based on the ABS Index of Relative Socio-economic Disadvantage (IRSD). A lower SEIFA quintile indicates relatively greater disadvantage and a lack of advantage in general. A higher SEIFA quintile indicates a relative lack of disadvantage and greater advantage in general. Each SEIFA quintile represents approximately 20 per cent of the national population, but does not necessarily represent 20 per cent of the population in each State or Territory. Disaggregation by SEIFA is based on Statistical Local Area (SLA). Not all quintiles are represented in
- (e) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.
- (f) Total accessing casualty/outpatients/day clinic, or consulting a doctor or other health professional, in the last 2 weeks. Data are not comparable to data for 2004-05 or to 2012-13 data for Aboriginal and Torres Strait Islander people due to differences in survey methodology.
– Nil or rounded to zero. **np** Not published.

Source: ABS unpublished *Australian Health Survey, 2011-13* (2011-12 NHS component), Cat. no. 4364.0.

TABLE EA.73

Table EA.73 **Proportion of people who accessed health services by health status, by SEIFA, 2004-05 (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Health status (excellent/very good/good)										
Quintile 1										
Admitted to hospital	%	14.5	12.5	14.5	15.7	13.7	13.7	np	np	14.0
Casualty/outpatients/day clinic	%	3.6	5.6	3.2	4.1	4.6	4.3	–	–	4.1
Doctor consultation (GP and/or specialist)	%	25.2	25.2	21.6	15.6	23.7	21.8	np	np	23.5
Dental consultation (d)	%	4.4	2.6	3.7	7.8	3.4	4.5	–	–	4.0
Consultation with other health professional	%	9.6	8.3	10.5	12.0	11.2	9.2	–	–	9.7
Total accessing health care (e)	%	42.5	39.1	39.1	34.9	42.3	38.3	np	np	40.3
Quintile 2										
Admitted to hospital	%	15.0	15.5	12.3	16.1	13.6	8.6	np	np	14.3
Casualty/outpatients/day clinic	%	4.0	7.9	3.1	6.5	6.0	np	6.8	np	4.8
Doctor consultation (GP and/or specialist)	%	20.7	20.2	21.5	23.4	23.4	20.3	np	np	21.4
Dental consultation (d)	%	4.2	4.2	4.1	4.4	6.4	8.4	np	np	4.4
Consultation with other health professional	%	11.7	14.9	12.8	13.7	14.1	12.8	10.5	–	12.9
Total accessing health care (e)	%	41.5	39.5	38.4	42.7	44.7	37.8	np	np	40.7
Quintile 3										
Admitted to hospital	%	13.1	12.4	12.4	17.4	16.5	12.7	np	np	13.5
Casualty/outpatients/day clinic	%	3.0	5.4	3.7	3.3	5.2	np	np	np	3.9
Doctor consultation (GP and/or specialist)	%	19.8	18.7	20.1	20.4	27.3	22.8	12.6	51.8	20.4
Dental consultation (d)	%	6.4	6.0	5.6	6.4	7.0	3.2	np	np	6.1
Consultation with other health professional	%	12.3	14.2	15.6	13.7	14.1	12.9	9.6	32.6	13.9
Total accessing health care (e)	%	41.0	39.8	43.3	44.0	48.3	41.1	16.5	66.2	42.0
Quintile 4										
Admitted to hospital	%	13.2	12.9	14.0	11.1	13.1	14.5	15.0	8.1	13.1
Casualty/outpatients/day clinic	%	3.1	5.7	4.4	3.5	3.6	6.0	2.1	–	4.3
Doctor consultation (GP and/or specialist)	%	21.8	22.2	18.6	22.0	19.8	23.8	np	np	20.8
Dental consultation (d)	%	5.7	6.3	6.1	5.8	7.6	9.2	5.7	5.5	6.2
Consultation with other health professional	%	11.0	14.6	13.0	12.5	15.8	13.2	np	np	13.3
Total accessing health care (e)	%	42.5	41.3	40.6	39.7	43.8	44.8	37.8	19.9	41.3
Quintile 5										
Admitted to hospital	%	15.0	14.9	14.8	17.7	11.9	14.7	12.9	28.1	14.9
Casualty/outpatients/day clinic	%	3.3	4.5	3.9	5.9	3.6	5.1	np	np	4.1
Doctor consultation (GP and/or specialist)	%	18.8	21.4	20.9	27.4	17.4	17.1	20.3	30.4	20.6
Dental consultation (d)	%	6.8	7.8	7.3	8.2	7.0	8.4	np	np	7.3

TABLE EA.73

Table EA.73 **Proportion of people who accessed health services by health status, by SEIFA, 2004-05 (a), (b), (c)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Consultation with other health professional	%	13.7	17.4	20.2	14.4	14.7	20.4	np	np	15.8
Total accessing health care (e)	%	41.7	46.2	46.2	49.2	39.1	45.6	39.8	64.3	44.1
Health status (fair/poor)										
Quintile 1										
Admitted to hospital	%	25.7	25.0	26.0	30.5	20.5	26.0	–	–	25.4
Casualty/outpatients/day clinic	%	11.2	9.6	12.1	6.4	13.7	10.6	np	np	11.0
Doctor consultation (GP and/or specialist)	%	45.9	49.2	51.1	28.9	38.1	45.0	np	np	46.0
Dental consultation (d)	%	4.5	5.3	np	np	7.6	3.1	–	–	4.4
Consultation with other health professional	%	15.0	15.5	25.3	10.4	13.4	16.4	–	–	17.0
Total accessing health care (e)	%	64.7	66.5	73.7	60.6	61.4	58.2	np	np	66.0
Quintile 2										
Admitted to hospital	%	33.6	30.4	30.0	27.0	27.2	18.2	np	np	30.8
Casualty/outpatients/day clinic	%	3.1	11.6	11.8	13.1	5.8	4.5	np	np	7.5
Doctor consultation (GP and/or specialist)	%	36.0	48.0	47.5	56.1	36.8	46.1	44.7	–	42.3
Dental consultation (d)	%	6.9	5.7	4.2	np	10.3	np	–	–	6.3
Consultation with other health professional	%	18.7	25.3	30.2	34.2	23.5	18.3	np	np	24.3
Total accessing health care (e)	%	62.1	71.2	70.9	70.4	64.6	54.9	np	np	66.0
Quintile 3										
Admitted to hospital	%	23.1	24.6	28.6	28.4	20.8	34.9	–	34.6	25.4
Casualty/outpatients/day clinic	%	11.5	13.8	8.6	9.8	12.2	12.6	np	np	11.6
Doctor consultation (GP and/or specialist)	%	47.4	49.0	36.3	29.7	52.4	42.7	np	np	44.2
Dental consultation (d)	%	3.2	2.6	9.0	4.8	9.4	np	–	np	4.7
Consultation with other health professional	%	29.0	22.1	23.8	14.4	35.3	30.5	np	np	24.6
Total accessing health care (e)	%	59.1	65.1	54.6	52.5	68.1	60.8	np	np	59.7
Quintile 4										
Admitted to hospital	%	22.0	25.7	19.6	29.1	34.0	29.8	26.2	34.1	24.6
Casualty/outpatients/day clinic	%	8.2	8.8	8.1	25.1	13.4	19.2	3.9	–	10.0
Doctor consultation (GP and/or specialist)	%	37.0	40.1	30.8	38.3	45.7	36.9	27.5	35.6	37.2
Dental consultation (d)	%	11.3	4.3	np	np	9.9	np	3.8	np	7.3
Consultation with other health professional	%	18.0	22.0	18.0	33.9	29.8	22.3	np	np	22.0
Total accessing health care (e)	%	52.5	61.8	52.0	70.2	63.1	59.3	61.0	80.6	57.9
Quintile 5										
Admitted to hospital	%	32.1	18.8	22.1	26.6	26.4	26.2	np	np	25.7
Casualty/outpatients/day clinic	%	6.5	5.7	10.2	9.2	14.0	15.2	np	np	7.8

TABLE EA.73

Table EA.73 **Proportion of people who accessed health services by health status, by SEIFA, 2004-05 (a), (b), (c)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Doctor consultation (GP and/or specialist)	%	43.4	34.0	43.0	32.2	37.6	48.3	np	np	38.3
Dental consultation (d)	%	3.7	18.9	14.0	8.7	6.7	14.1	10.1	–	10.8
Consultation with other health professional	%	18.5	27.9	19.3	21.4	22.8	20.1	np	np	23.1
Total accessing health care (e)	%	60.6	64.9	57.3	60.8	67.5	60.1	59.1	100.0	62.4
95 per cent confidence interval for Health status (excellent/very good/good)										
Quintile 1										
Admitted to hospital	± %	2.7	3.4	3.2	6.2	3.2	2.7	np	np	1.7
Casualty/outpatients/day clinic	± %	1.5	2.6	1.5	2.5	1.8	1.4	–	–	0.9
Doctor consultation (GP and/or specialist)	± %	4.0	4.7	3.1	5.9	4.6	3.3	np	np	2.2
Dental consultation (d)	± %	1.8	1.5	1.7	3.6	1.6	1.5	–	–	0.9
Consultation with other health professional	± %	2.8	3.0	3.6	5.4	3.2	2.1	–	–	1.4
Total accessing health care (e)	± %	4.3	4.8	3.9	6.8	4.7	3.9	np	np	2.4
Quintile 2										
Admitted to hospital	± %	3.4	4.6	2.5	3.2	3.5	6.2	np	np	1.7
Casualty/outpatients/day clinic	± %	1.7	3.9	1.2	2.5	1.8	np	5.7	np	1.0
Doctor consultation (GP and/or specialist)	± %	3.1	6.5	2.9	3.6	4.2	7.8	np	np	1.7
Dental consultation (d)	± %	1.4	2.2	1.5	1.7	2.0	5.5	np	np	0.7
Consultation with other health professional	± %	2.1	4.6	2.8	3.2	3.2	5.5	19.6	–	1.4
Total accessing health care (e)	± %	4.6	7.2	3.2	4.4	4.8	8.7	np	np	2.3
Quintile 3										
Admitted to hospital	± %	2.4	2.5	3.8	3.9	3.4	3.9	np	np	1.3
Casualty/outpatients/day clinic	± %	1.3	2.2	2.1	1.8	2.6	np	np	np	0.7
Doctor consultation (GP and/or specialist)	± %	3.8	3.3	4.1	5.1	5.0	7.1	34.5	42.1	1.8
Dental consultation (d)	± %	1.9	2.1	2.0	2.3	2.4	2.5	np	np	1.0
Consultation with other health professional	± %	2.7	2.9	3.3	4.2	3.6	5.4	13.0	46.2	1.4
Total accessing health care (e)	± %	4.5	4.4	5.5	5.9	6.0	7.5	26.3	32.1	2.2
Quintile 4										
Admitted to hospital	± %	3.8	2.8	2.7	3.8	2.7	6.0	4.3	5.9	1.5
Casualty/outpatients/day clinic	± %	1.9	1.6	1.9	1.8	1.3	4.5	1.5	–	0.8
Doctor consultation (GP and/or specialist)	± %	4.6	2.7	2.6	5.5	2.3	4.8	np	np	1.6
Dental consultation (d)	± %	1.7	2.1	1.9	3.0	2.0	4.6	3.3	8.9	0.9
Consultation with other health professional	± %	2.9	2.8	2.7	4.5	2.6	6.3	np	np	1.5
Total accessing health care (e)	± %	5.8	3.4	3.6	7.2	3.8	7.8	6.1	18.3	2.4

TABLE EA.73

Table EA.73 **Proportion of people who accessed health services by health status, by SEIFA, 2004-05 (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Quintile 5										
Admitted to hospital	± %	2.7	3.3	4.1	4.8	2.9	6.0	2.5	43.9	1.5
Casualty/outpatients/day clinic	± %	1.5	1.5	1.9	2.6	2.2	3.1	np	np	0.9
Doctor consultation (GP and/or specialist)	± %	2.2	2.6	3.7	4.7	3.0	5.1	3.9	36.7	1.3
Dental consultation (d)	± %	1.8	2.4	2.2	3.0	2.6	3.9	np	np	1.1
Consultation with other health professional	± %	2.6	3.5	5.1	3.7	2.9	6.8	np	np	1.8
Total accessing health care (e)	± %	3.5	3.6	5.7	5.4	4.6	6.9	4.0	30.6	2.0
95 per cent confidence interval for Health status (fair/poor)										
Quintile 1										
Admitted to hospital	± %	9.1	9.5	7.5	16.7	11.5	9.2	–	–	4.8
Casualty/outpatients/day clinic	± %	7.9	5.0	7.2	8.4	9.3	5.9	np	np	3.3
Doctor consultation (GP and/or specialist)	± %	8.2	12.1	12.1	13.7	12.4	10.1	np	np	5.1
Dental consultation (d)	± %	4.1	5.5	np	np	7.6	3.7	–	–	2.2
Consultation with other health professional	± %	6.6	8.1	8.8	10.6	7.8	6.3	–	–	3.9
Total accessing health care (e)	± %	8.9	11.4	9.0	18.7	12.0	12.3	np	np	4.6
Quintile 2										
Admitted to hospital	± %	10.4	12.6	7.8	11.6	8.3	16.7	np	np	5.8
Casualty/outpatients/day clinic	± %	2.0	6.6	7.2	8.7	3.6	6.9	np	np	2.2
Doctor consultation (GP and/or specialist)	± %	9.0	13.5	10.9	10.9	11.0	15.9	57.8	–	4.6
Dental consultation (d)	± %	8.3	7.4	2.8	np	10.4	np	–	–	4.0
Consultation with other health professional	± %	7.6	12.1	8.3	11.7	9.0	18.6	np	np	4.8
Total accessing health care (e)	± %	11.4	16.8	7.4	12.1	11.8	17.7	np	np	5.8
Quintile 3										
Admitted to hospital	± %	9.6	9.8	9.0	12.6	8.2	16.7	–	78.5	5.0
Casualty/outpatients/day clinic	± %	6.1	7.7	6.1	8.0	8.3	12.3	np	np	3.5
Doctor consultation (GP and/or specialist)	± %	11.3	15.7	13.6	10.7	16.7	16.6	np	np	6.7
Dental consultation (d)	± %	2.7	3.2	6.0	5.1	9.1	np	–	np	1.9
Consultation with other health professional	± %	12.7	9.8	10.2	9.7	16.2	15.9	np	np	5.9
Total accessing health care (e)	± %	12.7	13.4	13.0	13.9	17.3	16.5	np	np	6.4
Quintile 4										
Admitted to hospital	± %	8.7	9.4	7.6	14.8	9.4	16.5	15.5	34.4	4.3
Casualty/outpatients/day clinic	± %	8.7	5.4	4.9	15.0	7.0	20.2	4.2	–	3.2
Doctor consultation (GP and/or specialist)	± %	12.6	9.4	10.8	17.0	9.4	28.8	13.2	30.6	5.3
Dental consultation (d)	± %	8.4	3.8	np	np	9.6	np	4.6	np	3.3

Table EA.73 Proportion of people who accessed health services by health status, by SEIFA, 2004-05 (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Consultation with other health professional	± %	9.3	11.0	7.0	18.4	7.6	19.9	np	np	4.2
Total accessing health care (e)	± %	13.8	11.5	10.2	15.1	9.0	25.4	16.8	41.1	6.1
Quintile 5										
Admitted to hospital	± %	12.1	10.0	16.6	17.4	10.7	13.2	np	np	5.2
Casualty/outpatients/day clinic	± %	4.7	4.6	13.6	6.6	12.5	16.8	np	np	3.0
Doctor consultation (GP and/or specialist)	± %	11.8	13.6	19.0	15.3	16.1	18.7	np	np	6.0
Dental consultation (d)	± %	3.7	13.4	10.8	12.0	6.0	12.8	6.2	–	4.5
Consultation with other health professional	± %	8.9	12.7	13.6	14.8	13.1	17.9	np	np	5.0
Total accessing health care (e)	± %	11.8	14.1	23.6	24.8	13.3	20.0	9.8	–	6.9

- (a) Rates are age standardised by State/Territory to the 2001 estimated resident population (5 year age ranges from 15 years).
- (b) People aged 15 years or over who accessed at least one of the health services noted in the table in the last two weeks or were admitted to hospital in the last 12 months.
- (c) Data are not comparable to data for 2011-12 (table EA.72) due to differences in survey methodology.
- (d) Socio-Economic Indexes for Areas (SEIFA) quintiles are based on the ABS Index of Relative Socio-economic Disadvantage (IRSD). A lower SEIFA quintile indicates relatively greater disadvantage and a lack of advantage in general. A higher SEIFA quintile indicates a relative lack of disadvantage and greater advantage in general. Each SEIFA quintile represents approximately 20 per cent of the national population, but does not necessarily represent 20 per cent of the population in each State or Territory. Disaggregation by SEIFA is based on SLA (Statistical Local Area). Not all quintiles are represented in every jurisdiction.
- (e) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.
- (f) Total accessing any of the selected health services noted above. Components may not add to total because persons may have accessed more than one type of health service. Data are not comparable with data for 2011-12 due to methodological differences between the surveys.
– Nil or rounded to zero. **np** Not published.

Source: ABS unpublished, *National Health Survey, 2004-05*, Cat. no. 4364.0.

Data quality information — Health sector overview E

Data quality information

Data quality information (DQI) provides information against the seven ABS data quality framework dimensions, for a selection of performance indicators in the Health sector overview. DQI for additional indicators will be progressively introduced in future reports.

Technical DQI has been supplied or agreed by relevant data providers. Additional Steering Committee commentary does not necessarily reflect the views of data providers.

DQI are available for the following performance indicators and measures:

Babies born of low birthweight	2
Prevalence of risk factors to the health of Australians	6
Prevalence of overweight and obesity	6
Rates of current daily smokers	10
Levels of risky alcohol consumption	12
Selected potentially preventable diseases	16
Incidence of selected cancers	16
Incidence of heart attacks	20
Prevalence of type 2 diabetes	24
Potentially avoidable deaths	28
Mortality and life expectancy	32
Life expectancy	32
Mortality rates — Infant and child	34
Mortality rates by major cause of death	38
Profile of employed health workforce	42

Babies born of low birthweight

Data quality information for this indicator has been sourced from the Australian Institute of Health and Welfare (AIHW) with additional Steering Committee comments.

Indicator definition and description

Indicator	The incidence of low birthweight among liveborn babies of Aboriginal and Torres Strait Islander mothers and other mothers as a proportion of liveborn infants.
Measure/s (computation)	<p>Numerator:</p> <ul style="list-style-type: none">• Number of low birthweight live-born singleton infants born in a calendar year. Low birthweight is defined as less than 2500 grams. <p>Denominator:</p> <ul style="list-style-type: none">• Number of live-born singleton infants born in a calendar year. <p>Calculation: $100 \times (\text{Numerator} \div \text{Denominator})$</p> <p>Variability band:</p> <ul style="list-style-type: none">• calculated using the standard method for estimating 95% confidence intervals as follows: $CI (CR)95\% = CR \pm 1.96 \times CR / \sum_{\alpha}^l d$ <ul style="list-style-type: none">• where<ul style="list-style-type: none">- n=number of live-born singleton infants.- CI = confidence interval- CR = crude rate (expressed as a percentage)
Data source/s	<p>This indicator is calculated using data from the AIHW National Perinatal Data Collection (NPDC).</p> <p>For data by socioeconomic status: calculated by AIHW using the ABS' Socioeconomic Index for Areas (SEIFA) Index of Relative Socioeconomic Disadvantage (IRSD). Each Statistical Local Area in Australia is ranked and divided into quintiles in a population-based manner, such that each quintile has approximately 20 per cent of the population and each decile has approximately 10 per cent of the population.</p> <p>For data by remoteness: ABS' Australian Standard Geographical Classification.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The National Perinatal Epidemiology and Statistics Unit (NPESU) calculated this indicator on behalf of the Australian Institute of Health and Welfare (AIHW).</p> <p>The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health and Ageing. For further information see the AIHW website.</p> <p>State and Territory health authorities receive these data from patient administrative and clinical records. This information is usually collected by midwives or other birth attendants. States and territories use these data for service planning, monitoring and internal and public reporting.</p>
Relevance	<p>The National Perinatal Data Collection comprises data items as specified in the Perinatal NMDS plus additional items collected by the states and territories. The purpose of the Perinatal NMDS is to collect information at birth for monitoring pregnancy, childbirth and the neonatal period for both the mother and baby(s).</p> <p>The Perinatal NMDS is a specification for data collected on all births in Australia in hospitals, birth centres and the community. It includes information for all live births and stillbirths of at least 400 grams birthweight or at least 20 weeks gestation, except in WA, where births are included if gestational age is 20 weeks or more, or if</p>

gestation unknown, if birthweight is at least 400 grams, and in Victoria where livebirths are included of any gestational age and stillbirths if gestational age is 20 weeks or more, or if gestation unknown, if birthweight is at least 400 grams. It includes data items relating to the mother, including demographic characteristics and factors relating to the pregnancy, labour and birth; and data items relating to the baby, including birth status (live or stillbirth), sex, gestational age at birth, birth weight, Apgar score and neonatal length of stay.

The NPDC includes all relevant data elements of interest for this indicator. Birthweight is a Perinatal NMDS item. In 2011, very few (0.02 per cent) records for live-born singleton babies were missing the data for birthweight.

While each jurisdiction has a unique perinatal form for collecting data on which the format of the Indigenous status question and recording categories varies slightly, all systems include the NMDS item on Indigenous status of mother.

No formal national assessment has been undertaken to determine completeness of the coverage of Indigenous mothers in the Perinatal NMDS. However, the proportion of Indigenous mothers for the period 2002–2012 has been consistent, at 3.6–4.0 per cent of women who gave birth. For maternal records where Indigenous status was not stated (0.2 per cent), data were excluded from Indigenous and non-Indigenous analyses.

The indicator is presented by Socio-Economic Indexes for Areas (SEIFA) Index of Relative Socio-Economic Disadvantage (IRSD). The data supplied to the NPDC include a code for SLA from all states and territories. Reporting by remoteness is in accordance with the Australian Statistical Geography Standard (ASGS).

Timeliness

The reference period for the data is 2007 to 2012. Collection of data for the NPDC is annual.

Accuracy

Inaccurate responses may occur in all data provided to the AIHW. The AIHW does not have direct access to perinatal records to determine the accuracy of the data provided. However, the NPESU undertakes validation on receipt of data by the AIHW. Data received from states and territories are checked for completeness, validity and logical errors. Potential errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The NPESU does not adjust data to account for possible data errors.

Errors may occur during the processing of data by the states and territories or at the AIHW. Processing errors prior to data supply may be found through the validation checks applied by the NPESU. This indicator is calculated on data that has been reported to the AIHW. Prior to publication, these data are referred back to jurisdictions for checking and review. The NPESU does not adjust the data to correct for missing values. Note that because of data editing and subsequent updates of State/Territory databases, and because data are being reported by place of residence rather than place of birth the numbers reported for this indicator differ from those in reports published by the states and territories. The data are not rounded.

The data supplied for the 2011 Perinatal NMDS by Victoria to prepare this indicator was provisional and subject to vary with data quality activities. Further minor changes to the data are not foreseen to produce any detectable change to the indicator.

The geographical location code for the area of usual residence of the mother is included in the Perinatal NMDS. Only 0.1 per cent of records were non-residents or could not be assigned to a state or territory of residence. There is no scope in the data element Area of usual residence of mother to discriminate temporary residence of mother for the purposes of accessing birthing services from usual residence. The former may differentially impact populations from remote and very remote areas, where services are not available locally.

Birthweight is nearly universally reported. Less than 0.06 per cent of records were missing these data overall. Data presented by Indigenous status are influenced by the quality and completeness of Indigenous identification of mothers which is likely to differ among jurisdictions. Approximately 0.2 per cent of mothers who gave birth in the reference period had missing Indigenous status information. Jurisdictional differences in the level of data missing for Indigenous status ranges from less than 0.1% to 1.8% and there may also be differences in the rates of Indigenous under-

identification. Therefore, jurisdictional comparisons of Indigenous data should not be made.

Disaggregated data by Indigenous status is reported by single year for time series and by three-year combined data for the current reporting period. Single year data by Indigenous status should be used with caution due to the small number of low birthweight infants born to Indigenous mothers each year.

Coherence

Data for this indicator are published annually in Australia's mothers and babies; and biennially in reports such as the Aboriginal and Torres Strait Islander Health Performance Framework report, the Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, and the Overcoming Indigenous Disadvantage report. The numbers presented in these publications will differ slightly from those presented here as this measure excludes multiple births and stillbirths.

Changing levels of Indigenous identification over time and across jurisdictions may also affect the accuracy of compiling a consistent time series in future years.

In 2011, the ABS updated the standard geography used in Australia for most data collections from the Australian Standard Geographical Classification (ASGC) to the Australian Statistical Geography Standard (ASGS). Also updated at this time were remoteness areas and the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing.

The new remoteness areas will be referred to as RA 2011, and the previous remoteness areas as RA 2006. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006.

Data for 2007 through to 2010 reported by remoteness are reported for RA 2006. Data from 2011 are reported for RA 2011. The AIHW considers the change from RA 2006 to RA 2011 to be a series break when applied to data supplied for this indicator, therefore remoteness data for 2010 and previous years are not comparable to remoteness data for 2011 and subsequent years.

Data for 2007 through to 2010 reported for SEIFA quintiles and deciles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data from 2011 are reported using SEIFA 2011, at the SLA level for 2011. Data for 2012 are reported using SEIFA 2011 at the SA2 (NSW VIC, QLD, WA, SA and TAS) or SLA level (ACT and NT). The AIHW considers the change from SEIFA 2006 to SEIFA 2011 to be a series break when applied to data supplied for this indicator, therefore SEIFA data for 2011 are not directly comparable with SEIFA data from previous years.

Accessibility

The AIHW provides a variety of products that draw upon the NPDC. Published products available on the AIHW website are:

- *Australia's mothers and babies* annual report
- *Indigenous mothers and their babies, Australia 2001–2004*
- METeOR – online metadata repository
- National health data dictionary.

Ad-hoc data are also available on request (charges apply to recover costs).

Interpretability

Supporting information on the use and quality of the Perinatal NMDS are published annually in Australia's mothers and babies (Chapter 1), available in hard copy or on the AIHW website. Comprehensive information on the quality of Perinatal NMDS elements are published in *Perinatal National Minimum Data Set compliance evaluation: 2006-2009*. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. More detailed information on the quality of Indigenous data that might affect interpretation of the indicator was published in *Indigenous mothers and their babies, Australia 2001–2004* (Chapter 1 and Chapter 5).

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Birthweight is included in the Perinatal National Minimum Data Set (NMDS) and data are complete for over 99.9 per cent of babies.
- This measure only includes births of at least 20 weeks gestation or 400 grams birthweight. It excludes multiple births and stillbirths and the measure may

therefore differ slightly from information presented in other publications on low birthweight.

- The National Perinatal Data Collection (NPDC) includes information on the Indigenous status of the mother only. Since 2005, all jurisdictions have collected information on Indigenous status of the mother in accordance with the Perinatal NMDS.
- No formal national assessment has been undertaken to determine completeness of the coverage or identification of Indigenous mothers in the NPDC. The current data have not been adjusted for under-identification of Indigenous status of the mother and thus jurisdictional comparisons of Indigenous data should not be made.
- Remoteness data for 2010 and previous years are not directly comparable to remoteness data for 2011 and subsequent years.
- SEIFA data for 2011 are not directly comparable with SEIFA data from previous years.

Prevalence of risk factors to the health of Australians

Prevalence of overweight and obesity

Data quality information for this indicator has been sourced from the Australian Bureau of Statistics (ABS) with additional Steering Committee comments.

Indicator definition and description

Indicator	Prevalence of risk factors to the health of Australians — Proportion of adults and children who are overweight or obese.
Measure/s (computation)	<p>Numerator:</p> <ul style="list-style-type: none">• Number of people aged 18 years or over with a Body Mass Index (BMI) greater than or equal to 25, and number of children aged 5–17 years exceeding age and sex specific BMI values for overweight and obesity. <p>Denominator:</p> <ul style="list-style-type: none">• Number of people aged 18 years or over and number of children aged 5–17 years, for whom height and weight measurements were taken. <p>Calculation: $100 \times (\text{Numerator} \div \text{Denominator})$</p>
Data source/s	<p>For the 2014 and 2015 Reports, the denominator and numerator for this indicator, for the general and non-indigenous population, use data from the full sample or Core component of the general population component of the ABS Australian Health Survey (AHS) from approximately 32 000 people, which is weighted to benchmarks for the total AHS in-scope estimated resident population (ERP) at 31 October 2011.</p> <p>This information replaces data supplied for the 2013 Report, which was based on the National Health Survey (NHS) subset (20 500 people) of the full sample (32 000 people). The larger sample size (the full sample or core) supplied for the 2014 reporting cycle provides more accurate estimates and allows for analysis at a finer level of disaggregation. For more information on the structure of the AHS, see <i>Structure of the Australian Health Survey</i>.</p> <p>For the 2015 Report, the denominator and numerator for the Aboriginal and Torres Strait Islander population use data from the full sample or Core component of the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) of approximately 13 000 people, which is weighted to benchmarks for the Australian Aboriginal and Torres Strait Islander ERP at 30 June 2011, based on the 2011 Census of Population and Housing.</p> <p>This information replaces data supplied for the 2014 Report, which was based on the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) subset (9300 people) of the full sample (13 000 people). The larger sample size used for the 2015 Report provides more accurate estimates and allows for analysis at a finer level of disaggregation. For more information on the structure of the AATSIHS, see <i>Structure of the Australian Aboriginal and Torres Strait Islander Health Survey</i>.</p> <p>For information on scope and coverage, see the <i>Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide</i> (cat. no. 4727.0.55.002) on the ABS website, www.abs.gov.au.</p> <p>Data reported for 2007-08 are from the ABS 2007-08 NHS. Data reported for 2004-05 are from the ABS 2004-05 NHS and the ABS 2004-05 NATSIHS.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The AHS and NATSIHS were collected, processed, and published by the ABS. The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and</p>
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	mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website, www.abs.gov.au .
Relevance	<p>The 201112 AHS and 2012-13 AATSIHS collected measured height and weight from persons aged 2 years and over. For the purposes of this indicator, Body Mass Index (BMI) values are derived from measured height and weight information using the formula: weight (kg) / height (m)².</p> <p>Despite some limitations, BMI is widely used internationally as a relatively straightforward way of measuring overweight and obesity.</p>
Timeliness	<p>The AHS is conducted every three years over a 12 month period. Results from the Core component of the AHS were released in June 2013.</p> <p>The AATSIHS is conducted over a 12 month period, approximately every 6 years. Results from the Core component of the 2012-13 AATSIHS were released in June 2014. The previous NATSIHS was conducted in 2004-05.</p>
Accuracy	<p>The AHS was conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the NT, where such persons make up approximately 23 per cent of the population. The response rate for the 2011 12 Core component was 82 per cent. Results are weighted to account for non-response.</p> <p>The AATSIHS was conducted in all States and Territories, including very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were excluded from the survey. The response rate for the Core component of the 2012-13 AATSIHS was 80 per cent. Results are weighted to account for non-response.</p> <p>As they are drawn from a sample survey, data for the indicator are subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use.</p> <p>The following comments apply to data for the general and non-Indigenous populations only.</p> <ul style="list-style-type: none"> • Data for overweight and obesity are not directly comparable to the 2004-05 NHS due to the difference in collection methodology and possible erroneous estimation of respondent self-reported measurements in 2004-05 • Data for the NT for 2011-12 are not comparable to previous years due to the increase in sample size. Data for the NT for 2007-08 should be used with caution due to large RSEs resulting from the small sample size. • RSEs for adult overweight and obesity rates by State/Territory and Remoteness Areas are within acceptable limits, except for remote Queensland for which data should be used with caution. • RSEs for child overweight and obesity rates by State/Territory and Remoteness Areas are within acceptable limits, except for inner regional WA and SA, outer regional New South Wales and Victoria, and total remote Australia, for which data should be used with caution, and for remote areas in Queensland, Western Australia and South Australia where rates are considered too unreliable for general use. • The breakdown by State/Territory and SEIFA quintiles for adults in general has sampling error within acceptable limits, except quintile 5 in the NT which should be used with caution. • Data by State/Territory and SEIFA quintiles for children in general have sampling error within acceptable limits, except for some quintiles in Tasmania, the Australian Capital Territory and Northern Territory which should be used with caution. Rates for quintile 5 in Tasmania and quintile 1 in the Australian Capital Territory are considered too unreliable for general use.

- Sampling errors for BMI categories for adults by State/Territory are within acceptable limits, though rates of underweight for Tasmania and the ACT should be used with caution.
- Sampling errors for BMI data for children by State/Territory are generally within acceptable limits, though rates of underweight for most States/Territories should be used with caution.

The following comments apply to data for the Aboriginal and Torres Strait Islander population:

- Data for overweight and obesity are not directly comparable to the 2004-05 NATSIHS due to the difference in collection methodology and possible erroneous estimation of respondent self-reported measurements in 2004-05.
- Data collected on measured height, weight and waist circumference in the 2012-13 AATSIHS used the same methodology and equipment as the 2011-12 NHS (neither survey collected self-reported measurements), so the two are directly comparable.

Coherence

The methods used to construct the indicator are consistent and comparable with other collections and with international practise.

Most surveys, including Computer-Assisted Telephone Interviewing (CATI) health surveys conducted by the States and Territories, collect only self reported height and weight. There is a general tendency across the population for people to overestimate height and underestimate weight, which results in BMI scores based on self-reported height and weight to be lower than BMI scores based on measured height and weight. Therefore, NHS and NATSIHS data for 2004-05 are not comparable with 2011–13 data which are based on measured height and weight.

The age- and sex-specific cutoff points for BMI categories for children are from the work of Cole TJ, Bellizzi MC, Flegal KM & Dietz WH 2000, *Establishing a standard definition for child overweight and obesity worldwide: international survey*, *BMJ* 320:1240.

The AHS collected a range of other health-related information that can be analysed in conjunction with BMI.

Accessibility

See *Australian Health Survey: First Results* (Cat. no. 4364.0.55.001) and *Australian Health Survey: Health Service Usage and Health Related Actions* (Cat. no. 4364.0.55.002) for an overview of results from the NHS component of the AHS. See: *Australian Health Survey: Updated Results* (Cat. no. 4364.0.55.003) for results from the Core component of AHS. Other information from this survey is also available on request.

The data for NATSIHS are available from the ABS website in the publication *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13* (Cat. no. 4727.0.55.001). See *Australian Aboriginal and Torres Strait Islander Health Survey: Updated Results* (Cat. no. 4727.0.55.006) for results from the Core component of the AATSIHS. Other information from the AATSIHS is also available from the ABS website, www.abs.gov.au.

Interpretability

Information to aid interpretation of the data is available on the ABS website from the *Australian Health Survey: User Guide, 2011-13* (Cat. no. 4363.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Many health-related issues are closely associated with age; therefore data for this indicator have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Information for the 2015 Report for the Aboriginal and Torres Strait Islander population replaces data supplied for the 2014 Report which was based on the National Aboriginal and Torres Strait Islander Health Survey subset (9300 people) of the full sample (13 000 people). The larger sample size used for the 2015 reporting cycle provides more accurate estimates and allows for analysis at a finer level of disaggregation.

For information on how the results compare between the two samples, see *Comparison of Results in Australian Health Survey: Updated Results* (Cat. No. 4364.0.55.003).

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The data provide relevant information on the proportion of people who are overweight and obese.
- Data for the total and non-Indigenous populations in the AHS do not include people living in very remote areas, which affects the comparability of the NT results.
- Data by Indigenous status are not directly comparable over time as data for 2004-05 were based on self-reported height and weight and data for 2011-13 are based on measured height and weight
- Data are of acceptable accuracy. Some relative standard errors for disaggregations are greater than 25 per cent and these data should be used with caution.
- AATSIHS data are only available every six years. An assessment of the relative speed of change in results for this indicator is required to determine whether more regular data collection is necessary. Subject to cost-benefit analysis, it is recommended that relevant questions be included in both the AATSIHS and the NATSISS, to provide data on a rotating three yearly cycle across the two collections.
- The size of the standard errors mean that the survey data may not be adequate for measuring change over time. Small year to year movements may be difficult to detect if the size of the standard errors is large compared to the size of the difference between estimates.

Rates of current daily smokers

Data quality information for this indicator has been sourced from the Australian Bureau of Statistics (ABS) with additional Steering Committee comments.

Indicator definition and description

Indicator	Prevalence of risk factors to the health of Australians — Rates of current daily smokers.
Measure/s (computation)	Numerator: <ul style="list-style-type: none">• Number of persons aged 18 years or over who smoke tobacco every day. Denominator: <ul style="list-style-type: none">• Number of people aged 18 years or over. Calculation: $100 \times (\text{Numerator} \div \text{Denominator})$
Data source/s	<p>For the 2014 and 2015 Reports, the denominator and numerator for this indicator, for the general and non-indigenous population, use data from the full sample or Core component of the general population component of the ABS Australian Health Survey (AHS) from approximately 32 000 people, which is weighted to benchmarks for the total AHS in-scope estimated resident population (ERP) at 31 October 2011.</p> <p>This information replaces data supplied for the 2013 Report, which was based on the National Health Survey (NHS) subset (20 500 people) of the full sample (32 000 people). The larger sample size (the full sample or core) supplied for the 2014 reporting cycle provides more accurate estimates and allows for analysis at a finer level of disaggregation. For more information on the structure of the AHS, see <i>Structure of the Australian Health Survey</i>.</p> <p>For the 2015 Report, the denominator and numerator for the Aboriginal and Torres Strait Islander population use data from the full sample or Core component of the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) of approximately 13 000 people, which is weighted to benchmarks for the Australian Aboriginal and Torres Strait Islander ERP at 30 June 2011, based on the 2011 Census of Population and Housing.</p> <p>This information replaces data supplied for the 2014 Report, which was based on the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) subset (9300 people) of the full sample (13 000 people). The larger sample size used for the 2015 Report provides more accurate estimates and allows for analysis at a finer level of disaggregation. For more information on the structure of the AATSIHS, see <i>Structure of the Australian Aboriginal and Torres Strait Islander Health Survey</i>.</p> <p>For information on scope and coverage, see the <i>Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide</i> (cat. no. 4727.0.55.002) on the ABS website, www.abs.gov.au.</p> <p>Data reported for 2007-08 are from the ABS 2007-08 NHS and the ABS 2008 National Aboriginal and Torres Strait Islander Social Survey.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The 2011-12 AHS and 2012-13 AATSIHS were collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website, www.abs.gov.au.</p>
Relevance	<p>The 2011-12 AHS and 2012-13 AATSIHS collected self-reported information on smoker status from persons aged 15 years and over. This refers to the smoking of tobacco, including manufactured (packet) cigarettes, roll-your-own cigarettes, cigars</p>

	<p>and pipes, but excluding smoking of non-tobacco products. The 2012-13 AATSIHS included Chewing tobacco was included in the 2012-13 AATSIHS but not the 2011-12 AHS. The 'current daily smoker' category includes respondents who reported at the time of interview that they regularly smoked one or more cigarettes, cigars or pipes per day.</p>
Timeliness	<p>The AHS is conducted every three years over a 12 month period. Results from the Core component of the AHS were released in June 2013.</p> <p>The AATSIHS is conducted over a 12 month period, approximately every 6 years. Results from the Core component of the 2012-13 AATSIHS were released in June 2014.</p>
Accuracy	<p>The AHS was conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the NT, where such persons make up approximately 23 per cent of the population. The response rate for the 2011-12 Core component was 82 per cent. Results are weighted to account for non-response.</p> <p>The AATSIHS was conducted in all States and Territories, including very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were excluded from the survey. The response rate for the Core component of the 2012-13 AATSIHS was 80 per cent. Results are weighted to account for non-response. Results are weighted to account for non-response.</p> <p>As they are drawn from a sample survey, data for the indicator are subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use.</p> <p>The following comments apply to data for the general and non-Indigenous populations:</p> <ul style="list-style-type: none"> • Data for the NT in 2011-12 are not comparable to previous years due to the increase in sample size. Data for the NT for 2007-08 should be used with caution due to large RSEs resulting from the small sample size. • This indicator generally has acceptable levels of sampling error for State/Territory by sex and age, for persons under the age of 65 years. For persons aged 65 years or over, data should be used with caution. Rates for 18-24 year old males in the ACT and for 18-24 year old females in SA, the NT and the ACT should be used with caution. • RSEs for adult smoking rates by State/Territory for remote areas other than in the NT, and for outer regional Victoria, are greater than 25% and should either be used with caution or are considered too unreliable for general use. • Adult smoking rates generally have acceptable levels of sampling error for State/Territory and SEIFA quintiles, though some rates for Victoria, Queensland, South Australia, Tasmania, the ACT and the NT should either be used with caution or are considered too unreliable for general use. <p>The following comments apply to data for the Aboriginal and Torres Strait Islander population:</p> <ul style="list-style-type: none"> • Smoking questions were changed in the 2012-13 AATSIHS to include chewing tobacco in order to account for potential high levels of use among Aboriginal and Torres Strait Islander people. Data for 2012-13 are considered comparable with data for the Aboriginal and Torres Strait Islander population for 2007-08, and with data for the non-Indigenous population for all years. • This indicator has acceptable levels of sampling error, with RSEs of less than 25 per cent for all states and territories.
Coherence	<p>The methods used to construct the indicator are consistent and comparable with other collections and with international practice. The AHS collected a range of other health-related information that can be analysed in conjunction with smoker status.</p>

Other non-ABS collections, such as the National Drug Strategy Household Survey (NDSHS), report estimates of smoker status. Results from the recent NDSHS in 2010 show slightly lower estimates for current daily smoking than in the 2011-12 AHS. These differences may be due to the greater potential for non-response bias in the NDSHS and the differences in collection methodology.

Accessibility

See *Australian Health Survey: First Results* (Cat. no. 4364.0.55.001) and *Australian Health Survey: Health Service Usage and Health Related Actions* (Cat. no. 4364.0.55.002) for an overview of results from the NHS component of the AHS. See: *Australian Health Survey: Updated Results* (Cat. no. 4364.0.55.003) for results from the Core component of AHS. Other information from this survey is also available on request.

The data for NATSIHS are available from the ABS website in the publication *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13* (Cat. no. 4727.0.55.001). See *Australian Aboriginal and Torres Strait Islander Health Survey: Updated Results* (Cat. no. 4727.0.55.006) for results from the Core component of the AATSIHS. Other information from the AATSIHS is also available from the ABS website, www.abs.gov.au.

Interpretability

Information to aid interpretation of the data is available on the ABS website from the *Australian Health Survey: User Guide, 2011-13* (Cat. no. 4363.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Many health-related issues are closely associated with age; therefore data for this indicator have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Information for the 2015 Report for the Aboriginal and Torres Strait Islander population replaces data supplied for the 2014 Report which was based on the National Aboriginal and Torres Strait Islander Health Survey subset (9300 people) of the full sample (13 000 people). The larger sample size used for the 2015 reporting cycle provides more accurate estimates and allows for analysis at a finer level of disaggregation

For information on how the results compare between the two samples, see *Comparison of Results in Australian Health Survey: Updated Results* (Cat. No. 4364.0.55.003).

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The data provide relevant information on the proportion of adults who reported that they are daily smokers.
- Data for the total and non-Indigenous populations in the AHS do not include people living in very remote areas, which affects the comparability of the NT results.
- Data are of acceptable accuracy. Some relative standard errors for age, Indigenous, SES and remoteness disaggregations are greater than 25 per cent and these data should be used with caution.
- The size of the RSEs mean that the survey data may not be adequate for measuring change over time. Small year to year movements may be difficult to detect if the size of the standard errors is large compared to the size of the difference between estimates.

Levels of risky alcohol consumption

Data quality information for this indicator has been sourced from the Australian Bureau of Statistics (ABS) with additional Steering Committee comments.

Indicator definition and description

Indicator	Prevalence of risk factors to the health of Australians — Levels of risky alcohol consumption.
Measure/s (computation)	Numerator: <ul style="list-style-type: none">• Number of persons aged 18 years or over who reported an average of more than 2 standard drinks per day in the last week. Denominator: <ul style="list-style-type: none">• Number of people aged 18 years or over. Calculation: $100 \times (\text{Numerator} \div \text{Denominator})$
Data source/s	<p>For the 2014 and 2015 Reports, the denominator and numerator for this indicator, for the general and non-indigenous population, use data from the full sample or Core component of the general population component of the ABS Australian Health Survey (AHS) from approximately 32 000 people, which is weighted to benchmarks for the total AHS in-scope estimated resident population (ERP) at 31 October 2011. For information on scope and coverage, see the <i>Australian Health Survey: Users' Guide</i> (Cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au.</p> <p>For the 2014 and 2015 Reports, the denominator and numerator for the Aboriginal and Torres Strait Islander population use data from the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) component of the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) from approximately 9300 people, which is weighted to benchmarks for the Aboriginal and Torres Strait Islander ERP at 30 June 2011. For more information on the structure of the AATSIHS, see <i>Structure of the Australian Aboriginal and Torres Strait Islander Health Survey</i>.</p> <p>Data reported for 2007-08 are from the ABS 2007-08 NHS. Data reported for 2004-05 are from the ABS 2004-05 NHS and the ABS 2004-05 NATSIHS.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The AHS and NATSIHS were collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website, www.abs.gov.au.</p>
Relevance	<p>The 2011-12 NHS and 2012-13 NATSIHS collected self-reported information on alcohol consumption from persons aged 15 years and over. Respondents were asked to report the number of drinks of each type they had consumed, the size of the drinks, and, where possible, the brand name(s) of the drink(s) consumed on each of the most recent three days in the last week on which they had consumed alcohol.</p> <p>Intake of alcohol refers to the quantity of alcohol contained in any drinks consumed, not the quantity of the drinks.</p> <p>To measure against the 2009 guidelines, reported quantities of alcoholic drinks consumed were converted to millilitres (mls) of alcohol present in those drinks, using the formula:</p> <ul style="list-style-type: none">• alcohol content of the type of drink consumed (%) x number of drinks (of that type) consumed x vessel size (in millilitres). <p>An average daily amount of alcohol consumed was calculated (i.e. an average over</p>

the 7 days of the reference week), using the formula:

- average consumption over the 3 days for which consumption details were recorded x number of days consumed alcohol / 7.

According to average daily alcohol intake over the 7 days of the reference week, persons who consumed more than 2 standard drinks on any day were at risk of long term health problems.

Timeliness

The AHS is conducted every three years over a 12 month period. Results from the 2011-12 NHS component of the AHS were released in October 2012.

The AATSIHS is conducted over a 12 month period, approximately every 6 years. Results from the NATSIHS component of the AATSIHS were released in November 2013. The previous NATSIHS was conducted in 2004-05.

Accuracy

The AHS was conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the NT, where such persons make up approximately 23 per cent of the population. The response rate for the 2011-12 Core component was 82 per cent. Results are weighted to account for non-response.

The AATSIHS was conducted in all States and Territories, including very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were excluded from the survey. The final response rate for the 2012-13 NATSIHS component was 80 per cent. Results are weighted to account for non-response.

As they are drawn from a sample survey, data for the indicator are subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use.

The collection of accurate data on quantity of alcohol consumed is difficult, particularly where recall is concerned, given the nature and possible circumstances of consumption. The use of the one week reference period (with collection of data for the most recent three days in the last week on which the person drank) is considered to be short enough to minimise recall bias but long enough to obtain a reasonable indication of drinking behaviour. While the last week exact recall method may not always reflect the usual drinking behaviour of the respondent at the individual level, at the population level this is expected to largely average out.

The collection and coding of individual brands and container size ensures that no mental calculation is required of the respondent in reporting standard drinks, and is considered to eliminate potential for the underestimation bias which is known to occur when people convert drinks into standard drinks.

The following comments apply to data for the general and non-Indigenous populations only.

- Data for the NT in 2011-12 are not comparable to previous years due to the increase in sample size in 2011-12. Data for the NT for 2007-08 should be used with caution due to large RSEs resulting from the small sample size
- This indicator generally has acceptable levels of sampling error for State/Territory and Remoteness Areas, except for remote areas where some rates are considered too unreliable for general use. The breakdown by State/Territory and SEIFA quintiles in general has sampling error within acceptable limits, except for the two lowest quintiles in the ACT which should either be used with caution or are considered too unreliable for general use.

Coherence

The AHS and AATSIHS collected a range of other health-related information that can be analysed in conjunction with alcohol risk level. For more detailed information see the *Australian Health Survey: Users' Guide* and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide*, available on the ABS website.

Aggregate levels of alcohol consumption implied by the AHS are somewhat less than the estimates of apparent consumption of alcohol based on the availability of alcoholic beverages in Australia from taxation and customs data, see *Apparent Consumption of Alcohol, 2010-11* (Cat. no. 4307.0.55.001). This suggests a tendency towards under-reporting of alcohol consumption in self-report surveys.

Other collections, such as the National Drug Strategy Household Survey (NDSHS), report against the same NHMRC guidelines. Results from the most recent NDSHS in 2010 show slightly lower estimates for long-term harm from alcohol than in the 2011-13 AHS. These differences may be due to the greater potential for non-response bias in the NDSHS and the differences in collection methodology.

Accessibility

See *Australian Health Survey: First Results* (Cat. no. 4364.0.55.001) and *Australian Health Survey: Health Service Usage and Health Related Actions* (Cat. no. 4364.0.55.002) for an overview of results from the NHS component of the AHS. See: *Australian Health Survey: Updated Results* (Cat. no. 4364.0.55.003) for results from the Core component of AHS. Other information from this survey is also available on request.

The data for NATSIHS are available from the ABS website in the publication *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13* (Cat. no. 4727.0.55.001). Other information from the survey is available on request.

Interpretability

Information to aid interpretation of the data is available on the ABS website from the *Australian Health Survey: User Guide, 2011-13* (Cat. no. 4363.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Many health-related issues are closely associated with age; therefore data for this indicator have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The data provide relevant information on the proportion of adults who are at risk of long-term harm from alcohol.
- Data for the total and non-Indigenous populations in the AHS do not include people living in very remote areas, which affects the comparability of results for the NT.
- Data are of acceptable accuracy. Some relative standard errors for Indigenous status, SES and remoteness disaggregations are greater than 25 per cent and should be used with caution.
- The size of the standard errors means that the survey data may not be adequate for measuring change over time. Small year to year movements may be difficult to detect if the size of the standard errors is large compared to the size of the difference between estimates.
- AATSIHS data are only available every six years. An assessment of the relative speed of change in results for this indicator is required to determine whether more regular data collection is necessary. Subject to cost-benefit analysis, it is recommended that relevant questions be included in both the AATSIHS and the NATSISS, to provide data on a rotating three yearly cycle across the two collections.

Selected potentially preventable diseases

Incidence of selected cancers

Data quality information for this indicator has been sourced from the Australian Institute of Health and Welfare (AIHW) with additional Steering Committee comments.

Indicator definition and description

Indicator	Selected potentially preventable diseases — Incidence of selected cancers
Measure/s (computation)	<p>The selected cancers of public health importance are bowel cancer, lung cancer, melanoma of the skin, breast cancer in females and cervical cancer.</p> <p>For bowel cancer, lung cancer and melanoma, the numerator is the number of new cases occurring in the Australian population in the reported year. The denominator is the total Australian population for the same year.</p> <p>For breast and cervical cancer the numerator is the number of new cases occurring in the Australian female population in the reported year. The denominator is the total Australian female population for the same year.</p> <p>Calculation is $100\,000 \times (\text{Numerator} \div \text{Denominator})$, calculated separately for each type of cancer, presented as a rate per 100 000 and age-standardised to the Australian population as at 30 June 2001.</p>
Data source/s	<p>Numerators: Australian Cancer Database (ACD)</p> <p>Denominators:</p> <ul style="list-style-type: none">• For bowel cancer, lung cancer and melanoma: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP).• For breast and cervical cancer: ABS ERP for female population.• For data by Indigenous status: ABS <i>Aboriginal and Torres Strait Islander Estimates and Projections</i> (Indigenous population) Series B.• For data by Remoteness area: ABS ERPs for Australian Standard Geographical Classifications (ASGC) Remoteness Areas.• For data by socioeconomic status: calculated by AIHW using the ABS 2011 Index of Relative Socio-economic Disadvantage (IRSD) and ERPs by Statistical Area Level 2 (SA2). Each SA2 in Australia is ranked by IRSD score and divided into quintiles and deciles in a population-based manner, such that each quintile has approximately 20 per cent of the population and each decile has approximately 10 per cent of the population.

Data Quality Framework Dimensions

Institutional environment	<p>The National Cancer Statistics Clearing House (NCSCCH), housed at the AIHW, is a collaborative partnership between the AIHW and the Australasian Association of Cancer Registries (AACR).</p> <p>Cancer incidence data are supplied to the AIHW by state and territory cancer registries. These data are compiled by AIHW to form the Australian Cancer Database (ACD). All jurisdictions have legislation requiring mandatory reporting of all cancer cases with the exception of basal cell carcinoma of the skin and squamous cell carcinoma of the skin.</p>
Relevance	<p>The data used to calculate this indicator are accurate and of high quality. The mandatory reporting of cancers and the use of ERPs based on Census data for denominators provides the most comprehensive data coverage possible. The data are appropriate for this indicator.</p>
Timeliness	<p>Data available for the 2015 Report are based on cancers diagnosed in 2007–2011, noting that cancers for NSW and ACT for 2010 and 2011 are based on estimates.</p>
Accuracy	<p>The 2010 and 2011 incidence data for NSW and the ACT were not available for inclusion in the 2011 version of the ACD. The development of the new NSW Cancer</p>

Registries system has resulted in a delay in processing incidence data for 2010 onwards and therefore the most recent NSW data available for inclusion in the ACD are for 2009. Full details about this situation are given on the web page www.cancerinstitute.org.au/data-and-statistics/accessing-our-data/availability-of-nsw-central-cancer-registry-data. As the coding of ACT cancer notifications is contracted to the NSW Cancer Registry, the most recent data available for the ACT are also for 2009. The 2010 and 2011 incidence data for NSW and the ACT were estimated by the AIHW. Although the estimation procedure has been shown to be reasonably accurate for estimating overall cancer incidence, its accuracy with respect to individual cancers will vary. Until the actual 2010 and 2011 cancer data are available from these jurisdictions caution should be exercised when comparing data for 2010 and 2011 for NSW, the ACT and national totals with data from previous years. The estimates of 2010 and 2011 incidence in NSW and ACT cannot be disaggregated by Indigenous status, remoteness area or socioeconomic status. The national totals for these tables do not include NSW and ACT.

The 2009 incidence data for NSW and the ACT provided to the AIHW excluded the provisional death-certificate-only (DCO) cases. The reason the provisional DCO cases were not available is explained on the web page www.cancerinstitute.org.au/data-and-statistics/accessing-our-data/availability-of-nsw-central-cancer-registry-data. The AIHW has estimated the number of provisional DCO cases in 2009 for each cancer, sex and age group based on the numbers observed for 2004–2008. Overall for the five cancers covered in the Indicator, about 1.2 per cent of NSW cases and 1.4 per cent of ACT cases are estimated DCO cases. The percentage varies by cancer type.

For Indigenous status, the numerator for 'Indigenous' is the number of people who self-reported that they were Indigenous at the time of diagnosis. 'Other' includes those who self-reported that they were not Indigenous at the time of diagnosis and those who chose not to identify as either Indigenous or non-Indigenous.

The completeness of Indigenous identification in cancer registry data varies between jurisdictions. Those with sufficiently complete identification to enable reliable reporting of cancer incidence rates are NSW, Qld, WA and NT. Indigenous data for the other jurisdictions are not published. As stated above, 2010 and 2011 incidence data for NSW are estimated and Indigenous status for these estimates is not available. Therefore, for 2010 and 2011 the national totals data exclude NSW and the figures therein cannot be compared to their pre-2010 counterparts.

Socioeconomic status rankings (by IRSD score) are calculated by SA2 using a population-based method at the Australia-wide level. That is, the quintiles are national quintiles, not state and territory quintiles.

An SA2-to-remoteness-area concordance and SA2-to-socioeconomic-status concordance were used to allocate remoteness area and socioeconomic status to each record on the ACD based on the person's SA2 of residence at time of diagnosis.

Caution is required when examining differences across remoteness area and socioeconomic status categories. The SA2 of a person is determined by the cancer registry based on the address provided by the person. Some people may supply an address other than that where they normally reside or the details the person provides may not correspond to a valid address meaning that their cancer record cannot be allocated to a remoteness area or socioeconomic status category at all. Such records are excluded from the tables and this may affect some remoteness area and socioeconomic categories more than others. Also, because the concordances are based on the 2011 census, SA2 boundaries may have changed over time and these can create inaccuracies.

Due to the very small number of diagnoses involved, disaggregation by Indigenous status, or remoteness area, or socioeconomic status by state and territory is not necessarily robust.

This indicator only counts one year of incidence data. For jurisdictions that record relatively small numbers of cancers, rates may fluctuate widely from year to year; these changes should be interpreted with caution.

Incidence rates based on counts of between 1 and 4 persons have been suppressed because of statistical unreliability (relative standard error (RSE) \geq 50 per cent).

Coherence

This indicator is calculated on data that have been supplied to the AIHW and undergone extensive checks at both the source cancer registry and the AIHW. The state and territory cancer registries have checked the tables and given their approval for the AIHW to supply them to the Productivity Commission.

These data are published annually by the AIHW. While there are sometimes changes to coding for particular cancers, it is possible to map coding changes to make meaningful comparisons over time.

Not all state and territory cancer registries use the same ICD-10 code groupings to classify certain cancers, e.g. the AIHW defines bowel cancer as ICD-10 codes C18–C20 whereas some cancer registries also include C21. This may mean that data presented here are different to those reported by jurisdictional cancer registries, for certain cancers. The definitions used in this Indicator are as follows.

- Bowel cancer: ICD-10 codes C18–C20
- Lung cancer: ICD-10 codes C33–C34
- Melanoma of the skin: ICD-10 code C43
- Breast cancer in females: ICD-10 code C50 and sex female
- Cervical cancer: ICD-10 code C53.

The Cancer Institute NSW (CINSW) uses an imputation method to impute missing Indigenous status for reporting purposes. This may lead to differences between the Indigenous rates presented for NSW in this Indicator and the Indigenous rates presented in CINSW incidence reports.

The incidence rate in Indigenous Australians may fluctuate considerably from year to year due to the behaviour of rare events in small populations.

Accessibility

The NCSCCH provides summary cancer incidence and mortality data annually via the AIHW website where they can be downloaded free of charge. A biennial report, *Cancer in Australia*, is published and is also available on the AIHW website where it can be downloaded without charge. More specialised data can be requested via the AIHW website.

Interpretability

While numbers of new cancers are easy to interpret, calculation of age-standardised rates is more complex and the concept may be confusing to some readers. Information on how and why age-standardised rates have been calculated and how to interpret them is available in all AIHW cancer publications presenting data in this format, for example, *Cancer in Australia: an overview, 2014*. Information about the ACD is available on the AIHW website.

Data Gaps/Issues Analysis**Key data gaps /issues**

The Steering Committee notes the following issues:

- 2010 and 2011 incidence data for NSW and ACT were not available for inclusion in the 2011 version of the ACD. The development of the new NSW Cancer Registries system has resulted in a delay in processing incidence data for 2010 onwards and therefore the most recent NSW data available for inclusion in the ACD are for 2009. Full details about this situation are given on the web page www.cancerinstitute.org.au/data-and-statistics/accessing-our-data/availability-of-nsw-central-cancer-registry-data. As the coding of ACT cancer notifications is contracted to the NSW Cancer Registry, the most recent data available for the ACT are also for 2009. The 2010 and 2011 incidence data for NSW and the ACT were estimated by the Australian Institute of Health and Welfare (AIHW). Although the estimation procedure has been shown to be reasonably accurate for estimating overall cancer incidence, its accuracy with respect to individual cancers will vary. Until the actual 2010 and 2011 cancer data are available from these jurisdictions caution should be exercised when comparing the 2010 and 2011 NSW, ACT and Australian data with data from previous years. The estimates of 2010 and 2011 incidence in NSW and ACT cannot be disaggregated by Indigenous status, remoteness area or socioeconomic status. The Australian totals for these tables do not include NSW and ACT.
- For jurisdictions that record relatively small numbers of cancers, rates may fluctuate widely from year to year; these changes over time should be interpreted with caution.

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- The completeness of Indigenous identification in cancer registry data varies between jurisdictions. Those with sufficiently complete identification to enable reliable reporting of cancer incidence rates are NSW, Qld, WA and NT. Indigenous data for the other jurisdictions are not published.
 - The Cancer Institute NSW (CINSW) uses an imputation method to impute missing Indigenous status for reporting purposes. This may lead to differences between the Indigenous rates presented for NSW in this Indicator and the Indigenous rates presented in CINSW incidence reports.
 - The incidence rate for Indigenous Australians may fluctuate considerably from year to year due to the behaviour of rare events in small populations.
 - Remoteness area and socioeconomic status are based on Statistical Area Level 2 (SA2) of residential address at the time of diagnosis.
 - Incidence rates based on counts of between 1 and 4 persons have been suppressed because of statistical unreliability (RSE \geq 50 per cent).

Incidence of heart attacks (acute coronary events)

Data quality information for this indicator has been sourced from the Australian Institute of Health and Welfare (AIHW) with additional Steering Committee comments.

Indicator definition and description

Indicator Selected potentially preventable diseases — Incidence of heart attacks (acute coronary events).

Measure/s (computation) Number of deaths recorded with an underlying cause of acute coronary heart disease (ICD-10 codes I20–I24) (a) plus the number of non-fatal hospitalisations with a principal diagnosis of acute myocardial infarction (ICD-10-AM I21) or unstable angina (ICD-10-AM I20.0) that do not end in a transfer to another acute hospital (b). For ages 25 years and over.

Denominator: Total population aged 25 years and over for year in question.

Rates: $100,000 \times (\text{numerator} \div \text{denominator})$.

Age specific rates are presented for each 10 year age group 25 years or over. Jurisdiction specific rates are provided for each state/territory.

Total rates are directly age-standardised to the 2001 Australian population using 10 year age groups.

Indigenous

National incidence estimates for Indigenous and other Australians are calculated based on data from NSW, Qld, SA, WA and NT only.

Indigenous rates are directly age-standardised to the 2001 Australian population using 10 year age groups.

The estimates for Indigenous and Other Australians are derived using only data from the five jurisdictions where the quality of identification is considered reasonable in both the NHMD and the NMD (NSW, Qld, WA, SA and NT).

Data source/s Numerator: AIHW National Hospital Morbidity Database (NHMD), AIHW National Mortality Database (NMD)

Denominator:

- For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at (ERP for 2007 to 2011 are final, rebased to 2011 Census; ERP for 2012 is preliminary).
- For data by Indigenous status: ABS *Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026* (Series B).

Data Quality Framework Dimensions

Institutional environment The AIHW has calculated this indicator using data extracted from the AIHW NHMD, the NMD and ABS population data.

The AIHW is a national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through authoritative health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in

administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The Australian Institute of *Health and Welfare Act 1987*, in conjunction with compliance to the *Privacy Act 1988 (Commonwealth)*, ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au.

Relevance

The data provide an estimate of the incidence of acute coronary events in Australia and in each jurisdiction, based on administrative data currently available. Non-fatal events are estimated from the NHMD and fatal events from the NMD.

It is an estimate of 'events', not individuals. It should be noted that an individual may have multiple events in the one year or in different years. Each would be counted. Further, an individual may have one acute coronary event which resulted in multiple hospitalisations, due to transfers for treatment and on-going care. In the NHMD these are recorded as multiple unlinked hospital episodes. The method of estimation attempts to take account of duplicate events in the databases by excluding hospitalisations ending in a transfer to another acute hospital (so that each acute coronary syndrome (ACS) event is counted only once, regardless of the number of hospitalisation episodes per event) and by excluding hospitalisations for ACS ending in death in hospital (as these should be picked up in the NMD data).

The method of estimation has been developed based on an analysis of current hospital and deaths data (AIHW 2011, *Monitoring acute coronary syndrome using national hospital data: an information paper on trends and issues*, Cat. no. CVD 57, Canberra) www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737420971, and validated using linked data from WA and NSW (AIHW 2014, *Acute coronary syndrome: validation of the method used to monitor incidence in Australia*, Cat. no. CVD 68, Canberra) www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129547560.

The year in which the event occurred is determined from the separation date for hospitalisations, and from the year of registration of death. Data are reported by the state or territory of usual residence of the person at the time of hospitalisation or death.

Variability across jurisdictions (particularly in hospital transfer rates) indicates that the method of estimation may lead to an underestimation of incidence in some jurisdictions. This variation may be due to differences in treatment and referral patterns. Rates for Indigenous and Other Australians are based on data from those jurisdictions where the quality of identification is considered reasonable in both the NHMD and the NMD. Only NSW, Queensland, WA, SA and the NT are included in the estimates reported by Indigenous status. Rates for Other Australians are calculated by subtracting Indigenous estimates from total estimates for the five jurisdictions divided by the population of Other Australians in those jurisdictions. Other Australians therefore includes non-Indigenous people and people whose Indigenous status was not stated or inadequately described.

Timeliness

This indicator reports the latest information available (for years 2007 to 2012).

Accuracy

Recent validation work based on linked and unlinked data from WA and NSW has shown that the method underestimates the incidence of acute coronary events in at least those states. Nonetheless, these estimates provide a reasonable measure of the incidence of acute coronary events and may be useful for recording and monitoring each jurisdiction's progress over time.

Comparison between jurisdictions should not be made as the validation work suggested variations in the under-count of acute coronary event rates, as observed in WA and NSW (6% in WA and 11% in NSW in 2007). Factors such as differing treatment and referral patterns across states/territories are likely to have an impact on administrative records and affect jurisdictional comparability.

The accuracy of the estimates will depend on the accuracy of coding in the NHMD and the NMD (see data sources for DQS for each data source). In particular the accuracy of coding of principal diagnosis, hospital transfers, deaths in hospital and underlying cause of death are central to the accuracy of the estimates.

The accuracy of Indigenous estimates is also reliant on the appropriate identification of Indigenous people in the NHMD and the NMD. Only five jurisdictions are considered to have reasonable quality Indigenous identification in both datasets required (the NHMD and the NMD) to estimate this indicator. The five jurisdictions are NSW, QLD, WA, SA and the NT. Indigenous counts for the NT exclude acute coronary events treated in the private hospital in the NT. All non-fatal events treated in the private hospital in the NT are therefore included in the incidence counts for other Australians.

Data for 2010 have been adjusted for the additional deaths arising from outstanding registrations of deaths in Queensland in 2010. Deaths occurring between 1992 and 2006 but registered in 2010 by the Queensland Registry of Births, Deaths and Marriages are excluded from the estimates for Indigenous and Other Australians. For more details please refer to Technical note 3 in Causes of death, Australia, 2010 (ABS cat. no. 3303.0).

NMD data for 2010 and 2011 have been revised since the previous reporting cycle. In this reporting cycle, deaths registered in 2010 and earlier are based on the final version of cause of death data; deaths registered in 2011 and 2012 are based on revised and preliminary versions respectively and are subject to further revision by the ABS.

Coherence This is the third year in which this indicator has been reported. This is the first year in which this indicator is reported for each jurisdiction.

Accessibility The AIHW provide a variety of products that draw upon the NMD and NHMD including online data cubes and reports.

These products may be accessed on the AIHW website:

- www.aihw.gov.au/hospitals-data/
- www.aihw.gov.au/deaths/

Interpretability NHMD

The NHMD data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from public and private hospitals. States and territories use these data for service planning, monitoring, and internal and public reporting. Hospitals may be required to provide data to states and territories through administrative arrangements, contractual requirements or legislation.

The scope of the NHMD is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

States and territories supplied these data to the AIHW under the terms of the National Health Information Agreement.

The data quality statement for the AIHW National Hospital Morbidity Database can be found in <http://meteor.aihw.gov.au/content/index.phtml/itemId/568730> with further data quality information in Appendix 1 of Australian hospital statistics 2012-13 or at www.aihw.gov.au/publication-detail/?id=60129546922

NMD

The AIHW NMD contains cause of death information for all deaths registered in Australia. Deaths data are provided to the AIHW by the Registries of Births, Deaths and Marriages and the National Coronial Information System and coded by the ABS. The data are maintained by the AIHW in the National Mortality Database.

The data quality statements for the AIHW National Mortality Database can be found in the following ABS publications:

- ABS Quality declaration summary for Causes of death, Australia (Cat. no. 3303.0) www.abs.gov.au/ausstats/abs@.nsf/mf/3303.0/ and
- ABS *Quality declaration summary for Deaths, Australia* (Cat. no. 3302.0) www.abs.gov.au/ausstats/abs@.nsf/mf/3302.0/.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- This indicator estimates the incidence of acute coronary events from the National Hospital Morbidity Database (NHMD) and the National Mortality Database (NMD).
- The methodology for estimating the incidence of acute coronary events is based on AIHW analysis of hospital and mortality data, and has been validated using linked data from WA and NSW.
- The accuracy of the estimates is reliant on the accuracy and consistency of coding of the principal diagnosis and underlying cause of death in each jurisdiction. It also relies on the accuracy of coding of transfers to another acute hospital and of death in hospital.
- Comparisons between jurisdictions should not be made as variations in key variables (particularly in transfer rates between hospitals) are likely to impact on jurisdictional comparability. The validation study showed an underestimation of the incidence of acute coronary events in WA and NSW. The extent of this cannot be measured precisely for other jurisdictions without linked data sets for all states and territories.
- National estimates by age and sex, are derived using data from all jurisdictions.
- Estimates for each jurisdiction are derived using state/territory of usual residence.
- Estimates for Indigenous and other Australians are derived using only data from the five jurisdictions where the quality of identification is considered reasonable in both the NHMD and the NMD (NSW, Queensland, WA, SA and NT).

Prevalence of type 2 diabetes

Data quality information for this indicator has been sourced from the Australian Bureau of Statistics (ABS) with additional Steering Committee comments.

Indicator definition and description

Indicator	Selected potentially preventable diseases — Prevalence of type 2 diabetes
Measure/s (computation)	<p>Numerator:</p> <ul style="list-style-type: none">• number of persons aged 18 years or over with known diabetes (type 2) or newly diagnosed diabetes as determined by a fasting plasma glucose test.• number of persons aged 25 years and over with known diabetes (Type 2) or newly diagnosed diabetes as determined by a fasting plasma glucose test (supplementary measure). <p>Denominator:</p> <ul style="list-style-type: none">• Number of persons aged 18 years and over• Number of persons aged 18 years and over (supplementary measure).
Data source/s	<p>The numerator and denominator for this indicator for the general and non-Indigenous populations use data from the 2011-12 National Health Measures Survey (NHMS) component of the Australian Bureau Statistics (ABS) Australian Health Survey (AHS) (approximately 9500 people aged 18 years or over), which is weighted to benchmarks for the total AHS in-scope population as at 31 October 2011 derived from the Estimated Resident Population (ERP).</p> <p>For information on the structure of the AHS, see <i>Structure of the Australian Health Survey</i> on the ABS website, www.abs.gov.au. For information on scope and coverage, see <i>the Australian Health Survey: Users' Guide</i> (Cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au.</p> <p>The numerator and denominator for this indicator for the Aboriginal and Torres Strait Islander population use data from the 2012-13 National Aboriginal and Torres Strait Islander Health Measures Survey (NATSIHMS) component of the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) of approximately 3300 people, which is weighted to benchmarks for the Australian Aboriginal and Torres Strait Islander estimated resident population at 30 June 2011, based on the 2011 Census of Population and Housing.</p> <p>For information on the structure of the AATSIHS, see <i>Structure of the Australian Aboriginal and Torres Strait Islander Health Survey</i> on the ABS website, www.abs.gov.au.</p> <p>For information on scope and coverage, see the <i>Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide</i> (Cat. no. 4727.0.55.002) on the ABS website, www.abs.gov.au.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The AHS and AATSIHS were collected, processed and published by the ABS. The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>The interview components of the AHS and AATSIHS were conducted under the <i>Census and Statistics Act 1905</i>. The biomedical components (NHMS and NATSIHMS) were collected under the <i>Privacy Act 1988</i> and were subject to ethics approval which at the national level was sought and gained from the (then) Australian Government Department of Health and Ageing's Departmental Ethics Committee.</p> <p>Ethics approval for the NATSIHMS component was also required at the jurisdictional level for NSW, WA, the NT and for Queensland Health Service Districts. Ethics approval was sought and gained from the following Ethics Committees:</p> <ul style="list-style-type: none">• Aboriginal Health and Medical Research Council Ethics Committee in NSW
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<p>Relevance</p>	<ul style="list-style-type: none"> • Aboriginal Health Research Ethics Committee in SA • Western Australian Aboriginal Health Ethics Committee in WA • Western Australia Country Health Service (WACHS) Research Ethics Committee in WA • Central Australian Human Research Ethics Committee in the NT • Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research in the NT • several Human Research Ethics Committees of Queensland Government Hospital and Health Services districts. <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website, www.abs.gov.au.</p> <p>The The 2011-12 NHMS and 2012-13 NATSIHMS use a combination of blood test results for fasting plasma glucose and self-reported information on diabetes diagnosis and medication use to measure prevalence of Type 2 diabetes.</p> <p>A respondent to the survey is considered to have known diabetes (type 2) if they had ever been told by a doctor or nurse that they have Type 2 diabetes and:</p> <ul style="list-style-type: none"> • They were taking diabetes medication (either insulin or tablets); or • Their blood test result for fasting plasma glucose was greater than or equal to 7.0 mmol/L. <p>A respondent to the survey is considered to have newly diagnosed diabetes if they reported no prior diagnosis of diabetes, but had a fasting plasma glucose value greater than or equal to 7.0 mmol/L.</p> <p>Note: The type of diabetes for newly diagnosed cases cannot be determined from a fasting plasma glucose test alone. However, as it is assumed that the vast majority of newly diagnosed cases would be Type 2, all newly diagnosed cases of diabetes have been included in this measure.</p> <p>The estimates exclude persons who did not fast for 8 hours or more prior to their blood test. Excludes women with gestational diabetes.</p> <p>The same definition for diabetes will be used in the NATSIHMS.</p>
<p>Timeliness</p>	<p>The NHMS was conducted in 2011-12 with results released in August 2013.</p> <p>The NATSIHMS was conducted in 2012-13 with results released in September 2014.</p>
<p>Accuracy</p>	<p>The AHS was conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the Northern Territory, where such persons make up approximately 23 per cent of the population. The final response rate for the 'core' component of the AHS was 82 per cent.</p> <p>All selected persons aged 5 years and over were invited to participate in the voluntary NHMS. Of all of those who took part in the AHS, 37 per cent went on to complete the biomedical component.</p> <p>Analysis of the sample showed that the characteristics of persons who participated in the NHMS were similar with those for the AHS overall. The only significant difference was for smoking, where the NHMS sample had a lower rate of current smokers than the AHS sample (12.0 per cent compared with 17.6 per cent). For more information, see the Explanatory Notes in <i>Australian Health Survey: Biomedical Results for Chronic Disease</i> (Cat. no. 4364.0.55.005).</p> <p>In order to get an accurate reading for the fasting plasma glucose test, participants were asked to fast for 8 hours before their test. The results presented for this indicator refer only to those people who did fast (approximately 79 per cent of adults who participated in the NHMS). Analysis of the characteristics of people who fasted compared with those who did not fast showed no difference between fasters and non-fasters.</p>

The AATSIHS was conducted in all States and Territories, including very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were excluded from the survey. The response rate for the Core component of the 2012-13 AATSIHS was 80%.

All selected persons aged 18 years and over in the AATSIHS were invited to participate in the voluntary NATSIHMS. Of these, 40% went on to complete the biomedical component.

Analysis of the sample showed that the characteristics of persons who participated in the NATSIHMS were similar to those for the AATSIHS overall. For more information, see the Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: Biomedical Results* (Cat. no. 4727.0.55.003).

In order to get an accurate reading for the fasting plasma glucose test, participants were asked to fast for 8 hours before their test. The results presented for this indicator refer only to those people who did fast (approximately 77.6% of adults who participated in the NATSIHMS). Analysis of the characteristics of people who fasted compared with those who did not fast showed no difference between fasters and non-fasters.

As they are drawn from a sample survey, data for the indicator are subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use.

For the general and non-Indigenous populations, this indicator and the supplementary indicator generally have acceptable levels of sampling error for State/Territory by sex. However, rates for females in Victoria, males in the ACT, and males and females in the NT should be used with caution.

For the Aboriginal and Torres Strait Islander population, rates for males and females in Queensland, females in WA and WA, and males in the NT should be used with caution. Additionally, the rate for total all persons in SA should be used with caution. The rate for males in SA is considered too unreliable for general use.

Coherence

The methods used to construct the indicator are consistent and comparable with other collections. The AHS collected a range of other health-related information that can be analysed in conjunction with diabetes status.

Other non-ABS collections, such as the 1999–2000 Australian Diabetes, Obesity and Lifestyle Study (AusDiab) and the 2009-10 Victorian Health Monitor (VHM) have reported estimates of diabetes prevalence based on biomedical measures and self-reported diagnosis and medication use .

Results from the recent VHM were very similar to those from the NHMS. Results from AusDiab showed higher estimates of diabetes than the NHMS, however this difference is most likely due to the difference in test used to measure diabetes (AusDiab used an Oral Glucose Tolerance test, which is a more comprehensive test for diabetes than fasting plasma glucose).

For information on how these studies compare, see *Australian Health Survey: Biomedical Results for Chronic Disease* (Cat. no. 4364.0.55.005).

Accessibility

See *Australian Health Survey: Biomedical Results for Chronic Disease* (cat. no. 4364.0.55.005). Other information from this survey is also available on request.

Interpretability

Information to aid interpretation of the data is available from the *Australian Health Survey: Users' Guide* and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide* (Cat. no. 4727.0.55.002) on the ABS website.

Many health-related issues are closely associated with age; therefore data for this indicator have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The data provide relevant information on the prevalence of Type 2 diabetes.
- The 2011-12 NHMS was conducted for the first time as part of the 2011–13 AHS, with participation voluntary in the NHMS. Of those who took part in the AHS, 38 per cent took part in the NHMS. The NHMS sample was found to be similar to the AHS population.
- The 2012-13 NATSIHMS was conducted for the first time as part of the 2012-13 AATSIHS, with participation voluntary in the NATSIHMS. Of those who took part in the AATSIHS, 40 per cent took part in the NATSIHMS. The NHMS sample was found to be similar to the overall of the AATSIHS population.
- The NHMS does not include people living in very remote areas, which affects the comparability of the NT results.
- Data are of acceptable accuracy. Some RSEs for disaggregations are greater than 25 per cent and these data should be used with caution.

Potentially avoidable deaths

Data quality information for this indicator has been sourced from the Australian Bureau of Statistics (ABS) with additional Steering Committee comments.

Indicator definition and description

Indicator	Potentially avoidable deaths
Measure/s (computation)	<p>Numerator: Number of death registrations of persons aged less than 75 for 5 year aggregates 2003–2007, 2004–2008, 2005–2009 (updated for revised specification and updated Indigenous ERP), 2006–2010, 2007–2011 (updated for revised specification, updated Indigenous ERP and revision to ABS cause of death data), 2008–2012 and single years 2007, 2008, 2009 (resupplied for revised specification), 2010, 2011 (resupplied for updated specification and revision to ABS cause of death data), 2012 provided by state and territory Registrars of Births, Deaths and Marriages which have an ICD-10 code which has been further classified as potentially avoidable according to the NHA: PI 16 – Potentially avoidable deaths, 2015 revised specifications.</p> <p>Denominator: Population aged less than 75 years.</p> <ul style="list-style-type: none">• Indigenous: Estimates and Projections, Aboriginal and Torres Strait Islander Australians (3238.0)• Non-Indigenous: The projected Indigenous population (3238.0, Series B) subtracted from the ABS 2011 Census-based Estimated Resident Population (ERP).

Data source/s	<p>Numerator: ABS Causes of Death collection (Cat. no. 3303.0)</p> <p>Denominator: ABS ERP (3101.0); ABS 2014 <i>Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001–2026</i> (Cat. no. 3238.0), Series B.</p> <p>For the non-Indigenous population, the projected Indigenous population (Cat. no. 3238.0, Series B) is subtracted from the 2011 Census-based ERP.</p>
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Data Quality Framework Dimensions

Institutional environment	These collections are conducted under the <i>Census and Statistics Act 1905</i> . For information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, see ABS Institutional Environment.
Relevance	<p>The ABS Causes of Death collection includes all deaths that occurred and were registered in Australia, including deaths of persons whose usual residence is overseas. Deaths of Australian residents that occurred outside Australia may be registered by individual Registrars, but are not included in ABS deaths or causes of death statistics.</p> <p>Data in the Causes of Death collection include demographic items, as well as causes of death information, which is coded according to the International Statistical Classification of Diseases and Related health Problems (ICD). ICD is the international standard classification for epidemiological purposes and is designed to promote international comparability in the collection, processing, classification, and presentation of causes of death statistics. The classification is used to classify diseases and causes of disease or injury as recorded on many types of medical records as well as death records. The ICD has been revised periodically to incorporate changes in the medical field. The 10th revision of ICD (ICD-10) has been used by the ABS to code cause of death since 1997.</p> <p>For further information on the ABS Causes of Death collection, see the relevant Data Quality Statement.</p>
Timeliness	Causes of death data is published on an annual basis. Death records are provided electronically to the ABS by individual Registrars on a monthly basis for compilation into aggregate statistics on a quarterly and annual basis. One dimension of

timeliness in death registrations data is the interval between the occurrence and registration of a death. As a result, a small number of deaths occurring in one year are not registered until the following year or later.

Preliminary ERP data is compiled and published quarterly and is generally made available five to six months after the end of each reference quarter. Every year, the 30 June ERP is further disaggregated by sex and single year of age, and is made available five to six months after the end of the reference quarter. Commencing with data for September quarter 2006, revised estimates are released annually and made available 21 months after the end of the reference period for the previous financial year, once more accurate births, deaths and net overseas migration data becomes available. In the case of births and deaths, the revised data is compiled on a date of occurrence basis. In the case of net overseas migration, final data is based on actual traveller behaviour. Generally ERP data is not changed once it has been finalised unless there are compelling reasons to do so, as in June 2013 when data from September 1991 to June 2006 was revised (for more information on this recasting process, please see the feature article titled Recasting 20 years of ERP in the December quarter 2012 issue of *Australian Demographic Statistics* (cat. no. 3101.0)).

For further information on ABS ERP, see the relevant Data Quality Statement.

Accuracy

Information on causes of death is obtained from a complete enumeration of deaths registered during a specified period and is not subject to sampling error. However, deaths data sources are subject to non-sampling error which can arise from inaccuracies in collecting, recording and processing the data.

Although it is considered likely that most deaths of Aboriginal and Torres Strait Islander (Indigenous) Australians are registered, a proportion of these deaths are not registered as Indigenous. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred and may differ from the self-identified Indigenous origin of the deceased. Forms are often not subject to the same best practice design principles as statistical questionnaires, and respondent and/or interviewer understanding is rarely tested. Over-precise analysis of Indigenous deaths and mortality should be avoided.

All coroner certified deaths registered after 1 January 2006 are now subject to a revisions process. In this round of COAG reporting, 2008, 2009 and 2010 data is final, 2011 data is revised and 2012 data is preliminary. Data for 2011 and 2012 is subject to further revisions. Prior to 2006 all ABS processing of causes of death data for a particular reference period was finalised approximately 13 months after the end of the reference period. Where insufficient information was available to code a cause of death (e.g. a coroner certified death was yet to be finalised by the Coroner), less specific ICD codes were assigned as required by the ICD coding rules. The revision process enables the use of additional information relating to coroner certified deaths, as it becomes available over time. This results in increased specificity of the assigned ICD-10 codes.

Revisions will only impact on coroner certified deaths, as further information becomes available to the ABS about the causes of these deaths. See Technical Note: Causes of Death Revisions 2010 and 2011 in *Causes of Death, Australia, 2012* (Cat.no. 3303.0).

In November 2010, the Queensland Registrar of Births, Deaths and Marriages advised the ABS of an outstanding deaths registration initiative undertaken by the Registry. This initiative resulted in the November 2010 registration of 374 previously unregistered deaths which occurred between 1992 and 2006 (including a few for which a date of death was unknown). Of these, around three-quarters (284) were deaths of Aboriginal and Torres Strait Islander Australians.

The ABS discussed different methods of adjustment of Queensland death registrations data for 2010 with key stakeholders. Following the discussion, a decision was made by the ABS and key stakeholders to use an adjustment method that added together deaths registered in 2010 for usual residents of Queensland which occurred in 2007, 2008, 2009 and 2010. This method minimises the impact on mortality indicators used in various government reports. However, care should still be taken when interpreting Aboriginal and Torres Strait Islander death data for Queensland for 2010. Please note that there are differences between data output in the *Causes of Death, Australia, 2010* publication (Cat. no. 3303.0) and 2010 data

reported for COAG, as this adjustment was not applied in the publication. For further details see Technical Note: Registration of outstanding deaths, Queensland 2010, from the *Deaths, Australia, 2010* publication (Cat. no. 3302.0) and Explanatory Note 103 in the *Causes of Death, Australia, 2010* publication (Cat. no. 3303.0).

Investigation conducted by the WA Registrar of Births, Deaths and Marriages indicated that some deaths of non-Indigenous people were wrongly identified as deaths of Indigenous people in WA for 2007, 2008 and 2009. The ABS discussed this issue with a range of key stakeholders and users of Aboriginal and Torres Strait Islander deaths statistics. Following this discussion, the ABS did not release WA Aboriginal and Torres Strait Islander deaths data for the years 2007, 2008 and 2009 in the 2010 issue of *Deaths, Australia* publication, or in the 2011 COAG data supply. The WA Registry corrected the data and resupplied the corrected data to the ABS. These corrected data were then released by the ABS in spreadsheets attached to *Deaths, Australia, 2010* (Cat. no. 3302.0) publication on 24 May 2012, and are included in this round of COAG reporting. In addition, 3 deaths in WA for 2009 which were wrongly coded as deaths of Indigenous people have been corrected as deaths of non-Indigenous people in this round of COAG reporting.

All ERP data sources are subject to non-sampling error. Non-sampling error can arise from inaccuracies in collecting, recording and processing the data. In the case of Census and Post Enumeration Survey (PES) data, every effort is made to minimise reporting error by the careful design of questionnaires, intensive training and supervision of interviewers, and efficient data processing procedures. The ABS does not have control over any non-sampling error associated with births, deaths and migration data. For more information see the *Demography Working Paper 1998/2 - Quarterly birth and death estimates, 1998* (Cat. no. 3114.0) and *Australian Demographic Statistics* (Cat. no. 3101.0).

Non-Indigenous estimates are available for census years only. In the intervening years, Indigenous population projections are based on assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the projected Indigenous population from the total population. For the current round of COAG reporting, the non-Indigenous population denominator has been calculated by subtracting the 2011 Census-based Indigenous estimates/projections from the 2011 Census-based Estimated Resident Population (3101.0). Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.

Non-Indigenous data from the Causes of Death collection do not include death registrations with a 'not stated' Indigenous status.

Some rates are unreliable due to small numbers of deaths over the reference period. Resultant rates could be misleading, for example, where the non-Indigenous mortality rate is higher than the indigenous mortality rate. Age-standardised death rates based on a very low death count have been deemed unpublishable. Some cells have also not been published to prevent back-calculation of these suppressed cells. Caution should be used when interpreting rates for this indicator.

Coherence	The methods used to construct the indicator are consistent and comparable with other collections and with international practice.
Accessibility	Causes of death data are available in a variety of formats on the ABS website under the 3303.0 product family. ERP data is available in a variety of formats on the ABS website under the 3101.0 and 3201.0 product families. Further information on deaths and mortality may be available on request. The ABS observes strict confidentiality protocols as required by the <i>Census and Statistics Act (1905)</i> . This may restrict access to data at a very detailed level.
Interpretability	Data for this indicator have been age-standardised, using the direct method, to 'under 75 years' of age. Direct age-standardisation to the 2001 total Australian population was used (see Data Cube: Standard Population for Use in Age-Standardisation Table in <i>Australian Demographic Statistics</i> , Dec 2013 (Cat. no. 3101.0)). Age-standardised results provide a measure of relative difference only between populations.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Revised specifications were nationally agreed for potentially avoidable deaths in 2014. Data are resupplied to the revised specifications.
- The data provide relevant information on potentially avoidable deaths.
- A large number of unregistered deaths in Queensland dating back to 1992 were identified and registered in 2010. Care should be taken when interpreting Aboriginal and Torres Strait Islander death data for Queensland for 2010.
- Data by Indigenous status are reported for NSW, Queensland, WA, SA and the NT. Only these jurisdictions have evidence of a sufficient level of Indigenous identification, have sufficient numbers of Indigenous deaths and do not have significant data quality issues.
- Data are of acceptable accuracy. Although most deaths of Indigenous Australians are registered, it is likely that some are not identified as Indigenous. Therefore data are likely to underestimate the Indigenous mortality rate. Rates should be used with caution.

Mortality and life expectancy

Life expectancy

Data quality information for this indicator has been sourced from the Australian Bureau of Statistics (ABS) with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Mortality and life expectancy — Life expectancy
Measure/s (computation)	<p>Life tables for the Australian population, from which life expectancy at birth is obtained. Age/sex-specific death rates used in the construction of the life tables are calculated as follows.</p> <p>Numerator: death registrations for 2011–2013 provided by State and Territory Registrars of Births, Deaths and Marriages.</p> <p>Denominator: Estimated resident population (ERP) for the period 2011–2013.</p>
Data source/s	<i>Life Tables, States, Territories and Australia, 2011-2013</i> (Cat. no. 3302.0.55.001)

Data Quality Framework Dimensions

Institutional environment	<p>For information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.</p> <p>Death statistics are sourced from death registrations systems administered by the various State and Territory Registrars of Births, Deaths and Marriages. It is a legal requirement of each State and Territory that all deaths are registered. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred.</p>
Relevance	<p>Life tables based on assumed improvements in mortality are produced by the ABS using assumptions on future life expectancy at birth, based on recent trends in life expectancy. These life tables are not published by the ABS, they are used as inputs into ABS population projections.</p> <p>The life tables are current or period life tables, based on death rates for a short period of time during which mortality has remained much the same. Mortality rates for the Australian and state and territory life tables are based on death registrations and estimated resident population for the period 2011–2013. The life tables do not take into account future assumed improvements in mortality.</p> <p>Life tables are presented separately for males and females. The life table depicts the mortality experience of a hypothetical group of newborn babies throughout their entire lifetime. It is based on the assumption that this group is subject to the age-specific mortality rates of the reference period. Typically this hypothetical group is 100 000 in size.</p>
Timeliness	ABS estimates of all Australian life expectancy at birth are calculated for a 3 year period and published on an annual basis.
Accuracy	<p>Compilation of life tables requires complete and accurate data on deaths that occur in a period, and reliable estimates of the population exposed to the risk of dying during that period. These data are required by age and sex so as to calculate age-sex specific death rates.</p> <p>Information on deaths is obtained from a complete enumeration of deaths registered during a specified period and are not subject to sampling error. However, deaths data sources are subject to non-sampling error which can arise from inaccuracies in collecting, recording and processing the data.</p>

Sources of non-sample error include:

- completeness of an individual record at a given point in time;
- completeness of the dataset (eg impact of registration lags, processing lags and duplicate records);
- extent of coverage of the population (whilst all deaths are legally required to be registered, some cases may not be registered for an extended time, if at all); and
- lack of consistency in the application of questions or forms used by data providers, both through time and between different jurisdictions.

In November 2010, the Queensland Registry of Births, Deaths and Marriages registered 374 previously unregistered deaths which occurred between 1992 and 2006 (including a few for which a date of death was unknown). The ABS life tables are based on deaths by year of occurrence, and are therefore unaffected by this late registration of deaths.

Every effort is made to minimise error by working closely with data providers, the careful design of forms, training of processing staff, and efficient data processing procedures.

ERP is based on Census counts by place of usual residence, adjusted for net Census undercount and the number of Australian residents temporarily overseas on Census night, and backdated from the Census date to 30 June. For post-censal years, ERP is obtained by adding post-censal births, deaths and migrations to the Census ERP.

Coherence	The methods used to construct the indicator are consistent and comparable with other collections and with international practice.
Accessibility	ABS life expectancy estimates are published on the ABS website www.abs.gov.au (see <i>Life Tables, States, Territories and Australia, 2011–2013</i> (Cat. no. 3302.0.55.001)).
Interpretability	Please view Explanatory Notes and Glossary that provide information on the data sources, terminology, classifications and other technical aspects associated with these statistics.

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none">• A large number of unregistered deaths in Queensland dating back to 1992 were identified and registered in 2010. Care should be taken when interpreting Indigenous death data for Queensland for 2010.• Data are not available by socioeconomic status (SES). Disaggregation of this indicator by SES is a priority.• The measure for this indicator is based on a three year average. Multiple year averages may not be able to determine trends over time as each reporting year incorporates the two previous years. Further work is required to determine what level of disaggregation is reliable for single year data.
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Mortality rates — Infant and child

Data quality information for this indicator has been sourced from the Australian Bureau of Statistics (ABS) with additional Steering Committee comments.

Indicator definition and description

Indicator	Mortality rates — Infant and child
Measure/s (computation)	<p>Numerators: number of death registrations for the period 2007-2012 (single years) provided by state and territory Registrars of Births, Deaths and Marriages, for:</p> <ul style="list-style-type: none">• Infants — children aged under 1 year• Child 0–4 — children aged 0 to 4 years <p>Denominators:</p> <ul style="list-style-type: none">• Infants — Number of live births in the period• Child 0–4 — Population aged 0 to 4 years
Data source/s	<p>Numerators</p> <ul style="list-style-type: none">• ABS Deaths Collection (3302.0) <p>Denominators</p> <ul style="list-style-type: none">• Infants — ABS Births Collection (3301.0)• Child 0-4: ABS Population Projections (2011 Census based), (3222.0)• Indigenous: <i>ABS Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians</i> (2011 Census based), (3238.0)

Data Quality Framework Dimensions

Institutional environment	These collections are conducted under the <i>Census and Statistics Act 1905</i> . For information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, see ABS Institutional Environment.
Relevance	<p>Deaths data are published on an annual basis. The ABS Deaths collection includes all deaths that occurred and were registered in Australia, including deaths of persons whose usual residence is overseas. Deaths of Australian residents that occurred outside Australia may be registered by individual Registrars, but are not included in ABS deaths or causes of death statistics.</p> <p>The ABS Births collection includes all births that are live born and have not been previously registered, births to temporary visitors to Australia, births occurring within Australian Territorial waters, births occurring in Australian Antarctic Territories and other external territories, births occurring in transit (i.e. on ships or planes) if registered in the state or territory of "next port of call", births to Australian nationals employed overseas at Australian legations and consular offices and births that occurred in earlier years that have not been previously registered (late registrations). Births data exclude fetal deaths, adoptions, sex changes, legitimations and corrections, and births to foreign diplomatic staff, and births occurring on Norfolk Island.</p> <p>For further information on the ABS Deaths and Births collections, see the relevant Data Quality Statements.</p>
Timeliness	<p>Death records are provided electronically to the ABS by individual Registrars on a monthly basis for compilation into aggregate statistics on a quarterly and annual basis. One dimension of timeliness in death registrations data is the interval between the occurrence and registration of a death. As a result, a small number of deaths occurring in one year are not registered until the following year or later.</p> <p>Births records are provided electronically to the ABS by individual Registrars on a monthly basis for compilation into aggregate statistics on a quarterly and annual basis. One dimension of timeliness in birth registrations data is the interval between the occurrence and registration of a birth. As a result, some births occurring in one</p>

year are not registered until the following year or even later. This can be caused by either a delay by the parent(s) in submitting a completed form to the registry, or a delay by the registry in processing the birth (for example, due to follow up activity due to missing information on the form, or resource limitations).

Preliminary ERP data is compiled and published quarterly and is generally made available five to six months after the end of each reference quarter. Every year, the 30 June ERP is further disaggregated by sex and single year of age, and is made available five to six months after end of the reference quarter. Commencing with data for September quarter 2006, revised estimates are released annually and made available 21 months after the end of the reference period for the previous financial year, once more accurate births, deaths and net overseas migration data becomes available. In the case of births and deaths, the revised data is compiled on a date of occurrence basis. In the case of net overseas migration, final data is based on actual traveller behaviour. Final estimates are made available every 5 years after a census and revisions are made to the previous inter-censal period. Generally ERP data is not changed once it has been finalised unless there are compelling reasons to do so, as in June 2013 when data from September 1991 to June 2006 was revised (for more information on this recasting process, please see the feature article titled Recasting 20 years of ERP in the December quarter 2012 issue of Australian Demographic Statistics (cat. no. 3101.0).

For further information on ABS Estimated Resident Population, see the relevant Data Quality Statement.

Accuracy

Information on births and deaths is obtained from a complete enumeration of births and deaths registered during a specified period and are not subject to sampling error. However, births and deaths data sources are subject to non-sampling error which can arise from inaccuracies in collecting, recording and processing the data.

Concerns have been raised with the accuracy of the NSW births counts in recent years. In response to these concerns the ABS, in conjunction with the NSW Registry of Births, Deaths and Marriages, has undertaken an investigation which has led to the identification of an ABS systems processing error. The ABS acknowledges that this has resulted in previous undercounts of births in NSW. Data for NSW and Australia have been revised to include previously unprocessed NSW birth registrations for the period 2005 to 2011.

Although it is considered likely that most deaths of Aboriginal and Torres Strait Islander (Indigenous) Australians are registered, a proportion of these deaths are not registered as Indigenous. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred and may differ from the self-identified Indigenous origin of the deceased. Forms are often not subject to the same best practice design principles as statistical questionnaires, and respondent and/or interviewer understanding is rarely tested. Over-precise analysis of Indigenous deaths and mortality should be avoided.

In November 2010, the Queensland Registrar of Births, Deaths and Marriages advised the ABS of an outstanding deaths registration initiative undertaken by the Registry. This initiative resulted in the November 2010 registration of 374 previously unregistered deaths which occurred between 1992 and 2006 (including a few for which a date of death was unknown). Of these, around three-quarters (284) were deaths of Aboriginal and Torres Strait Islander Australians.

The ABS discussed different methods of adjustment of Queensland death registrations data for 2010 with key stakeholders. Following the discussion, a decision was made by the ABS and key stakeholders to use an adjustment method that added together deaths registered in 2010 for usual residents of Queensland which occurred in 2007, 2008, 2009 and 2010. This method minimises the impact on mortality indicators used in various government reports. However, care should still be taken when interpreting Aboriginal and Torres Strait Islander death data for Queensland for 2010.

Investigation conducted by the WA Registrar of Births, Deaths and Marriages indicated that some deaths of non-Indigenous people were wrongly recorded as deaths of Indigenous people in WA for 2007, 2008 and 2009. The ABS discussed this issue with a range of key stakeholders and users of Aboriginal and Torres Strait Islander deaths statistics. Following this discussion, the ABS did not release WA

Aboriginal and Torres Strait Islander deaths data for the years 2007, 2008 and 2009 in the 2010 issue of Deaths, Australia publication, or in the 2011 COAG data supply. The WA Registry corrected the data and resupplied the corrected data to the ABS. These corrected data were then released by the ABS in spreadsheets attached to Deaths, Australia, 2010 (cat. no. 3302.0) publication on 24 May 2012, and are included in this round of COAG reporting.

All ERP data sources are subject to non-sampling error. Non-sampling error can arise from inaccuracies in collecting, recording and processing the data. In the case of Census and Post Enumeration Survey (PES) data every effort is made to minimise reporting error by the careful design of questionnaires, intensive training and supervision of interviewers, and efficient data processing procedures. The ABS does not have control over any non-sampling error associated with births, deaths and migration data. For more information see the Demography Working Paper 1998/2 - Quarterly birth and death estimates, 1998 (cat. no. 3114.0) and Australian Demographic Statistics (cat. no. 3101.0).

Indigenous and non-Indigenous population estimates are available for Census years only. In the intervening years, Indigenous population projections are based on assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the projected Indigenous population from the total population. For the current round of COAG reporting, non-Indigenous population estimates have been derived by subtracting the 2011 Census-based Indigenous population estimates/projections from the 2011 Census-based total persons Estimated Resident Population (ERP). Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases. Total population estimates for 2012, used in the calculation of non-Indigenous comparison rates, are preliminary estimates.

Non-Indigenous data from the Deaths collection do not include death registrations with a 'not stated' Indigenous status.

Some rates are unreliable due to small numbers of deaths over the reference period. Resultant rates could be misleading for example where the non-Indigenous mortality rate is higher than the indigenous mortality rate. All rates in this indicator must be used with caution.

Coherence	The methods used to construct the indicator are consistent and comparable with other collections and with international practice.
Accessibility	Deaths data are available in a variety of formats on the ABS website under the 3302.0 product family. Births data are available in a variety of formats on the ABS website under the 3301.0 product family. ERP data is available in a variety of formats on the ABS website under the 3101.0 product family. Further information on deaths and mortality may be available on request. The ABS observes strict confidentiality protocols as required by the <i>Census and Statistics Act (1905)</i> . This may restrict access to data at a very detailed level.
Interpretability	Data for this indicator have been presented as crude rates, either per 1000 live births or per 1000 estimated resident population.

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none">• The data provide relevant information on infant (<1 year) and child (0–4 years) mortality rates.• Single year data for child mortality by Indigenous status have been backcast to the baseline reporting year of 2007 due to revised ERP data.• Data are of acceptable accuracy. Although most deaths of Indigenous Australians are registered, it is likely that some are not identified as Indigenous. Therefore data are likely to underestimate the Indigenous mortality rate.• A large number of unregistered deaths in Queensland dating back to 1992 were identified and registered in 2010. Care should be taken when interpreting Aboriginal and Torres Strait Islander death data for Queensland for 2010.
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- Data by Indigenous status are reported for NSW, Queensland, WA, SA and the NT only. Only these jurisdictions have evidence of a sufficient level of Indigenous identification, have sufficient numbers of Indigenous deaths and do not have significant data quality issues.
 - Variability bands provided with rates describe the range of potential results for mortality rates. Variability bands are calculated for single-year and aggregate years data by State and Territory (for within jurisdiction comparisons only — they cannot be used to make comparisons across jurisdictions).
 - Further work is required to improve the completeness of Indigenous identification for registered deaths.

Mortality rates by major cause of death

Data quality information for this indicator has been sourced from the Australian Bureau of Statistics (ABS) with additional Steering Committee comments.

Indicator definition and description

Indicator	Age standardised mortality by major cause of death
Measure/s (computation)	Numerator <ul style="list-style-type: none">• Death registrations by major cause of death. Denominators <ul style="list-style-type: none">• Estimated Resident Population (ERP)• Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians
Data source/s	Numerator: ABS Causes of Death collection (Cat. no. 3303.0) Denominators: <ul style="list-style-type: none">• ABS ERP (Cat. no. 3101.0)• <i>ABS Estimates and Projections, Aboriginal and Torres Strait Islander Australians</i> (Cat. no. 3238.0), Series B.• For the non-Indigenous population, the projected Indigenous population (3238.0, Series B) is subtracted from the ABS 2011 Census-based ERP.

Data Quality Framework Dimensions

Institutional environment	These collections are conducted under the <i>Census and Statistics Act 1905</i> . For information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, see ABS Institutional Environment.
Relevance	<p>The ABS Causes of Death collection includes all deaths that occurred and were registered in Australia, including deaths of persons whose usual residence is overseas. Deaths of Australian residents that occurred outside Australia may be registered by individual Registrars, but are not included in ABS deaths or causes of death statistics.</p> <p>Data in the Causes of Death collection include demographic items, as well as causes of death information, which is coded according to the International Statistical Classification of Diseases and Related Health Problems (ICD). ICD is the international standard classification for epidemiological purposes and is designed to promote international comparability in the collection, processing, classification, and presentation of causes of death statistics. The classification is used to classify diseases and causes of disease or injury as recorded on many types of medical records as well as death records. The ICD has been revised periodically to incorporate changes in the medical field. The 10th revision of ICD (ICD-10) has been used by the ABS to code cause of death since 1997.</p> <p>For further information on the ABS Causes of Death collection, see the relevant Data Quality Statement.</p>
Timeliness	<p>Death records are provided electronically to the ABS by individual Registrars and the National Coroners Information System (NCIS) on a monthly basis, for compilation into aggregate statistics on an annual basis. One dimension of timeliness in causes of death registrations data is the interval between the occurrence and registration of a death. As a result, a small number of deaths occurring in one year are not registered until the following year or later.</p> <p>Preliminary ERP data is compiled and published quarterly and is generally made available five to six months after the end of each reference quarter. Every year, the 30 June ERP is further disaggregated by sex and single year of age, and is made available five to six months after the end of the reference quarter. Commencing with data for September quarter 2006, revised estimates are released annually and made available 21 months after the end of the reference period for the previous financial</p>

year, once more accurate births, deaths and net overseas migration data becomes available. In the case of births and deaths, the revised data is compiled on a date of occurrence basis. In the case of net overseas migration, final data is based on actual traveller behaviour. Final estimates are made available every 5 years after a Census and revisions are made to the previous intercensal period. Generally ERP data is not changed once it has been finalised unless there are compelling reasons to do so, as in June 2013 when data from September 1991 to June 2006 was revised (for more information on this recasting process, please see the feature article titled *Recasting 20 years of ERP in the December quarter 2012 issue of Australian Demographic Statistics* (Cat. no. 3101.0).

For further information on ABS Estimated Resident Population, see the relevant Data Quality Statement.

Accuracy

Information on causes of death is obtained from a complete enumeration of deaths registered during a specified period, so is not subject to sampling error. However, causes of death data sources are subject to non-sampling error which can arise from inaccuracies in collecting, recording and processing the data.

Although it is considered likely that most deaths of Aboriginal and Torres Strait Islander (Indigenous) Australians are registered, a proportion of these deaths are not registered as Indigenous. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred and may differ from the self-identified Indigenous origin of the deceased. Forms are often not subject to the same best practice design principles as statistical questionnaires, and respondent and/or interviewer understanding is rarely tested. Over-precise analysis of Indigenous deaths and mortality should be avoided.

All coroner certified deaths registered after 1 January 2006 are now subject to a revisions process. In this round of COAG reporting, 2008, 2009 and 2010 data are final, 2011 data are revised and 2012 data are preliminary. Data for 2011 and 2012 are subject to further revisions. Prior to 2006 all ABS processing of causes of death data for a particular reference period was finalised approximately 13 months after the end of the reference period. Where insufficient information was available to code a cause of death (e.g. a coroner certified death was yet to be finalised by the Coroner), less specific ICD codes were assigned as required by the ICD coding rules. The revision process enables the use of additional information relating to coroner certified deaths, as it becomes available over time. This results in increased specificity of the assigned ICD-10 codes.

Revisions will only impact on coroner certified deaths, as further information becomes available to the ABS about the causes of these deaths. See Technical Note: Causes of Death Revisions 2010 and 2011 in *Causes of Death, Australia, 2012* (Cat. no. 3303.0).

In November 2010, the Queensland Registrar of Births, Deaths and Marriages advised the ABS of an outstanding deaths registration initiative undertaken by the Registry. This initiative resulted in the November 2010 registration of 374 previously unregistered deaths which occurred between 1992 and 2006 (including a few for which a date of death was unknown). Of these, around three-quarters (284) were deaths of Aboriginal and Torres Strait Islander Australians.

The ABS discussed different methods of adjustment of Queensland death registrations data for 2010 with key stakeholders. Following the discussion, a decision was made by the ABS and key stakeholders to use an adjustment method that added together deaths registered in 2010 for usual residents of Queensland which occurred in 2007, 2008, 2009 and 2010. This method minimises the impact on mortality indicators used in various government reports. However, care should still be taken when interpreting Aboriginal and Torres Strait Islander death data for Queensland for 2010. Please note that there are differences between data output in the *Causes of Death, Australia, 2010* publication (cat. No. 3303.0) and 2010 data reported for COAG, as this adjustment was not applied in the publication. For further details see Technical Note: Registration of outstanding deaths, Queensland 2010, from *Deaths, Australia, 2010* (Cat. no. 3302.0) and Explanatory Note 103 in the *Causes of Death, Australia, 2010* (Cat. no. 3303.0).

Investigation conducted by the WA Registrar of Births, Deaths and Marriages indicated that some deaths of non-Indigenous people were wrongly recorded as

deaths of Indigenous people in WA for 2007, 2008 and 2009. The ABS discussed this issue with a range of key stakeholders and users of Aboriginal and Torres Strait Islander deaths statistics. Following this discussion, the ABS did not release WA Aboriginal and Torres Strait Islander deaths data for the years 2007, 2008 and 2009 in the 2010 issue of Deaths, Australia publication, or in the 2011 COAG data supply. The WA Registry corrected the data and resupplied the corrected data to the ABS. These corrected data were then released by the ABS in spreadsheets attached to *Deaths, Australia, 2010* (ABS, 2011) publication on 24 May 2012, and are included in this round of COAG reporting. In addition to that, 3 deaths in WA for 2009 which were wrongly coded as deaths of Indigenous people have been corrected as deaths of non-Indigenous people in this round of COAG reporting.

All ERP data sources are subject to non-sampling error. Non-sampling error can arise from inaccuracies in collecting, recording and processing the data. In the case of Census and Post Enumeration Survey (PES) data every effort is made to minimise reporting error by the careful design of questionnaires, intensive training and supervision of interviewers, and efficient data processing procedures. The ABS does not have control over any non-sampling error associated with births, deaths and migration data. For more information see the *Demography Working Paper 1998/2 - Quarterly birth and death estimates, 1998* (Cat. no. 3114.0) and *Australian Demographic Statistics* (Cat. no. 3101.0).

Non-Indigenous estimates are available for census years only. In the intervening years, Indigenous population projections are based on assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the projected Indigenous population from the total population. In the present tables, non-Indigenous population estimates have been derived by subtracting the 2011 Census-based Indigenous population estimates/projections from the 2011 Census-based total persons Estimated Resident Population (ERP). Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases. Total population estimates for 2012, used in the calculation of non-Indigenous comparison rates, are preliminary estimates.

Non-Indigenous data from the Causes of Death collection do not include death registrations with a 'not stated' Indigenous status.

Some rates are unreliable due to small numbers of deaths over the reference period. Resultant rates could be misleading, for example, where the non-Indigenous mortality rate is higher than the indigenous mortality rate. Age-standardised death rates based on a very low death count have been deemed unpublishable. Some cells have also not been published to prevent back-calculation of these suppressed cells. Caution should be used when interpreting rates for this indicator.

Mortality rates for neoplasms may differ compared to individual State and Territory Cancer Registry mortality rates due to different sources of death data being used to calculate these rates. ABS mortality data is the cause of death data used for this indicator.

Coherence	The methods used to construct the indicator are consistent and comparable with other collections and with international practice.
Accessibility	Causes of death data are available in a variety of formats on the ABS website under the 3303.0 product family. Further information on deaths and mortality may be available on request. The ABS observes strict confidentiality protocols as required by the <i>Census and Statistics Act (1905)</i> . This may restrict access to data at a very detailed level.
Interpretability	Data for all deaths in this indicator have been age-standardised, using the direct method, to 85 years +. Data for Indigenous deaths in this indicator have been age-standardised, using the direct method, to 75 years + to account for differences between the age structures of the Indigenous and non-Indigenous populations. Direct age-standardisation to the 2001 total Australian population was used (see Data Cube: Standard Population for Use in Age-Standardisation Table in <i>Australian Demographic Statistics, Dec 2013</i> (Cat. no. 3101.0)). Age-standardised results provide a measure of relative difference only between populations.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The data provide relevant information on major causes of death. Data are available for all states and territories, and by Indigenous status for selected jurisdictions. Data are not available by socioeconomic status (SES).
- A large number of unregistered deaths in Queensland dating back to 1992 were identified and registered in 2010. Care should be taken when interpreting Aboriginal and Torres Strait Islander death data for Queensland for 2010.
- Data by Indigenous status are reported for NSW, Queensland, WA, SA and the NT. Only these jurisdictions have evidence of a sufficient level of Indigenous identification, have sufficient numbers of Indigenous deaths and do not have significant data quality issues.
- Data are of acceptable accuracy. Although most deaths of Indigenous Australians are registered, it is likely that some are not identified as Indigenous. Therefore data are likely to underestimate the Indigenous mortality rate. Rates should be used with caution.
- Variability bands provided with rates describe the range of potential results for mortality rates. Variability bands are calculated for single-year and aggregate years data by State and Territory (for within jurisdiction comparisons only — they cannot be used to make comparisons across jurisdictions).
- Further work is required to improve the completeness of Indigenous identification for registered deaths

Profile of employed health workforce

Data quality information for this indicator has been sourced from the Australian Bureau of Statistics (ABS) with additional Steering Committee comments.

Indicator definition and description

Indicator	Profile of employed health workforce
Measure/s (computation)	Full time equivalent employed health practitioners per 100 000 population (by age group). Age profiles are reported for nurse and midwife, medical practitioner, and allied health practitioner workforces. It shows the numbers of each of these registered professions in ten year age brackets, both by jurisdiction and by region.
Data source/s	National Health Workforce Data Set: medical practitioners 2013. National Health Workforce Data Set: nurses and midwives 2013. National Health Workforce Data Set: allied health practitioners 2013.

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) has calculated this indicator using estimates derived from the National Health Workforce Data Set (NHWDS). The NHWDS is developed through the collaboration of three agencies.</p> <p>The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the National Registration and Accreditation Scheme (NRAS) across Australia, including collecting registration data and administering the workforce surveys.</p> <p>Health Workforce Australia was responsible for the development of the health workforce surveys until its closure by the Australian Government on 6 August 2014.</p> <p>The AIHW receives registration and survey data from the AHPRA. The registration and workforce survey data are combined, cleansed and adjusted for non-response to form NHWDS, and the findings reported by profession. AIHW is the data custodian of the NHWDS. These data are used for workforce planning, monitoring and reporting.</p> <p>The AIHW is an independent statutory authority within the Health portfolio, which is accountable to the Parliament of Australia through the Minister. For further information, see the AIHW website.</p>
Relevance	<p>Medical practitioners, nurses/midwives and allied health practitioners, as well as dental practitioners, are required by law to be registered with their relevant national board to practise in Australia. All medical practitioners, dental practitioners, nurses/midwives and nominated allied health practitioners must complete the formal registration renewal form(s) to practise in Australia. This is the compulsory component of the renewal process. The exception is Aboriginal and Torres Strait Islander health practitioners in the allied health workforce; where those who are not required by their employer to use the title 'Aboriginal and Torres Strait Islander health practitioner', 'Aboriginal health practitioner' or 'Torres Strait Islander health practitioner' are not required to be registered, and can continue to work using their current titles (e.g. 'Aboriginal health worker', 'drug and alcohol worker' and 'mental health worker').</p> <p>The health workforce surveys for each of these professions is voluntary and only practitioners who renew their registration receive a questionnaire for completion. New registrants will not receive a survey form until they renew their registration the following year, during the registration renewal period. Practitioners with limited registration are due for renewal on the anniversary of their first registration and can thus renew and complete a survey at any time through the year.</p>

National Health Workforce Data Set: medical practitioners 2010, 2011, 2012 and 2013

- The NHWDS: medical practitioners 2010, 2011, 2012 and 2013 contain registration details of all registered medical practitioners in Australia, at 30 September on the annual renewal date. Data were extracted from the AHPRA database at the end of November of the same year. The NHWDS also contains workforce data of respondents whose principal state of practice was not Queensland or Western Australia, obtained from the Medical Workforce Survey 2010. These states were excluded from the survey because not all registrations in these states expired prior to the national registration deadline. In 2011, 2012 and 2013, the NHWDS also contains workforce data obtained from the Medical Workforce Survey for all states and territories.

National Health Workforce Data Set: nurses and midwives 2011, 2012 and 2013

- The NHWDS: nurses and midwives 2011, 2012 and 2013 contain registration details of all registered nurses/midwives in Australia at 31 May on the annual renewal date. Data were extracted from the AHPRA database at the end of November of the same year. In 2011, 2012 and 2013, the NHWDS also contains workforce data obtained from the Nursing and Midwifery Workforce Survey.

National Health Workforce Data Set: allied health practitioners 2012 and 2013.

- The NHWDS: allied health practitioners 2012 and 2013 contain registration details of all registered allied health practitioners in Australia, at 30 November on the annual renewal date. Data were extracted from the AHPRA database at the end of January the following year. The NHWDS also contains workforce data obtained from each profession-specific health workforce survey.
- Indicator data for allied health practitioners are not comparable between 2012 and 2013.
 - Due to transitional arrangements with the migration of data from state and territory-based systems to NRAS, in 2012, many medical radiation practitioners in Queensland, WA and Tasmania were not required to renew their registrations and, as a result did not complete a workforce survey. As a consequence, data for Queensland, WA and Tasmania for this profession are excluded from the indicator data for allied health practitioners.
 - For the same reason, occupational therapists in Queensland, WA and SA are excluded from the indicator data for allied health practitioners in 2012.

National Health Workforce Data Set: dental practitioners 2011, 2012 and 2013

- The NHWDS: dental practitioners 2011, 2012 and 2013 contain registration details of all registered dental practitioners in Australia, at 30 November on the annual renewal date. Data were extracted from the AHPRA database at the end of January the following year. In 2011, 2012 and 2013, the NHWDS also contains workforce data obtained from the Dental Workforce Survey.

Timeliness

National Health Workforce Data Set:

- The NHWDS for each of the registered professions will be produced annually during the national registration renewal process. Each profession will also be administered a Workforce Survey as part of the registration renewal process.
- Medical practitioners 2010, 2011, 2012 and 2013
 - The NHWDS: medical practitioners is produced annually from information collected by the national registration renewal process, conducted between 1 July and 30 September each year, including the collection of the Medical Workforce Survey. The period for the 2010 renewal process was extended to the end of January 2011. Despite this extension, there were still Queensland and WA registrants with expiry dates after January. Therefore data from these states were not included in the 2010 data set.
- Nurses and midwives 2011, 2012 and 2013
 - The NHWDS: nurses and midwives is produced annually from information collected by the national registration renewal process, conducted between 1 April and 31 May each year, including the collection of the Nursing and Midwifery Workforce Survey. The period for the 2011 renewal process was extended to the end of June 2011 for Queensland and end of December 2011 for Western Australia registrants.

- Allied health practitioners 2012 and 2013
 - The NHWDS: allied health practitioners is produced annually from information collected by the national registration renewal process, conducted between 1 September and 30 November each year, including the collection of the profession-specific workforce surveys. Practitioners with limited registration are due for renewal on the anniversary of their first registration and can thus renew and complete a survey at any time through the year.

Accuracy

Data manipulation and estimation processes

- The registration and workforce survey data for each health profession are combined, cleansed and adjusted for non-response to form the NHWDS. The cleaning and editing procedures included range and logic checks, clerical scrutiny at unit record level, and validation of unit record and aggregate data.
- Imputation methods are used to account for item non-response and survey non-response. In 2013, the methodology for survey non-response was changed from a weighting-based methodology to a randomised sequential hot deck-based imputation.
 - It should be noted that both of these kinds of non-response is likely to introduce some bias in the estimates and any bias is likely to become more pronounced when response rates are low or when estimates are based on a small number of records. Care should be taken when drawing conclusions about the size of the differences between estimates.
- As a result of the estimation method to adjust for non-response, numbers of medical practitioners, dental practitioners, nurses/midwives or allied health practitioners may have been in fractions, but have been rounded to whole numbers for this indicator. The full-time equivalent (FTE) rate calculations are based on rounded numbers.

Registration data from the National Registration and Accreditation Scheme (NRAS)

- Registration details were migrated from the respective state and territory professional board (or council) for practitioners with registrations expiring after the official AHPRA closing date for their profession.
- Some data items previously collected by the AIHW Labour Force Surveys are now collected by the NRAS. However, some data quality issues due to migrated data items from the respective state and territory health profession boards may have affected the weighting method.
- Medical practitioners, nurses/midwives and allied health practitioners who reside overseas have been included with practitioners whose state or territory of principal practice and state or territory of main job, respectively, could not be determined.

Health Workforce Survey

- In 2013, the online survey questionnaire include for the first time electronic sequencing of questions to automatically guide the respondent to the next appropriate question based on previous responses to questions.
- For the online survey questionnaire prior to 2013, and the paper version of the questionnaire, respondents may have made inconsistent responses by not correctly following the sequencing instructions.
- The order of the response categories for some questions may have also impacted on the accuracy of the information captured. In addition, there was variation in some responses between the online and paper surveys.

NHWDS data by profession

The following should be noted when comparing state and territory indicator data:

- The data include employed professionals who did not state or adequately describe their state of principal practice and employed professionals who reside overseas. The national estimates include this group.
- National Health Workforce Data Set: medical practitioners 2010, 2011, 2012 and 2013
 - The overall response rate for 2010 (excluding Queensland and Western Australia) was 76.6 per cent.
 - The overall response rate for 2011 was 85.3 per cent.

- The overall response rate for 2012 was 90.1 per cent.
- The overall response rate for 2013 was 88.6 per cent.
- National Health Workforce Data Set: nurses and midwives 2011, 2012 and 2013
 - The overall response rate for 2011 was 85.1 per cent.
 - The overall response rate for 2012 was 93.3 per cent.
 - The overall response rate for 2013 was 87.6 per cent.
- National Health Workforce Data Set: allied health practitioners 2013
 - The overall response rate for 2013 was 87.9 per cent.

Coherence

Health Workforce Survey—coherence with previous surveys

- Labour force data published by the AIHW before the NRAS was established in July 2010, were the result of collated jurisdiction-level occupation-specific surveys. The current Health Workforce Survey gathers similar information from each professional group through a separate questionnaire, tailored slightly to take account of profession-specific responses to certain questions, e.g. work setting of main job.
- For this indicator, the workforce surveys for medical practitioners, dental practitioners, nurses/midwives and allied health practitioners collect similar data items, but the methodology differs from previous years. The AHPRA is now the single source of registered practitioner data instead of eight state and territories bodies for each profession, and there is greater consistency between jurisdictions and years in the scope of registration information.
- The scope and coverage of the Health Workforce Survey is also different from that of the previous series of AIHW Labour Force Surveys as not all jurisdictions surveyed all types of registered health practitioners.
- If the location of principal practice recorded in the registration data was different from the corresponding details of their main job self-reported by practitioners in the survey, the location was derived hierarchically based on main job information and then on principal practice location then place of residence.
- Date of birth is one of many data items previously collected by the AIHW Labour Force Surveys, which is now collected by the NRAS.
- The three employment-related questions in the new survey are now nationally consistent, but vary from the previous AIHW Labour Force Survey. Due to the differences in data collection (including survey design and questionnaire), processing and estimation methods, it is recommended that comparisons between workforce data from the NHWDS and the previous AIHW Labour Force Survey be made with caution.

AIHW Published Numbers

- For this indicator, the rates are based on practitioners employed in the medical, allied health and nursing and midwifery workforces, which is consistent with data published in AIHW's workforce reports.

Accessibility

Published products available on the AIHW website include workforce reports, survey questionnaires, user guides to the data sets and supplementary detailed tables.

Interpretability

Explanatory information for the Medical Workforce Survey, Dental Workforce Survey and the Nursing and Midwifery Workforce Survey is contained in the published reports, supplementary detailed tables and data quality statements to the data set for each. For the allied health professions, information about their workforce surveys is available in the National Health Workforce Data Set: allied health practitioners data quality statement. This includes collection method, scope and coverage, survey response, imputation and weighting procedures, and assessment of data quality (including comparison with other data sources).

These are available via the AIHW website and readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The rates have been calculated per 100 000 population for this indicator to assist with interpretation.

-
- Due to the differences in data collection, processing and estimation methods, including survey design and questionnaire, it is recommended that comparisons between workforce data from the National Health Workforce Data Set (NHWDS) and the previous AIHW Labour Force Survey be made with caution and noted in any analyses.
 - Results for the indicator are estimates because the survey data have undergone imputation and weighting to adjust for non-response. It should be noted that any of these adjustments may have introduced some bias in the estimates and any bias is likely to become more pronounced when response rates are low or when estimates are based on a small number of survey records. Care should be taken when drawing conclusions about the size of the differences between estimates.
 - The 2012 and 2013 medical, allied health and dental workforce indicator data exclude provisional registrants (there is no provisional registrant type for nurses and midwives).

10 Primary and community health

CONTENTS

10.1 Profile of primary and community health	10.2
10.2 Framework of performance indicators	10.16
10.3 Key performance indicator results	10.18
10.4 Future directions in performance reporting	10.94
10.5 Definitions of key terms	10.96
10.6 List of attachment tables	10.100
10.7 References	10.104

Attachment tables

Attachment tables are identified in references throughout this chapter by a '10A' prefix (for example, table 10A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

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 scope of this chapter does not extend to:

- public hospital emergency departments and outpatient services (reported in chapter 11, 'Public hospitals')
- community mental health services (reported in chapter 12, 'Mental health management')
- Home and Community Care program services (reported in chapter 13, 'Aged care' and chapter 14, 'Services for people with disability').

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.

Improvements to reporting on primary and community health services in this edition include:

- expenditure data for primary healthcare services more closely approximate the services covered in this chapter than in previous reports
- data are reported for the first time for occupational therapists and psychologists working in the public sector
- data for the availability of male GPs are reported for the first time alongside data for the availability of female GPs
- the proportion of general practices enrolled in the Practice Incentives Program (PIP) that are registered for the PIP diabetes incentive is reported for the first time, in place of the proportion of people with diabetes who received an annual cycle of care within general practice
- updated data for asthma management by Indigenous status are reported
- extending time series for reporting on some indicators
- data quality information (DQI) is available for the first time for the indicator GPs with vocational registration and for the measure effectiveness of access to GPs — bulk billing rates.

10.1 Profile of primary and community health

Definitions, roles and responsibilities

Primary and community healthcare services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Those funded largely by governments include general practice, community health services, the PBS and public dental services. The Australian Government provides some funding for private dental and allied health services — for the general community through the private health insurance rebate, and for people with specific conditions or needs (for example, mental illness) through DHS Medicare.

The Australian Government also funds a national network of 61 Medicare Locals. These are independent primary health care organisations, established under the National Health Reform agenda in 2011 and 2012, with responsibility to coordinate primary health care delivery and address health care needs and service gaps within their boundaries (AIHW 2014a). Following a review of Medicare Locals, they will be replaced from July 2015 with a smaller number of Primary Health Networks with the objective of improving the efficiency and effectiveness of medical services for patients at risk of poor health

outcomes and improving coordination of care, particularly for those with chronic and complex conditions.

Definitions for common health terms are provided in section 10.5.

General practice

General practice is a major provider of primary healthcare in Australia. It is defined by the Royal Australian College of General Practitioners (RACGP) as providing ‘person centred, continuing, comprehensive and coordinated whole person health care to individuals and families in their communities’ (RACGP 2014a). General practice is the business structure within which one or more general practitioners (GPs) and other staff, such as practice nurses, provide and supervise healthcare for patients presenting to the practice. General practices are predominantly privately owned, by GPs or corporate entities.

General practitioners must be registered with the Medical Board of Australia. General practice data reported in this chapter relate mainly to services provided by those general practitioners who are recognised for Medicare as defined below:

- vocationally registered GPs — GPs who are recognised under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or equivalent, or hold a recognised training placement
- other medical practitioners (OMP) — medical practitioners who are not vocationally registered GPs.

Services provided in general practice include:

- diagnosis and treatment of illness (both chronic and acute) and injury
- preventative care through to palliative care
- referrals to consultants, allied health professionals, community health services and hospitals.

The Australian Government provides the majority of general practice income through DHS Medicare, including fee-for-service payments via the Medicare Benefits Schedule (MBS) and other payments. Through its funding role, the Australian Government seeks to influence the supply, regional distribution and quality of general practice services. State and Territory governments also provide some funding to influence general practice services, particularly regional distribution, within jurisdictions.

While the majority of GPs provide services as part of a general practice, some are employed by hospitals, community health services or other organisations.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

The Australian Government subsidises the cost of around 80 per cent of prescription medicines through the PBS (Department of Health 2010). The PBS aims to provide affordable, reliable and timely access to prescription medicines for all Australians. Users make a co-payment, which in 2014 was \$6.00 for concession card holders and up to \$36.90 for general consumers (Department of Health 2014). The Australian Government pays the remaining cost of medicines eligible for the subsidy. Co-payment amounts are normally adjusted by the rate of inflation on 1 January each year (Department of Health 2014).

Co-payments are also subject to a safety net threshold. Once consumer spending within a calendar year has reached the threshold, PBS medicines are generally cheaper or fully subsidised for the rest of the calendar year. The 2014 safety net threshold was \$1421.20 for general consumers and \$360.00 for concession card holders (Department of Health 2014).

The Repatriation Pharmaceutical Benefits Scheme (RPBS) provides subsidised pharmaceutical medicines, dressings and other items to war veterans and war widows. The RPBS is administered by the Department of Veterans' Affairs (DVA). Drugs eligible for subsidy under the RPBS may not be eligible under the PBS.

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.

Allied health services

Allied health services include, but are not limited to, physiotherapy, psychology, occupational therapy, audiology, podiatry and osteopathy. While some allied health

professionals are employed in community health services, allied health services are delivered mainly in the private sector. Governments provide some funding for private allied health services through insurance schemes and private insurance rebates. The Australian Government also makes some allied health services available under the MBS to patients with particular needs — for example, people with chronic conditions and complex care needs — and improves access to allied health services in rural and remote areas.

Nationally, there were 25.5 FTE occupational therapists and 31.5 FTE psychologists per 100 000 people working in the public sector in 2013 (table 10A.29).

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

Overall primary and community health expenditure data for services approximating those covered in this chapter are available for the first time for the 2015 Report (table 10.1).

Nationally, government expenditure on primary and community health services, including public health, was \$30.2 billion in 2012-13, of which State, Territory and local governments provided 24.7 per cent and the Australian Government 75.3 per cent (table 10.1). In that year, Australian Government expenditure on dental services was \$1.6 billion, of which 60.8 per cent was through the DVA and the Department of Health.

State, Territory and local government expenditure on dental services was around \$700 million in 2012-13. Dental expenditure data by state and territory are provided in table 10A.7. Additional expenditure is incurred by some states and territories through schemes that fund the provision of dental services to eligible people by private practitioners.

Table 10.1 Estimated funding on Primary healthcare, 2012-13 (\$ million) (2012-13 dollars)^a

	<i>Australian Government</i>			<i>Total^d</i>	<i>State, Territory and local government</i>	<i>Total government^d</i>	<i>Non-government</i>	<i>Total government and non-government^d</i>
	<i>DVA</i>	<i>Department of Health and other^b</i>	<i>Premium rebates^c</i>					
Unreferred medical services	838	7419	..	8257	..	8257	1909	10166
Dental services	100	843	606	1550	657	2207	6500	8706
Other health practitioners	241	1160	287	1688	13	1701	3508	5209
Community health and other ^e	1	1181	–	1182	5909	7092	352	7444
Public health	..	1150	..	1150	884	2034	109	2143
Benefit-paid medications	429	7994	..	8423	..	8423	1547	9970
All other medications	..	507	22	529	..	529	8781	9309
Total	1608	20 255	915	22 779	7463	30 242	22706	52 948

^a Data are not comparable to other expenditure data reported in this chapter, which are expressed in 2013-14 dollars. ^b 'Other' comprises expenditure on the National Healthcare Agreement and health-related National Partnerships, capital consumption, estimates of the medical expenses tax offset and health research not funded by the Department of Health. ^c Expenditure on insurance premium rebates relates to private health and dental services that are not within the scope of this chapter. ^d Totals may not add due to rounding. ^e Includes expenditure on community health and other recurrent health services (not elsewhere classified). .. Not applicable. – Nil or rounded to zero.

Source: AIHW (Australian Institute of Health and Welfare) (2014), Health Expenditure Australia 2012-13, Cat. no. HWE 61.

General practice

The Australian Government funds the majority of general practice services, primarily through DHS Medicare and the DVA. The remainder comes from insurance schemes, patient contributions, and State and Territory government programs. The annual Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity in Australia found that 95.4 per cent of direct general practice encounters where a payment

source was recorded in 2013-14 were for services at least partly funded by Medicare or the DVA (Britt et al. 2014) (table 10.2).

Table 10.2 General practice encounters and funding sources, April 2013 to March 2014^{a, b}

	Number ^c	Per cent of all encounters ^d	95% LCL	95% UCL
Total encounters for which BEACH data were recorded ^e	88 151	100	..	..
Direct encounters	86 607	98.2	98.0	98.5
No charge	332	0.4	0.3	0.5
DHS Medicare or DVA paid	84 136	95.4	95.1	95.8
Workers compensation paid	1 537	1.7	1.6	1.9
Other paid (such as, hospital, State)	603	0.7	0.5	0.8
Indirect encounters ^f	1 542	1.7	1.5	2.0

LCL = lower confidence limit. UCL = upper confidence limit. DVA = Department of Veterans' Affairs. ^a An encounter is any professional interchange between a patient and a GP or other health professional (other health professionals include practice nurses, Aboriginal health workers and allied health service professionals). ^b Data from the BEACH survey may not be directly comparable with other data on medical practitioners in this Report. ^c Number of encounters after post stratification weighting for GP activity and GP age and sex. ^d Missing data removed from analysis ($n = 7728$). ^e Includes 2 encounters for which direct/indirect was not specified. ^f For indirect encounters, the patient is not seen but a service is provided (for example, a prescription or referral). .. Not applicable.

Source: Britt et al. (2014) *General practice activity in Australia 2013-14*, Sydney University; table 10A.1.

The Australian Government also provides funding for general practice services under initiatives such as the Practice Incentives Program (PIP) and Medicare Locals. PIP provides financial incentives to eligible general practices to support quality care, and improve access and health outcomes (Australian Government DHS 2014).

Australian Government total expenditure on general practice in 2013-14 was \$7.9 billion (table 10A.2). This includes fee-for-service expenditure (\$7.3 billion, or 92 per cent of the total expenditure) through DHS Medicare and the Department of Veteran's Affairs (DVA), as well as expenditure on the PIP and Medicare Locals (around \$600 million, or 8 per cent of the total expenditure).

Age standardisation can be applied to fee-for-service expenditure on general practice to adjust for the effect of variations in age profiles on rates (see chapter 2 for details). The age-standardised expenditure on general practice per person was \$299 in 2013-14.

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

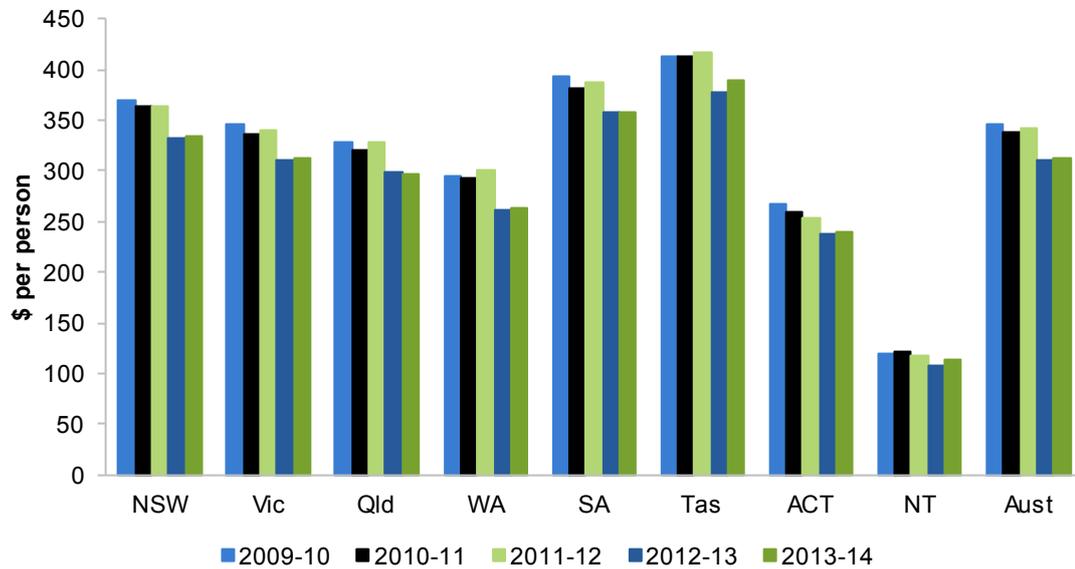
populations of Aboriginal and Torres Strait Islander Australians and people living in rural and remote areas.

State and Territory governments provide funding for general practice through a number of programs. Generally, this funding is provided indirectly through support services for GPs (such as assistance with housing and relocation, education programs and employment assistance for spouses and family members of doctors in rural areas) or education and support services for public health issues such as diabetes management, smoking cessation, sexual health, and mental health and counselling. Non-government sources — insurance schemes (such as, workers compensation and third party insurance) and private individuals — also provide payments to GPs.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Australian Government expenditure on medications through the PBS and RPBS was around \$7.7 billion in 2013-14 (tables 10A.4 and 10A.5). Expenditure on the PBS decreased from around \$7.7 billion (\$346 per person), to \$7.3 billion (\$313 per person) in the period 2009-10 to 2013-14 (in 2013-14 dollars) (figure 10.1). Over the same period, the proportion of PBS expenditure that is concessional rose from 77.9 to 78.5 per cent (tables 10A.4 and 10A.5). Data are presented for a ten year time series in Table 10A.4.

Figure 10.1 **PBS expenditure per person (2013-14 dollars)^{a, b, c, d, e, f, g}**



^a Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details. ^b From 2012-13, rates are derived using the ABS (Australian Bureau of Statistics) 2011 Census based ERP for 31 December and are not comparable with rates in figure 10.6 which use the 30 June ERP. Rates for earlier years are derived using ERPs based on earlier Censuses. Rates based on different Censuses are not comparable. ^c State and Territory data are only available on a cash basis for general and concessional categories. Data are not directly comparable to those published in the Department of Health's annual report which are prepared on an accrual accounting basis and include other categories administered under special arrangements (such as medications supplied to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing \$38.5 million for 2013-14, of which the NT accounted for 52.4 per cent [table 10A.6]). ^d Includes PBS general ordinary and safety net. ^e Includes PBS concessional ordinary and concessional free safety net. ^f Includes RPBS general ordinary and safety net. ^g Excludes PBS doctor's bag.

Source: Department of Health (unpublished) PBS Statistics; tables 10A.4 and 10A.5.

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 (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).

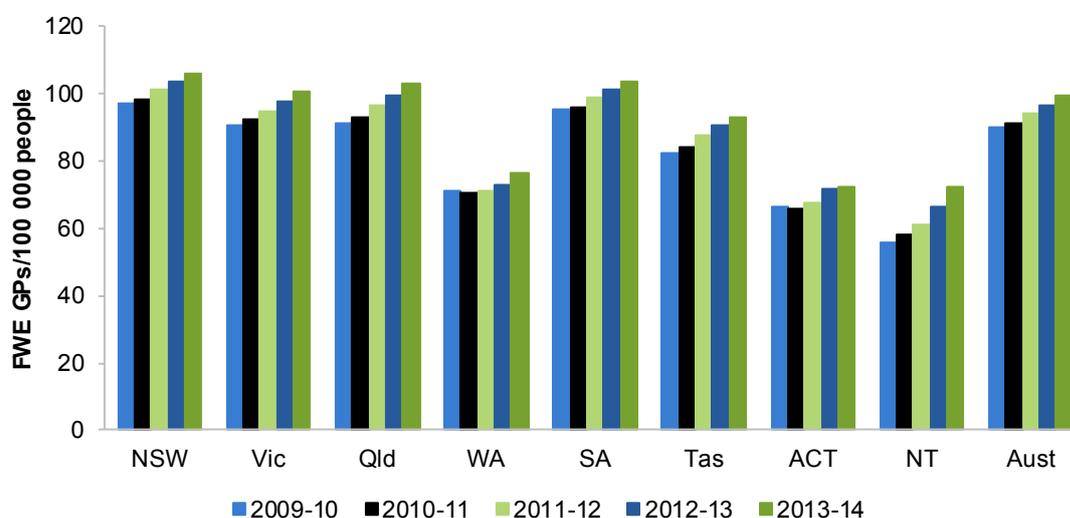
Size and scope

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 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 (figure 10.3).

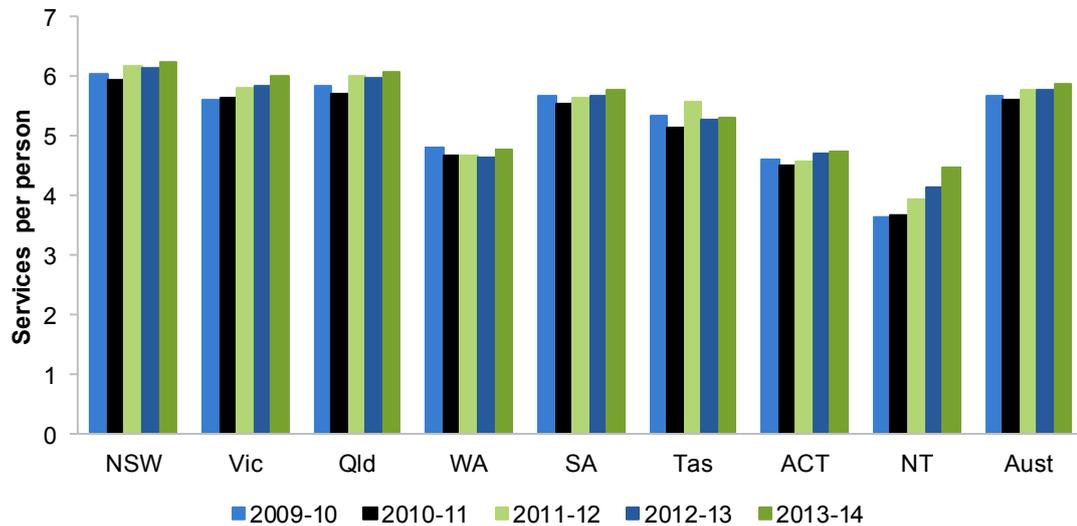
Figure 10.2 **Availability of GPs (full time workload equivalent)^{a, b}**



^a Data include vocationally registered GPs and OMPs billing Medicare who are allocated to a jurisdiction based on the postcode of their major practice. ^b ERPs used to derive rates are revised to the ABS' final 2011 Census rebased estimates for 31 December. See chapter 2 (table 2A.2) for details.

Source: Department of Health (unpublished) MBS Statistics; table 10A.9.

Figure 10.3 GP type service use^{a, b}



^a Rates are age standardised to the Australian population at 30 June 2001. Rates from 2011-12 are derived using ABS' 2011 Census based ERPs. Rates for previous years use ABS 2006 Census based ERPs. Rates derived using ERPs based on different Censuses are not comparable. See chapter 2 (table 2A.2) for details. ^b Includes non-referred attendances by vocationally registered GPs and OMPs, and practice nurses. From 2013-14, includes non-referred attendances by nurse practitioners.

Source: Department of Health (unpublished) MBS Statistics; DVA (unpublished) DVA data collection; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 10A.10.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Around 210 million services — 89.3 per cent of which were concessional — were provided under the PBS in 2013-14 (table 10.3). This amounted to 9.0 filled prescriptions per person. A further 12 million services were provided under the RPBS in the same period.

Table 10.3 PBS and RPBS services, 2013-14 (million services)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS general ^a	7.2	5.3	4.4	2.6	1.6	0.5	0.5	0.1	22.1
PBS concessional ^b	63.7	47.9	36.5	15.4	16.1	5.4	1.8	0.6	187.3
PBS doctor's bag ^c	0.1	0.1	0.1	–	–	–	–	–	0.4
PBS total	71.0	53.3	40.9	18.0	17.8	5.9	2.2	0.7	209.8
RPBS total ^d	4.1	2.6	3.0	1.0	0.9	0.4	0.2	0.0	12.3
Total	75.1	55.9	44.0	19.0	18.7	6.2	2.4	0.8	222.2
PBS services per person (no.) ^e	9.5	9.2	8.7	7.1	10.6	11.4	5.8	3.0	9.0

^a Includes PBS general ordinary and safety net. ^b Includes PBS concessional ordinary and concessional free safety net. ^c Supplies to prescribers for use in a medical emergency. ^d Includes RPBS general ordinary and safety net. ^e Excludes PBS doctor's bag. – Nil or rounded to zero.

Source: Department of Health (unpublished) PBS Statistics; tables 10A.11 and 10A.12.

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 10A.107–10A.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).

Maternal and child health

All jurisdictions provide maternal and child health services. These include: parenting support programs (including antenatal and postnatal programs); early childhood nursing programs; disease prevention programs (including childhood immunisations); and early intervention and treatment programs related to child development and health. Some jurisdictions also provide specialist programs through child health services, including hearing screening programs, and mothers and babies residential programs. Performance

indicators for maternity services in public hospitals are reported in chapter 11 (Public hospitals).

Public dental services

All jurisdictions provide some form of public dental service for primary school children. Some jurisdictions also provide dental services to preschool and secondary school students (tables 10A.107–10A.115).

State and Territory governments also provide some general dental services and a limited range of specialist dental services to disadvantaged adults who are holders of concession cards issued by Centrelink. The Australian Government contributes funding through the National Partnership Agreement on Treating More Public Dental Patients. In some jurisdictions, specialist dental services are provided mainly by qualified dental specialists; in others, they are provided in dental teaching hospitals as part of training programs for dental specialists (National Advisory Committee on Oral Health 2004). Most jurisdictions provided public dental services in 2013–14 targeted at disadvantaged people (tables 10A.107–10A.115). Current data are not available for use of public dental services for the 2015 Report — 2010 data are again reported in table 10.4.

Nationally, 74.4 public dental services were provided per 1000 people in 2010. Of these, around 19.5 per cent were emergency services (table 10.4).

Table 10.4 Use of public dental services by service type, per 1000 people, 2010^{a, b, c, d}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Emergency services ^e	9.6	10.4	26.9	12.4	13.3	29.3	14.6	25.6	14.5
General services	34.1	45.0	71.0	113.6	84.1	106.2	81.7	157.7	59.9
All services	43.7	55.4	97.9	126.0	97.3	135.4	96.3	183.3	74.4

^a Rates are age standardised to the Australian population at 30 June 2001. ^b Limited to dentate people aged 5 years or over. ^c Data are for the number of people who used a public dental service at least once in the preceding 12 months, not for the number of services provided. ^d Type of service at the most recent visit. ^e Emergency visit is a visit for relief of pain.

Source: AIHW (unpublished) National Dental Telephone Interview Survey; ABS (unpublished) *Australian Demographic Statistics*, Cat. no. 3101.0; table 10A.13.

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.

A total of 714 alcohol and other drug treatment agencies reported 2012-13 data to the AODTS–NMDS. Of these, 317 (44.4 per cent) identified as government providers and 397 (55.6 per cent) as non-government providers (table 10A.14). There were 162 362 reported closed treatment episodes in 2012-13 (table 10A.14) (see section 10.5 for a definition of a closed treatment episode). Clients seeking treatment for their own substance use, 68.1 per cent of whom were male, accounted for 155 151 closed treatment episodes (table 10A.14) (AIHW 2014b).

Alcohol was the most commonly reported principal drug of concern (41.1 per cent), followed by cannabis (23.6 per cent), amphetamines (14.4 per cent) and heroin (8.3 per cent), in closed treatment episodes for clients seeking treatment for their own substance abuse. Additional drugs of concern were reported in 62.9 per cent of the episodes (AIHW 2014b).

Alcohol was the most common principal drug of concern in all states and territories. Cannabis was the second most common principal drug in all states and territories except SA, where amphetamines were more common and the NT, where volatile solvents were more common (AIHW 2014b). Further information on alcohol and other drug treatment services funded by governments is included in tables 10A.107–10A.115.

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.107–10A.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 10.5). Of these, around 1.4 million (45.4 per cent) were in remote or very remote areas (table 10A.16).

Table 10.5 Estimated episodes of healthcare for Aboriginal and Torres Strait Islander Australians by services for which OSR data are reported ('000)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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.

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).

10.2 Framework of performance indicators

The performance indicator framework is based on shared government objectives for primary and community health (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.

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations).

The *National Healthcare Agreement* (NHA) covers the areas of health and aged care services, and health indicators in the *National Indigenous Reform Agreement* establish specific outcomes for reducing the level of disadvantage experienced by Aboriginal and Torres Strait Islander Australians. Both agreements include sets of performance indicators. The Steering Committee collates NIRA performance information for analysis by the Department of Prime Minister and Cabinet. Performance indicators reported in this chapter are aligned with health performance indicators in the most recent version of the NHA, where relevant.

Box 10.1 Objectives for primary and community health

Primary and community health services aim to support and improve the health of Australians by:

- providing a universally accessible point of entry to the healthcare system
- promoting health and preventing illness
- providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s)
- coordinating service provision to ensure continuity of care where more than one service type, and/or ongoing service provision, is required to meet individuals' healthcare needs.

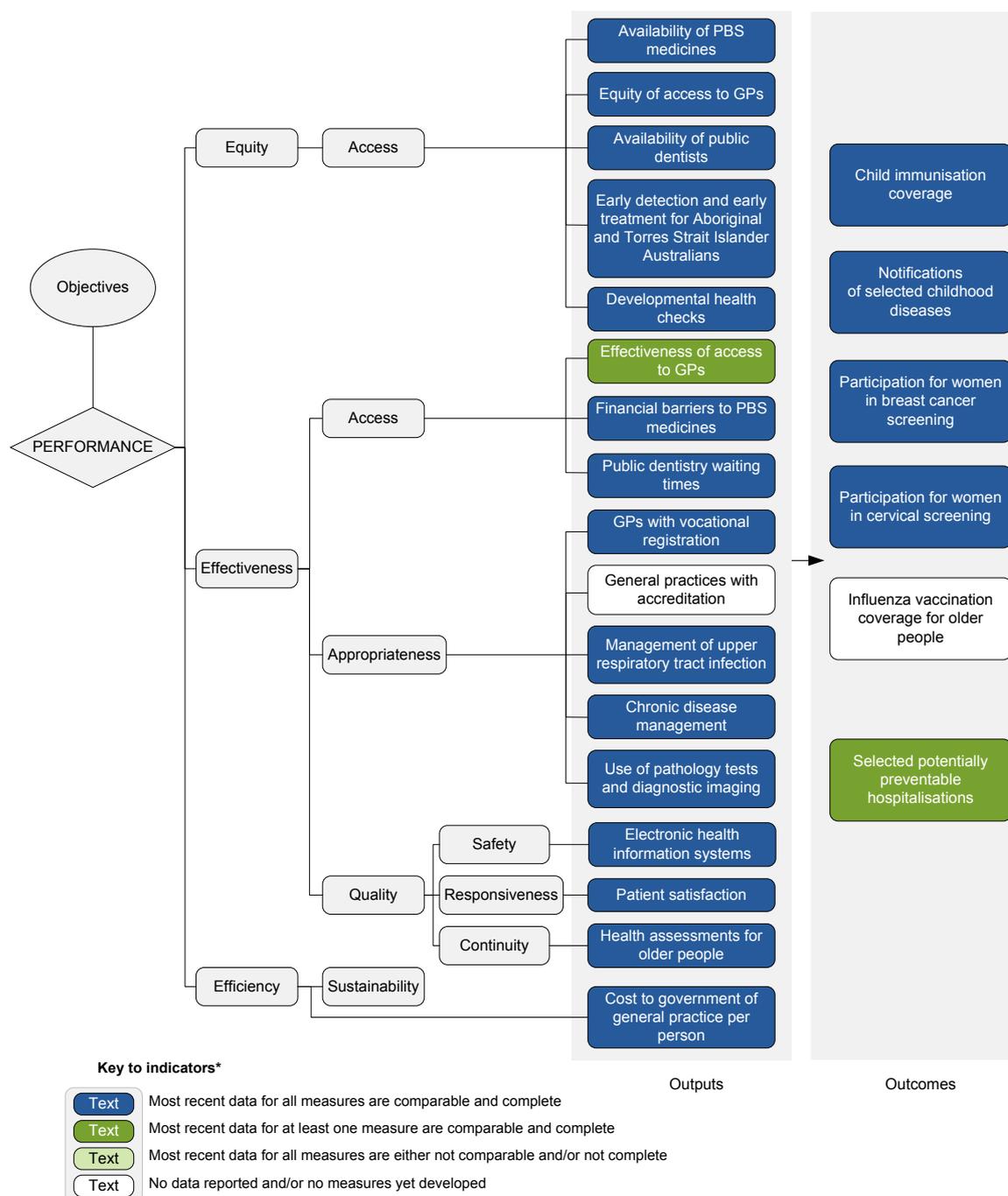
In addition, governments aim to ensure that interventions provided by primary and community health services are based on best practice evidence and delivered in an equitable and efficient manner.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of health services (figure 10.4). 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 section 1.6).

The Report's statistical context chapter contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic

and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous- and ethnic-status) (chapter 2).

Figure 10.4 Primary and community health performance indicator framework



Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators, in addition to the material in the chapter and attachment tables. DQI in this Report cover the seven dimensions in the Australian Bureau of Statistics (ABS) data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and key data gaps and issues identified by the Steering Committee. All DQI for the 2015 Report can be found at www.pc.gov.au/rogs/2015.

10.3 Key performance indicator results

Different delivery contexts, locations and client factors may affect the equity, effectiveness and efficiency of primary and community health services.

Outputs

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

Equity

For the purposes of this Report, equity is defined in terms of adequate access to government services for all Australians. Access to primary and community health services can be affected through factors such as disability, socioeconomic circumstance, age, geographic distance, cultural issues and English language proficiency (see chapter 1). Such issues have contributed to the generally poor health status of Aboriginal and Torres Strait Islander Australians relative to other Australians (SCRGSP 2014).

Access

Availability of PBS medicines

‘Availability of PBS medicines’ is an indicator of governments’ objective to provide equitable access to PBS medicines (box 10.2).

Box 10.2 Availability of PBS medicines

'Availability of PBS medicines' is defined by three measures:

- people per pharmacy by region, defined as the estimated resident population (ERP), divided by the number of pharmacies, in urban and in rural regions
- PBS expenditure per person by region, defined as expenditure on PBS medicines, divided by the ERP, in urban and in rural regions
- proportion of PBS prescriptions filled at a concessional rate, defined as the number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled.

This indicator is difficult to interpret. A low or decreasing number of people per pharmacy may indicate greater availability of PBS medicines. High or increasing PBS expenditure per person may indicate improved availability of PBS medicines. A high or increasing proportion of PBS prescriptions filled at a concessional rate may indicate improved availability of PBS prescriptions to disadvantaged people. It is also important that there are not large discrepancies by region in these measures.

Medicines are important in treating illness and can also be important in preventing illness from occurring. The availability of medicines is therefore a significant determinant of people's health and medicines should be available to those who require them, regardless of residential geolocation or socioeconomic circumstance.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them.

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 2014 for people per pharmacy by region and for 2013-14 for the measures PBS expenditure per person by region and proportion of PBS prescriptions filled at a concessional rate.

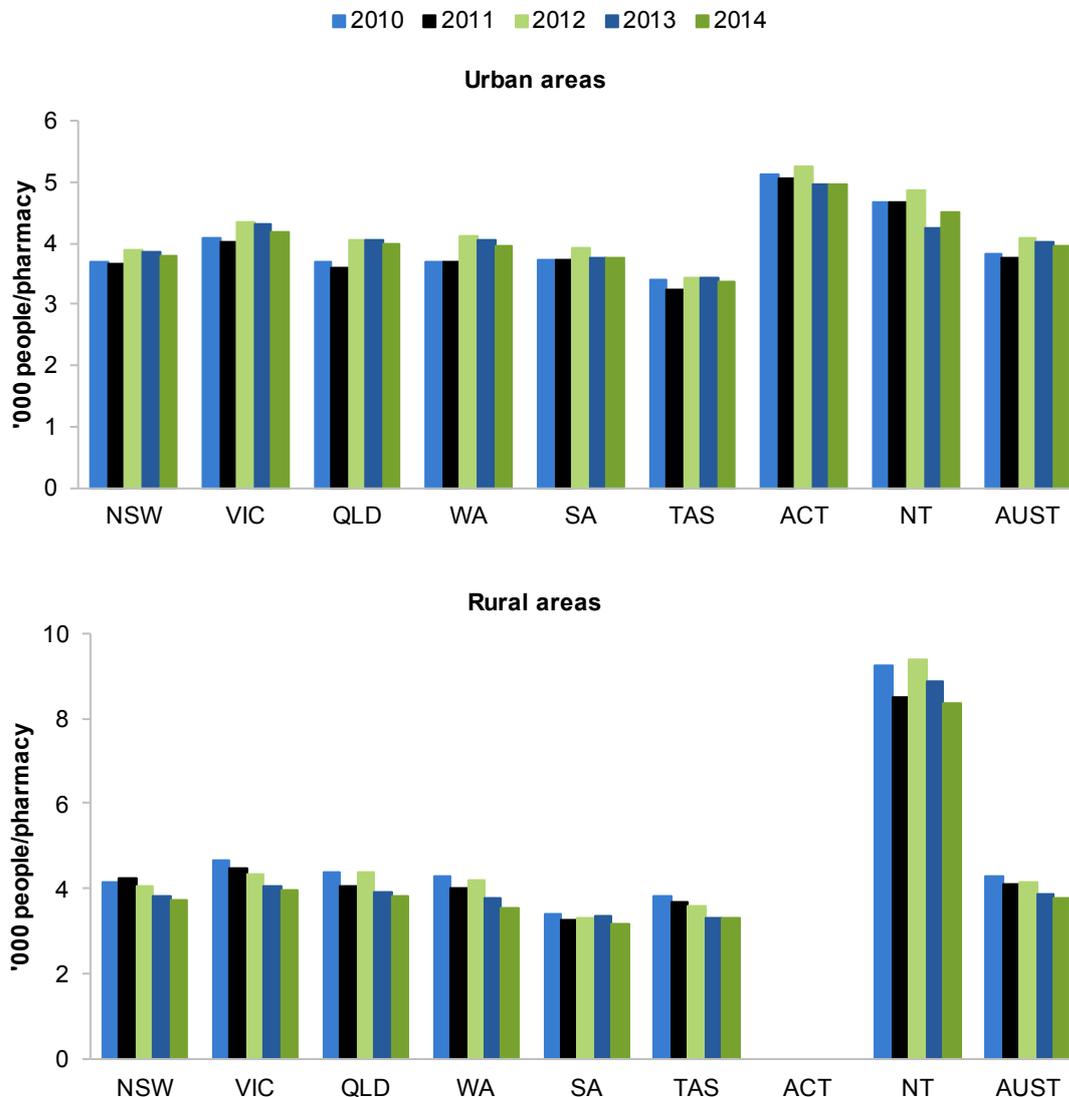
Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, the number of people per pharmacy in rural areas decreased from 4277 to 3771 in the period 2010 to 2014, falling below the number of people per pharmacy in urban areas, which rose from 3814 to 3963 in the same period (figure 10.5).

Medical practitioners and hospitals can also be approved to supply PBS medicines to the community, improving access for people in some locations. There were 24 medical practitioners and 263 hospitals — 104 private and 159 public¹ — approved to supply PBS medicines to the community at 30 June 2014. The approved medical practitioners and 49 of the approved public hospitals were located in rural areas (table 10A.20).

¹ PBS approved private hospitals supply medicines to patients of the hospital (inpatients and outpatients), while public hospitals provide medicines only to patients on discharge.

Figure 10.5 People per pharmacy^{a, b, c, d, e}

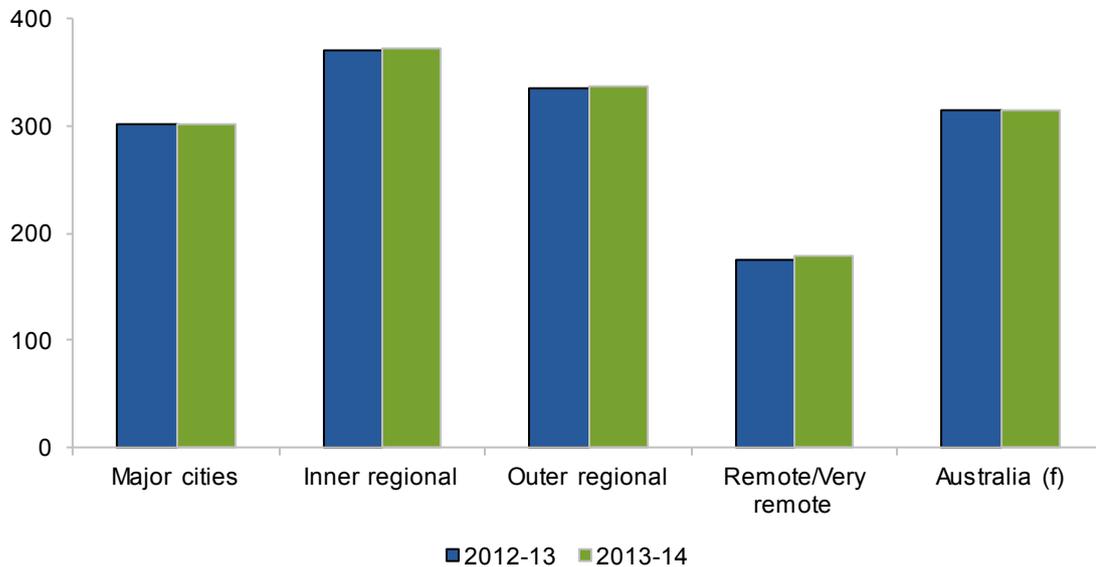


^a Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2–6. The ACT has no rural PhARIA areas. ^b Number of pharmacies as measured at 30 June is used to derive rates. ^c Excludes RPBS and doctor's bag. ^d The ERP used to derive rates in the early and latter parts of this time series are based on different ABS Censuses. Rates derived using ERPs based on different Censuses are not comparable. ^e Care should be taken in using data for the NT, as 43.9 per cent of the population live in remote and very remote areas and data exclude Aboriginal Medical Services that supply medications in these areas under s.100 of the *National Health Act 1953* (Cwlth).

Source: Department of Health (unpublished) derived from DHS Medicare, ABS (unpublished) 2006/2011 Census of Population and Housing and the University of Adelaide's Australian Population and Migration Research Centre; table 10A.20.

Nationally, PBS expenditure per person was around \$315 in 2013-14 (figure 10.6). PBS expenditure per person was highest in inner regional areas and lowest in remote/very remote areas (figure 10.6).

Figure 10.6 **PBS expenditure per person (2013-14 dollars)^{a, b, c, d}**



^a Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See Chapter 2 (sections 2.5-6) for details. ^b Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification. ^c Rates are derived using ABS 2011 Census based ERPs for 30 June and are not comparable with rates in figure 10.1 which are derived using 31 December ERPs. ^d Locality level data are only available on a cash basis for general and concessional categories. Data are not directly comparable to those published in the Department of Health’s annual report which are prepared on an accrual accounting basis and include other categories administered under special arrangements (such as medications dispensed to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing \$38.5 million in 2013-14 [table 10A.6]).

Source: Department of Health (unpublished) PBS Statistics; table 10A.21.

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory in table 10A.11. These data are not available by regional location. Nationally, 89.3 per cent of prescriptions subsidised under the PBS were concessional in 2013-14.

Equity of access to GPs

‘Equity of access to GPs’ is an indicator of governments’ objective to provide equitable access to primary healthcare services (box 10.3).

Box 10.3 **Equity of access to GPs**

'Equity of access to GPs' is defined by two measures:

- availability of GPs by region, defined as the number of FWE GPs per 100 000 people, by region
- availability of GPs by sex, defined as the number of FWE GPs per 100 000 population, by sex.

High or increasing availability of GPs can indicate improved access to GP services. Low availability of GPs by region can be associated with an increase in distance travelled and waiting times to see a GP, and increased difficulty in booking long consultations. Reduced competition for patients can also reduce bulk billing rates. State and Territory governments seek to influence the availability of GPs through incentives to recruit and retain GPs in rural and remote areas.

High or increasing availability of GPs of each sex means it is more likely that patients who prefer to visit GPs of their own sex for discussion of health matters and to receive primary care will have their preference met. Low availability of GPs of each sex can be associated with increased waiting times to see a GP, for patients who prefer to visit GPs of their own sex.

This indicator does not provide information on whether people are accessing GP services or whether the services are appropriate for the needs of the people receiving them.

Data reported for this indicator are:

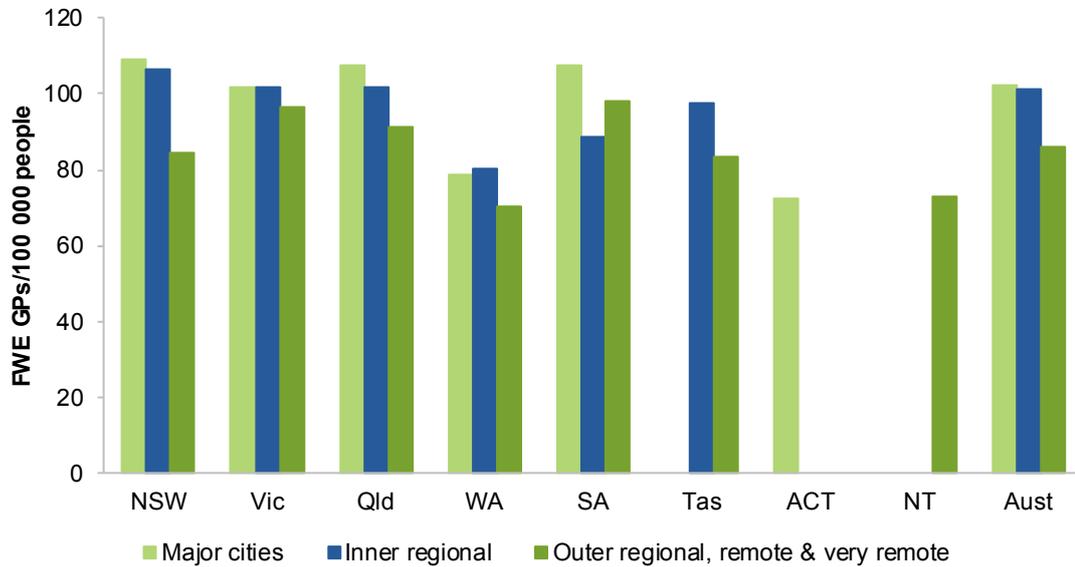
- comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012-13 are not comparable to data for previous years for the measure availability of GPs by region
- comparable (subject to caveats) across jurisdictions and over time for the measure availability of GPs by sex
- 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/rogs/2015.

Availability of GPs by region

In terms of FWE GPs per 100 000 people, there were more GPs available in major cities and inner regional areas than in outer regional, remote and very remote areas in most jurisdictions in 2013-14 (figure 10.7). The bulk billed proportion of non-referred attendances was higher in very remote areas than in major cities, where the proportion was in turn higher than in inner regional, outer regional and remote areas (table 10A.34).

Figure 10.7 **Availability of GPs (full time workload equivalent), 2013-14^{a, b, c}**



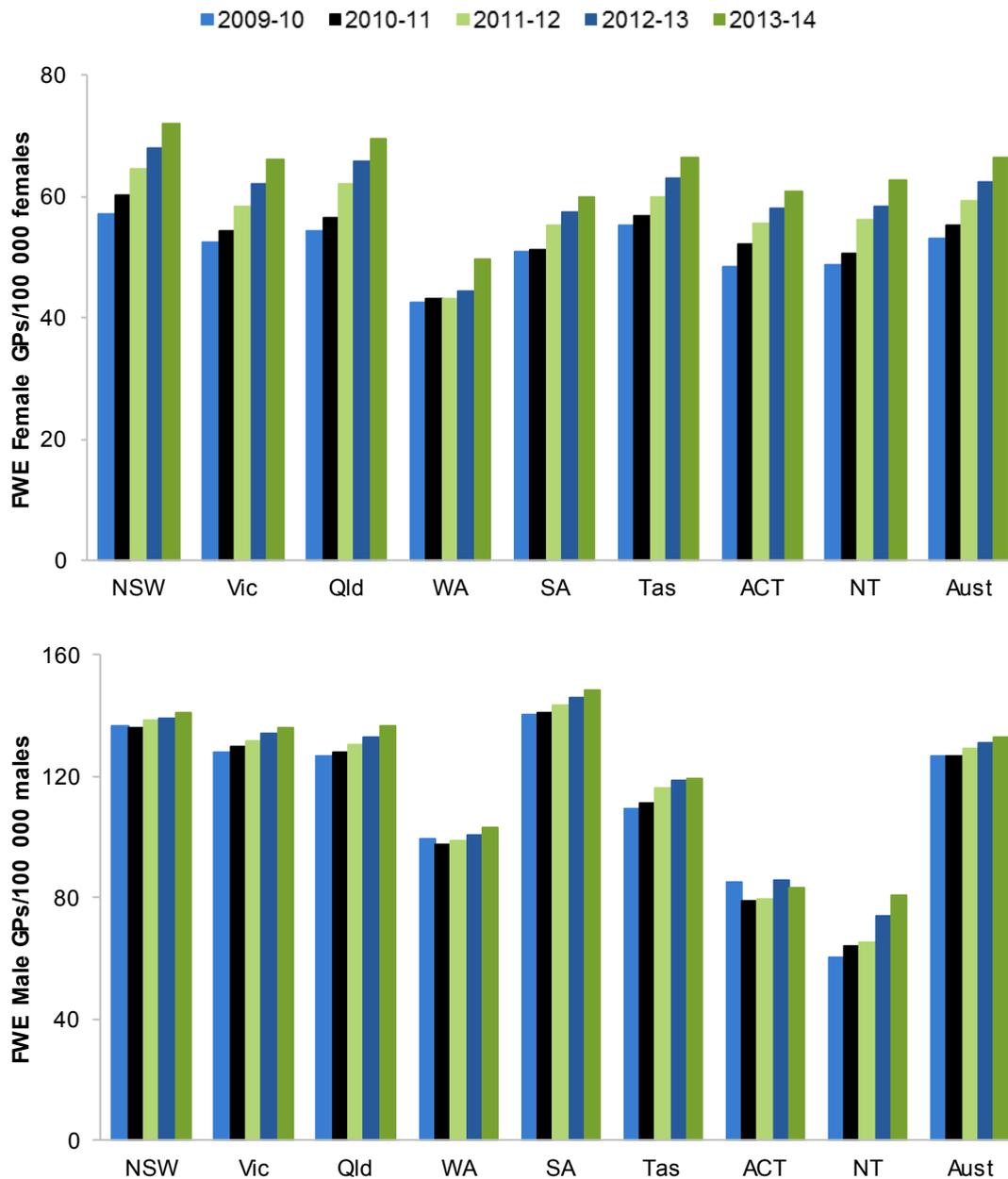
^a Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification. ^b FWE GP numbers include vocationally registered GPs and OMPs billing DHS Medicare, who are allocated to a jurisdiction based on the postcode of their major practice. ^c There are no major cities in Tasmania; no outer regional or remote areas in the ACT; no major cities or inner regional areas in the NT. For the ACT, major cities includes inner regional areas.

Source: Department of Health (unpublished) MBS Statistics; table 10A.23.

Availability of GPs by sex

In 2013-14, 43.2 per cent of Australia's GPs — 33.5 per cent of FWE GPs — were female (table 10A.25). The number of FWE female GPs per 100 000 females increased from 53.2 to 66.3 in the period 2009-10 to 2013-14 (figure 10.8). In the same period, the number of FWE male GPs per 100 000 males increased from 126.3 to 132.9 (figure 10.8, table 10A.26). Data for female GPs are presented for a ten year time series in table 10A.25.

Figure 10.8 Availability of GPs by sex (full time workload equivalent)^a



^a Data relate to vocationally registered GPs and OMPs billing DHS Medicare, who are allocated to a jurisdiction based on the postcode of their major practice.

Source: Department of Health (unpublished) MBS Statistics; tables 10A.25, 10A.26.

Availability of public dentists

‘Availability of public dentists’ is an indicator of governments’ objective to provide equitable access to dental services (box 10.4).

Box 10.4 Availability of public dentists

'Availability of public dentists' is defined as the number of full time equivalent (FTE) public dentists per 100 000 people by region.

High or increasing availability of public dentists can indicate improved access to public dental services. The availability of public dentists by region affects people's access to public dental services, particularly in rural and remote areas. Low availability can result in increased travel distance to a dentist and increased waiting times to see a dentist.

This indicator does not provide information on whether people are accessing the service or whether the services are appropriate for the needs of the people receiving them.

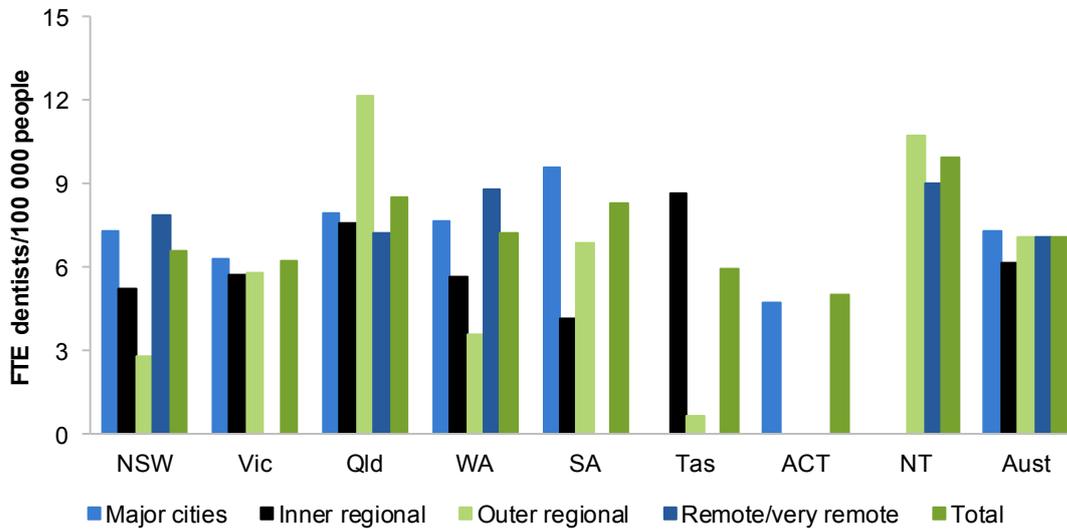
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- not available for the current reporting period (2013).

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Nationally, there were 7.3 FTE public dentists per 100 000 people in major cities — more than in regional and remote/very remote areas — in 2013 (figure 10.9, table 10A.27). Nationally, the number of FTE public dental therapists per 100 000 people was highest in outer regional areas (5.8), followed by remote/very remote (4.7) and inner regional (4.6) and lowest in major cities (3.1) in 2013 (table 10A.28). Data for FTE dental hygienists and dental therapists are presented in table 10A.28.

Figure 10.9 Availability of public dentists, 2013^{a, b, c, d}



^a FTE based on 40 hours per week. ^b Public dentists include those working in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and 'other public' areas. ^c There were no public dentists in remote or very remote areas in Victoria or Tasmania. Data for inner regional areas in the ACT are suppressed for confidentiality purposes. ^d Tasmania has no major cities. The ACT has no outer regional, remote or very remote areas. The NT has no major cities or inner regional areas.

Source: AIHW (unpublished) National Health Workforce Data Set; table 10A.27.

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 10.5).

Box 10.5 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).

(Continued next page)

Box 10.5 (Continued)

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).

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:

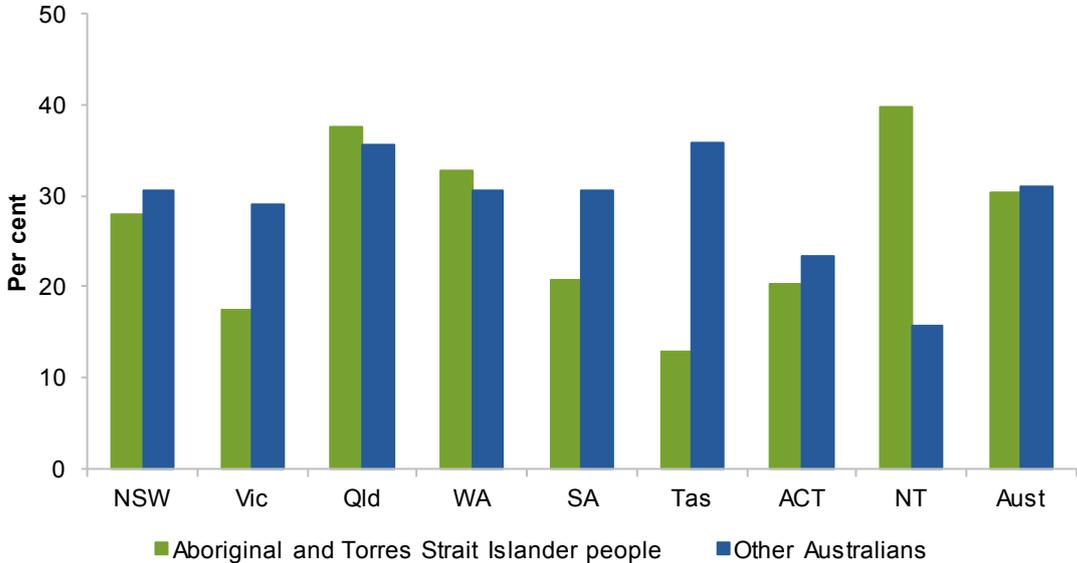
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions for 2013-14.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

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 10.10). There was considerable variation across States and Territories in the relative proportion of older people receiving a health assessment for these populations.

Figure 10.10 Older people who received an annual health assessment by Indigenous status, 2013-14^{a, b, c, d}

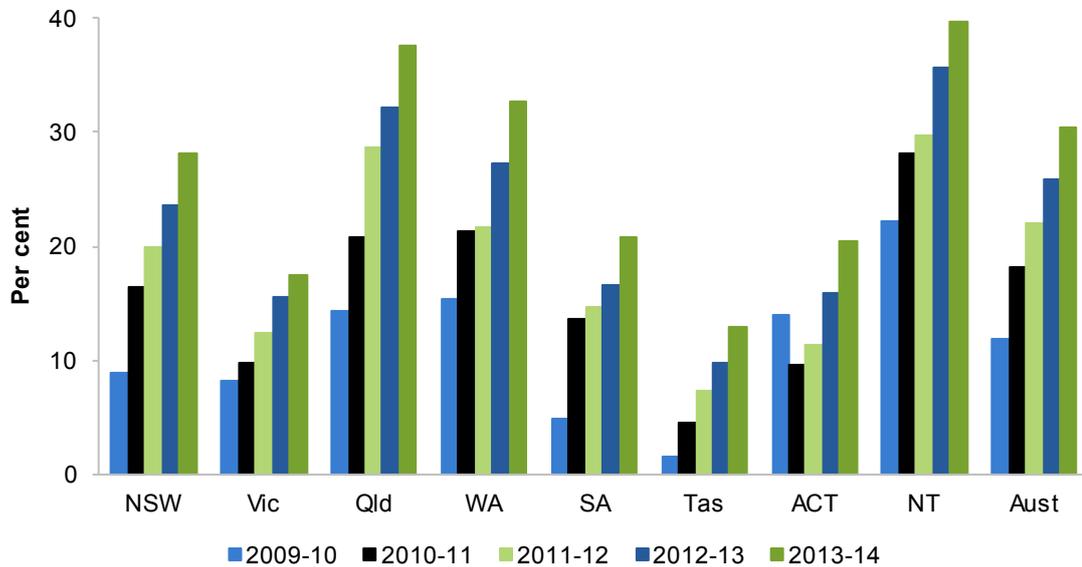


^a Older people are defined as Aboriginal and Torres Strait Islander Australians aged 55 years or over and other Australians aged 75 years or over. ^b The population of Aboriginal and Torres Strait Islander people is determined by self-identification. Aboriginal and Torres Strait Islander Australians 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.2 and 2A.13-14) 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.

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 10.11).

Figure 10.11 Older Aboriginal and Torres Strait Islander Australians who received an annual health assessment^{a, b, c}



^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 (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.

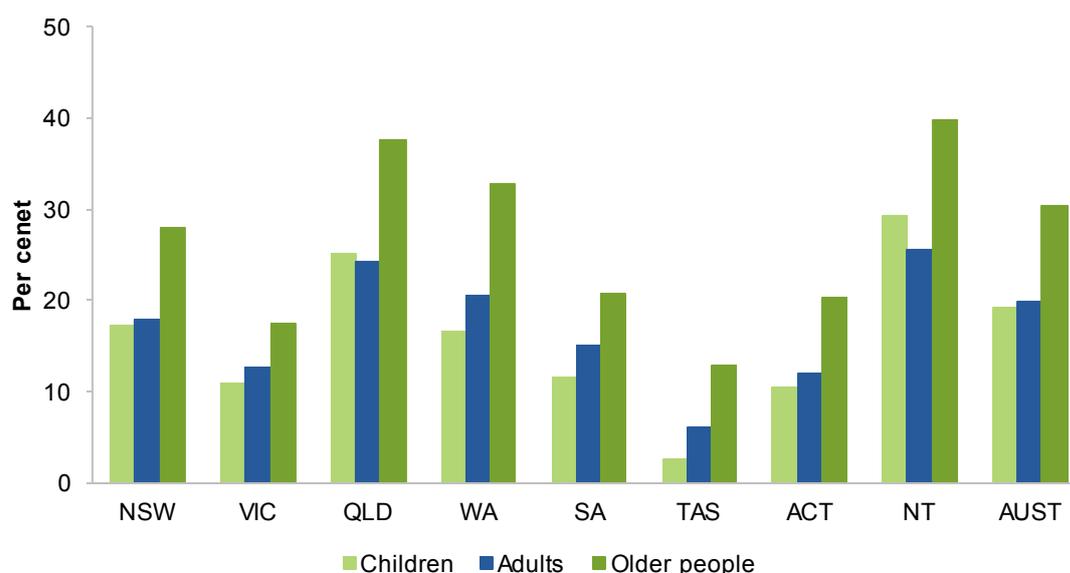
Health check MBS items were introduced for Aboriginal and Torres Strait Islander people aged 15–54 years in May 2004. Initially available biennially, since 1 May 2010 they have been available annually. Also available annually are health checks for Aboriginal and Torres Strait Islander children aged 0–14 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 10.12). 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 10.12 **Aboriginal and Torres Strait Islander Australians who received a health assessment by age, 2013-14^{a, b, c}**



^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 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 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 (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.

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 10.6).

Box 10.6 **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.

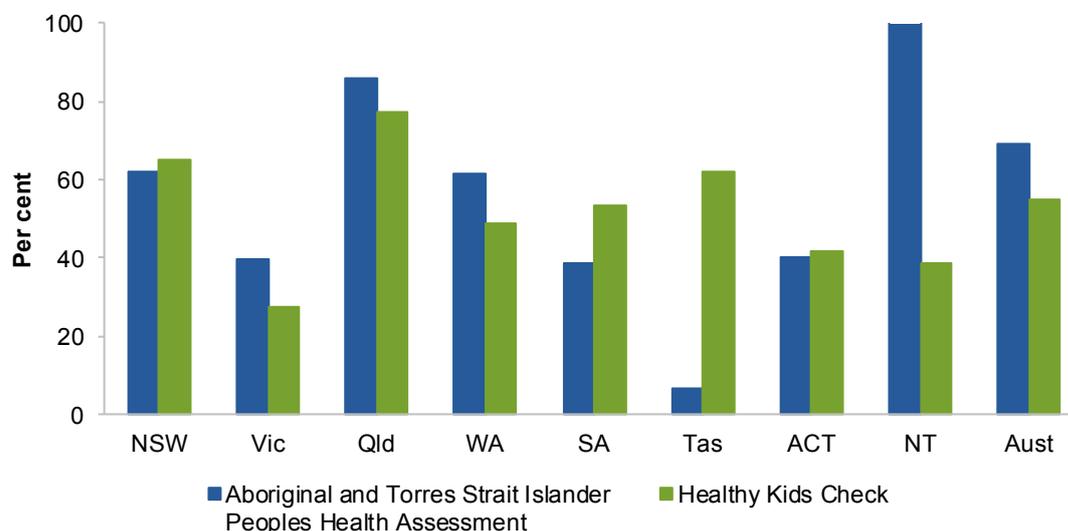
Data reported for this indicator are:

- 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/rogs/2015.

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 10.13).

Figure 10.13 **Children who received a fourth year developmental health check, by health check type, 2013-14^{a, b, c, d, e, f, g}**



^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 a 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 (tables 2A.2 and 2A.14) 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.

Effectiveness

Access

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

Box 10.7 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 10.7 (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.

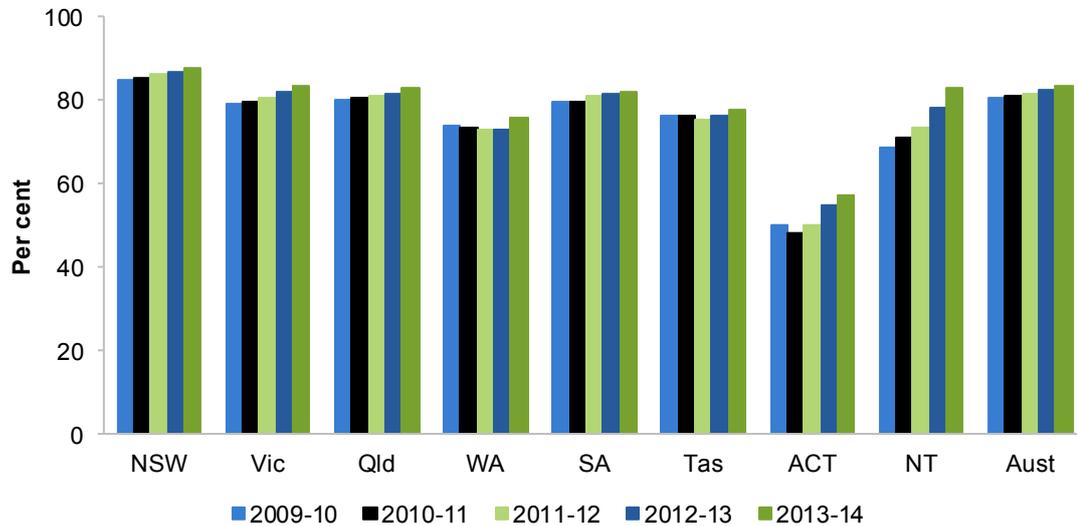
Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Effectiveness of access to GPs — bulk billing rates

Patient visits to GPs are either bulk billed, or the patient is required to pay part of the cost of the visit. GP visits are classed as non-referred attendances under DHS Medicare. Where a patient is bulk billed they make no out-of-pocket contribution; the GP bills DHS Medicare directly and, since 1 January 2005, receives 100 per cent of the Schedule fee (the patient rebate) as full payment for the service. The 100 per cent DHS Medicare rebate applies to most GP services.

Nationally, the bulk billed proportion of non-referred attendances, including those by practice nurses, was 83.6 per cent in 2013-14. For most jurisdictions, this proportion increased in the period 2009-10 to 2013-14 (figure 10.14). The bulk billed proportion of non-referred attendances was highest in very remote areas and lowest in inner regional, outer regional and remote areas (table 10A.34). The bulk billed proportion of non-referred attendances was higher for children under 16 years and older people than for people aged 16 to 64 years (table 10A.36).

Figure 10.14 GP visits that were bulk billed^{a, b}



^a Includes attendances by practice nurses. ^b Allocation to State/Territory based on patients' DHS Medicare enrolment postcode.

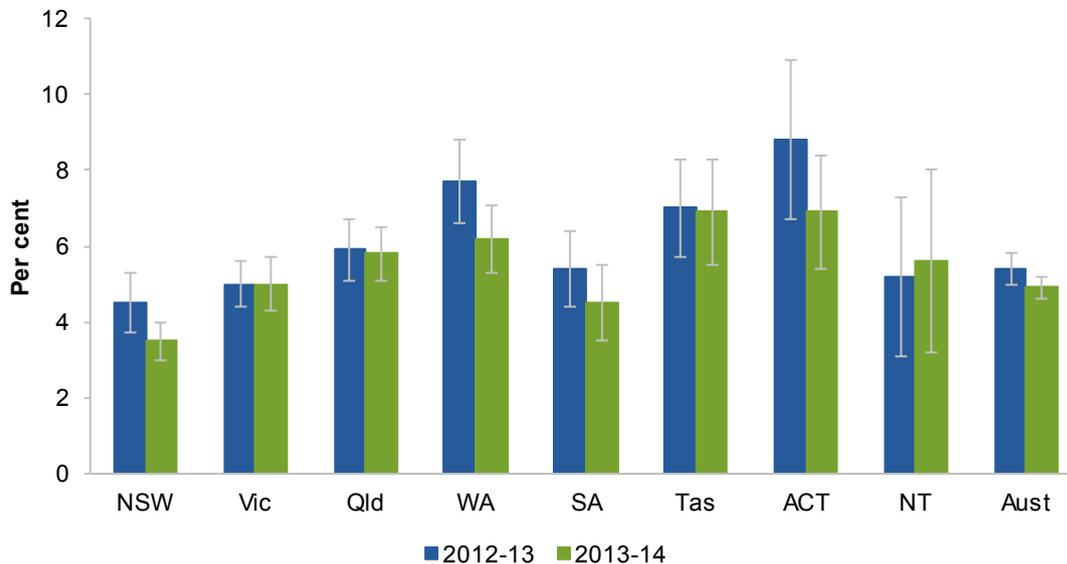
Source: Department of Health (unpublished) MBS Statistics; table 10A.36.

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

Timely access to healthcare services is important to people's health and wellbeing. Deferring or not visiting a GP can result in poorer health. Nationally, in 2013-14, 4.9 per cent of ABS Patient experience survey respondents reported that they delayed or did not visit a GP in the previous 12 months because of cost (figure 10.15).

Data for Aboriginal and Torres Strait Islander Australians deferring access to GPs due to cost, collected for the first time from the ABS 2011-12 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.

Figure 10.15 People deferring visits to GPs due to cost^{a, b, c, d, e, f}



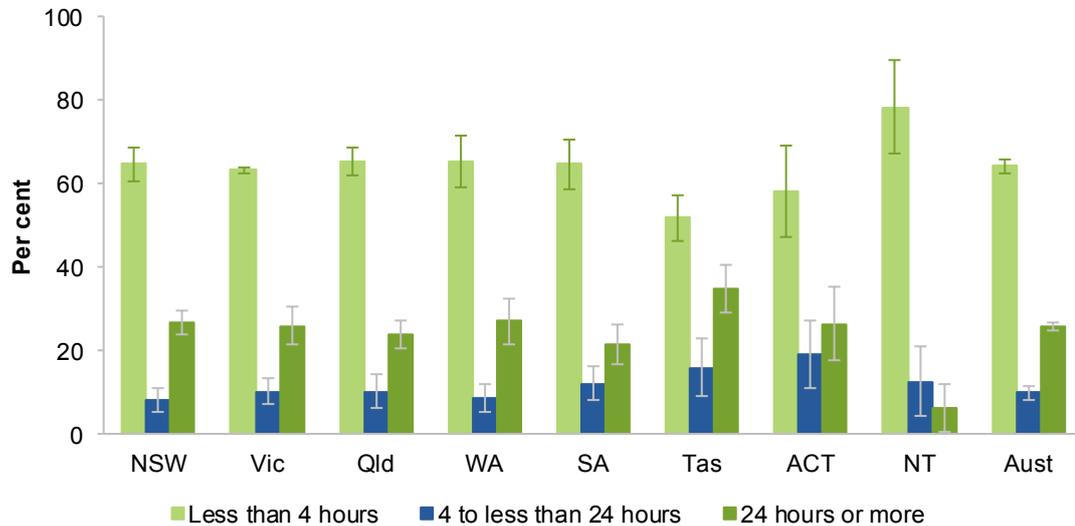
^a People aged 15 years or over. ^b Delayed visiting or did not visit a GP at any time in the previous 12 months due to cost. ^c Data are crude rates and may differ from data in previous reports in which rates were age-standardised. ^d Data for 2012-13 and 2013-14 are comparable. Data are not comparable with previous years due to a change in survey question wording and sequencing. ^e Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. ^f Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0; table 10A.37.

Effectiveness of access to GPs — GP waiting times

Nationally, 64.2 per cent of people who saw a GP for urgent care waited less than 4 hours in 2013-14 (figure 10.16). Around 10.0 per cent waited from 4 to less than 24 hours, and 25.8 per cent waited for 24 hours or more. Overall, 22.6 per cent of people who saw a GP for any reason waited longer than they felt was acceptable to get an appointment (table 10A.40).

Figure 10.16 Hours waited for urgent treatment by a GP, 2013-14^{a, b, c, d, e, f}



^a People aged 15 years or over who saw a GP for urgent medical care for their own health in the previous 12 months. ^b Time waited between making an appointment and seeing the GP for urgent medical care. ^c Data are comparable with data from 2011-12 but not with data for previous years due to a changed survey question. ^d Data are crude rates. ^e Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. ^f Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2013-14*, Cat. no. 4839.0; table 10A.39.

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

GP-type presentations to emergency departments are presentations for conditions that could be appropriately managed in the primary and community health sector (Van Konkelenberg, Esterman and Van Konkelenberg 2003). It is important to note that these include appropriate presentations to emergency departments that can only be retrospectively categorised as ‘GP-type’. Factors contributing to GP-type presentations at emergency departments where this is not the case include perceived or actual lack of access to GP services, the proximity of emergency departments and trust in emergency department staff.

Nationally, there were around 2.2 million GP-type presentations to public hospital emergency departments in 2013-14 (table 10.6).

Table 10.6 GP-type presentations to emergency departments, ('000)^{a, b, c, d}

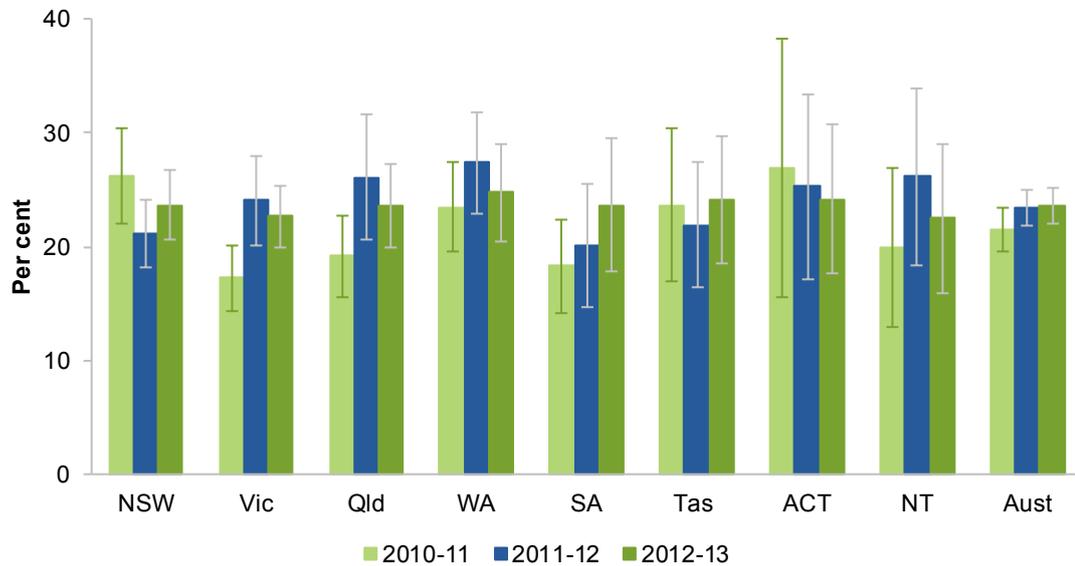
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2013-14	709.3	572.4	381.4	272.9	113.4	61.2	50.5	39.3	2 200.4

^a GP-type emergency department presentations are defined as presentations for which the type of visit was reported as emergency presentation, which did not arrive by ambulance or by police or other correctional vehicle, with a triage category of semi-urgent or non-urgent, and where the episode end status was not admitted to the hospital, or referred to another hospital, or died. ^b This is an interim measure, pending development of new methodology to more closely approximate the population that could receive services in the primary care sector. Data include appropriate presentations to emergency departments, where the categorisation 'GP-type' can only be applied retrospectively. ^c Data are presented by State/Territory of usual residence of the patient. ^d Data are for peer group A and B public hospitals only, based on 2012-13 peer groups.

Source: AIHW (unpublished) National non-admitted emergency patient database; table 10A.41.

Nationally, 23.6 per cent of people who went to a hospital emergency department for their own health in 2012-13 thought at the time that care could have been provided at a general practice (figure 10.17).

Figure 10.17 **People visiting a hospital emergency department for care they thought could have been provided at a general practice^{a, b, c, d}**



^a Proportion of people aged 15 years or over who went to a hospital emergency department for their own health and at the time, thought the care could have been provided at a general practice. ^b Rates are age-standardised to the 2001 ERP. ^c Data for 2010-11 for the NT should be used with care as the survey excluded very remote areas where around 23 per cent of the NT population usually reside. ^d Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.

Source: ABS unpublished, *Patient Experience Survey 2010-11, 2011-12, 2012-13*, Cat. no. 4839.0; table 10A.42.

Financial barriers to PBS medicines

‘Financial barriers to PBS medicines’ is an indicator of governments’ objective to ensure effective access to prescribed medicines (box 10.8).

Box 10.8 **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.

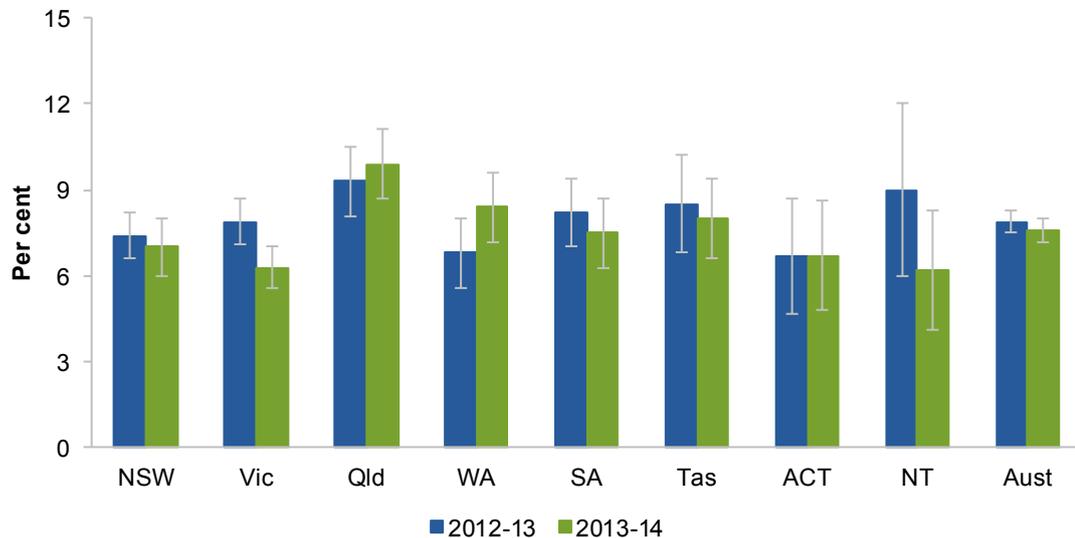
Data reported for this indicator are:

- 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/rogs/2015.

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 (figure 10.18). Data for Aboriginal and Torres Strait Islander Australians were collected for the first time from the ABS 2011-12 AATSIHS and are presented in table 10A.45. However, differences in survey design and methodology mean data from the Patient experience survey and the AATSIHS are not comparable.

Figure 10.18 **People deferring purchase of prescribed medicines due to cost^{a, b, c, d}**



^a People 15 years or over who, in the last 12 months, were prescribed medication and delayed getting or did not get the medication due to cost. ^b Data are comparable over time from the 2010-11 reference year. Data are crude rates and may differ from data in previous reports which were age-standardised. ^c Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. ^d Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey, 2012-13, 2013-14*, Cat. no. 4839.0; table 10A.43.

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 10.9).

Box 10.9 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.

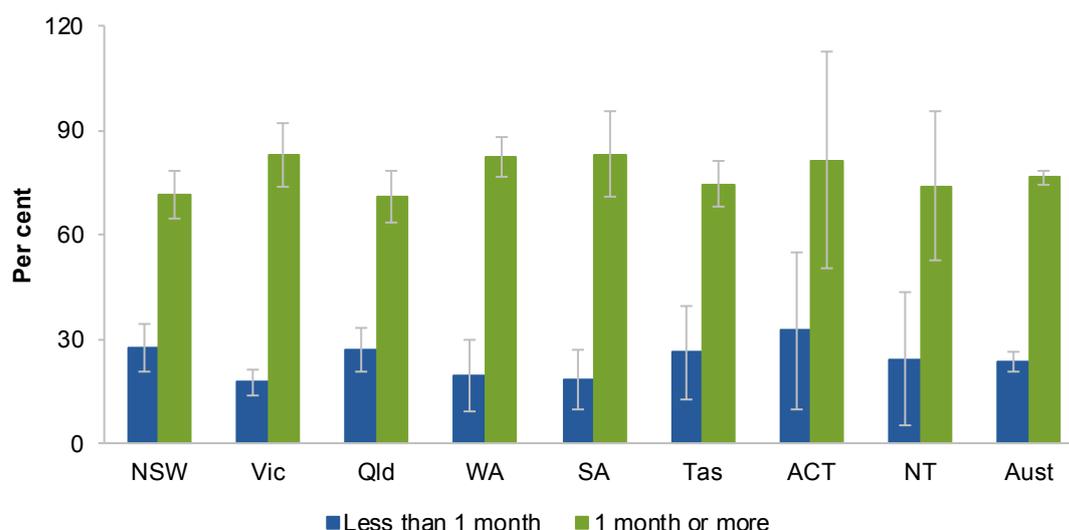
Data reported for this indicator are:

- 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/rogs/2015.

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 (figure 10.19). Data are presented by remoteness in 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 (see DQI for details).

Figure 10.19 Time waited for public dentistry services, 2013-14^{a, b, c, d, e}



^a Time waited for a public dental service, for people 15 years or over who were on a public dental waiting list in the last 12 months. ^b Data are not comparable with data for previous years. See DQI for further information. ^c Data are crude rates. ^d Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. ^e Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2013-14*; table 10A.45.

Appropriateness

GPs with vocational registration

‘GPs with vocational registration’ is an indicator of governments’ objective to ensure the GP workforce has the capability to deliver high quality services (box 10.10).

Box 10.10 **GPs with vocational registration**

'GPs with vocational registration' is defined as the proportion of FWE GPs with vocational registration. Vocationally registered GPs are considered to have the values, skills and knowledge necessary for competent unsupervised general practice within Australia (RACGP 2014b).

A high or increasing proportion of FWE GPs with vocational registration can indicate an improvement in the capability of the GP workforce to deliver high quality services. GPs without vocational registration may deliver services of equally high quality, however, their access to DHS Medicare rebates for the general practice services they provide is limited compared to vocationally registered GPs.

Data reported for this indicator are:

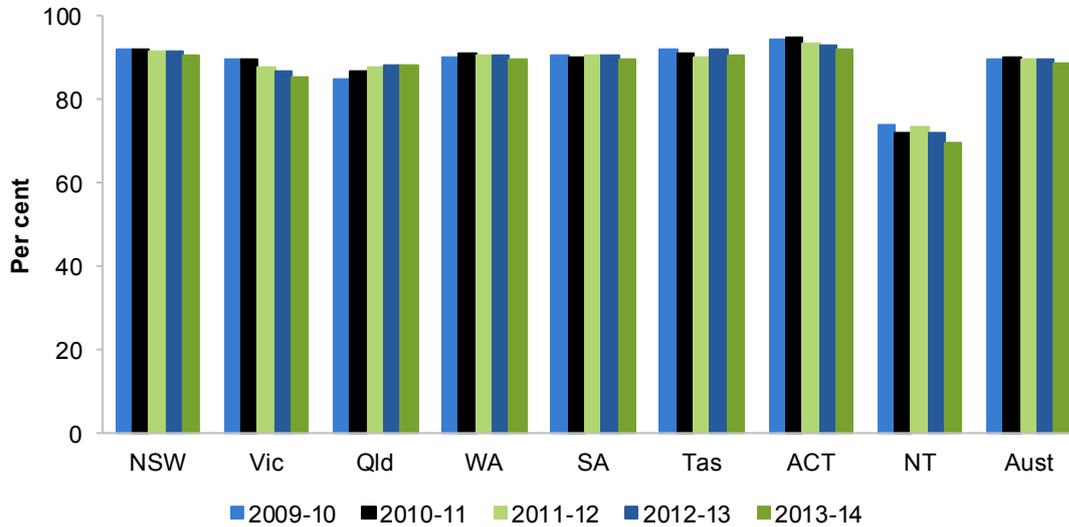
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Data quality information for this indicator is under development.

Since 1996, a GP can only achieve vocational registration by attaining Fellowship of the RACGP or (from April 2007) the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. GPs can attain Fellowship through the successful completion of a formal general practice training program or through the 'practice eligible' route. Once vocational registration is achieved, GPs must meet mandated registration standards which include Continuing Professional Development in order to maintain registration.

Nationally, the proportion of FWE GPs with vocational registration decreased slightly, from 89.7 to 88.5 per cent, in the period 2009-10 to 2013-14 (figure 10.20). The proportion of FWE GPs with vocational registration was highest in major cities and lowest in remote areas in 2013-14 (table 10A.48).

Figure 10.20 **GPs (full time workload equivalent) with vocational registration^a**



^a FWE GP numbers include vocationally registered GPs and OMPs billing DHS Medicare, who are allocated to a jurisdiction based on the postcode of their major practice.

Source: Department of Health (unpublished) MBS Statistics; table 10A.50.

General practices with accreditation

‘General practices with accreditation’ is an indicator of governments’ objective to ensure the general practitioner workforce has the capability to provide high quality services (box 10.11).

Box 10.11 **General practices with accreditation**

‘General practices with accreditation’ is defined as the number of general practices that are accredited as a proportion of all general practices in Australia. Accreditation of general practice is a voluntary process of independent third-party peer review that involves the assessment of general practices against a set of standards developed by the RACGP. Accredited practices, therefore, have been assessed as complying with a set of national standards.

(Continued next page)

Box 10.11 (Continued)

A high or increasing proportion of practices with accreditation can indicate an improvement in the capability of general practice to deliver high quality services. However, general practices without accreditation may deliver services of equally high quality. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards. Accreditation affects eligibility for some government programs (such as PIP), so there are financial incentives for gaining accreditation.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- not available for the current reporting period.

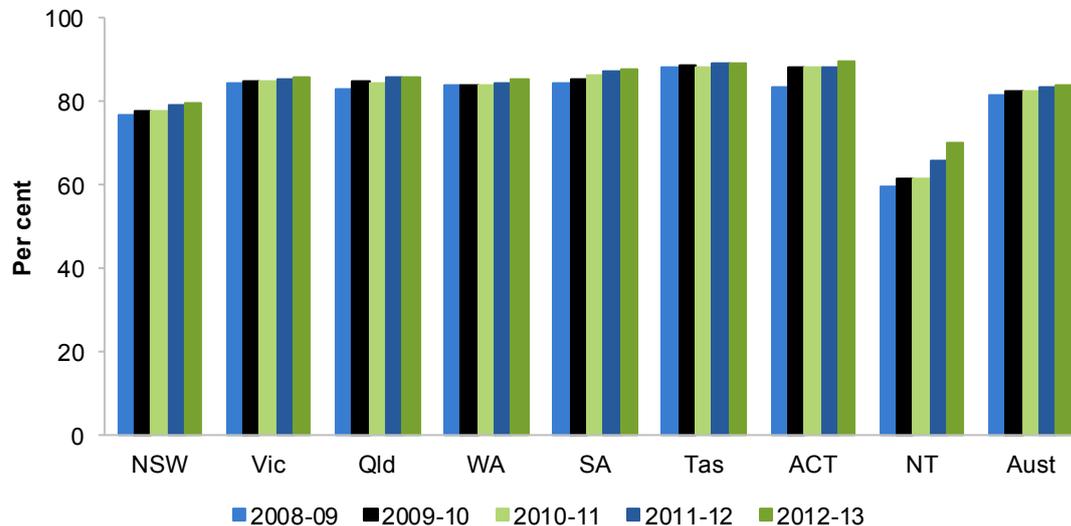
Data quality information for this indicator is under development.

The two providers of general practice accreditation services are Australian General Practice Accreditation Limited (AGPAL) and Quality Practice Accreditation Pty Ltd.

Data are not available for the 2015 Report because no current source of data can be identified for the number of general practices. Data for 2011 and previous years were sourced from the annual survey of Divisions of General Practice, which ceased on transition from Divisions of General Practice to Medicare Locals. Historical data are reported in table 10A.51.

The proportion of patients attending accredited practices provides useful additional information relating to accreditation. For this measure, PIP practices provide a proxy for accredited practices, as accreditation is a requirement for PIP registration. Nationally, the proportion of general practice patient care — measured as standardised whole patient equivalents (SWPEs) — provided by PIP practices has increased slightly in the period from 2008-09 to 2012-13 (figure 10.21).

Figure 10.21 **Proportion of general practice patient care provided by PIP practices^a**



^a Patients are measured as SWPEs. A SWPE is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.

Source: Department of Health (unpublished) PIP and MBS data collections; table 10A.52.

Management of acute upper respiratory tract infection

‘Management of acute upper respiratory tract infection’ is an indicator of governments’ objective to ensure that antibiotics are used appropriately and effectively (box 10.12).

Box 10.12 Management of upper respiratory tract infection

'Management of acute upper respiratory tract infection' (URTI) is defined by two measures:

- filled GP prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) per 1000 people
- proportion of visits to GPs for acute URTI where systemic antibiotics are prescribed.

Low or decreasing rates of prescription of the selected antibiotics and acute URTI GP visits where systemic antibiotics are prescribed can indicate that GPs' management of acute URTI more closely follows guidelines.

URTI without complication (acute URTI or the 'common cold') is most often caused by a virus. Antibiotics have no efficacy in the treatment of viral infections, but are nevertheless often prescribed for their treatment. Unnecessarily high rates of antibiotic prescription have the potential to increase both pharmaceutical costs and antibiotic resistance in the community (Tamma and Cosgrove 2014).

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 for the measure filled GP prescriptions for selected antibiotics
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Data quality information for the measure filled GP prescriptions for selected antibiotics is at www.pc.gov.au/rogs/2015. Data quality information for the measure acute URTI GP visits where systemic antibiotics are prescribed is under development.

Rate of prescription of selected antibiotics

Caution should be used in interpreting the rate of prescription of the selected antibiotics as the oral antibiotics most commonly prescribed to treat acute URTI are also prescribed for other illnesses. Information about the condition for which the antibiotics are prescribed is not available.

Nationally, the prescription rate for the oral antibiotics most commonly used to treat acute URTI was 295 per 1000 people in 2013-14 (figure 10.22; table 10A.53).

Figure 10.22 **Rate of prescription of oral antibiotics used most commonly to treat acute upper respiratory tract infection^{a, b, c}**



^a Prescriptions ordered by vocationally registered GPs and other medical practitioners (OMPs) and dispensed. ^b Data are not limited to prescriptions for treatment of upper respiratory tract infection. ^c Data from 2012-13 are for all people and are not comparable with data for previous years that were limited to prescriptions provided to holders of concession cards, and are reported in table 10A.54.

Source: Department of Health unpublished, PBS Statistics; table 10A.53.

Proportion of GP visits for acute URTI where systemic antibiotics are prescribed

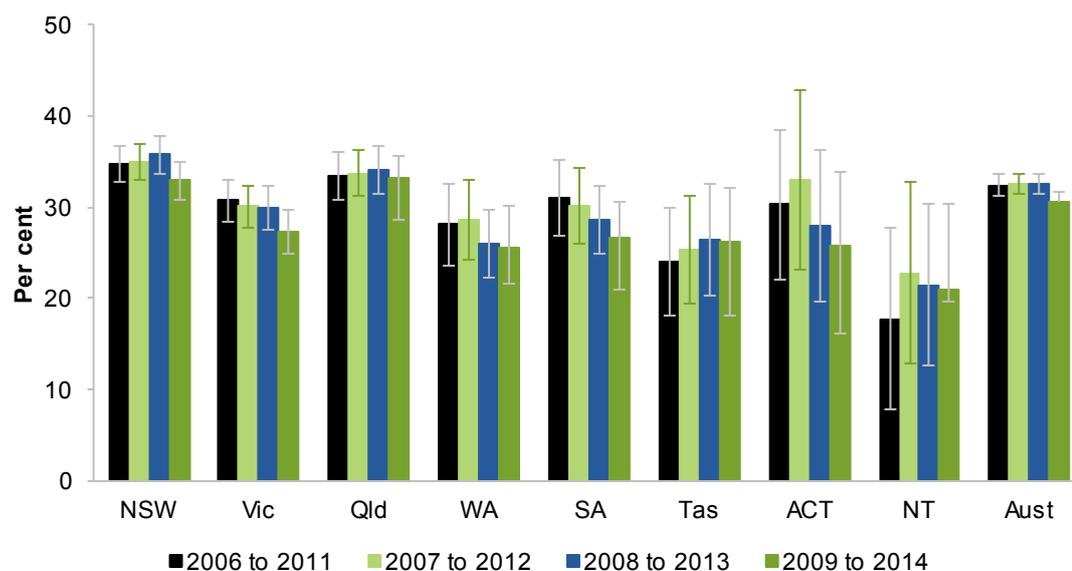
Data for the proportion of GP visits for acute URTI where systemic antibiotics are prescribed are available at State/Territory level, from the annual BEACH survey of general practice activity in Australia.

The BEACH survey collects information on the reason for the GP visit as well as the treatment prescribed or provided. This allows derivation of the proportion of visits to GPs for acute URTI for which systemic antibiotics were prescribed or supplied. Each year, the national BEACH sample comprises around 1000 GPs, each providing data for around 100 patient visits. Aggregation of data for a period of 5 years allows publication of data for all States and Territories (figure 10.23). This has some limitations — short-term change will be reflected only if substantive when averaged over a 5 year period, and proximate causes of change will not be directly identifiable. These limitations are to a degree mitigated by the reporting of data for each year in the reference period at the national level. This will assist in interpreting whether change reflected over rolling 5 year periods is due to substantive short-term change or to incremental change over several years.

The proportion of people presenting to GPs for acute URTI who were prescribed systemic antibiotics for its treatment decreased at the national level, from 32.4 per cent for

the 5 years April 2006 to March 2011 to 30.5 per cent for the 5 years April 2009 to March 2014, reflecting an overall decreasing trend in most states and territories for the same period (figure 10.23).

Figure 10.23 Proportion of acute URTI managements where systemic antibiotics were prescribed^{a, b}

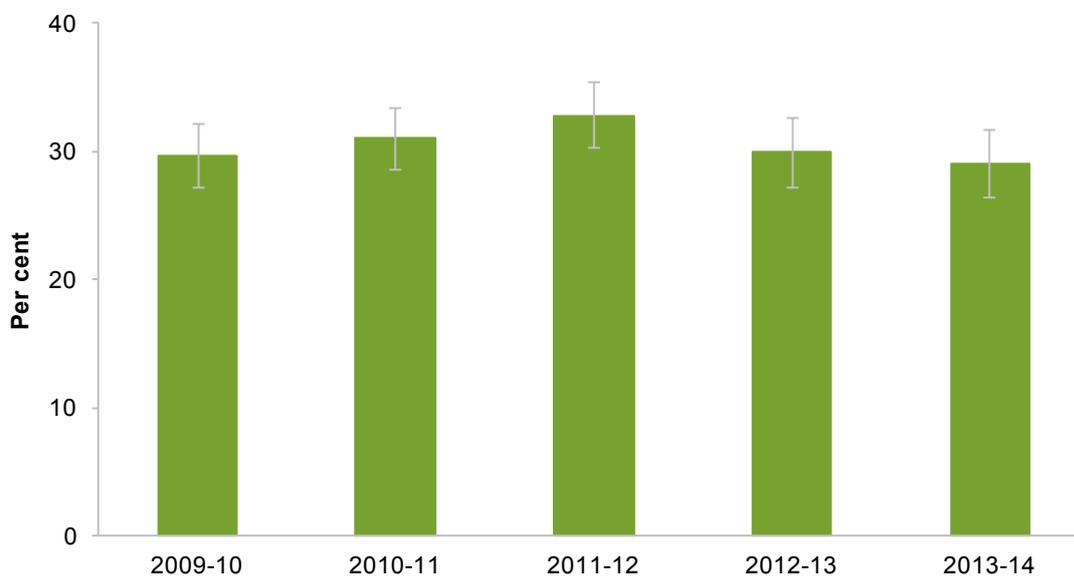


^a Error bars represent the 95 per cent confidence interval associated with each point estimate. ^b Participation in the survey is voluntary. Data are not necessarily representative of the prescribing behaviour of non-participating GPs.

Source: Britt et al. (unpublished) BEACH Statistics; table 10A.55.

Nationally, the proportion of acute URTI presentations for which systemic antibiotics were prescribed by GPs, in each 12 month period from April to the following March increased from 29.6 per cent in 2009-10 to 32.8 per cent in 2011-12, decreasing to 29.0 in 2013-14 (figure 10.24).

Figure 10.24 **Proportion of acute URTI managements where systemic antibiotics were prescribed, Australia^{a, b}**



^a Error bars represent the 95 per cent confidence interval associated with each point estimate. ^b Participation in the survey is voluntary. Data are not necessarily representative of the prescribing behaviour of non-participating GPs.

Source: Britt et al. (unpublished) BEACH Statistics; table 10A.56.

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 10.13).

Box 10.13 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).

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.

(Continued next page)

Box 10.13 (Continued)

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/rogs/2015 for the measures management of diabetes — HbA1c and management of asthma. DQI is under development for for the measures management of diabetes — PIP diabetes incentive and care planning/case conferencing.

Reporting against this indicator has improved as the measure management of diabetes — PIP diabetes incentive is reported for the first time. Updated data for asthma management by Indigenous status are also reported.

Chronic diseases are generally long term and often progressive conditions, for example, diabetes and asthma. Chronic disease is estimated to be responsible for more than 80 per cent of the burden of disease and injury suffered by Australians (Australian Government 2010).

Appropriate and effective management in the primary and community health sector can delay the progression of many chronic diseases as well as prevent or minimise the severity of complications (AIHW 2008b, NHPAC 2006). Effective management requires the provision of timely, high quality healthcare to meet individual needs and provide continuity of care (Australian Government 2010). Effective management can have profound effects on individuals and on the broader health system. Individuals benefit from improved health and wellbeing, and the capacity for greater economic and social participation. Reduced demand for treatment in the acute health sector can reduce the burden on the broader health system.

Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Chronic disease management — diabetes

Diabetes mellitus, a chronic disease of increasing prevalence, is an identified National Health Priority Area for Australia. People with diabetes ('diabetes' refers to diabetes mellitus; this Report does not consider diabetes insipidus) 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.

Appropriate management in the primary and community health sector can prevent or minimise the severity of diabetes complications (AIHW 2008b). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

The PIP Diabetes incentive provides incentives to eligible practices to improve management of patients with diabetes. In order to register for the PIP Diabetes incentive, general practices are required to maintain an active patient register and recall and reminder system for all known patients with diabetes mellitus, and to agree to implement an annual cycle of care for patients with diabetes mellitus. The annual cycle of care is generally based on the RACGP's clinical guidelines for the management of Type 2 diabetes in general practice, which represent the minimum required level of care.

Nationally, 47.3 per cent of PIP practices were registered for the PIP diabetes incentive although there was considerable variation across States and Territories, in 2013-14 (figure 10.25).

Figure 10.25 PIP practices registered for the PIP diabetes incentive, 2013-14^a



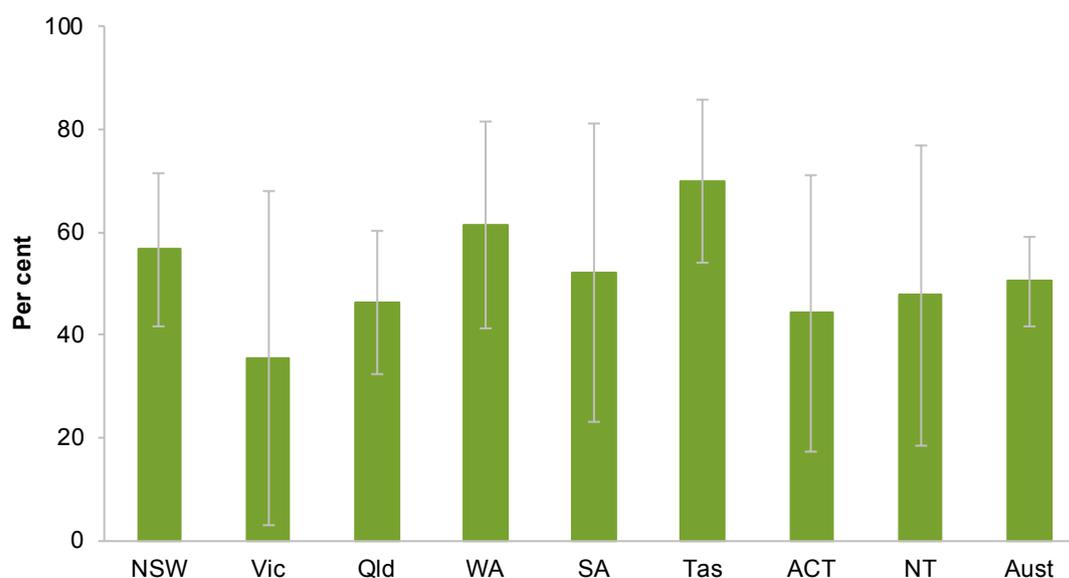
^a Not all practices are enrolled in the PIP, and the enrolled proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.52).

Source: Department of Health (unpublished) MBS and PIP data collections; table 10A.57.

HbA1c (glycosolated haemoglobin) provides a measure of the average blood glucose level for the preceding three months. RACGP guidelines for management of diabetes indicate that HbA1c levels should be tested at least every 6 months. Nationally, 77.5 per cent of people with known diabetes had a HbA1c test in the previous 12 months (table 10A.58).

An outcome of appropriate management of diabetes, by the primary and community health care sector in conjunction with the patient, is a HbA1c level at or below 7 per cent. Nationally, 50.5 per cent of people with known diabetes had a HbA1c level at or below 7 per cent (figure 10.26).

Figure 10.26 **People with known diabetes with HbA1c level 7 per cent or less^{a, b, c, d}**



^a People aged 18 years to 69 years with known diabetes. Includes pregnant women. ^b Known diabetes based on fasting plasma glucose test results and self-reported information on diagnosis/medication use. ^c Rates are not age-standardised. ^d Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to the exclusion of around 23 per cent of the NT population.

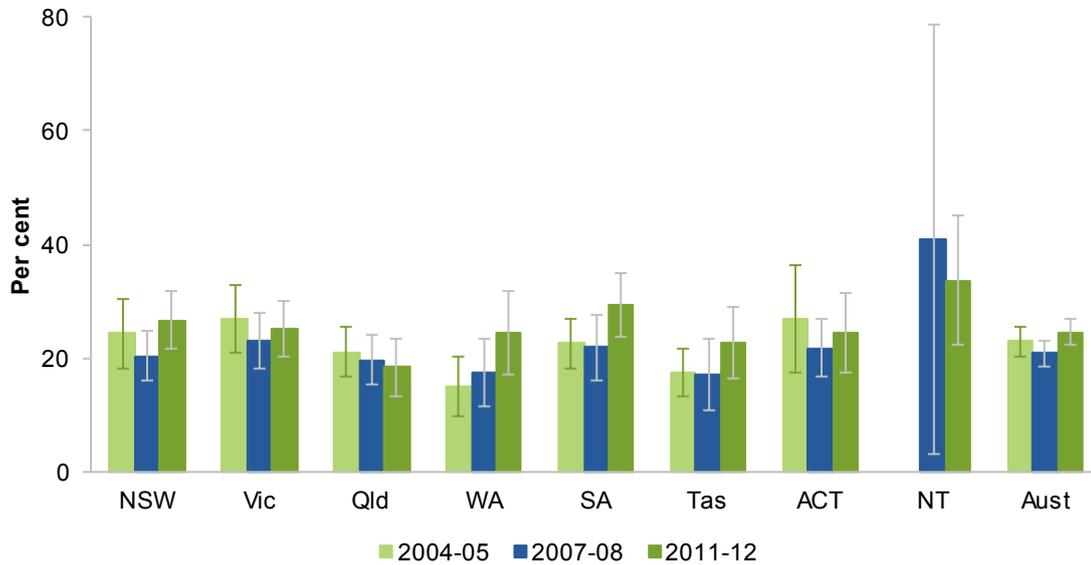
Source: ABS (unpublished) *Australian Health Survey, 2011-13* (2011-12 National Health Measures Survey component), Cat. No. 4364.0; table 10A.59.

Chronic disease management — asthma

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

Nationally, the proportion of people with asthma reporting that they have a written asthma action plan was 24.6 per cent for people of all ages in 2011-12, a slight increase from 22.9 per cent in 2004-05 (figure 10.27). The proportion of people with asthma reporting that they have a written asthma action plan was higher for children aged 0–14 years than for other age groups in all jurisdictions (table 10A.60).

Figure 10.27 Proportion of people with asthma who have a written asthma action plan, all ages^{a, b, c, d}



^a Rates 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 the NT should be used with care as the NHS (National Health Survey) excludes very remote areas and therefore around 23 per cent of the NT population. Data for the NT are not available for 2004-05. ^d Data for the NT for 2011-12 are not comparable to data for previous years due to the increased sample size.

Source: ABS (unpublished) *Australian Health Survey, 2011–2013* (2011-12 NHS component), Cat. No. 4364.0; ABS (unpublished) *National Health Survey, 2007-08, 2004-05*, Cat. No. 4364.0; table 10A.60.

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 10.28; table 10A.61). Data for people of all ages are reported by Indigenous status for 2004-05 and 2011–13 in table 10A.62. Data for people of all ages are reported by geographical region for 2007-08 in table 10A.63.

Figure 10.28 **Proportion of people with asthma who have a written asthma action plan by age, by Indigenous status, 2011–13^{a, b, c}**



^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* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0; table 10A.61.

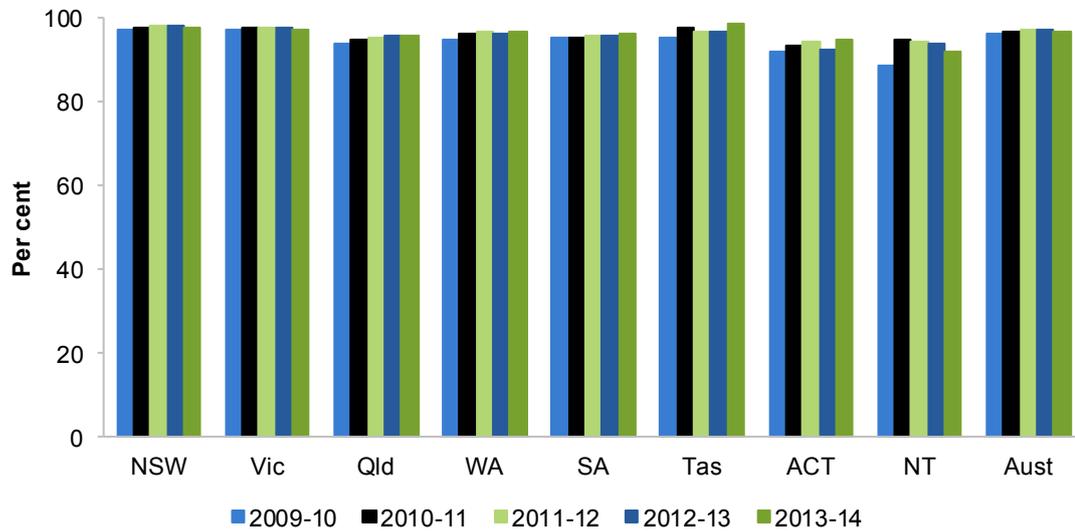
Chronic disease management — care planning and case conferencing

Individuals with chronic or terminal medical conditions commonly have complex, multidisciplinary care needs. Coordination of service provision to provide continuity of care and meet the changing needs of individuals over time is important in the effective management of such conditions. 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 planning and case conferencing.

Individual compliance with management measures is also a critical determinant of the occurrence and severity of complications for patients with chronic disease.

Nationally, the proportion of GPs who used chronic disease management MBS items for care planning or case conferencing increased slightly — from 96.1 to 97.0 per cent — in the period 2009-10 to 2013-14 (figure 10.29).

Figure 10.29 **GP use of chronic disease management MBS items for care planning and case conferencing^{a, b}**



^a The Strengthening Medicare initiative provides access to a range of allied health and dental care treatments for patients with chronic conditions and complex needs, on referral from a GP. ^b Additional chronic disease management MBS items have become available on several occasions since introduction of the Strengthening Medicare initiative in 2004.

Source: Department of Health (unpublished) MBS Statistics; table 10A.64.

Use of pathology tests and diagnostic imaging

‘Use of pathology tests and diagnostic imaging’ is an indicator of governments’ objective to ensure that primary healthcare services are appropriate (box 10.14).

Box 10.14 Use of pathology tests and diagnostic imaging

'Use of pathology tests and diagnostic imaging' is defined by four measures:

- MBS items rebated through DHS Medicare for pathology tests requested by vocationally registered GPs and OMPs, per person
- diagnostic imaging services provided on referral from vocationally registered GPs and OMPs and rebated through DHS Medicare, per person
- DHS Medicare benefits paid per person for pathology tests
- DHS Medicare benefits paid per person for diagnostic imaging.

This indicator needs to be interpreted with care as appropriate levels of use of pathology tests and diagnostic imaging cannot be determined. A high or increasing level of use can reflect overreliance on tools to support the diagnostic process. A low or decreasing level of use can contribute to misdiagnosis of disease and to relatively poor treatment decisions. Reporting differences across jurisdictions and over time contributes to consideration of these issues. Pathology tests and diagnostic imaging are important tools used by GPs in the diagnosis of many diseases, and in monitoring response to treatment. Pathology and diagnostic imaging services performed at the request of vocationally registered GPs and OMPs and rebated through DHS Medicare is used as a proxy in reporting against this indicator.

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.

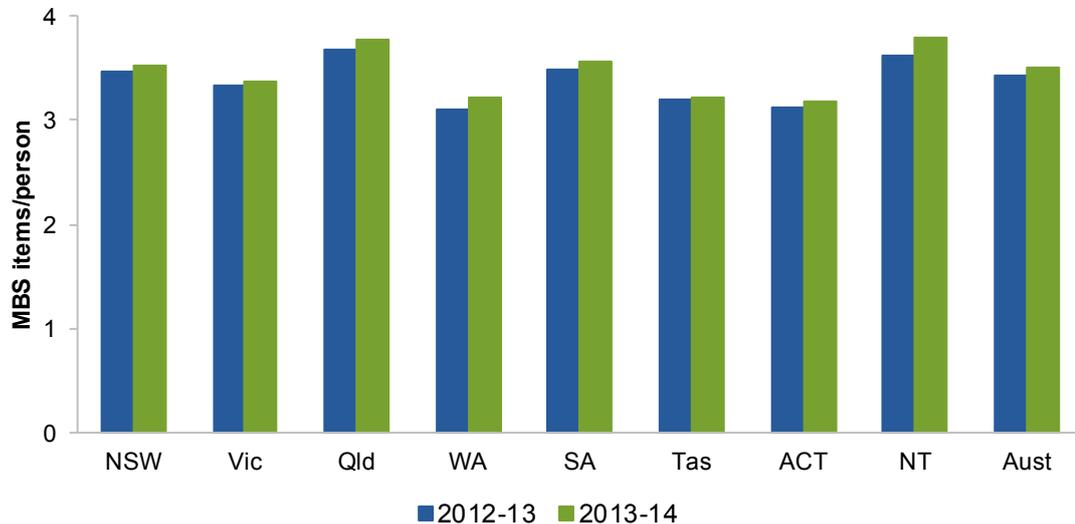
Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Available data do not exactly reflect the services requested and performed. For example, rebates are provided for a maximum of three MBS pathology items — additional pathology tests can be requested and performed, but are excluded from the data because rebates are not provided. A radiologist can identify the need for and perform more or different diagnostic imaging services than requested. DHS Medicare data reflect only those services provided and rebated.

Age-standardised rates are available from 2012-13. Historical data are crude rates and are provided in tables 10A.66 (pathology tests) and 10A.68 (diagnostic imaging).

Nationally, the number of rebated MBS items for pathology tests requested by GPs and eligible nurse practitioners was 3.5 per person in 2013-14 (figure 10.30).

Figure 10.30 **MBS items rebated through DHS Medicare for pathology tests requested by GPs, per person^{a, b}**

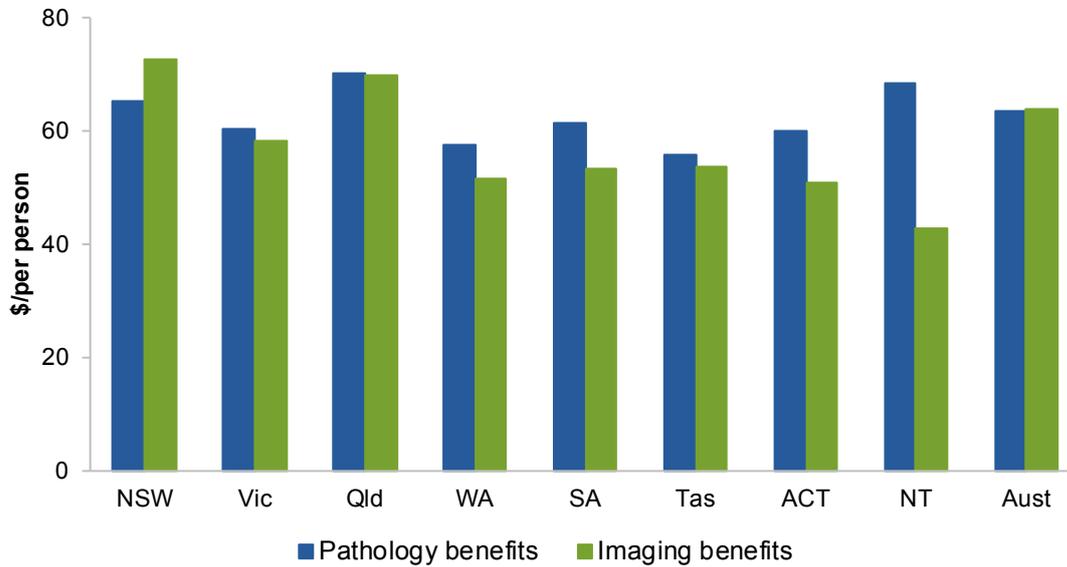


^a Data are age standardised to the 2001 Australian standard population. ^b Data include tests requested by vocationally registered GPs and OMPs and, from 2013-14, eligible nurse practitioners. Data include patient episode initiated items.

Source: Department of Health (unpublished) MBS and DVA data collections; table 10A.65.

Australian Government expenditure under DHS Medicare for pathology tests requested by vocationally registered GPs and OMPs and eligible nurse practitioners amounted to \$1.6 billion — around \$64 per person — in 2013-14 (figure 10.31). Australian Government expenditure under DHS Medicare for diagnostic imaging tests requested by vocationally registered GPs and OMPs and eligible nurse practitioners was also \$1.6 billion in 2013-14 although expenditure per person was less for diagnostic imaging than for pathology tests in most jurisdictions (figure 10.31).

Figure 10.31 **Benefits paid for GP-referred pathology tests and diagnostic imaging rebated through DHS Medicare, 2013-14^a**

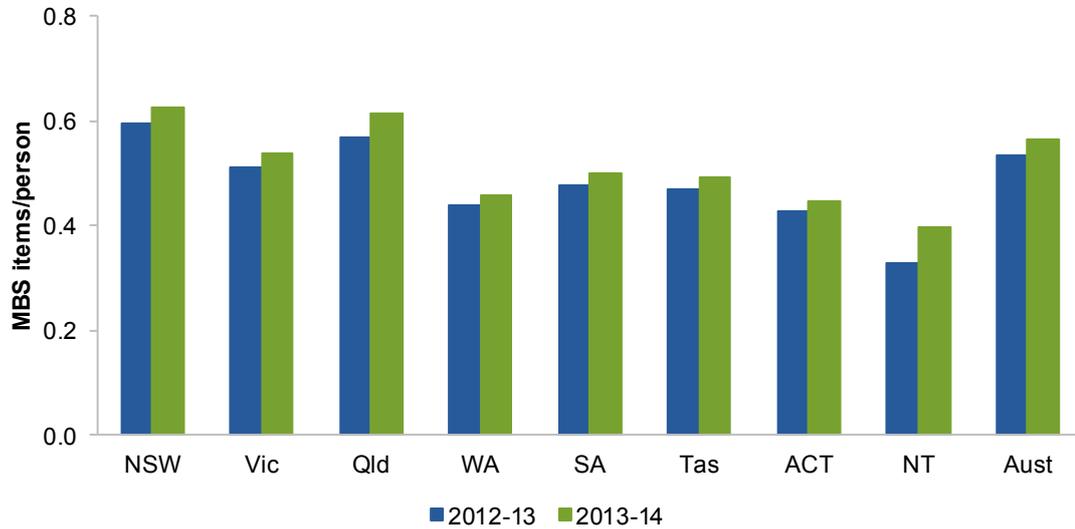


^a Includes benefits paid through DHS Medicare (including DVA data) for MBS pathology and diagnostic imaging items, for services provided on referral from vocationally registered GPs and OMPs and from eligible nurse practitioners.

Source: Department of Health (unpublished) MBS and DVA data collections; tables 10A.65 and 10A.67.

Nationally, the number of rebated MBS items for diagnostic imaging performed on referral from GPs and, for 2013-14, eligible nurse practitioners, was 0.54 per person in 2013-14 (figure 10.32).

Figure 10.32 **Diagnostic imaging services referred by GPs and rebated through DHS Medicare^{a, b}**



^a Data are age standardised to the 2001 Australian standard population. ^b Data include tests requested by vocationally registered GPs and OMPs and, from 2013-14, eligible nurse practitioners.

Source: Department of Health (unpublished) MBS and DVA data collections; table 10A.67.

Quality — safety

Electronic health information systems

‘Electronic health information systems’ is an indicator of governments’ objective to improve patient safety through enhanced access to patient health information at the point of care and the more efficient coordination of care across multiple providers and services (box 10.15).

Box 10.15 **Electronic health information systems**

'Electronic health information systems' is defined as the proportion of general practices enrolled in the Practice Incentives Program (PIP) that are registered for the PIP eHealth incentive.

A high or increasing proportion can indicate that patient health information at the point of care and coordination of care across multiple providers and services are desirable or are improved, minimising the likelihood of patient harm due to information gaps.

The PIP does not include all practices in Australia. PIP practices provided around 83.0 per cent of general practice patient care in Australia (measured as standardised whole patient equivalents) in 2010-11 (Department of Health unpublished; table 10A.52).

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 2014 data are available for all jurisdictions.

Data quality information for this indicator is under development.

The use of electronic health information systems can, for example, facilitate best practice chronic disease management as well as minimise errors of prescribing and dispensing that can cause adverse drug reactions (Hofmarcher, Oxley and Rusticelli 2007).

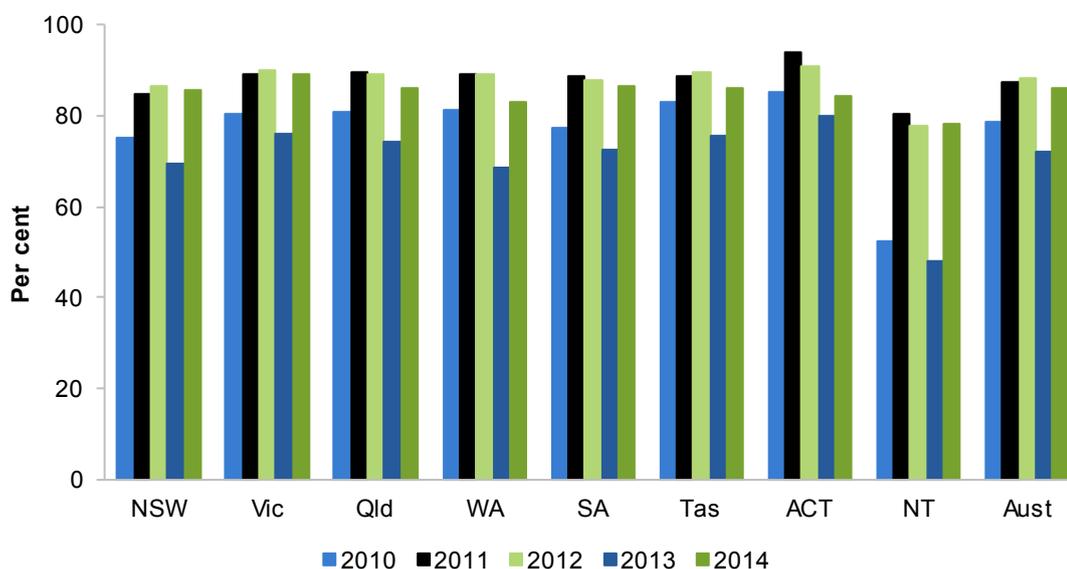
The PIP eHealth Incentive aims to encourage general practices to keep up to date with the latest developments in electronic health information systems. Accordingly, new eligibility requirements were introduced from 1 February 2013, requiring practices to:

- integrate healthcare identifiers into electronic practice records
- have a secure messaging capability
- use data records and clinical coding of diagnoses
- send prescriptions electronically to a prescription exchange service
- participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software.

Nationally, the proportion of PIP practices using electronic health systems was 86.3 per cent in May 2014, recovering most of the sharp decrease, from 88.3 per cent in May 2012 to 72.2 per cent in May 2013, that was associated with time taken to implement the new eligibility requirements for many practices (figure 10.33).

The proportion of PIP practices using electronic health systems increased in all areas between May 2013 and May 2014, remaining lower in remote and very remote areas than in other areas (figure 10.34).

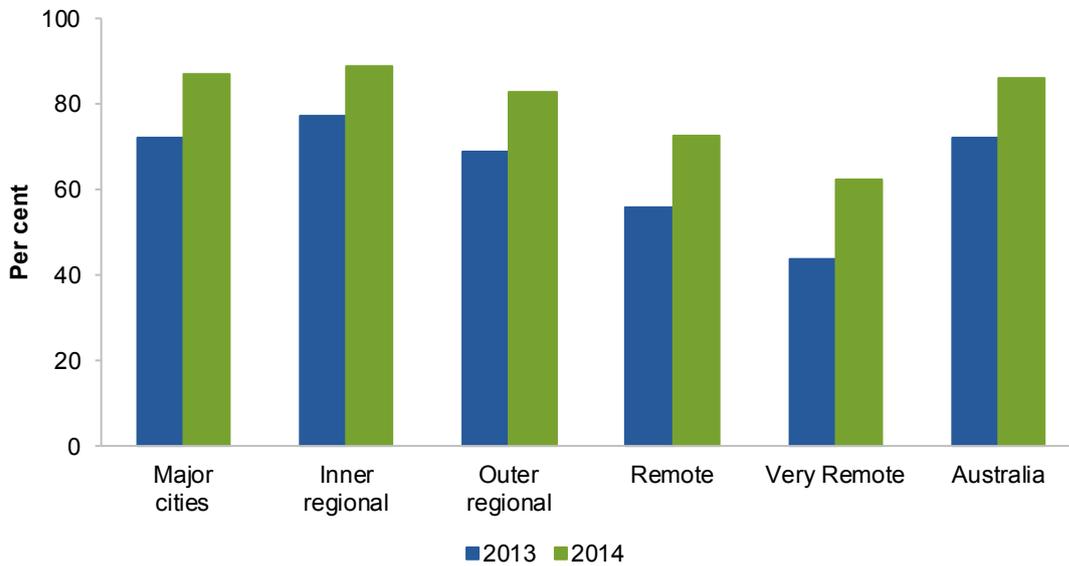
Figure 10.33 PIP practices using electronic health systems^a



^a Not all practices are enrolled in the PIP, and the enrolled proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.52).

Source: Department of Health (unpublished) MBS and PIP data collections; table 10A.69.

Figure 10.34 PIP practices using electronic health systems by area^{a, b}



^a Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification. ^b Not all practices are enrolled in the PIP, and the enrolled proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.52).

Source: Department of Health (unpublished) MBS and PIP data collections; table 10A.70.

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 10.16).

Box 10.16 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/rogs/2015.

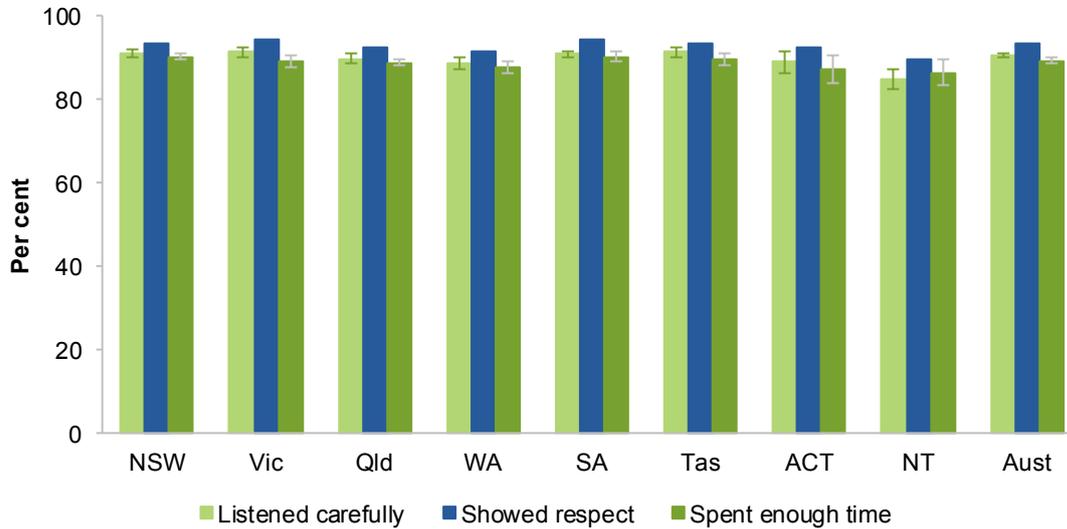
Patient satisfaction — experience with selected key aspects of GP care

Nationally, the majority of respondents reported that, in 2013-14, the GP always or often (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 are presented by remoteness area in tables 10A.72 and 10A.73. Data for Aboriginal and Torres Strait Islander Australians that are reported in table 10A.74 are not comparable to the data presented here (see DQI for details).

Figure 10.35 Proportion of people whose GP always or often listened carefully, showed respect, spent enough time, 2013-14^{a, b, c}



^a People aged 15 years or over who saw a GP in the last 12 months. ^b Data are crude rates. ^c Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.

Source: ABS (unpublished) *Patient Experience Survey 2013-14*, Cat. no. 4839.0; tables 10A.72, 10A.73.

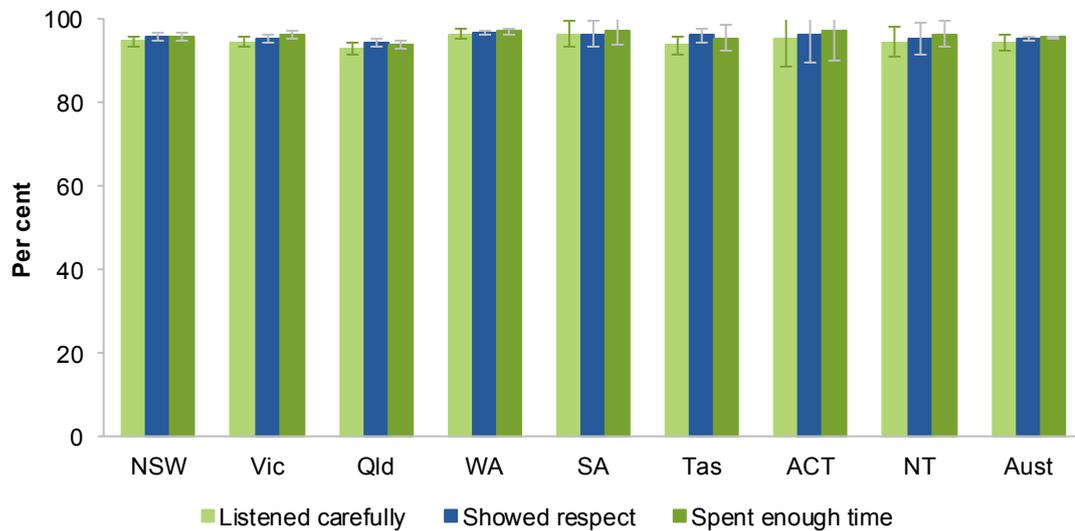
Patient satisfaction — experience with selected key aspects of dental professional care

Nationally, the majority of respondents reported that, in 2013-14, the dental professional always or often (figure 10.36):

- listened carefully to them (94.6 per cent)
- showed respect (95.5 per cent)
- spent enough time with them (95.7 per cent).

Data are presented by remoteness area in tables 10A.75 and 10A.76.

Figure 10.36 Proportion of people whose dental professional always or often listened carefully, showed respect, spent enough time, 2013-14^{a, b, c}



^a People aged 15 years or over who saw a dental professional in the last 12 months. ^b Data are crude rates. ^c Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.

Source: ABS (unpublished) *Patient Experience Survey 2013-14*, Cat. no. 4839.0; tables 10A.75, 10A.76.

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 10.17).

Box 10.17 **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 10.5).

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:

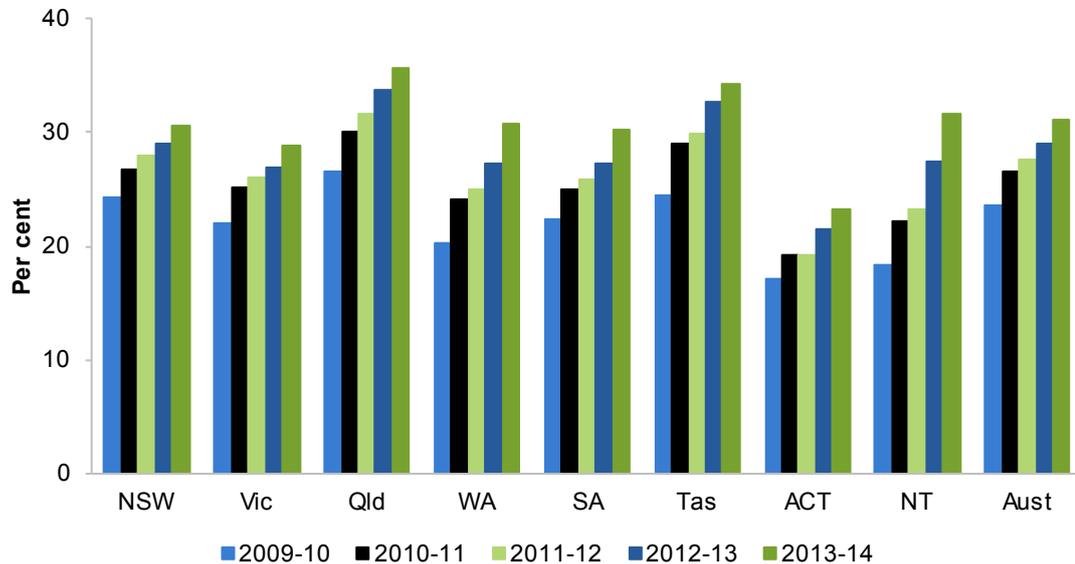
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

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 10.5).

There has been an increase in the proportion of older people receiving a health assessment in all jurisdictions in the period 2009-10 to 2013-14. Nationally, this proportion increased from 23.5 per cent in 2009-10 to 31.1 per cent in 2013-14 (figure 10.37). Data are presented for an 8 year time series in table 10A.77.

Figure 10.37 Older people who received an annual health assessment^{a, b}



^a Older people are defined as non-Indigenous Australians aged 75 years or over and Aboriginal and Torres Strait Islander Australians aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. ^b Rates are revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.2 and 2A.13-14) 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.77.

Sustainability

The Steering Committee has identified the sustainability of primary and community health as a key area for development in future reports.

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 10.18).

Box 10.18 **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:

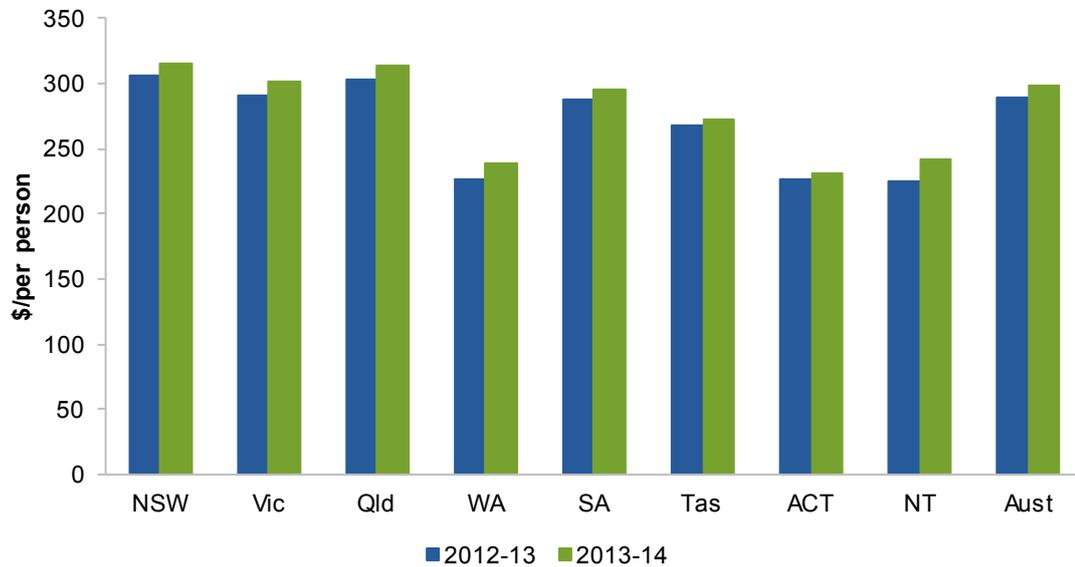
- comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012-13 are not comparable to data for previous years
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Data for this indicator have improved with the introduction of age-standardisation for fee-for-service expenditure data through DHS Medicare and the DVA from 2012-13. These data are not comparable with data for previous years that are not age-standardised and include expenditure on GP programs. Historical data are provided in table 10A.3.

Nationally, Australian Government fee-for-service expenditure on general practice was \$7.3 billion — \$299 per person — in 2013-14 (figure 10.38). Total Australian Government expenditure on general practice included PIP and Medicare Locals funding of a further \$600 million (table 10A.3).

Figure 10.38 **Australian Government fee-for-service expenditure per person on GPs (2013-14 dollars)^{a, b, c}**



^a Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details. ^b Data are directly age-standardised to the 2001 Australian standard population. ^c Data include DHS Medicare and DVA payments.

Source: Department of Health (unpublished) MBS Statistics; DVA (unpublished), DVA data collection; table 10A.2.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the services delivered) (see chapter 1, section 1.5). Intermediate outcomes (such as vaccination coverage within a target group) moderate final outcomes (such as the incidence of vaccine preventable diseases). Both intermediate and final primary and community health outcome indicators are reported.

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 10.19).

Box 10.19 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/rogs/2015.

Many providers deliver child immunisation services (table 10.7). 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 10.7 Valid vaccinations supplied to children under 7 years of age, by provider type, 2009–2014 (per cent)^{a, b, c}

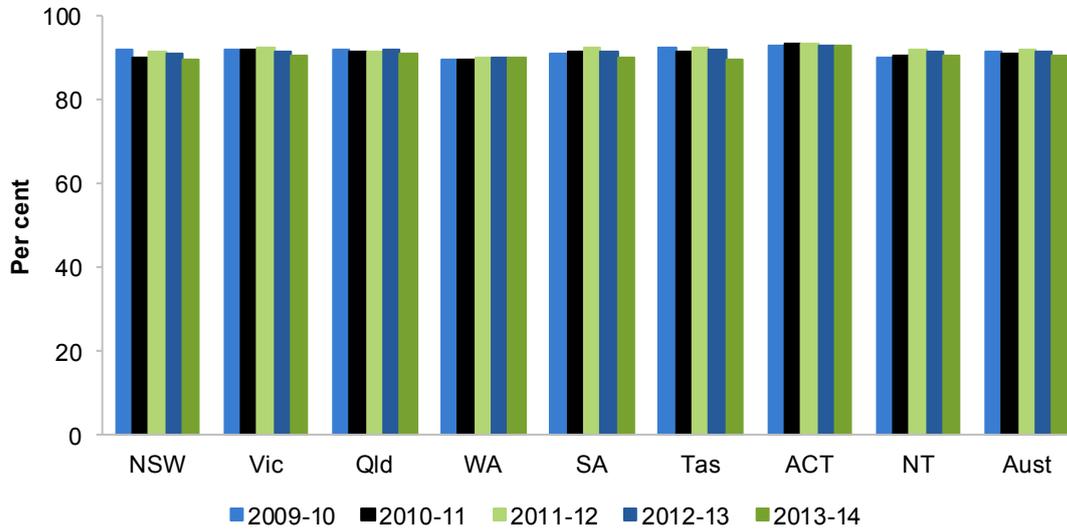
Provider	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
GP	88.8	59.5	84.6	69.2	73.0	93.1	59.6	71.8	75.9
Council	3.2	38.8	5.8	3.6	18.5	6.4	–	–	13.5
State or Territory health department	–	–	–	4.9	–	–	1.2	0.1	0.6
Public hospital	0.9	1.2	2.8	1.3	0.7	0.4	0.3	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
Other ^d	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.

Nationally, the proportion of Australian children aged 12 months to less than 15 months who were assessed as fully immunised in 2013-14 — 90.4 per cent — fell below 91 per cent for the first time in the 5 year period from 2009-10 (figure 10.39).

Figure 10.39 Children aged 12 months to less than 15 months who were fully immunised^{a, b, c}

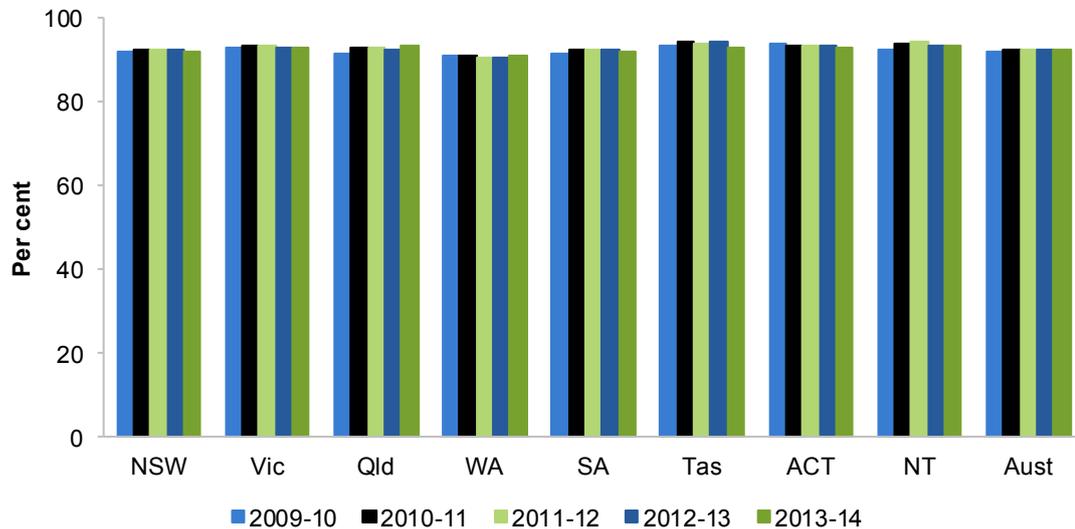


^a The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with DHS Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS Medicare. ^b There can be some under-reporting by providers, so vaccination coverage estimates based on ACIR data are considered minimum estimates (NCIRS 2000). ^c Data are for financial years and may differ from previous reports which presented data for the June quarter.

Source: Department of Health (unpublished) ACIR data collection; table 10A.79.

Nationally, 92.4 per cent of children aged 24 months to less than 27 months were assessed as fully immunised in 2013-14 (figure 10.40).

Figure 10.40 Children aged 24 months to less than 27 months who were fully immunised^{a, b, c}

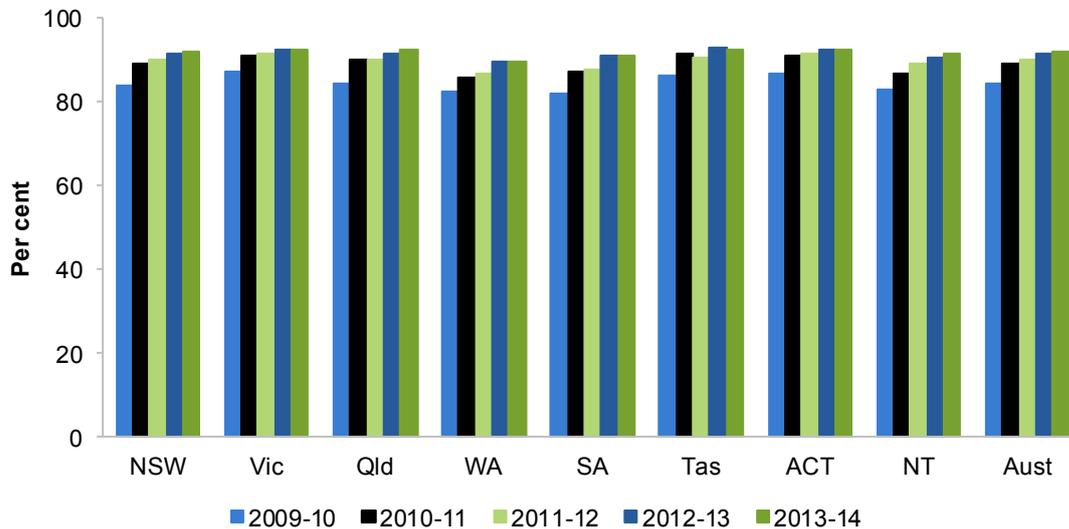


^a The ACIR includes all children under 7 years of age who are registered with DHS Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS Medicare (NCIRS 2000). ^b There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000). ^c Data are for financial years and may differ from previous reports which presented data for the June quarter.

Source: Department of Health (unpublished) ACIR data collection; table 10A.80.

Nationally, the proportion of children aged 60 months to less than 63 months who were assessed as fully immunised rose from 84.6 to 92.0 per cent in the period 2009-10 to 2013-14 (figure 10.41).

Figure 10.41 **Children aged 60 months to less than 63 months who were fully immunised^{a, b, c}**



^a The ACIR includes all children under 7 years of age who are registered with DHS Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS Medicare (NCIRS 2000). ^b There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000). ^c Data are for financial years and may differ from previous reports which presented data for the June quarter.

Source: Department of Health (unpublished) ACIR data collection; table 10A.81.

Notifications of selected childhood diseases

‘Notifications of selected childhood diseases’ is an indicator of governments’ objective to improve population health outcomes through the prevention of selected vaccine preventable childhood diseases (box 10.20).

Box 10.20 Notifications of selected childhood diseases

‘Notifications of selected childhood diseases’ is defined as the number of notifications of measles, pertussis and invasive *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System (NNDSS) by State and Territory health authorities for children aged 0–14 years, per 100 000 children in that age group.

(Continued next page)

Box 10.20 (Continued)

A low or reducing notification rate for the selected diseases indicates that the immunisation program is more effective. Measles, pertussis (whooping cough) and invasive *Haemophilus influenzae* type b are nationally notifiable vaccine preventable diseases. Notification of the relevant State or Territory authority is required when a nationally notifiable disease is diagnosed. The debilitating effects of these diseases can be long term or even life threatening. The complications from measles, for example, can include pneumonia, which occurs in 1 in 25 cases. The activities of GPs and community health services can reduce the prevalence of these diseases (and consequently the notification rates) through immunisation.

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.

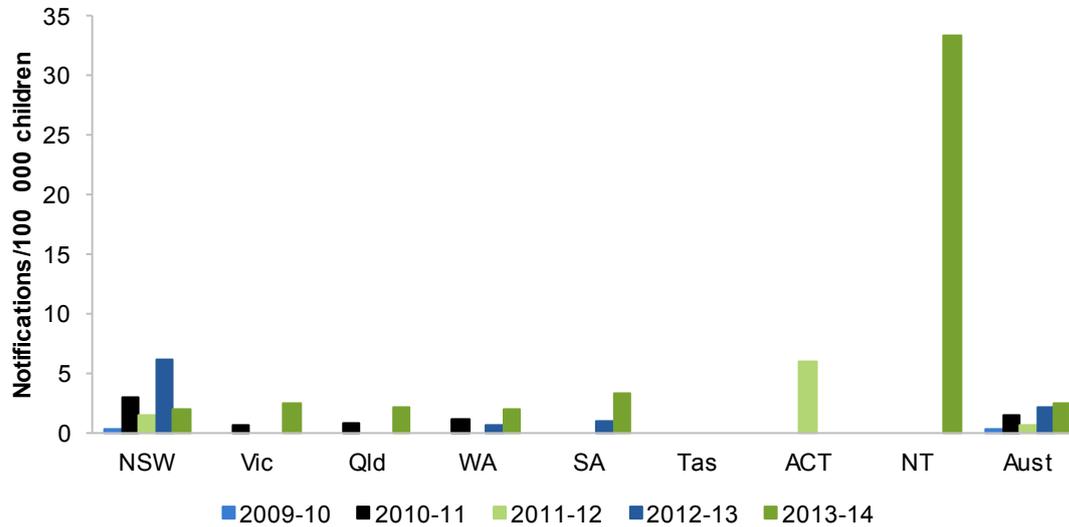
Data quality information for this indicator is under development.

Nationally, there were 113 notifications for measles for children aged 0–14 years in 2013-14 — a rate of 2.6 notifications per 100 000 children aged 0–14 years (figure 10.42). This was higher than for any other year in the period 2009-10 to 2013-14 (table 10A.82). Data are presented for an eight year time series in table 10A.82.

Nationally, notifications for pertussis (whooping cough) for children aged 0–14 years declined steadily from a peak of 18 200 (433 per 100 000 children 0–14 years) to less than 4000 (90 per 100 000 children 0–14 years) in the period 2010-11 to 2013-14 (figure 10.43). Data are presented for an eight year time series in table 10A.83.

In 2013-14, the national notification rate for invasive *Haemophilus influenzae* type b — 0.27 per 100 000 children aged 0–14 years — remained low, consistent with recent years (figure 10.44). Data are presented for an eight year time series in table 10A.84.

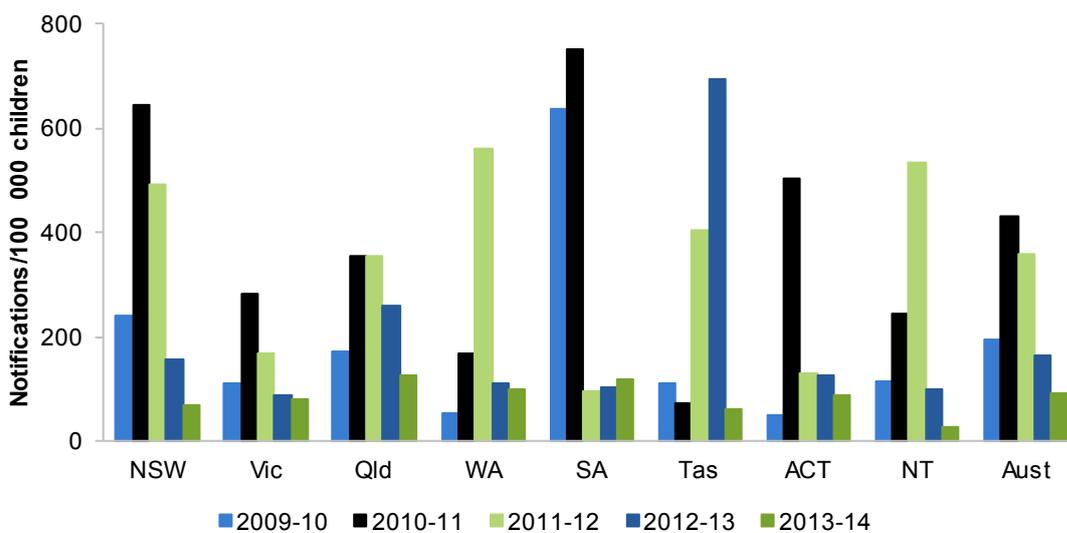
Figure 10.42 **Notifications of measles per 100 000 children aged 0–14 years^a**



^a Data are suppressed where the number of notifications reported for a jurisdiction is fewer than 5.

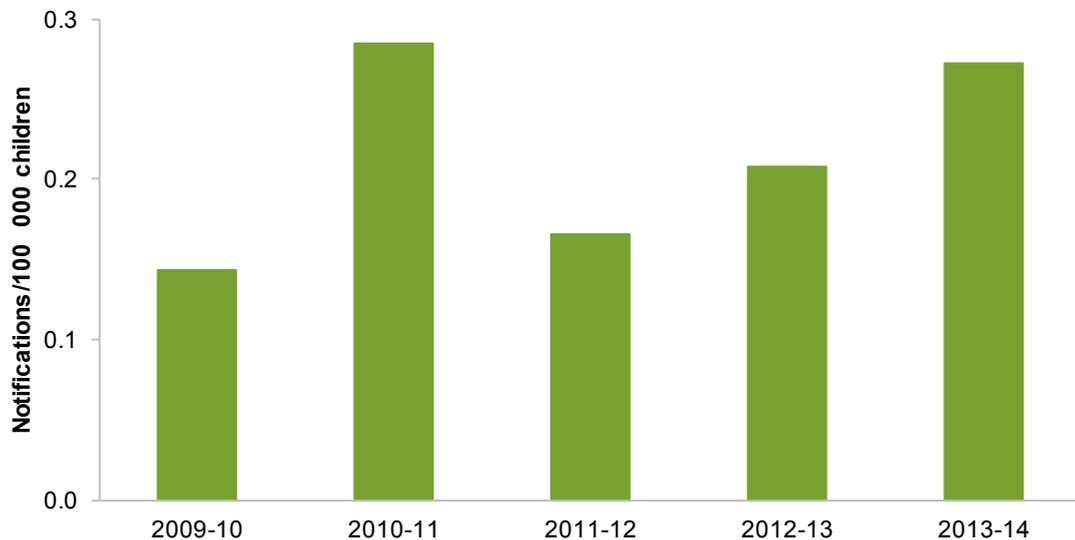
Source: Department of Health (unpublished) National Notifiable Diseases Surveillance System (NNDSS); ABS (various years) *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; table 10A.82.

Figure 10.43 **Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years**



Source: Department of Health (unpublished) NNDSS, ABS (various years) *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; table 10A.83.

Figure 10.44 **Notifications of invasive *Haemophilus influenzae* type b per 100 000 children aged 0–14 years, Australia**



Source: Department of Health (unpublished) NNDSS, ABS (various years) *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; table 10A.84.

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 10.21).

Box 10.21 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/rogs/2015.

Early detection of breast cancer is associated with improved morbidity and mortality outcomes. Early detection allows a wider range of treatment options — including less invasive procedures — and a higher likelihood of survival, than does later detection

(AIHW and NBCC 2007). The BreastScreen Australia Program is jointly funded by the Australian, State and Territory governments to undertake nationwide breast cancer screening. This is provided at no cost to the target group of women aged 50–69 years, for which it aims to achieve at least 70 per cent participation over a period of 24 months. Women aged 40–49 years and 70 years or over are also eligible for free screening.

An evaluation of the BreastScreen Australia Program found that it has been successful in reducing mortality from breast cancer in the target age group (women aged 50–69 years) by approximately 21–28 per cent since screening commenced in 1991 (Department of Health 2009). Further, the relatively high proportion of cancers detected early and treated with breast conserving surgery among Program participants was associated with reduced treatment related morbidity.

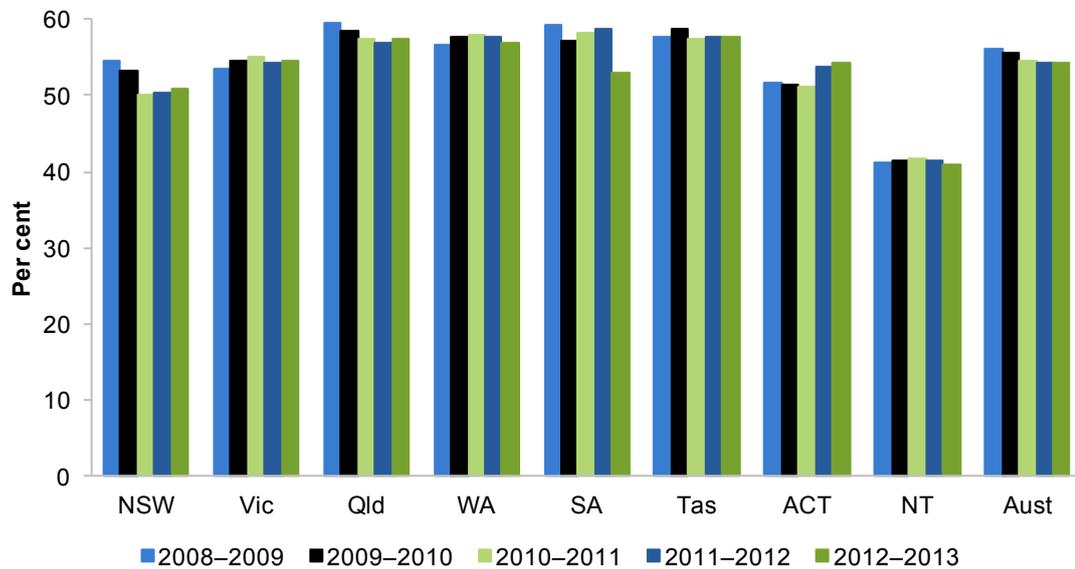
A decline in the national participation rate for women aged 50–69 years in BreastScreen Australia screening programs in the 24 month periods from 2008–2009 (56.0 per cent) to 2011–2012 (54.2 per cent) did not continue in the 24 month period 2012–2013 (54.3 per cent) (figure 10.45). These rates remain below the National Accreditation Standards aim of participation by 70 per cent of women in this age group.

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. Updated State and Territory data for participation rate by remoteness area were unavailable for the 2015 Report — data for 2009–2010 and previous years, as well as national data for 2010–2011, are reported in table 10A.89.

Participation rates in the BreastScreen Australia Program for women from selected community groups are shown in table 10.8. 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.

In the 24 month period 2012 and 2013, the national age standardised participation rate for NESB women aged 50–69 years was 51.4 per cent, lower than the total participation rate in that age group (54.3 per cent) (table 10A.88).

Figure 10.45 **Age standardised participation rate for women aged 50–69 years in BreastScreen Australia screening programs (24 month period)^{a, b, c, d, e}**



^a The participation rate is the number of women aged 50–69 years resident in the jurisdiction who were screened during the reference period, divided by the estimated number of women aged 50–69 years resident in the jurisdiction midway through the reference period. Data may differ from data published elsewhere reporting participation rates by screening jurisdiction. ^b The estimated resident population (ERP) is computed as the average of the ERP in each calendar year of the reference period. ERPs are revised to the ABS' final 2011 Census rebased ERPs and rates data may differ from previous reports. See Chapter 2 (table 2A.1) for details. ^c Rates are standardised to the 2001 ERP. ^d In general, women resident in the jurisdiction represent 99 per cent or more of the women screened in each jurisdiction. For the ACT, 2.2 per cent of those screened in the 2012–2013 reference period were not ACT residents, a decrease from 7–9 per cent in preceding reference periods associated with changed arrangements between NSW and the ACT. ^e Reduced participation rates for SA in 2012–2013 are associated with a temporary reduction in total women screened during a review of the Digital Mammography System and implementation of both the review findings and a new client information system.

Source: State and Territory governments (unpublished); ABS (various years) *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; tables 10A.85, 10A.86.

Table 10.8 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}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^d</i>	<i>NT</i>	<i>Aust</i>
Aboriginal and Torres Strait Islander women ^e	31.3	30.4	45.0	34.4	27.4	28.8	28.2	28.8	35.1
NESB ^f	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.85–10A.88.

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 10.22).

Box 10.22 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.

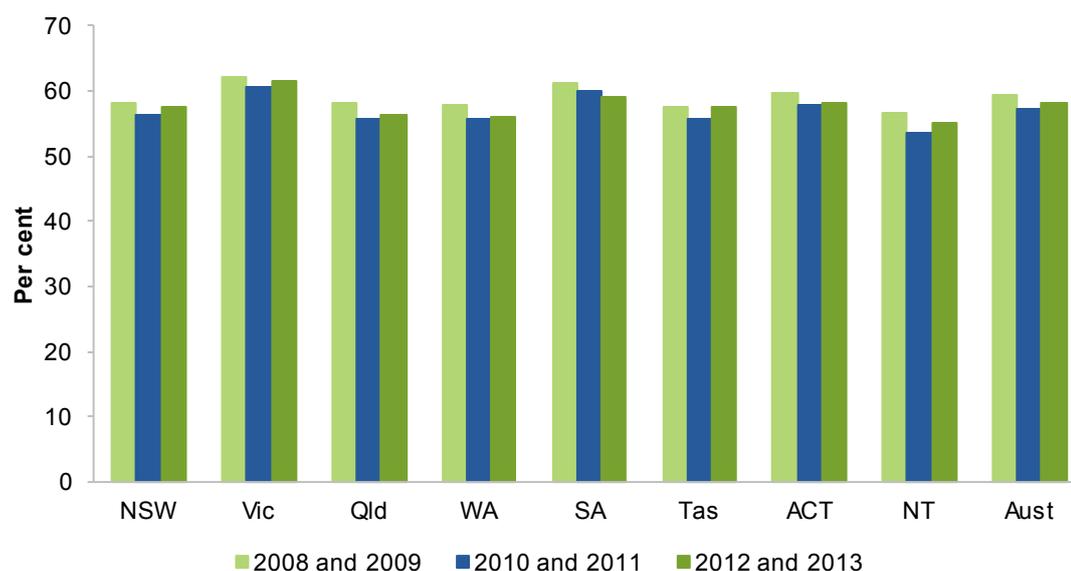
Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

It is estimated that up to 90 per cent of the most common type of cervical cancer (squamous cervical cancer) can be prevented if cell changes are detected and treated early (Department of Health 2012; Mitchell, Hocking and Saville 2003). A range of healthcare providers offer cervical screening tests (Pap smears). The National Cervical Screening Program involves GPs, gynaecologists, family planning clinics and hospital outpatient clinics.

The national age-standardised participation rate for women aged 20–69 years in cervical screening decreased from 59.3 per cent for the 24 month period 1 January 2008 to 31 December 2009 to 58.2 per cent for the period 1 January 2012 to 31 December 2013 (figure 10.46). Data are presented for a ten year time series in table 10A.90.

In 2011-12, 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).

Figure 10.46 Participation rates for women aged 20–69 years in cervical screening (24 month period)^{a, b, c, d}



^a Rates are the number of women screened as a proportion of the eligible female population, calculated as the average of the ABS ERP (based on the 2011 Census) in each calendar year in the reference period and age standardised to the 2001 Australian population. ^b Eligible female population adjusted for the estimated proportion who have had a hysterectomy. ^c Excludes women who have opted off the cervical cytology register. ^d Data include all women screened in the jurisdiction except for Victoria and the ACT, for which data include only residents of the jurisdiction (and immediate border residents).

Source: AIHW (unpublished) State and Territory Cervical Cytology Registry data collections; table 10A.90.

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 10.23).

Box 10.23 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.

Updated data were not available for non-Indigenous Australians for the 2015 Report — historical data are presented in tables 10A.92-10A.93. 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 2011-12 (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 10.24).

Box 10.24 Selected potentially preventable hospitalisations

'Selected potentially preventable hospitalisations' is defined as hospital admissions that may be avoided by effective management of illness and injury in the primary and community healthcare sector or, in some cases, by preventing illness and injury altogether.

Three measures of selected potentially preventable hospitalisations are reported (the first measure is reported against the indicator of the same name in the NHA):

- potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions as defined in the Victorian Ambulatory Care Sensitive Conditions Study (AIHW 2012b; DHS 2002)
- potentially preventable hospitalisations for diabetes
- potentially preventable hospitalisations of older people for falls.

Low or decreasing separation rates for selected potentially preventable hospitalisations can indicate improvements in the effectiveness of preventative programs and/or more effective management of selected conditions in the primary and community healthcare sector.

Factors outside the control of the primary and community healthcare sector also influence hospitalisation rates for these conditions (AIHW 2014a, 2012b). For example, the underlying prevalence of conditions, patient compliance with treatment and older people's access to aged care services and other support.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time except for the measure potentially preventable hospitalisations for diabetes
- complete (subject to caveats) for the current reporting period except for the measure potentially preventable hospitalisations for diabetes, for which data are not published for Tasmania, the ACT and the NT. All other required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

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

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

Variation in hospitalisation rates data can also be affected by differences in hospital protocols for clinical coding and admission between and within jurisdictions. This

particularly affects diagnoses of dehydration and gastroenteritis and diabetes complications. The effect is exacerbated for diabetes hospitalisations data disaggregated by Indigenous status because of the high prevalence of diabetes in 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.

Data are age-standardised to account for differences in the age structures of the populations across states and territories.

Nationally, the age-standardised hospital separation rate for the selected vaccine preventable, acute and chronic conditions reported here was 23.9 per 1000 people in 2012-13 (table 10.9). Of these, 49.5 per cent were for acute and 47.2 per cent for chronic conditions (table 10A.95). Data are presented disaggregated by Indigenous status in table 10A.96 and remoteness in table 10A.97. National data by Indigenous status and remoteness are presented in table 10A.98.

Table 10.9 Separations for selected potentially preventable hospitalisations per 1000 people, 2012-13^{a, b, c}

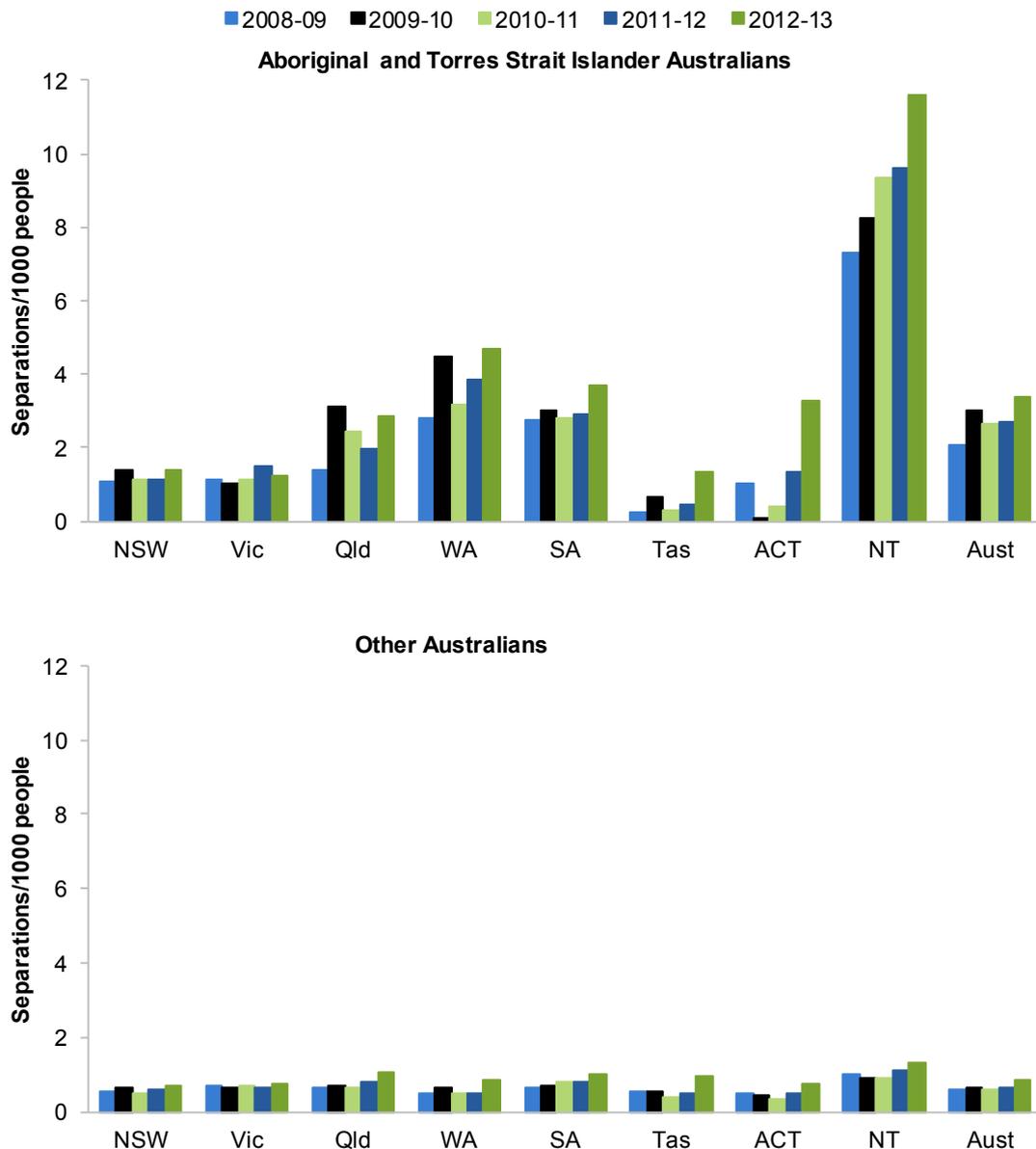
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust^d</i>
Vaccine preventable conditions	0.7	0.8	1.1	1.0	1.1	1.0	0.8	3.7	0.9
Selected acute conditions ^e	10.8	10.2	13.8	13.6	13.6	9.9	9.3	20.5	11.8
Selected chronic conditions ^f	10.4	10.8	12.9	11.3	11.9	10.1	8.3	22.1	11.3
Total^{g, h}	21.9	21.7	27.7	25.7	26.4	20.8	18.2	45.8	23.9

^a Separation rates are directly age-standardised to the Australian population at 30 June 2001. ^b Rates are based on State/Territory of usual residence. ^c A nationally agreed revised definition of selected potentially preventable hospitalisations applies. See DQI for more information. ^d Includes other territories. Excludes overseas residents and unknown state of residence. ^e Selected acute conditions excluding dehydration and gastroenteritis. ^f Selected chronic conditions excluding diabetes complications (additional diagnoses only). ^g Total is all potentially preventable hospitalisations excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only). ^h Totals may not add as more than one condition may be reported for a separation.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 10A.95.

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 10.47). 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 10.48). 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 10.49).

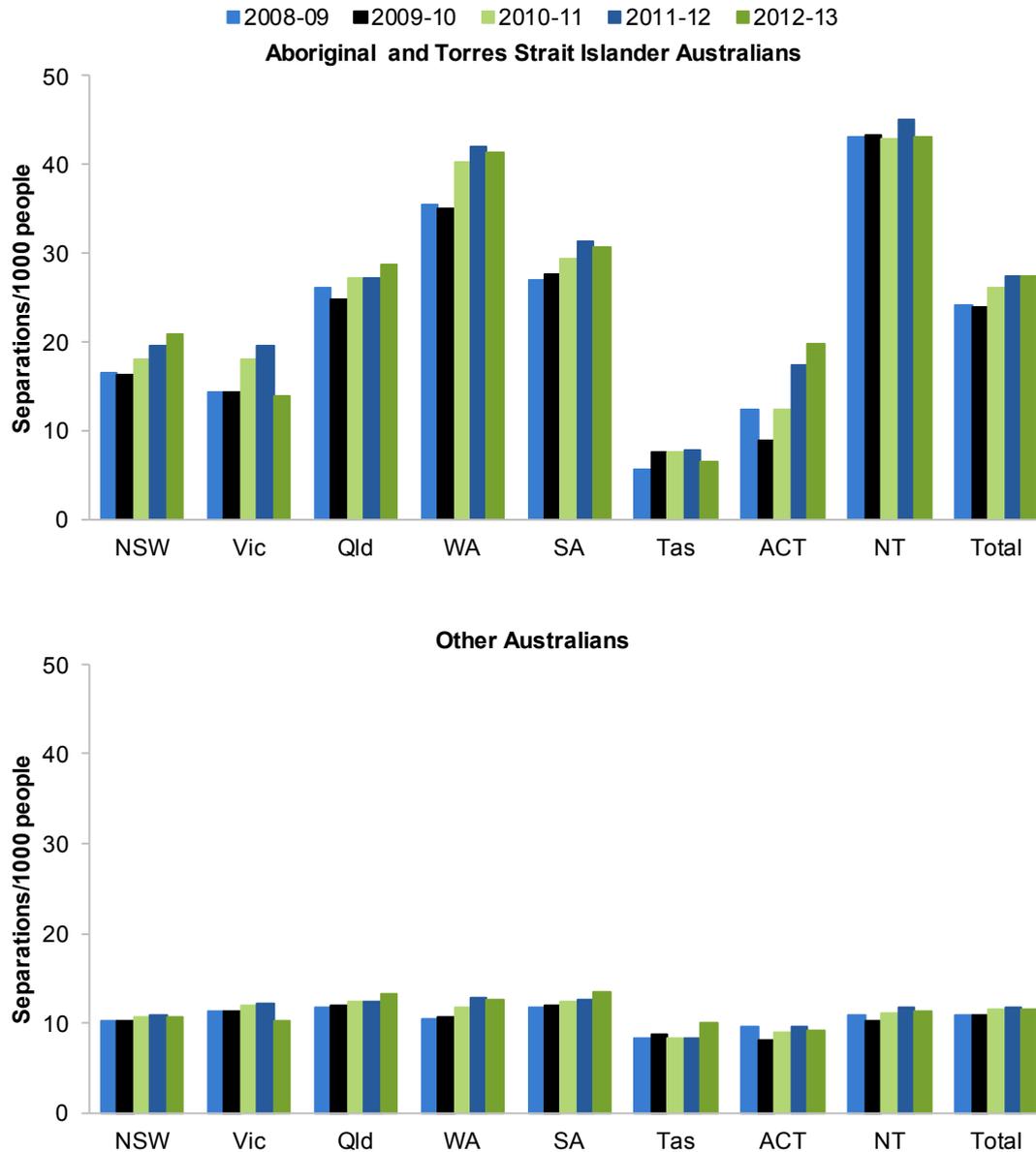
Figure 10.47 Separations for vaccine preventable conditions by Indigenous status^{a, b, c, d, e, f, g}



^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; tables 10A.95 and 10A.99.

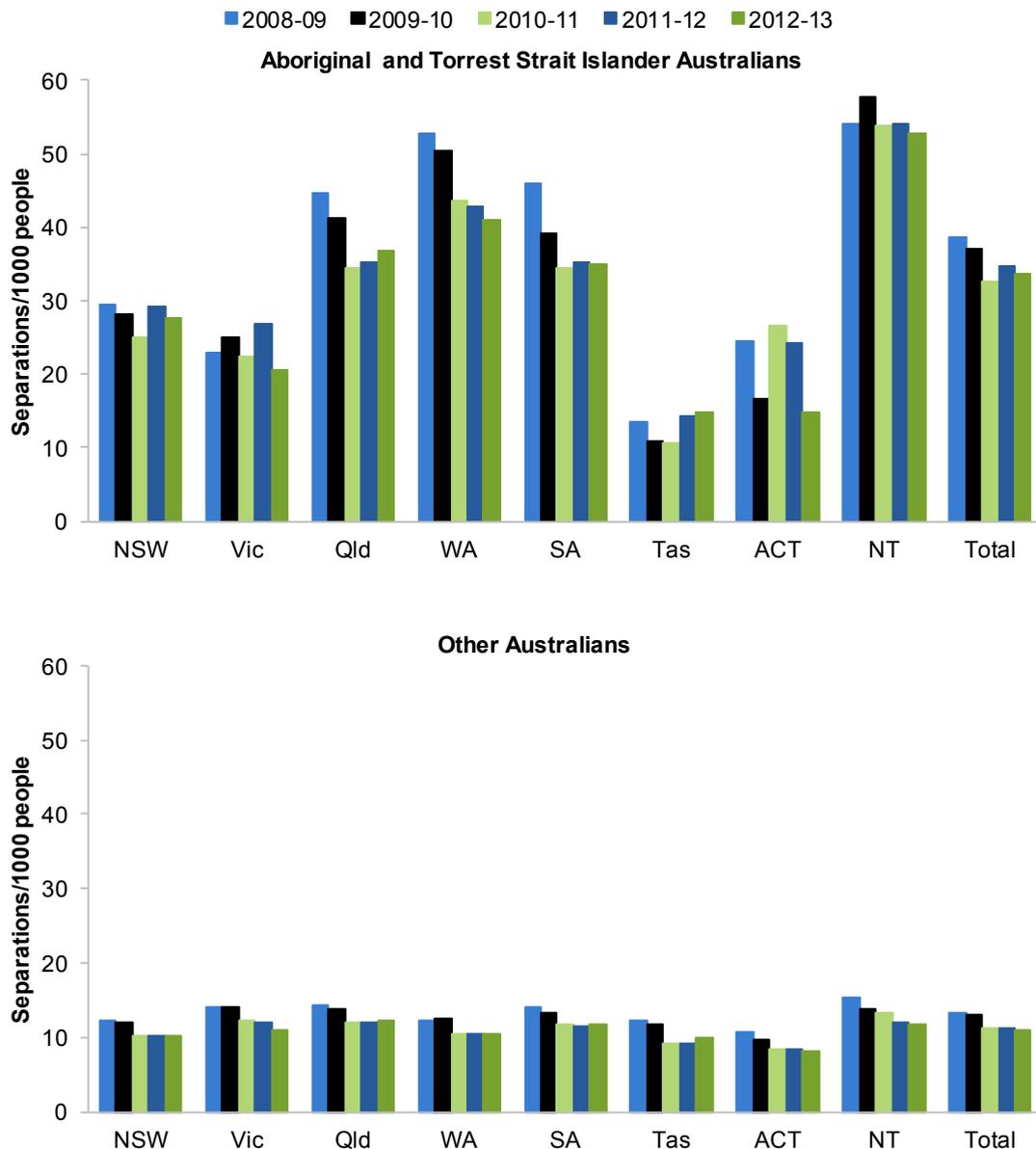
Figure 10.48 Separations for selected acute conditions by Indigenous status^{a, b, c, d, e, f, g}



^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; tables 10A.95 and 10A.100.

Figure 10.49 **Separations for selected chronic conditions by Indigenous status^{a, b, c, d, e, f, g}**



^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; tables 10A.95 and 10A.101.

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 (figure 10.50).

Figure 10.50 **Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2012-13^{a, b, c}**

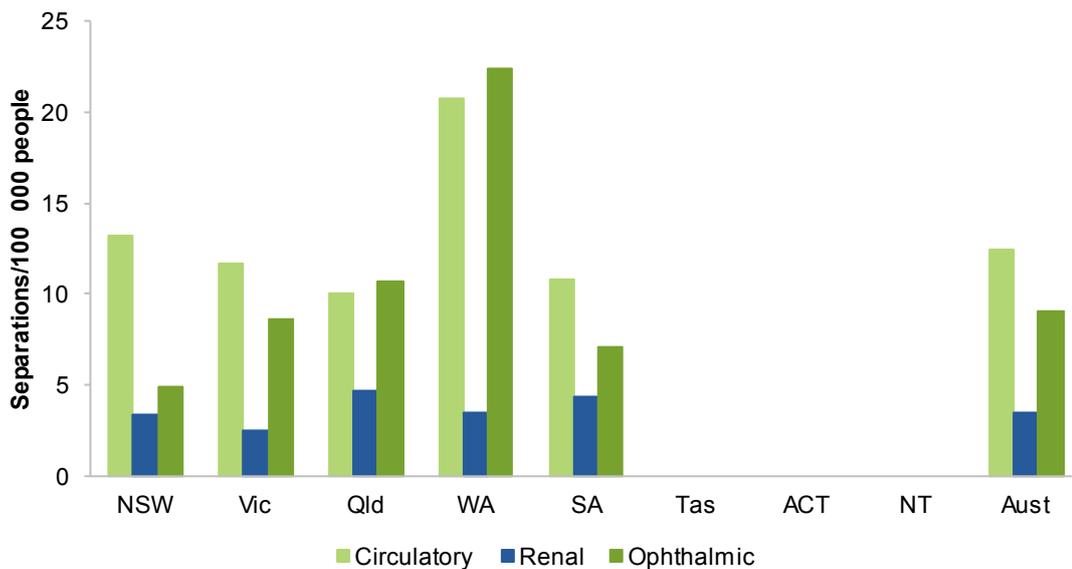


^a Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. ^b Morbidity data are coded under coding standards that can differ over time and across jurisdictions — 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. ^c Data for Tasmania, the ACT and the NT are not published separately (due to hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 10A.103.

The three complications of Type 2 diabetes most commonly leading to hospitalisation in 2012-13 were ophthalmic, renal and circulatory complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 10.51).

Figure 10.51 Separations for principal diagnosis of Type 2 diabetes mellitus by selected complication, all hospitals, 2012-13^{a, b, c, d, e}



^a Results for individual complications can be affected by small numbers, and need to be interpreted with care. ^b Patients can have one or more complication(s) for each separation. ^c Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. ^d Morbidity data are coded under coding standards that can differ over time and across jurisdictions — 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 Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 10A.103.

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings but these data are not included in the hospital separations data. Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients affect hospital separation rates. This effect is partly reflected in the variation in the proportion of separations that are ‘same day’ across jurisdictions. Nationally, 24.6 per cent of separations for Type 2 diabetes were same day separations in 2012-13 (table 10A.104).

Serious circulatory complications of diabetes can necessitate amputation of a lower limb. In 2012-13, there were 16.4 hospital separations per 100 000 people (age standardised) for

lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 10.52).

Figure 10.52 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2012-13^{a, b, c}**



^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Includes unspecified diabetes. Data are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370-00, 44373-00, 44367-00, 44367-01 and 44367-02 for lower limb amputation. Reporting of diabetes increased by an average of 29.6 per cent as a principal diagnosis and 247 per cent as an additional diagnosis 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. ^c Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 10A.105.

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 10.53).

Figure 10.53 **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}**



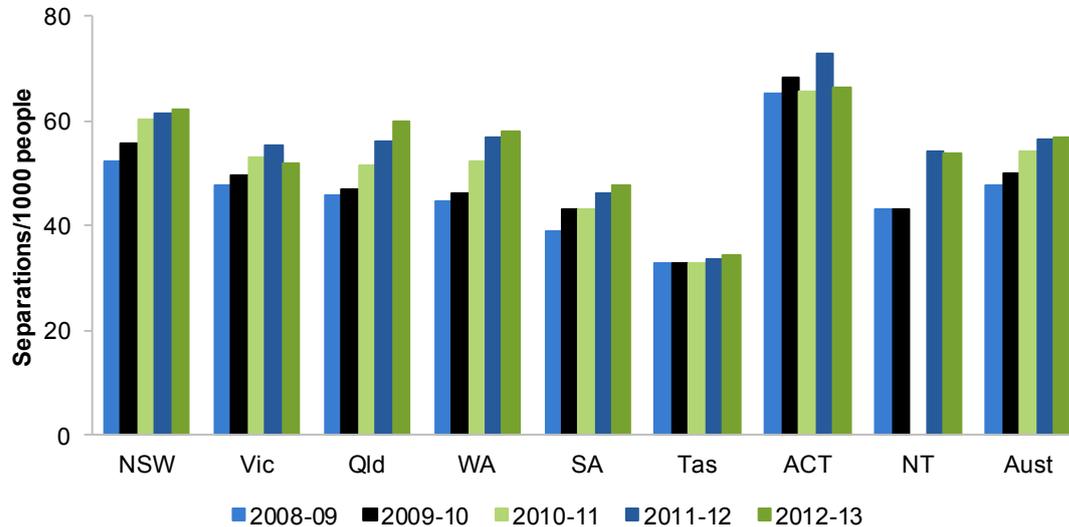
^a Excludes separations with diabetes complications as an additional diagnosis. ^b Ratios are directly age standardised to the Australian population at 30 June 2001. ^c Separation rates are based on state of usual residence. ^d Reporting of diabetes as a principal diagnosis increased by an average of 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.

Potentially preventable hospitalisations of older people for falls

Falls were the leading external cause of unintentional injury in older Australians in 2011-12 (Tovell, Harrison & Pointer 2014). For people over 65 years, injurious falls accounted for one in ten days spent in hospital in 2009-10 (Bradley 2013). The number of hospital separations for older people with a reported external cause of falls per 1000 older people, adjusted to take account of differences in State and Territory age distributions, increased from 47.7 in 2008-09 to 56.8 in 2012-13 (figure 10.54).

Figure 10.54 **Separations for older people with a reported external cause of falls^{a, b, c}**



^a Older people are defined as people aged 65 years or over. ^b Separation rates are age standardised to the Australian population aged 65 years or over at 30 June 2001. ^c Excludes separations records for hospital boarders and posthumous organ procurement. ^d Data for the NT are not available for 2010-11 and are not included in the Australian total.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 10A.106.

10.4 Future directions in performance reporting

The topic of this chapter is all primary and community health services. However, the indicators remain heavily focused on general practice services. This partly reflects the lack of nationally consistent data available to report potential indicators for other primary and community health services. Allied health professional workforce data are anticipated to be available for the 2016 Report from the new National Registration and Accreditation Scheme. Priorities for future reporting on primary and community health services include:

- further improving the reporting of public dental health services
- reporting of community-based drug and alcohol treatment services
- reporting of additional indicators relating to the use of the MBS chronic disease management items.

The scope of this chapter can also be further refined to ensure the most appropriate reporting of primary health services against the Review's terms of reference and reporting framework (see chapter 1).

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 Australian Institute of Health and Welfare (AIHW) includes an ongoing program to improve identification of Aboriginal and Torres Strait Islander status in Australian, State and Territory government administrative systems.

10.5 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.
Annual cycle of care for people with diabetes mellitus within general practice	<p>The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice. based on RACGP guidelines.</p> <p>MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines.</p>
Asthma Action Plan	<p>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.</p> <p><i>Source:</i> 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.</p>
Cervical screening rates for target population	Proportion of eligible women aged 20–69 years who are screened for cervical cancer over a 2 year period. Eligible women are those who have not had a hysterectomy.
Closed treatment episode	A closed treatment episode is a period of contact between a client and an alcohol and other drug treatment agency. It has defined dates of commencement and cessation, during which the principal drug of concern, treatment delivery setting and main treatment type did not change. Reasons for cessation of a treatment episode include treatment completion, and client non-participation in treatment for three months or more. Clients may be involved in more than one closed treatment episode in a data collection period.
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.
Consultations	The different types of services provided by GPs.
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.
Divisions of General Practice	<p>Geographically-based networks of GPs were active until end June 2012. There were 109 Divisions of General Practice, 8 State Based Organisations and a peak national body, the Australian General Practice Network (AGPN).</p> <p>The Divisions of General Practice Program (DGPP) aims were to contribute to improved health outcomes for communities by working with GPs and other health service providers to improve the quality and accessibility of healthcare at the local level. From 30 June 2011, Medicare Locals progressively assumed responsibility for general practice support initiatives previously funded under the DGPP. The DGPP ceased on 30 June 2012.</p>
Full time workload equivalents (FWE)	<p>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.</p> <p>Full time equivalents (FTE) are calculated in the same way as FWE except that FTE are capped at 1 per practitioner.</p>

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 <i>Haemophilus influenzae</i> 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 <i>Haemophilus influenzae</i> 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 <i>Haemophilus influenzae</i> 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 <i>Health Insurance Act 1973</i> (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.
<i>Haemophilus influenzae</i> type b	A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (Department of Health 2013b).
Immunisation coverage	The proportion of a target population fully immunised with National Immunisation Program specified vaccines for that age group.
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.
Medicare Locals	Medicare Locals (MLs) are independent regional primary health care organisations with responsibility for supporting improved co-ordination of primary health care service delivery, as well as identifying and addressing gaps in primary health care services, across their regions (www.amlalliance.com.au/about-us , accessed 25 November 2013). Established progressively from 1 July 2011 under the National Health Reform agenda, the national network of 61 MLs and a national body, the Australian Medicare Local Alliance (AML Alliance), were operational at 1 July 2012.
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.
Non-referred attendances that are bulk billed	Number of non-referred attendances that are bulk billed and provided by medical practitioners, divided by the total number of non-referred non-specialist attendances.

Nationally notifiable disease	A communicable disease that is on the Communicable Diseases Network Australia's endorsed list of diseases to be notified nationally (Department of Health 2013c). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority.
Notifications of selected childhood diseases	Number of cases of measles, pertussis and <i>Haemophilus influenzae</i> type b reported to the National Notifiable Diseases Surveillance System by State and Territory health authorities.
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.
PBS doctor's bag	Emergency drug supplies provided without charge to prescribers for use in medical emergencies in the clinic or the community at no charge to the patient.
Per person benefits paid for GP ordered pathology	Total benefits paid under DHS Medicare for pathology tests requested by GPs, divided by the population.
Per person benefits paid for GP referred diagnostic imaging	Total benefits paid for diagnostic imaging services performed on referral by GPs, divided by the population.
Primary healthcare	The primary and community healthcare sector includes services that: <ul style="list-style-type: none"> • 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).
Proportion of GPs who are female	Number of all FWE GPs who are female, divided by the total number of FWE GPs.
Proportion of GPs with vocational recognition	Number of FWE GPs who are vocationally registered, divided by the total number of FWE GPs.
Proportion of general practices registered for accreditation	Number of practices registered for accreditation through either of the two accreditation bodies (AGPAL and Quality Practice Accreditation Pty Ltd), divided by the total number of practices.
Proportion of general practices with electronic health information systems	Number of PIP-registered practices that have taken up the eHealth PIP incentive, divided by the total number of practices registered.
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.
Recognised immunisation provider	A provider recognised by DHS Medicare as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist by the Medical Board of Australia and on the DHS Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.

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: <ul style="list-style-type: none">• 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).
Vocationally registered general practitioner	A medical practitioner who is vocationally registered under s.3F of the <i>Health Insurance Act 1973</i> (Cwth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her DHS Medicare billing from non-referred attendances.

10.6 List of attachment tables

Attachment tables are identified in references throughout this chapter by a '10A' prefix (for example, table 10A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

Table 10A.1	Types of encounter where a payment source was recorded, 2013-14
Table 10A.2	Australian Government expenditure on GPs through DHS Medicare (fee-for-service) and age standardised expenditure per person (2013-14 dollars)
Table 10A.3	Australian Government total expenditure on GPs and expenditure per person (crude rates) (2013-14 dollars)
Table 10A.4	Australian government expenditure on the Pharmaceutical Benefits Scheme (2013-14 dollars)
Table 10A.5	Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2013-14 dollars)
Table 10A.6	Australian Government expenditure on PBS medicines supplied to Aboriginal Health Services in remote areas
Table 10A.7	Expenditure on dental services (2012-13 dollars) (\$ million)
Table 10A.8	Australian Government funding of Aboriginal and Torres Strait Islander Primary Health Care Services
Table 10A.9	Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs
Table 10A.10	Number of GP-type services used per 1000 people
Table 10A.11	PBS services
Table 10A.12	PBS services, by service type ('000)
Table 10A.13	Use of public dental services, by service type, 2010
Table 10A.14	Alcohol and other drug treatment services, 2012-13 (number)
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.20	Approved providers of PBS medicines, by urban and rural location, at 30 June
Table 10A.21	PBS expenditure per person, by remoteness area (2013-14 dollars)
Table 10A.22	PBS expenditure per person, by urban and rural location, 2009-10 to 2011-12 (2013-14 dollars)
Table 10A.23	Availability of GPs by region, 2013-14
Table 10A.24	Availability of GPs by region, 2004-05 to 2011-12
Table 10A.25	Availability of female GPs

Table 10A.26	Availability of male GPs
Table 10A.27	Availability of public dentists (per 100 000 people)
Table 10A.28	Availability of public dental hygienists and dental therapists (per 100 000 people)
Table 10A.29	Availability of public occupational therapists and psychologists (per 100 000 people)
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.34	Non-referred attendances that were bulk billed, by region and age (per cent)
Table 10A.35	Non-referred attendances that were bulk billed, by region and age, 2006-07 to 2011-12 (per cent)
Table 10A.36	Non-referred attendances that were bulk billed by age (per cent)
Table 10A.37	People deferring access to GPs due to cost (per cent)
Table 10A.38	Aboriginal and Torres Strait Islander people deferring access to GPs due to cost, 2012-13 (per cent)
Table 10A.39	Waiting time for GPs for an urgent appointment (per cent)
Table 10A.40	Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment (per cent)
Table 10A.41	Selected potentially avoidable GP-type presentations to emergency departments (number)
Table 10A.42	People attending a hospital emergency department who thought the care could have been provided at a general practice
Table 10A.43	People deferring access to prescribed medication due to cost (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.45	Waiting time for public dentistry (per cent)
Table 10A.46	Waiting time for public dentistry by remoteness, Australia
Table 10A.47	Waiting times for public dentistry, Aboriginal and Torres Strait Islander people, by remoteness, Australia, 2012-13 (per cent)
Table 10A.48	Proportion of full time workload equivalent (FWE) GPs with vocational registration by region (per cent)
Table 10A.49	Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region, 2003-04 to 2011-12 (per cent)
Table 10A.50	Number and proportion of full time workload equivalent (FWE) GPs with vocational registration
Table 10A.51	General practices that are accredited at 30 June
Table 10A.52	General practice activity in PIP practices (per cent)
Table 10A.53	Filled prescriptions, ordered by GPs, for oral antibiotics that are used most commonly for treatment of upper respiratory tract infections

Table 10A.54	Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and provided to PBS concession card holders, 2009-10 to 2011-12
Table 10A.55	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied
Table 10A.56	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia
Table 10A.57	Uptake by Practices in the Practice Incentives Program (PIP) of the PIP Diabetes Incentive
Table 10A.58	Proportion of people with known diabetes who had a HbA1c test in the last 12 months, 2011-12 (per cent)
Table 10A.59	Proportion of people aged 18 to 69 years with known diabetes who have a HbA1c (glycated haemoglobin) level less than or equal to 7.0 per cent, by sex, 2011-12 (per cent)
Table 10A.60	Proportion of people with asthma with a written asthma action plan, by age (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.63	Proportion of people with asthma with a written asthma plan, by region, 2007-08
Table 10A.64	GP use of chronic disease management Medicare items for care planning or case conferencing
Table 10A.65	Pathology tests requested by GPs, real benefits paid (2013-14 dollars) and number of rebated MBS pathology items
Table 10A.66	Pathology tests requested by GPs, real benefits paid, 2009-10 to 2011-12 (2013-14 dollars) and number of rebated MBS pathology items
Table 10A.67	Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid (2013-14 dollars) and number of rebated MBS imaging items
Table 10A.68	Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid, 2008-09 to 2011-12 (2013-14 dollars) and number of rebated MBS imaging items
Table 10A.69	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes
Table 10A.70	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region
Table 10A.71	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region, 2010 to 2012
Table 10A.72	Client experience of GPs by remoteness, States and Territories
Table 10A.73	Client experience of GPs by remoteness, Australia
Table 10A.74	Client experience of GPs by remoteness, Aboriginal and Torres Strait Islander people, Australia, 2012-13
Table 10A.75	Client experience of dental professionals by remoteness, States and Territories
Table 10A.76	Client experience of dental professionals by remoteness, Australia
Table 10A.77	Annual health assessments for older people

Table 10A.78	Valid vaccinations supplied to children under seven years of age, by type of provider, 2009–2014
Table 10A.79	Children aged 12 months to less than 15 months who were fully immunised (per cent)
Table 10A.80	Children aged 24 months to less than 27 months who were fully immunised (per cent)
Table 10A.81	Children aged 60 months to less than 63 months who were fully immunised (per cent)
Table 10A.82	Notifications of measles, children aged 0–14 years
Table 10A.83	Notifications of pertussis (whooping cough), children aged 0–14 years
Table 10A.84	Notifications of invasive Haemophilus influenzae type b, children aged 0–14 years
Table 10A.85	Participation rates for women in BreastScreen Australia (24 month period)
Table 10A.86	Participation rates for women in BreastScreen Australia by residential status, 2012 and 2013 (24 month period)
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.88	Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 10A.89	Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent)
Table 10A.90	Participation rates for women in cervical screening programs, by age group (per cent) (24 month period)
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.92	Influenza vaccination coverage, people aged 65 years or over
Table 10A.93	Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009
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.95	Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people)
Table 10A.96	Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people)
Table 10A.97	Separations for selected potentially preventable hospitalisations by remoteness, 2012-13 (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
Table 10A.103	Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2012-13 (per 100 000 people)
Table 10A.104	Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2012-13 (per cent)
Table 10A.105	Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2012-13
Table 10A.106	Separation rates for older people for injuries due to falls
Community health services 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

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10A Primary and community health — attachment

Definitions for the indicators and descriptors in this attachment are in section 10.5 of the chapter. Unsourced information was obtained from the Australian, State and Territory governments.

Data in this Report are examined by the Health Working Group, but have not been formally audited by the Secretariat.

Data reported in the attachment tables are the most accurate available at the time of data collection. Historical data may have been updated since the last edition of RoGS.

This file is available in Adobe PDF format on the Review web page (www.pc.gov.au/gsp).

Attachment contents

Table 10A.1	Types of encounter where a payment source was recorded, 2013-14
Table 10A.2	Australian Government expenditure on GPs through DHS Medicare (fee-for-service) and age standardised expenditure per person (2013-14 dollars)
Table 10A.3	Australian Government total expenditure on GPs and expenditure per person (crude rates) (2013-14 dollars)
Table 10A.4	Australian government expenditure on the Pharmaceutical Benefits Scheme (2013-14 dollars)
Table 10A.5	Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2013-14 dollars)
Table 10A.6	Australian Government expenditure on PBS medicines supplied to Aboriginal Health Services in remote areas
Table 10A.7	Expenditure on dental services (2012-13 dollars) (\$ million)
Table 10A.8	Australian Government funding of Aboriginal and Torres Strait Islander Primary Health Care Services
Table 10A.9	Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs
Table 10A.10	Number of GP-type services used per 1000 people
Table 10A.11	PBS services
Table 10A.12	PBS services, by service type ('000)
Table 10A.13	Use of public dental services, by service type, 2010
Table 10A.14	Alcohol and other drug treatment services, 2012-13 (number)
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.20	Approved providers of PBS medicines, by urban and rural location, at 30 June
Table 10A.21	PBS expenditure per person, by remoteness area (2013-14 dollars)
Table 10A.22	PBS expenditure per person, by urban and rural location, 2009-10 to 2011-12 (2013-14 dollars)
Table 10A.23	Availability of GPs by region, 2013-14
Table 10A.24	Availability of GPs by region, 2004-05 to 2011-12
Table 10A.25	Availability of female GPs
Table 10A.26	Availability of male GPs
Table 10A.27	Availability of public dentists (per 100 000 people)
Table 10A.28	Availability of public dental hygienists and dental therapists (per 100 000 people)
Table 10A.29	Availability of public occupational therapists and psychologists (per 100 000 people)
Table 10A.30	Annual health assessments for older people by Indigenous status (per cent)

Attachment contents

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.34	Non-referred attendances that were bulk billed, by region and age (per cent)
Table 10A.35	Non-referred attendances that were bulk billed, by region and age, 2006-07 to 2011-12 (per cent)
Table 10A.36	Non-referred attendances that were bulk billed by age (per cent)
Table 10A.37	People deferring access to GPs due to cost (per cent)
Table 10A.38	Aboriginal and Torres Strait Islander people deferring access to GPs due to cost, 2012-13 (per cent)
Table 10A.39	Waiting time for GPs for an urgent appointment (per cent)
Table 10A.40	Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment (per cent)
Table 10A.41	Selected potentially avoidable GP-type presentations to emergency departments (number)
Table 10A.42	People attending a hospital emergency department who thought the care could have been provided at a general practice
Table 10A.43	People deferring access to prescribed medication due to cost (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.45	Waiting time for public dentistry (per cent)
Table 10A.46	Waiting time for public dentistry by remoteness, Australia
Table 10A.47	Waiting times for public dentistry, Aboriginal and Torres Strait Islander people, by remoteness, Australia, 2012-13 (per cent)
Table 10A.48	Proportion of full time workload equivalent (FWE) GPs with vocational registration by region (per cent)
Table 10A.49	Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region, 2003-04 to 2011-12 (per cent)
Table 10A.50	Number and proportion of full time workload equivalent (FWE) GPs with vocational registration
Table 10A.51	General practices that are accredited at 30 June
Table 10A.52	General practice activity in PIP practices (per cent)
Table 10A.53	Filled prescriptions, ordered by GPs, for oral antibiotics that are used most commonly for treatment of upper respiratory tract infections
Table 10A.54	Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and provided to PBS concession card holders, 2009-10 to 2011-12
Table 10A.55	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied
Table 10A.56	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia

Attachment contents

Table 10A.57	Uptake by Practices in the Practice Incentives Program (PIP) of the PIP Diabetes Incentive
Table 10A.58	Proportion of people with known diabetes who had a HbA1c test in the last 12 months, 2011-12 (per cent)
Table 10A.59	Proportion of people aged 18 to 69 years with known diabetes who have a HbA1c (glycated haemoglobin) level less than or equal to 7.0 per cent, by sex, 2011-12 (per cent)
Table 10A.60	Proportion of people with asthma with a written asthma action plan, by age (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.63	Proportion of people with asthma with a written asthma plan, by region, 2007-08
Table 10A.64	GP use of chronic disease management Medicare items for care planning or case conferencing
Table 10A.65	Pathology tests requested by GPs, real benefits paid (2013-14 dollars) and number of rebated MBS pathology items
Table 10A.66	Pathology tests requested by GPs, real benefits paid, 2009-10 to 2011-12 (2013-14 dollars) and number of rebated MBS pathology items
Table 10A.67	Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid (2013-14 dollars) and number of rebated MBS imaging items
Table 10A.68	Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid, 2008-09 to 2011-12 (2013-14 dollars) and number of rebated MBS imaging items
Table 10A.69	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes
Table 10A.70	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region
Table 10A.71	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region, 2010 to 2012
Table 10A.72	Client experience of GPs by remoteness, States and Territories
Table 10A.73	Client experience of GPs by remoteness, Australia
Table 10A.74	Client experience of GPs by remoteness, Aboriginal and Torres Strait Islander people, Australia, 2012-13
Table 10A.75	Client experience of dental professionals by remoteness, States and Territories
Table 10A.76	Client experience of dental professionals by remoteness, Australia
Table 10A.77	Annual health assessments for older people
Table 10A.78	Valid vaccinations supplied to children under seven years of age, by type of provider, 2009–2014
Table 10A.79	Children aged 12 months to less than 15 months who were fully immunised (per cent)
Table 10A.80	Children aged 24 months to less than 27 months who were fully immunised (per cent)
Table 10A.81	Children aged 60 months to less than 63 months who were fully immunised (per cent)
Table 10A.82	Notifications of measles, children aged 0–14 years
Table 10A.83	Notifications of pertussis (whooping cough), children aged 0–14 years
Table 10A.84	Notifications of invasive Haemophilus influenzae type b, children aged 0–14 years
Table 10A.85	Participation rates for women in BreastScreen Australia (24 month period)

Attachment contents

Table 10A.86	Participation rates for women in BreastScreen Australia by residential status, 2012 and 2013 (24 month period)
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.88	Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 10A.89	Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent)
Table 10A.90	Participation rates for women in cervical screening programs, by age group (per cent) (24 month period)
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.92	Influenza vaccination coverage, people aged 65 years or over
Table 10A.93	Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009
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.95	Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people)
Table 10A.96	Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people)
Table 10A.97	Separations for selected potentially preventable hospitalisations by remoteness, 2012-13 (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
Table 10A.103	Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2012-13 (per 100 000 people)
Table 10A.104	Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2012-13 (per cent)
Table 10A.105	Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2012-13
Table 10A.106	Separation rates for older people for injuries due to falls
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

Attachment contents

- 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

TABLE 10A.1

Table 10A.1 **Types of encounter where a payment source was recorded, 2013-14 (a), (b)**

	Number	Per cent of encounters (c)		Per cent of direct encounters		Medicare/DVA-
		(n = 88 151)	95% LCL	95% UCL	(n = 86 607)	paid GP items (n = 84 142)
	no.	%	%	%	%	%
Direct encounters	86 607	98.2	98.0	98.5	100.0	..
No charge	332	0.4	0.3	0.5	0.4	..
MBS/DVA items of service (direct encounters only) (d)	84 136	95.4	95.1	95.8	97.1	..
MBS/DVA items of service (GPs only)	84 142	95.5	94.9	95.8	97.2	100.0
Short surgery consultations	1 654	1.9	1.6	2.2	–	2.0
Standard surgery consultations	66 304	75.2	74.0	76.5	0.8	78.8
Long surgery consultations	8 983	10.2	9.5	10.9	0.1	10.7
Prolonged surgery consultations	707	0.8	0.6	1.0	–	0.8
Home or institution visits (excluding RACF)	755	0.9	0.7	1.1	–	0.9
Residential aged care facility	1 558	1.8	1.2	2.3	–	1.9
Health assessments	355	0.4	0.3	0.5	–	0.4
Chronic disease management items	1 255	1.4	1.2	1.6	–	1.5
Case conferences	6	0.0	–	–	–	–
GP mental health care items	1 205	1.4	1.2	1.5	–	1.4
Attendances associated with practice incentive payments	159	0.2	0.1	0.2	–	0.2
Other items	1 201	1.4	0.1	0.7	–	1.4
Workers compensation	1 537	1.7	1.6	1.9	–	..
Other paid (hospital, State, etc.)	603	0.7	0.5	0.8	–	..

TABLE 10A.1

Table 10A.1 **Types of encounter where a payment source was recorded, 2013-14 (a), (b)**

	<i>Number</i>	<i>Per cent of encounters (c) (n = 88 151)</i>	<i>95% LCL</i>	<i>95% UCL</i>	<i>Per cent of direct encounters (n = 86 607)</i>	<i>Medicare/DVA-paid GP items (n = 84 142)</i>
Indirect encounters (e)	1 542	1.7	1.5	2.0	..	..
Direct/indirect encounter unspecified	2	–	–	–	..	..
Total encounters	88 151	100.0	..	..	..	..
MBS/DVA items of service (all encounters)	84 153	95.5			..	..

LCL=lower confidence limit; **UCL**=upper confidence limit; **MBS**=Medicare Benefits Schedule; **DVA**=Department of Veterans' Affairs; **RACF** = Residential aged care facility.

- (a) An encounter is any professional interchange between a patient and a GP or other health professional (other health professionals include practice nurses, Aboriginal health workers and allied health service professionals).
- (b) One Medicare item number counted per encounter (where applicable).
- (c) Missing data removed from analysis ($n=7\ 728$).
- (d) Direct encounters are encounters where the patient is seen by the health professional. Includes direct encounters at which either a GP or other health professional item (or both) was recorded.
- (e) Indirect encounters are encounters where the patient is not seen but a service is provided (for example, a prescription or referral). Includes indirect encounters involving a GP or other health professional (or both). Includes five encounters involving chronic disease management or case conference items.
- .. Not applicable. – Nil or rounded to zero.

Source: Britt, H., Miller, G.C, Henderson, J., Bayram, C., Harrison, C., Valenti, L., Wong, C., Gordon, J., Pollack, A.J., Pan, Y. and Charles, J. 2014, *General practice activity in Australia 2013–14*, General practice series no. 36, Sydney University Press, Sydney.

Table 10A.2 Australian Government expenditure on GPs through DHS Medicare (fee-for-service) and age standardised expenditure per person (2013-14 dollars) (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
Expenditure through DHS Medicare fee for service — total										
2012-13	\$m	2 374.6	1 728.0	1 425.1	562.2	519.2	150.4	84.2	47.0	6 890.7
2013-14	\$m	2 491.7	1 829.7	1 512.7	611.6	540.9	154.8	87.2	52.1	7 280.8
Expenditure through DHS Medicare fee for service — per person (ASR) (e), (f)										
2012-13	\$	305.6	290.4	302.4	226.5	287.3	267.2	226.9	224.9	288.4
2013-14	\$	314.8	301.2	314.2	238.6	295.6	272.5	230.7	241.4	298.6

ASR = age standardised rate. **DHS** = Department of Human Services (Australian Government).

(a) Age standardised expenditure per person data are available from the 2012-13 reference year. Data for previous years are provided in table 10A.3.

(b) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.

(b) Some primary care services are provided by salaried GPs in community health services, particularly in rural and remote areas, through emergency departments and Aboriginal community controlled health services (ACCHSs). Consequently, expenditure reported through Medicare fee-for-service statistics will be understated in jurisdictions with larger proportions of rural and remote populations.

(c) Data include expenditure on DHS Medicare and the DVA. Data exclude expenditure on the Practice Incentives Program (PIP), the General Practice Immunisation Incentive Scheme (GPPI) and Medicare Locals (ML). Data are not comparable with data in table 10A.3 that include this expenditure.

(d) Data for Australia includes expenditure on patients of unknown age.

(e) Expenditure per person is directly age standardised to the 2001 Australian standard population. Expenditure on Medicare Locals, GPPI and PIP is excluded as these are not related to age and cannot be age-standardised. Data are not comparable to previous years for which crude rates are reported (see table 10A.3).

(f) Rates are derived using the ABS first preliminary estimated resident population based on the 2011 Census.

Source: Department of Health unpublished, MBS statistics; DVA unpublished; table 2A.51.

TABLE 10A.3

Table 10A.3 **Australian Government total expenditure on GPs and expenditure per person (crude rates) (2013-14 dollars) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Expenditure (c)										
2006-07	\$m	2 226.3	1 543.6	1 235.8	528.3	499.7	144.2	77.5	34.6	6 289.9
2007-08	\$m	2 308.9	1 630.0	1 303.7	553.2	521.7	150.9	81.3	38.1	6 587.7
2008-09	\$m	2 301.1	1 634.8	1 322.6	548.2	524.2	147.8	80.6	38.2	6 597.6
2009-10	\$m	2 326.7	1 674.7	1 362.8	558.4	530.4	151.4	80.8	41.3	6 726.5
2010-11	\$m	2 333.1	1 695.8	1 383.4	558.2	528.1	151.3	80.6	43.5	6 773.9
2011-12	\$m	2 378.5	1 722.1	1 425.7	558.3	529.3	153.1	82.3	45.1	6 894.4
2012-13	\$m	2 553.8	1 873.5	1 544.1	624.3	572.9	168.6	90.5	59.8	7 487.5
2013-14 (e)	\$m	2 668.6	1 977.2	1 634.7	673.1	594.3	177.4	94.0	66.2	7 885.5
Expenditure per person (crude rates) (f)										
2006-07	\$	328.1	302.4	304.7	254.4	320.1	293.4	229.0	164.0	304.9
2007-08	\$	335.4	313.5	313.4	259.1	330.5	304.3	236.2	175.9	313.5
2008-09	\$	328.6	307.7	309.3	248.2	328.1	294.6	229.6	171.7	307.2
2009-10	\$	327.6	309.0	312.0	246.7	327.7	298.9	225.8	181.3	307.6
2010-11	\$	324.9	308.6	311.8	240.7	323.5	296.5	220.9	188.9	305.5
2011-12	\$	328.2	308.9	315.9	233.9	321.8	299.2	222.0	194.1	306.6
2012-13	\$	347.5	329.9	334.9	252.5	344.7	329.0	238.4	252.5	326.9
2013-14	\$	357.5	341.4	348.5	263.9	354.3	345.2	244.7	272.9	338.2

(a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.

(b) Rates are derived using the ABS final 2011 Census rebased estimated resident population (ERP).

(c) Data include expenditure on Department of Human Services—Medicare, the Practice Incentives Program (PIP), the Department of Veterans' Affairs (DVA) and the General Practice Immunisation Incentive Scheme (GPPI). Data include expenditure on the Divisions of General Practice Program (DGPP) for 2011-12 and previous years. From 2012-13, total expenditure data include core operational expenditure on Medicare Locals (ML).

Table 10A.3 Australian Government total expenditure on GPs and expenditure per person (crude rates) (2013-14 dollars) (a), (b), (c), (d), (e)

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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- (d) From 2010-11, DVA data include expenditure only on specialist GPs. DVA data for 2009-10 and previous years include expenditure on all local medical officers (LMO). Other data include expenditure on vocationally registered GPs and other medical practitioners (OMPs).
- (e) Some primary care services are provided by salaried GPs in community health services, particularly in rural and remote areas, through emergency departments and Aboriginal community controlled health services (ACCHSs). Consequently, expenditure reported through Medicare fee-for-service statistics will be understated in jurisdictions with larger proportions of rural and remote populations.
- (f) Expenditure data for 2011-12 and previous years are crude rates and are not comparable with data for 2012-13 and subsequent years, which are age-standardised. See table 10A.2 for age-standardised expenditure per person data for 2012-13.

Source: Department of Health unpublished, MBS, PIP, GPPII, DGPP, ML and DVA data collections; table 2A.51.

Table 10A.4 **Australian government expenditure on the Pharmaceutical Benefits Scheme (2013-14 dollars) (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS Total (d)										
2004-05	\$m	2 433.0	1 756.7	1 316.5	605.5	588.0	185.8	88.7	24.9	6 999.4
2005-06	\$m	2 348.5	1 710.4	1 273.6	585.9	581.5	184.1	85.3	24.7	6 793.9
2006-07	\$m	2 296.6	1 660.0	1 263.0	578.1	564.3	178.1	82.5	23.7	6 646.2
2007-08	\$m	2 384.0	1 725.6	1 312.2	603.7	591.3	187.4	85.1	25.1	6 914.4
2008-09	\$m	2 554.1	1 830.2	1 408.4	650.8	622.7	199.4	90.3	26.7	7 382.6
2009-10	\$m	2 658.0	1 907.6	1 476.0	669.4	643.9	208.8	94.8	27.2	7 685.8
2010-11	\$m	2 645.6	1 886.3	1 462.7	678.6	629.5	210.3	94.2	28.0	7 635.1
2011-12	\$m	2 643.9	1 897.5	1 486.5	717.5	638.0	213.5	94.1	27.7	7 718.7
2012-13	\$m	2 442.7	1 762.8	1 382.0	646.1	597.5	194.1	90.5	25.7	7 141.4
2013-14	\$m	2 503.9	1 815.8	1 395.6	672.7	599.9	200.7	92.4	27.6	7 308.6
RPBS Total (e)										
2004-05	\$m	218.6	135.6	137.3	47.1	47.2	18.7	8.8	1.2	614.4
2005-06	\$m	202.4	126.8	127.5	44.2	44.9	17.9	8.4	1.2	573.2
2006-07	\$m	187.4	117.1	120.4	41.7	41.6	16.0	7.8	1.0	533.1
2007-08	\$m	183.2	112.2	118.2	41.4	40.2	15.8	7.9	1.0	520.0
2008-09	\$m	184.3	109.9	119.0	41.3	40.1	15.6	8.0	1.0	519.3
2009-10	\$m	182.4	107.7	119.6	39.7	40.3	15.4	7.9	1.0	514.1
2010-11	\$m	168.9	97.8	113.5	37.4	35.6	14.3	7.5	0.9	475.8
2011-12	\$m	159.9	90.8	110.9	36.6	34.3	14.0	7.0	0.9	454.4
2012-13	\$m	140.6	78.1	98.7	31.1	28.9	12.1	6.5	0.8	396.8
2013-14	\$m	127.2	71.6	90.9	29.7	25.4	10.8	6.0	0.8	362.4
PBS and RPBS TOTAL										
2004-05	\$m	2 651.5	1 892.3	1 453.8	652.5	635.2	204.5	97.6	26.1	7 613.8
2005-06	\$m	2 550.9	1 837.2	1 401.1	630.1	626.4	202.0	93.7	25.8	7 367.2
2006-07	\$m	2 484.0	1 777.1	1 383.3	619.8	605.9	194.1	90.3	24.7	7 179.3

Table 10A.4

Australian government expenditure on the Pharmaceutical Benefits Scheme (2013-14 dollars) (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2007-08	\$m	2 567.2	1 837.8	1 430.4	645.1	631.5	203.2	93.0	26.2	7 434.4
2008-09	\$m	2 738.4	1 940.1	1 527.5	692.1	662.8	215.1	98.3	27.7	7 901.9
2009-10	\$m	2 840.4	2 015.3	1 595.6	709.0	684.2	224.3	102.7	28.2	8 199.8
2010-11	\$m	2 814.5	1 984.0	1 576.3	716.0	665.1	224.6	101.6	28.9	8 111.0
2011-12	\$m	2 803.9	1 988.3	1 597.4	754.1	672.3	227.5	101.0	28.6	8 173.1
2012-13	\$m	2 583.3	1 840.9	1 480.7	677.2	626.4	206.2	97.0	26.5	7 538.2
2013-14	\$m	2 631.1	1 887.3	1 486.5	702.4	625.3	211.5	98.4	28.4	7 670.9
PBS total expenditure per person (f)										
2004-05	\$	357.78	348.55	331.79	300.13	380.87	381.93	272.69	123.09	343.27
2005-06	\$	345.18	335.50	313.82	287.08	372.26	376.18	255.91	117.89	329.85
2006-07	\$	334.36	320.75	304.97	277.41	357.48	361.58	244.69	111.07	318.11
2007-08	\$	343.34	328.21	309.53	282.80	370.72	377.29	249.05	115.16	325.71
2008-09	\$	361.93	340.41	322.97	294.71	385.56	397.91	259.07	119.88	340.34
2009-10	\$	368.90	346.39	329.25	294.36	393.41	412.57	266.59	119.14	346.23
2010-11	\$	363.12	337.04	320.81	292.39	380.78	412.25	259.72	121.43	339.02
2011-12	\$	364.18	339.79	328.75	300.11	387.20	416.73	253.32	118.82	342.69
2012-13	\$	331.72	309.70	299.00	260.84	358.78	378.20	238.04	107.95	311.11
2013-14	\$	334.65	312.86	296.79	263.23	356.95	389.87	240.08	113.25	312.72
Proportion of PBS expenditure that is concessional										
2004-05	%	79.8	79.8	79.4	77.8	81.4	84.6	66.0	66.8	79.6
2005-06	%	80.3	80.3	79.6	77.9	82.3	85.0	66.7	67.1	80.0
2006-07	%	80.8	80.8	80.0	77.2	82.4	84.9	66.8	68.6	80.4
2007-08	%	79.9	80.1	78.6	75.0	81.8	84.7	65.5	66.8	79.3
2008-09	%	78.7	78.8	76.8	73.0	80.8	82.6	63.7	64.1	77.9
2009-10	%	78.9	78.8	76.8	72.6	81.0	82.0	62.7	63.7	77.9

Table 10A.4

Australian government expenditure on the Pharmaceutical Benefits Scheme (2013-14 dollars) (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2010-11	%	78.7	78.4	76.9	71.7	80.6	81.8	62.3	62.1	77.7
2011-12	%	79.0	78.2	77.6	71.3	80.8	81.9	62.5	62.7	77.8
2012-13	%	79.7	78.8	78.8	71.3	81.2	83.2	63.2	64.1	78.5
2013-14	%	79.4	78.2	78.8	70.5	80.7	83.0	63.1	63.4	78.1

- (a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.
- (b) From 2012-13, rates are derived using the 31 December ABS 2011 Census based estimated resident population (ERP) for the reference year and differ from rates reported in table 10A.21 which use the June 30 ERP preceding the reference year. Rates for earlier years are derived using ERPs based on earlier Censuses. Rates based on different Censuses are not comparable.
- (c) State and Territory level data are only available on a cash basis for general, concessional and doctor's bag categories. These figures are not directly comparable to those published in the Department of Health annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements (such as medicines supplied in bulk to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing \$36.9 million for 2012-13, of which the NT accounted for 51 per cent [table 10A.6]).
- (d) PBS total includes PBS general ordinary, general safety net, concessional ordinary, concessional safety net and doctor's bag.
- (e) Includes RPBS general ordinary and RPBS general safety net.
- (f) PBS expenditure per person exclude RPBS and doctor's bag.

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

TABLE 10A.5

Table 10A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2013-14 dollars) (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>2009-10</i>										
PBS General Ordinary	\$m	479.8	348.6	295.1	160.3	106.8	33.0	30.8	9.2	1 463.6
PBS General Safety Net	\$m	76.4	52.8	43.7	21.8	14.2	4.2	4.4	0.6	218.1
<i>PBS General total</i>	\$m	556.1	401.4	338.8	182.1	121.0	37.3	35.2	9.8	1 681.7
PBS Concessional Ordinary	\$m	1 607.5	1 156.9	866.9	382.9	404.3	131.1	47.7	15.2	4 612.4
PBS Concessional Free Safety Net	\$m	489.4	345.6	267.0	103.3	117.5	40.1	11.7	2.1	1 376.7
<i>PBS Concessional total (a)</i>	\$m	2 096.8	1 502.5	1 133.9	486.2	521.8	171.2	59.4	17.3	5 989.2
PBS Unknown Free Safety Net	\$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	\$m	5.0	3.7	3.3	1.1	1.1	0.3	0.2	0.1	14.8
<i>PBS Unknown free safety net plus Doctors bag</i>	\$m	5.0	3.7	3.3	1.1	1.1	0.3	0.2	0.1	14.8
PBS Total	\$m	2 658.0	1 907.6	1 476.0	669.4	643.9	208.8	94.8	27.2	7 685.8
RPBS Total (d)	\$m	182.4	107.7	119.6	39.7	40.3	15.4	7.9	1.0	514.1
PBS and RPBS TOTAL	\$m	2 840.4	2 015.3	1 595.6	709.0	684.2	224.3	102.7	28.2	8 199.8
PBS total expenditure per person (e)	\$	368.9	346.4	329.2	294.4	393.4	412.6	266.6	119.1	346.2
Proportion of PBS expenditure that is concessional	%	78.9	78.8	76.8	72.6	81.0	82.0	62.7	63.7	77.9
<i>2010-11</i>										
PBS General Ordinary	\$m	481.5	350.2	289.7	167.8	106.6	33.8	30.7	9.8	1 470.1
PBS General Safety Net	\$m	76.2	53.1	44.1	23.0	14.7	4.0	4.7	0.7	220.5
<i>PBS General total</i>	\$m	557.7	403.3	333.8	190.8	121.3	37.8	35.4	10.5	1 690.7
PBS Concessional Ordinary	\$m	1 591.9	1 131.4	856.6	381.3	389.0	132.6	47.0	15.2	4 545.0

TABLE 10A.5

Table 10A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2013-14 dollars) (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS Concessional Free Safety Net	\$m	491.1	347.8	268.9	105.4	118.2	39.5	11.6	2.2	1 384.7
<i>PBS Concessional total (a)</i>	\$m	2 083.0	1 479.2	1 125.5	486.7	507.1	172.1	58.6	17.4	5 929.7
PBS Unknown Free Safety Net	\$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	\$m	4.9	3.7	3.4	1.1	1.1	0.4	0.2	0.1	14.8
<i>PBS Unknown free safety net plus Doctors bag</i>	\$m	4.9	3.7	3.4	1.1	1.1	0.4	0.2	0.1	14.8
PBS Total	\$m	2 645.6	1 886.3	1 462.7	678.6	629.5	210.3	94.2	28.0	7 635.1
RPBS Total (d)	\$m	168.9	97.8	113.5	37.4	35.6	14.3	7.5	0.9	475.8
PBS and RPBS TOTAL	\$m	2 814.5	1 984.0	1 576.3	716.0	665.1	224.6	101.6	28.9	8 111.0
PBS total expenditure per person (e)	\$	363.1	337.0	320.8	292.4	380.8	412.2	259.7	121.4	339.0
Proportion of PBS expenditure that is concessional	%	78.7	78.4	76.9	71.7	80.6	81.8	62.3	62.1	77.7
<i>2011-12</i>										
PBS General Ordinary	\$m	479.9	357.3	287.4	182.1	106.9	34.4	30.4	9.6	1 488.0
PBS General Safety Net	\$m	71.4	52.4	42.2	22.9	14.8	4.1	4.7	0.6	213.1
<i>PBS General total</i>	\$m	551.3	409.7	329.6	205.0	121.7	38.4	35.1	10.3	1 701.1
PBS Concessional Ordinary	\$m	1 587.2	1 128.1	876.2	402.3	392.1	133.8	46.7	15.2	4 581.5
PBS Concessional Free Safety Net	\$m	501.0	356.4	277.9	109.1	123.2	41.0	12.1	2.2	1 422.9
<i>PBS Concessional total (a)</i>	\$m	2 088.2	1 484.5	1 154.1	511.4	515.3	174.8	58.8	17.4	6 004.4
PBS Unknown Free Safety Net	\$m	–	–	–	–	–	–	–	–	–

TABLE 10A.5

Table 10A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2013-14 dollars) (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS Doctors Bag	\$m	4.4	3.4	2.9	1.1	1.0	0.3	0.2	0.1	13.3
<i>PBS Unknown free safety net plus Doctors bag</i>	\$m	4.4	3.4	2.9	1.1	1.0	0.3	0.2	0.1	13.3
PBS Total	\$m	2 643.9	1 897.5	1 486.5	717.5	638.0	213.5	94.1	27.7	7 718.7
RPBS Total (d)	\$m	159.9	90.8	110.9	36.6	34.3	14.0	7.0	0.9	454.4
PBS and RPBS TOTAL	\$m	2 803.9	1 988.3	1 597.4	754.1	672.3	227.5	101.0	28.6	8 173.1
PBS total expenditure per person (e)	\$	364.2	339.8	328.7	300.1	387.2	416.7	253.3	118.8	342.7
Proportion of PBS expenditure that is concessional	%	79.0	78.2	77.6	71.3	80.8	81.9	62.5	62.7	77.8
<i>2012-13</i>										
PBS General Ordinary	\$m	431.8	330.4	256.5	166.3	98.6	29.1	29.2	8.6	1 350.5
PBS General Safety Net	\$m	59.3	40.2	32.9	18.2	12.5	3.2	3.9	0.5	170.6
<i>PBS General total</i>	\$m	491.1	370.6	289.3	184.4	111.1	32.3	33.1	9.1	1 521.0
PBS Concessional Ordinary	\$m	1 465.8	1 050.1	821.9	357.9	365.6	122.1	45.5	14.3	4 243.0
PBS Concessional Free Safety Net	\$m	480.9	338.3	267.5	102.7	119.6	39.5	11.8	2.1	1 362.4
<i>PBS Concessional total (a)</i>	\$m	1 946.7	1 388.4	1 089.4	460.6	485.2	161.5	57.2	16.4	5 605.5
PBS Unknown Free Safety Net	\$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	\$m	4.9	3.8	3.3	1.1	1.2	0.3	0.2	0.1	14.9
<i>PBS Unknown free safety net plus Doctors bag</i>	\$m	4.9	3.8	3.3	1.1	1.2	0.3	0.2	0.1	14.9
PBS Total	\$m	2 442.7	1 762.8	1 382.0	646.1	597.5	194.1	90.5	25.7	7 141.4
RPBS Total (d)	\$m	140.6	78.1	98.7	31.1	28.9	12.1	6.5	0.8	396.8

TABLE 10A.5

Table 10A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2013-14 dollars) (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS and RPBS TOTAL	\$m	2 583.3	1 840.9	1 480.7	677.2	626.4	206.2	97.0	26.5	7 538.2
PBS total expenditure per person (e)	\$	331.7	309.7	299.0	260.8	358.8	378.2	238.0	107.9	311.1
Proportion of PBS expenditure that is concessional	%	79.7	78.8	78.8	71.3	81.2	83.2	63.2	64.1	78.5
<i>2013-14</i>										
PBS General Ordinary	\$m	457.3	355.7	263.2	180.0	102.9	30.9	30.3	9.5	1 429.9
PBS General Safety Net	\$m	53.4	36.4	29.4	16.9	11.6	2.9	3.6	0.5	154.7
<i>PBS General total</i>	<i>\$m</i>	<i>510.7</i>	<i>392.1</i>	<i>292.7</i>	<i>196.9</i>	<i>114.5</i>	<i>33.8</i>	<i>33.9</i>	<i>10.0</i>	<i>1 584.6</i>
PBS Concessional Ordinary	\$m	1 498.0	1 075.0	826.2	368.7	364.5	125.7	46.0	15.3	4 319.4
PBS Concessional Free Safety Net	\$m	489.6	344.6	273.3	105.9	119.8	40.9	12.3	2.2	1 388.6
<i>PBS Concessional total (a)</i>	<i>\$m</i>	<i>1 987.6</i>	<i>1 419.7</i>	<i>1 099.6</i>	<i>474.5</i>	<i>484.2</i>	<i>166.6</i>	<i>58.3</i>	<i>17.5</i>	<i>5 708.0</i>
PBS Unknown Free Safety Net	\$m	—	—	—	—	—	—	—	—	—
PBS Doctors Bag	\$m	5.6	4.0	3.4	1.3	1.2	0.3	0.2	0.1	16.0
<i>PBS Unknown free safety net plus Doctors bag</i>	<i>\$m</i>	<i>5.6</i>	<i>4.0</i>	<i>3.4</i>	<i>1.3</i>	<i>1.2</i>	<i>0.3</i>	<i>0.2</i>	<i>0.1</i>	<i>16.0</i>
PBS Total	\$m	2 503.9	1 815.8	1 395.6	672.7	599.9	200.7	92.4	27.6	7 308.6
RPBS Total (d)	\$m	127.2	71.6	90.9	29.7	25.4	10.8	6.0	0.8	362.4
PBS and RPBS TOTAL	\$m	2 631.1	1 887.3	1 486.5	702.4	625.3	211.5	98.4	28.4	7 670.9
PBS total expenditure per person (e)	\$	334.6	312.9	296.8	263.2	356.9	389.9	240.1	113.2	312.7
Proportion of PBS expenditure that is concessional	%	79.4	78.2	78.8	70.5	80.7	83.0	63.1	63.4	78.1

Table 10A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2013-14 dollars) (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(a)	Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.									
(b)	From 2012-13, rates are derived using the 31 December ABS 2011 Census based estimated resident population (ERP) for the reference year and differ from rates reported in table 10A.21 which use the June 30 ERP preceding the reference year. Rates for earlier years are derived using ERPs based on earlier Censuses. Rates based on different Censuses are not comparable.									
(c)	State and Territory level data are only available on a cash basis for general, concessional and doctor's bag categories. These figures are not directly comparable to those published in the Department of Health annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements (such as medicines supplied in bulk to remote and very remote areas under s.100 of the <i>National Health Act 1953</i> [Cwith] — costing \$36.9 million for 2012-13, of which the NT accounted for 51 per cent [table 10A.6]).									
(d)	Includes RPBS ordinary and RPBS safety net.									
(e)	PBS expenditure per person excludes RPBS and PBS doctor's bag. – Nil or rounded to zero.									

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

Table 10A.6 **Australian Government expenditure on PBS medicines supplied to Aboriginal Health Services in remote areas (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
2012-13	\$'000	105.0	–	6 691.1	10 534.2	808.9	89.0	–	18 978.5	37 206.6
2013-14	\$'000	93.7	–	6 845.3	10 363.0	905.6	110.9	–	20 194.8	38 513.4

(a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.

(b) Includes expenditure on PBS medicines supplied in bulk under s.100 of the *National Health Act 1953* (Cwlth) to Aboriginal Health Services in remote and very remote areas.

(c) This program seeks to address identified barriers to accessing essential medicines experienced by Aboriginal and Torres Strait Islander people living in remote areas (see <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-indigenous-faq> accessed 15 September 2014).

(d) Allocation to state and territory is based on location of the Aboriginal Health Service. Clients are not necessarily resident in the same state or territory.
– Nil or rounded to zero.

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

TABLE 10A.7

Table 10A.7 Expenditure on dental services (2012-13 dollars) (\$ million)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
2012-13									
Government									
Australian Government									
DVA	34	17	30	10	9	2	-2	-	100
Department of Health and other (a)	390	197	157	21	61	9	6	3	843
Insurance premium rebates (b)	191	121	126	90	53	11	11	4	606
Total	614	335	313	121	123	22	15	7	1 550
State, Territory and Local Government	158	153	169	77	62	18	10	9	657
Total government	772	489	482	197	185	40	25	17	2 207
Non-government	1 852	2 197	870	993	272	108	132	75	6 500
Total government and non-government	2 624	2 686	1 352	1 190	457	149	157	92	8 706

DVA = Department of Veterans' Affairs

- (a) 'Department of Health and other' comprises Department of Health funded expenditure such as on MBS and PBS, and other Australian Government expenditure such as for the SPP associated with the National Healthcare Agreement and health-related NP payments, capital consumption, estimates of the medical expenses tax offset, and health research not funded by Department of Health.
- (b) Includes the 30-40 per cent rebate on health insurance premiums that can be claimed either directly from the Australian Government through the taxation system or it may involve a reduced premium being charged by the private health insurance fund.
- Nil or rounded to zero.

Source: AIHW 2014, *Health Expenditure Australia 2012-13*, Health and Welfare Expenditure Series no. 52, Cat. no. HWE 61.

Table 10A.8 Australian Government funding of Aboriginal and Torres Strait Islander Primary Health Care Services (a), (b), (c), (d)

	<i>Unit</i>	<i>NSW/ACT</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2009-10	\$m	95.1	39.3	106.7	81.5	41.5	8.4	np	145.4	517.7
2010-11	\$m	97.9	42.3	99.4	91.2	45.2	8.8	np	135.4	520.3
2011-12	\$m	105.9	41.5	102.6	93.9	42.6	10.1	np	145.0	541.6
2012-13	\$m	109.3	43.4	95.0	90.9	45.5	9.8	np	141.3	535.3
2013-14	\$m	128.2	43.8	124.9	97.3	45.6	14.8	np	127.7	582.4

(a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.

(b) Data reflect funding provided to all organisations for which primary function is primary health care and/or substance use and/or mental health services (excludes GST). Excludes funding to Peak bodies.

(c) Funding for Capital Works is not included.

(d) Data for NSW and the ACT have been combined in order to avoid the identification of individual services.

np = Not published.

Source: Department of Health unpublished, table 2A.51.

TABLE 10A.9

Table 10A.9 **Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
GP numbers										
2004-05	no.	7 590	5 721	4 644	2 175	1 944	609	375	320	23 378
2005-06	no.	7 708	5 802	4 793	2 240	1 980	625	381	305	23 834
2006-07	no.	7 855	5 914	4 864	2 310	1 990	642	373	324	24 272
2007-08	no.	7 934	6 062	5 052	2 357	2 099	661	383	355	24 903
2008-09	no.	8 105	6 240	5 340	2 458	2 141	679	385	378	25 726
2009-10	no.	8 389	6 449	5 564	2 492	2 201	704	398	416	26 613
2010-11	no.	8 654	6 710	5 810	2 614	2 253	719	416	463	27 639
2011-12	no.	8 998	7 033	6 199	2 744	2 348	770	440	479	29 011
2012-13	no.	9 427	7 344	6 629	2 973	2 448	810	470	580	30 681
2013-14	no.	9 969	7 800	6 970	3 192	2 554	855	466	595	32 401
FWE GPs										
2004-05	no.	6 222	4 167	3 389	1 457	1 364	378	200	95	17 273
2005-06	no.	6 310	4 283	3 489	1 473	1 404	386	208	97	17 649
2006-07	no.	6 483	4 407	3 564	1 500	1 416	391	226	104	18 091
2007-08	no.	6 600	4 584	3 683	1 542	1 455	401	232	116	18 613
2008-09	no.	6 792	4 738	3 861	1 574	1 511	404	235	116	19 231
2009-10	no.	6 893	4 901	3 993	1 615	1 546	417	238	127	19 729
2010-11	no.	7 067	5 063	4 126	1 640	1 570	429	239	134	20 267
2011-12	no.	7 338	5 270	4 343	1 698	1 628	449	250	142	21 119
2012-13	no.	7 593	5 544	4 573	1 803	1 681	464	272	158	22 087
2013-14	no.	7 927	5 828	4 818	1 953	1 739	476	277	175	23 194
FWE GPs per 100 000 people (e)										
2004-05	per 100 000 people	93.3	84.1	87.5	73.1	89.0	78.0	60.7	46.8	86.2
2005-06	per 100 000 people	93.9	85.3	88.0	72.6	90.9	79.2	62.2	46.6	86.9
2006-07	per 100 000 people	95.5	86.3	87.9	72.2	90.7	79.6	66.9	49.1	87.7

TABLE 10A.9

Table 10A.9 **Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2007-08	per 100 000 people	95.9	88.2	88.5	72.2	92.2	81.0	67.5	53.4	88.6
2008-09	per 100 000 people	97.0	89.2	90.3	71.3	94.6	80.5	67.0	52.0	89.5
2009-10	per 100 000 people	97.1	90.4	91.4	71.3	95.5	82.4	66.6	55.6	90.2
2010-11	per 100 000 people	98.4	92.1	93.0	70.7	96.2	84.1	65.5	58.1	91.4
2011-12	per 100 000 people	101.2	94.5	96.2	71.1	99.0	87.8	67.6	61.0	93.9
2012-13	per 100 000 people	103.3	97.6	99.2	72.9	101.1	90.5	71.8	66.5	96.4
2013-14	per 100 000 people	106.2	100.6	102.7	76.6	103.7	92.7	72.0	72.3	99.5

- (a) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.
- (b) GP and FWE data include vocationally registered GPs and other medical practitioners (OMPs).
- (c) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.
- (d) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.
- (e) Estimated Resident Populations (ERPs) used to derive rates are revised to the ABS' final 2011 Census rebased estimates for 31 December. See chapter 2 (table 2A.2) for details.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.10

Table 10A.10 Number of GP-type services used per 1000 people (a), (b), (c), (d)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09	5 951.8	5 491.1	5 656.2	4 740.2	5 519.4	5 072.6	4 494.6	3 363.1	5 552.9
2009-10	6 043.5	5 612.1	5 845.4	4 808.3	5 666.4	5 341.4	4 621.9	3 633.1	5 678.9
2010-11	5 956.6	5 631.5	5 705.4	4 676.2	5 554.2	5 154.3	4 520.8	3 670.6	5 598.9
2011-12	6 161.8	5 809.9	6 000.2	4 663.8	5 651.8	5 574.4	4 560.2	3 955.0	5 783.1
2012-13 (e)	6 125.6	5 839.5	5 968.5	4 626.3	5 690.2	5 268.3	4 705.6	4 156.1	5 767.6
2013-14	6 238.5	5 991.9	6 087.3	4 767.2	5 764.4	5 315.1	4 755.9	4 465.6	5 889.4

(a) Includes non-referred attendances by vocationally registered GPs and OMPs, and practice nurses.

(b) Rates are directly age standardised to the Australian population as at 30 June 2001.

(c) From 2011-12, age-standardised rates are derived using the ABS estimated resident population (ERP) at 31 December, based on the 2011 Census. Rates for previous years are derived using the ABS ERP at 30 June preceding the reference year, based on the 2006 Census. Rates derived using ERPs based on different Censuses are not comparable.

(d) DVA data are included.

Source: Department of Health unpublished, MBS Statistics; DVA unpublished, DVA data collection.

Table 10A.11

PBS services

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
PBS Total (b)										
2004-05	'000	58 751.2	42 867.3	32 156.7	14 851.4	14 314.0	4 777.0	1 971.1	589.8	170 278.5
2005-06	'000	57 822.1	42 716.2	31 508.1	14 609.4	14 319.8	4 838.5	1 918.6	590.0	168 322.6
2006-07	'000	58 050.4	42 583.8	32 008.2	14 571.3	14 144.5	4 723.0	1 881.9	572.6	168 535.5
2007-08	'000	58 467.4	43 649.9	32 693.8	14 593.3	14 537.4	4 864.0	1 897.3	592.9	171 296.0
2008-09	'000	62 123.6	46 221.7	34 874.5	15 602.7	15 319.6	5 089.4	1 990.4	614.1	181 836.1
2009-10	'000	62 716.4	46 882.6	35 292.2	15 531.6	15 727.3	5 115.7	2 024.2	621.5	183 911.5
2010-11	'000	64 112.6	47 935.7	36 242.5	15 976.2	15 837.6	5 296.6	2 106.1	635.0	188 142.3
2011-12	'000	65 896.3	49 189.6	37 910.2	17 107.8	16 445.8	5 563.3	2 112.7	647.4	194 873.1
2012-13	'000	66 639.3	49 861.2	38 932.6	16 735.9	16 821.3	5 494.5	2 156.6	664.1	197 305.4
2013-14	'000	70 984.7	53 297.9	40 920.3	18 041.8	17 752.1	5 856.6	2 238.5	724.1	209 816.0
RPBS Total (c)										
2004-05	'000	5 547.3	3 517.0	3 491.2	1 215.7	1 213.1	524.6	197.3	28.5	15 734.7
2005-06	'000	5 311.9	3 415.1	3 336.3	1 183.1	1 187.0	510.3	195.7	28.4	15 167.8
2006-07	'000	5 172.0	3 321.8	3 312.7	1 168.2	1 143.4	479.5	197.6	27.6	14 822.8
2007-08	'000	4 915.7	3 177.8	3 234.6	1 123.5	1 116.8	461.9	197.2	28.6	14 256.1
2008-09	'000	4 936.2	3 160.3	3 298.2	1 136.7	1 122.3	454.3	199.2	28.9	14 336.1
2009-10	'000	4 768.4	3 047.3	3 213.5	1 073.9	1 097.4	438.0	197.5	27.8	13 863.9
2010-11	'000	4 572.5	2 900.6	3 111.1	1 032.3	1 020.5	419.1	194.2	26.3	13 276.7
2011-12	'000	4 403.5	2 784.2	3 108.2	1 036.7	1 004.3	410.1	186.5	27.1	12 960.6
2012-13	'000	4 177.1	2 655.0	3 030.2	975.2	942.7	374.7	189.3	27.0	12 371.3
2013-14	'000	4 118.8	2 649.6	3 038.8	1 007.8	932.5	371.7	190.9	28.1	12 338.3
PBS and RPBS Total										
2004-05	'000	64 298.5	46 384.2	35 647.9	16 067.1	15 527.2	5 301.5	2 168.4	618.3	186 013.1
2005-06	'000	63 134.0	46 131.3	34 844.4	15 792.5	15 506.8	5 348.8	2 114.3	618.4	183 490.5
2006-07	'000	63 222.3	45 905.6	35 320.9	15 739.5	15 287.9	5 202.5	2 079.4	600.2	183 358.3

TABLE 10A.11

Table 10A.11

PBS services

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
2007-08	'000	63 383.1	46 827.7	35 928.4	15 716.9	15 654.2	5 325.9	2 094.5	621.5	185 552.2
2008-09	'000	67 059.8	49 382.0	38 172.8	16 739.4	16 441.9	5 543.7	2 189.6	643.0	196 172.2
2009-10	'000	67 484.8	49 929.9	38 505.8	16 605.6	16 824.6	5 553.8	2 221.7	649.3	197 775.4
2010-11	'000	68 685.0	50 836.3	39 353.6	17 008.5	16 858.1	5 715.8	2 300.3	661.3	201 418.9
2011-12	'000	70 299.8	51 973.8	41 018.4	18 144.4	17 450.1	5 973.4	2 299.3	674.5	207 833.7
2012-13	'000	70 816.4	52 516.1	41 962.8	17 711.1	17 764.1	5 869.2	2 345.9	691.1	209 676.6
2013-14	'000	75 103.5	55 947.5	43 959.2	19 049.6	18 684.6	6 228.3	2 429.4	752.2	222 154.3
PBS total services per person (d)										
2004-05	no.	8.6	8.5	8.1	7.4	9.3	9.8	6.0	2.9	8.3
2005-06	no.	8.5	8.4	7.8	7.2	9.2	9.9	5.8	2.8	8.2
2006-07	no.	8.5	8.2	7.7	7.0	9.0	9.6	5.6	2.7	8.1
2007-08	no.	8.4	8.3	7.7	6.8	9.1	9.8	5.6	2.7	8.1
2008-09	no.	8.8	8.6	8.0	7.1	9.5	10.2	5.7	2.8	8.4
2009-10	no.	8.7	8.5	7.9	6.8	9.6	10.1	5.7	2.7	8.3
2010-11	no.	8.8	8.6	8.0	6.9	9.6	10.4	5.8	2.8	8.4
2011-12	no.	9.1	8.8	8.4	7.2	10.0	10.9	5.7	2.8	8.7
2012-13	no.	9.1	8.8	8.4	6.8	10.1	10.7	5.7	2.8	8.6
2013-14	no.	9.5	9.2	8.7	7.1	10.6	11.4	5.8	3.0	9.0
Proportion of PBS services that are concessional										
2004-05	%	83.0	83.3	83.1	81.6	85.3	87.2	68.6	70.0	83.1
2005-06	%	83.9	84.1	83.7	82.1	86.0	87.7	70.3	71.6	83.8
2006-07	%	85.4	85.6	84.8	83.0	87.2	88.8	72.5	74.4	85.2
2007-08	%	86.0	86.3	85.2	83.0	87.7	89.6	73.2	75.5	85.7
2008-09	%	85.6	86.1	84.7	82.2	87.6	88.9	72.1	74.4	85.3
2009-10	%	86.0	86.4	85.0	82.3	87.9	89.0	72.3	75.1	85.7

Table 10A.11 **PBS services**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
2010-11	%	86.4	86.7	85.6	82.4	88.2	89.3	72.9	75.6	86.0
2011-12	%	86.9	87.0	86.2	82.7	88.6	89.8	73.8	75.9	86.5
2012-13	%	88.2	88.5	87.6	83.9	89.5	91.0	76.3	77.7	87.8
2013-14	%	89.7	89.9	89.1	85.6	90.8	92.2	79.2	79.7	89.3

(a) Care should be taken in using data for the NT as around 43 per cent of the population live in remote and very remote areas where Aboriginal Medical Services can supply medicines under s.100 of the *National Health Act 1953* (Cwlth).

(b) Includes PBS general ordinary, general free safety net, concessional ordinary, concessional free safety net and doctor's bag.

(c) Includes RPBS general ordinary and RPBS general safety net.

(d) PBS services per person exclude RPBS and doctor's bag.

Source: Department of Health unpublished, PBS Statistics.

TABLE 10A.12

Table 10A.12

PBS services, by service type ('000)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
<i>2009-10</i>										
PBS General Ordinary	'000	6 927	5 130	4 289	2 281	1 543	457	462	138	21 227
PBS General Safety Net	'000	1 714	1 148	914	449	330	96	95	15	4 763
<i>PBS General total</i>	'000	8 641	6 279	5 203	2 730	1 873	554	557	153	25 990
PBS Concessional Ordinary	'000	41 698	31 666	23 283	10 197	10 864	3 525	1 188	413	122 832
PBS Concessional Free Safety Net	'000	12 266	8 856	6 732	2 580	2 964	1 030	276	54	34 757
<i>PBS Concessional total (b)</i>	'000	53 963	40 521	30 015	12 777	13 828	4 555	1 463	467	157 589
PBS Unknown Free Safety Net	'000	—	—	—	—	—	—	—	—	—
PBS Doctors Bag	'000	112	83	74	25	26	7	3	2	332
<i>PBS Unknown free safety net plus Doctors bag</i>	'000	112	83	74	25	26	7	3	2	332
PBS Total	'000	62 716	46 883	35 292	15 532	15 727	5 116	2 024	621	183 912
RPBS Total (c)	'000	4 768	3 047	3 214	1 074	1 097	438	198	28	13 864
PBS and RPBS TOTAL	'000	67 485	49 930	38 506	16 606	16 825	5 554	2 222	649	197 775
PBS total services per person (d)	no.	8.7	8.5	7.9	6.8	9.6	10.1	5.7	2.7	8.3
Proportion of PBS services that are concessional	%	86.0	86.4	85.0	82.3	87.9	89.0	72.3	75.1	85.7
<i>2010-11</i>										
PBS General Ordinary	'000	6 847	5 114	4 199	2 308	1 500	464	463	137	21 032
PBS General Safety Net	'000	1 747	1 196	956	480	345	97	105	16	4 943
<i>PBS General total</i>	'000	8 595	6 310	5 155	2 788	1 845	561	568	153	25 976
PBS Concessional Ordinary	'000	42 608	32 256	23 945	10 442	10 858	3 670	1 245	423	125 447

TABLE 10A.12

Table 10A.12

PBS services, by service type ('000)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
PBS Concessional Free Safety Net	'000	12 798	9 283	7 065	2 723	3 109	1 058	290	57	36 382
<i>PBS Concessional total (b)</i>	'000	55 406	41 539	31 010	13 164	13 967	4 728	1 535	480	161 829
PBS Unknown Free Safety Net	'000	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	'000	112	86	77	24	26	8	4	2	338
<i>PBS Unknown free safety net plus Doctors bag</i>	'000	112	86	77	24	26	8	4	2	338
PBS Total	'000	64 113	47 936	36 242	15 976	15 838	5 297	2 106	635	188 142
RPBS Total (c)	'000	4 572	2 901	3 111	1 032	1 020	419	194	26	13 277
PBS and RPBS TOTAL	'000	68 685	50 836	39 354	17 009	16 858	5 716	2 300	661	201 419
PBS total services per person (d)	no.	8.8	8.6	8.0	6.9	9.6	10.4	5.8	2.8	8.4
Proportion of PBS services that are concessional	%	86.4	86.7	85.6	82.4	88.2	89.3	72.9	75.6	86.0
<i>2011-12</i>										
PBS General Ordinary	'000	6 867	5 130	4 232	2 445	1 514	465	447	139	21 239
PBS General Safety Net	'000	1 682	1 175	926	484	341	94	104	15	4 821
<i>PBS General total</i>	'000	8 549	6 305	5 158	2 929	1 855	559	550	155	26 060
PBS Concessional Ordinary	'000	43 912	33 102	25 259	11 300	11 296	3 885	1 256	433	130 442
PBS Concessional Free Safety Net	'000	13 329	9 700	7 421	2 853	3 270	1 112	303	58	38 047
<i>PBS Concessional total (b)</i>	'000	57 240	42 802	32 681	14 153	14 565	4 997	1 559	491	168 489
PBS Unknown Free Safety Net	'000	na	na	na	na	na	na	na	na	na
PBS Doctors Bag	'000	107	83	72	26	25	7	3	1	324

TABLE 10A.12

Table 10A.12

PBS services, by service type ('000)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
<i>PBS Unknown free safety net plus Doctors bag</i>	'000	107	83	72	26	25	7	3	1	324
PBS Total	'000	65 896	49 190	37 910	17 108	16 446	5 563	2 113	647	194 873
RPBS Total (c)	'000	4 404	2 784	3 108	1 037	1 004	410	187	27	12 961
PBS and RPBS TOTAL	'000	70 300	51 974	41 018	18 144	17 450	5 973	2 299	674	207 834
PBS total services per person (d)	no.	9.1	8.8	8.4	7.2	10.0	10.9	5.7	2.8	8.7
Proportion of PBS services that are concessional	%	86.9	87.0	86.2	82.7	88.6	89.8	73.8	75.9	86.5
<i>2012-13</i>										
PBS General Ordinary	'000	6 229	4 608	3 902	2 223	1 415	405	410	133	19 324
PBS General Safety Net	'000	1 535	1 037	849	442	317	81	97	14	4 371
<i>PBS General total</i>	'000	7 763	5 645	4 750	2 664	1 732	486	506	146	23 695
PBS Concessional Ordinary	'000	44 882	34 074	26 304	11 119	11 629	3 858	1 326	454	133 647
PBS Concessional Free Safety Net	'000	13 880	10 051	7 798	2 925	3 432	1 142	321	62	39 612
<i>PBS Concessional total (b)</i>	'000	58 762	44 125	34 102	14 045	15 061	5 001	1 647	516	173 259
PBS Unknown Free Safety Net	'000	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	'000	114	91	80	26	28	8	4	2	352
<i>PBS Unknown free safety net plus Doctors bag</i>	'000	114	91	80	26	28	8	4	2	352
PBS Total	'000	66 639	49 861	38 933	16 736	16 821	5 495	2 157	664	197 305
RPBS Total (c)	'000	4 177	2 655	3 030	975	943	375	189	27	12 371
PBS and RPBS TOTAL	'000	70 816	52 516	41 963	17 711	17 764	5 869	2 346	691	209 677

TABLE 10A.12

Table 10A.12

PBS services, by service type ('000)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
PBS total services per person (d)	no.	9.1	8.8	8.4	6.8	10.1	10.7	5.7	2.8	8.6
Proportion of PBS services that are concessional	%	88.2	88.5	87.6	83.9	89.5	91.0	76.3	77.7	87.8
<i>2013-14</i>										
PBS General Ordinary	'000	5 783	4 325	3 600	2 155	1 312	375	370	131	18 050
PBS General Safety Net	'000	1 414	966	782	415	295	76	92	14	4 053
<i>PBS General total</i>	'000	7 197	5 290	4 382	2 569	1 606	451	462	145	22 103
PBS Concessional Ordinary	'000	48 971	37 286	28 182	12 288	12 500	4 178	1 425	511	145 340
PBS Concessional Free Safety Net	'000	14 695	10 628	8 277	3 156	3 619	1 219	348	67	42 009
<i>PBS Concessional total (b)</i>	'000	63 667	47 914	36 459	15 444	16 119	5 397	1 772	577	187 349
PBS Unknown Free Safety Net	'000	—	—	—	—	—	—	—	—	—
PBS Doctors Bag	'000	121	94	80	29	27	8	4	2	364
<i>PBS Unknown free safety net plus Doctors bag</i>	'000	121	94	80	29	27	8	4	2	364
PBS Total	'000	70 985	53 298	40 920	18 042	17 752	5 857	2 238	724	209 816
RPBS Total (c)	'000	4 119	2 650	3 039	1 008	933	372	191	28	12 338
PBS and RPBS TOTAL	'000	75 104	55 947	43 959	19 050	18 685	6 228	2 429	752	222 154
PBS total services per person (d)	no.	9.5	9.2	8.7	7.1	10.6	11.4	5.8	3.0	9.0
Proportion of PBS services that are concessional	%	89.7	89.9	89.1	85.6	90.8	92.2	79.2	79.7	89.3

(a) Care should be taken in using data for the NT as around 43 per cent of the population live in remote and very remote areas where Aboriginal Medical Services can supply medicines under s.100 of the *National Health Act 1953* (Cwth).

Table 10A.12 **PBS services, by service type ('000)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
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(b) Includes PBS concessional ordinary and concessional free safety net.

(c) Includes RPBS general ordinary and RPBS general safety net.

(d) PBS services per person exclude RPBS and doctor's bag.

na Not available. – Nil or rounded to zero.

Source: Department of Health unpublished, PBS Statistics.

TABLE 10A.13

Table 10A.13 Use of public dental services, by service type, 2010 (a), (b), (c), (d)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Dental services per 1000 population (ASR)									
Emergency services	9.6	10.4	26.9	12.4	13.3	29.3	14.6	25.6	14.5
General services	34.1	45.0	71.0	113.6	84.1	106.2	81.7	157.7	59.9
All services	43.7	55.4	97.9	126.0	97.3	135.4	96.3	183.3	74.4
RSE (per cent)									
Emergency services	24.6	28.8	20.9	30.4	29.9	25.9	50.0	28.5	11.3
General services	13.8	12.0	11.9	9.0	10.2	8.1	17.5	9.3	5.0
All services	11.9	11.1	10.0	8.4	9.3	8.3	16.4	8.6	4.5
95 per cent CI									
Emergency services	± 4.6	± 5.9	± 11.0	± 7.4	± 7.8	± 14.9	± 14.3	± 14.3	± 3.2
General services	± 9.2	± 10.6	± 16.6	± 19.9	± 16.8	± 16.9	± 28.0	± 28.7	± 5.9
All services	± 10.2	± 12.0	± 19.2	± 20.9	± 17.8	± 22.0	± 31.0	± 30.8	± 6.5

ASR = Age standardised rate. **RSE** = relative standard error. **CI** = confidence interval.

- (a) Data are for number of people who used a public dental service at least once in the previous 12 months, not for number of services provided.
- (b) Type of service at the most recent visit. Emergency visit is a visit for relief of pain. Classification of service type as per Australian Dental Association Schedule of Dental Services.
- (c) Rates are age standardised to the Australian population as at 30 June 2001.
- (d) Limited to dentate persons aged 5 years or over.

Source: AIHW unpublished, National Dental Telephone Interview Survey 2010; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE 10A.14

Table 10A.14 **Alcohol and other drug treatment services, 2012-13 (number) (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA (a)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Treatment services by sector										
Government	no.	186	–	56	14	48	7	1	5	317
Non-government (b), (c)	no.	59	129	77	54	45	10	9	14	397
Total	no.	245	129	133	68	93	17	10	19	714
Closed treatment episodes by sector										
Government	no.	26 197	–	18 923	2 475	6 566	1 570	2 383	1 177	59 291
Non-government (b), (c)	no.	9 105	54 184	11 641	18 139	4 757	768	2 033	2 444	103 071
Total	no.	35 302	54 184	30 564	20 614	11 323	2 338	4 416	3 621	162 362
Closed treatment episodes for client's own drug use by sex										
Male	no.	23 428	34 156	20 738	12 771	7 972	1 449	2 781	2 418	105 713
Female	no.	10 738	16 869	8 643	6 632	3 279	681	1 579	909	49 330
Total (d)	no.	34 177	51 112	29 385	19 405	11 254	2 130	4 360	3 328	155 151

(a) Includes only services that receive public funding.

(b) WA has a number of integrated services that include both government and non-government providers.

(c) Includes agencies funded by Department of Health under the Non-Government Organisation Treatment Grants Program.

(d) Totals include episodes for people of unknown sex

– Nil or rounded to zero.

Source: AIHW 2014, *Alcohol and Other Drug Treatment Services in Australia 2012-13*, Cat. no. HSE 150, Drug Treatment Series no. 24.

TABLE 10A.15

Table 10A.15 **Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare (number) (a), (b), (c), (d), (e)**

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Aboriginal and Torres Strait Islander primary healthcare services										
2008-09	no.	39	24	31	28	14	10	2	57	205
2009-10	no.	50	26	33	37	13	10	1	53	223
2010-11	no.	56	25	37	35	15	11	1	55	235
2011-12	no.	52	25	37	35	13	9	1	52	224
2012-13	no.	45	24	28	31	14	7	1	55	205
Episodes of healthcare provided										
2008-09	'000	452	160	336	306	191	35	23	586	2 089
2009-10	'000	542	185	379	409	192	36	26	622	2 391
2010-11	'000	522	201	310	473	222	38	30	704	2 498
2011-12	'000	516	234	475	462	216	44	34	641	2 621
2012-13	'000	622	238	575	583	217	53	38	743	3 068

- (a) Includes only services which report data for the Online Services Report (OSR; previously the OATSIH Services Report).
- (b) The OSR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some of their funding from the Australian government to facilitate access to primary health care (including health promotion, dental and counselling services).
- (c) The number of services that provide OSR data changes each year. Changes are due to new Australian government funded primary health care services opening and existing services gaining Australian government funding. In addition, previously excluded Australian government funded services may be required to commence OSR data reporting if there are changes in the types of services provided and/or reporting arrangements.
- (d) An episode of care involves contact between an individual client and service staff for the provision of health care. Group work is not included. Transport is included only if it involves provision of health care/information by staff. Outreach provision, for example episodes at outstation visits, park clinics, satellite clinics, is included. Episodes of health care delivered over the phone are included.
- (e) The OSR data collection replaced the previous Service Activity Reporting (SAR) data collection from 2008-09. OSR data are not comparable with SAR data due to changes in collection methodology.

Source: AIHW 2014 and previous issues, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2008-09, 2009-10, 2010-11, 2011-12 and 2012-13*, Cat. no.s IHW 31, 56, 79, 104, 139.

Table 10A.16 Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare, by remoteness category (number) (a), (b), (c), (d), (e)

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote</i>	<i>Very remote</i>	<i>Total</i>
Aboriginal and Torres Strait Islander primary healthcare services							
2008-09	no.	26	40	50	29	60	205
2009-10	no.	29	48	55	33	58	223
2010-11	no.	34	52	59	29	61	235
2011-12	no.	33	48	53	28	62	224
2012-13	no.	23	43	47	27	65	205
Episodes of healthcare provided							
2008-09	'000	290	313	539	503	444	2 089
2009-10	'000	364	395	583	557	491	2 391
2010-11	'000	399	413	496	532	658	2 498
2011-12	'000	436	460	493	560	671	2 621
2012-13	'000	555	557	563	652	741	3 068

- (a) Includes only services which report data for the Online Services Report (OSR; previously the OATSIH Services Report).
- (b) The OSR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some of their funding from the Australian government to facilitate access to primary health care (including health promotion, dental and counselling services).
- (c) Remoteness categories are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS 2006 *Census of population and housing*.
- (d) An episode of care involves contact between an individual client and service staff for the provision of health care. Group work is not included. Transport is included only if it involves provision of health care/information by staff. Outreach provision, for example episodes at outstation visits, park clinics, satellite clinics, is included. Episodes of health care delivered over the phone are included.
- (d) The OSR data collection replaced the previous Service Activity Reporting (SAR) data collection from 2008-09. OSR data are not comparable with SAR data due to changes in collection methodology.

Source: AIHW 2014 and previous issues, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2008-09, 2009-10, 2010-11, 2011-12 and 2012-13*, Cat. nos IHW 31, 56, 79, 104, 139.

Table 10A.17 Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities, 2012-13 (per cent) (a), (b), (c), (d)

Diagnosis and treatment of chronic illness/diseases	88.8
Transport	89.3
24 hour emergency care	40.0
Child immunisation	85.4
Women's groups	51.7
Housing	82.9
Dental assessment/treatment	51.2
Regional health planning processes	87.3
Dialysis service on site	5.4

(a) Includes only services which report data for the Online Services Report (OSR).

(b) The OSR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some of their funding from the Australian government to facilitate access to primary health care (including health promotion, dental and counselling services).

(c) Some services in the OSR are funded for and provide a full range of comprehensive primary health care activities, while others focus on specific elements of primary health care such as health promotion.

(d) The health related activities section of the OSR data collection instrument was extensively revised for the 2012-13 collection period and data are not comparable with data for previous years. From 2012-13, data are collected for a smaller range of health related activities. This does not indicate that activities undertaken by services in previous years are no longer provided. Data for previous years are provided in table 10A.18.

Source: AIHW 2014, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2012-13*, Cat. no. IHW 139.

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) (a), (b), (c), (d), (e)

	2008-09 (f)	2009-10	2010-11	2011-12
Diagnosis and treatment of illness/disease	85.0	82.1	81.2	80.4
Management of chronic illness	89.0	87.0	85.0	86.2
Transportation to medical appointments	86.0	87.0	88.5	90.2
Outreach clinic services	55.0	55.6	52.6	60.7
24 hour emergency care	31.0	27.8	23.5	28.1
Monitoring child growth	64.0	76.2	71.8	79.0
School-based activities	68.0	70.4	74.4	79.0
Hearing screening	72.0	74.9	70.9	76.3
Pneumococcal immunisation	76.0	74.9	70.9	69.6
Influenza immunisation	82.0	81.6	78.2	81.3
Child immunisation	81.0	81.6	76.9	80.8
Women's health group	77.0	76.2	78.2	78.1
Support for public housing issues	58.0	67.7	59.0	71.0
Community development work	60.0	66.8	65.4	75.0
Legal/police/prison/advocacy services	42.0	43.1	44.9	46.0
Dental services	52.0	48.9	45.3	53.1
Involvement in steering groups on health	77.0	81.2	79.5	86.2
Participation in regional planning forums	57.0	57.9	59.0	67.0
Dialysis services	4.0	6.3	4.7	3.6

- (a) Includes only services which report data for the Online Services Report (OSR; previously the OATSIH Services Report).
- (b) The OSR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some of their funding from the Australian government to facilitate access to primary health care (including health promotion, dental and counselling services).
- (c) Some services in the OSR are funded for and provide a full range of comprehensive primary health care activities, while others focus on specific elements of primary health care such as health promotion.
- (d) The health related activities section of the OSR data collection instrument was extensively revised for the 2012-13 collection period and data for 2008-09 to 2011-12 are not comparable with data for 2012-13. From 2012-13, data are collected for a smaller range of selected health related activities (see table 10A.17). This does not indicate that particular activities are no longer undertaken by services.
- (e) The OSR data collection replaced the previous Service Activity Reporting (SAR) data collection from 2008-09. OSR data are not comparable with SAR data due to changes in collection methodology.
- (f) In 2008-09, 4 of 205 services reporting to the OSR collection did not provide valid data for this question. The denominator for 2008-09 is the number of services that provided valid data for this question (201).

Source: AIHW 2013 and previous issues, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2008-09, 2009-10, 2010-11 and 2011-12*, Cat. no.s IHW 31, 56,79,104.

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) (a), (b)**

	2010	2011	2012	2013
<i>Aboriginal and Torres Strait Islander staff</i>				
Aboriginal and Torres Strait Islander health workers	836.6	899.4	896.5	1 414.0
Aboriginal and Torres Strait Islander health practitioners (c)	..	..	..	74.0
Doctors	16.1	26.0	20.7	26.8
Nurses	72.2	72.9	101.3	119.6
Specialists	1.2	0.2	0.3	–
Counsellors/social workers	52.3	59.2	33.4	69.5
Other social and emotional wellbeing staff (d)	242.3	220.8	203.7	164.3
Allied health professionals (e)	49.7	31.8	58.1	6.1
Dentists	4.4	7.4	4.6	6.8
Dental assistants	47.9	43.9	46.2	52.4
Traditional healers	8.1	10.8	4.7	12.0
Sexual health workers	44.5	38.7	43.3	33.9
Substance misuse workers	77.5	101.2	104.7	100.3
Tobacco workers/coordinators (c)	..	..	..	66.0
Health promotion/prevention workers (c)	..	..	..	98.3
Environmental health workers	24.0	23.8	32.7	33.0
Driver/field officers	218.1	255.6	250.0	274.6
Other health staff (f)	6.0	142.3	145.8	349.7
Total Aboriginal and Torres Strait Islander st	1 700.9	1 933.9	1 946.0	2 385.8
<i>Non-Indigenous staff</i>				
Aboriginal and Torres Strait Islander health workers	30.7	14.0	34.3	11.5
Aboriginal and Torres Strait Islander health practitioners (c)	..	..	..	2.0
Doctors	319.3	335.4	331.8	347.8
Nurses	615.3	710.7	681.8	711.8
Specialists	7.4	13.0	12.1	16.9
Counsellors/social workers	84.6	89.1	40.6	213.7
Other social and emotional wellbeing staff (d)	66.2	97.6	82.5	85.5
Allied health professionals (e)	108.2	144.2	115.9	115.8
Dentists	39.8	48.7	55.8	60.7
Dental assistants	27.8	35.1	31.0	30.9
Traditional healers	0.0	3.1	0.5	–
Sexual health workers	20.0	16.6	11.7	12.7
Substance misuse workers	43.4	50.7	54.3	49.4

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) (a), (b)**

	2010	2011	2012	2013
Tobacco workers/coordinators (c)	..	..	..	25.9
Health promotion/prevention workers (c)	..	..	..	47.9
Environmental health workers	6.0	10.3	8.5	6.0
Driver/field officers	40.1	39.4	36.7	46.6
Other health staff (f)	–	67.5	25.4	173.0
Total non-Indigenous staff (g)	1 408.7	1 675.2	1 522.9	1 958.0
<i>Total health staff (d), (e)</i>				
Aboriginal and Torres Strait Islander health workers	867.4	913.4	930.8	910.1
Aboriginal and Torres Strait Islander health practitioners (c)	..	..	..	76.0
Doctors	335.4	361.4	352.5	374.6
Nurses	691.5	787.6	783.1	831.4
Specialists	8.7	13.2	12.3	16.9
Counsellors/social workers	136.8	148.3	74.0	283.2
Other social and emotional wellbeing staff (d)	309.5	319.4	286.2	249.8
Allied health professionals (e)	157.9	176.0	174.0	121.9
Dentists	44.2	56.1	60.5	67.5
Dental assistants	75.7	79.1	77.2	83.3
Traditional healers	8.2	13.9	5.2	12.0
Sexual health workers	64.5	55.3	55.0	46.6
Substance misuse workers	120.9	151.9	159.0	149.7
Tobacco workers/coordinators (c)	..	..	..	91.9
Health promotion/prevention workers (c)	..	..	..	146.2
Environmental health workers	30.0	34.1	41.2	39.0
Driver/field officers	258.2	294.9	286.7	321.2
Other health staff (f)	6.0	209.7	171.2	522.7
Total health staff (g), (h)	3 114.9	3 614.4	3 468.9	4 343.8

(a) Includes only services which report data for the Online Services Report (OSR; previously the OATSIH Services Report).

(b) The number of services that provide OSR data changes each year. Changes are due to new Australian government funded primary health care services opening and existing services gaining Australian government funding. In addition, previously excluded Australian government funded services may be required to commence OSR data reporting if there are changes in the types of services provided and/or reporting arrangements.

(c) Data for Aboriginal health practitioners, Tobacco workers/coordinators and Health promotion/ prevention workers were first collected for 2013.

(d) Other social and emotional wellbeing staff includes: Bringing Them Home and Link Up support workers, psychologists, mental health workers and other social and emotional wellbeing staff.

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) (a), (b)

	2010	2011	2012	2013
(e) Allied health professionals include diabetes educators and other patient educators, health program coordinators, nutrition workers, community care workers, child and family health workers, child protection workers, welfare workers, pharmacy assistants/technicians, Brighter Futures Program caseworkers, foster carers, Healthy for Life workers, sports and recreation workers, youth workers, and masseurs.				
(f) Other health staff' include: outreach workers, special program support workers, patient liaison officers, and other health-related positions.				
(g) Totals may not add due to rounding and cell suppression.				
(h) Totals include health staff for whom Indigenous status was not provided.				
.. Not applicable. – Nil or rounded to zero.				

Source: AIHW 2014 and previous issues, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2009-10, 2010-11, 2011-12 and 2012-13*, Cat. no.s IHW 56, 79, 104, 139.

TABLE 10A.20

Table 10A.20 **Approved providers of PBS medicines, by urban and rural location, at 30 June (a), (b)**

	<i>NSW (c)</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust (e)</i>
Number of people per pharmacy									
Urban									
2010	3 700	4 082	3 701	3 691	3 725	3 409	5 131	4 681	3 814
2011	3 677	4 031	3 615	3 699	3 725	3 248	5 051	4 681	3 777
2012	3 891	4 363	4 059	4 116	3 921	3 445	5 243	4 861	4 082
2013	3 855	4 319	4 065	4 066	3 775	3 440	4 952	4 254	4 034
2014 (f)	3 803	4 199	4 002	3 970	3 754	3 368	4 952	4 504	3 963
Rural									
2010	4 172	4 655	4 386	4 305	3 405	3 836	..	9 272	4 277
2011	4 232	4 462	4 037	4 021	3 269	3 694	..	8 500	4 108
2012	4 051	4 344	4 381	4 202	3 287	3 593	..	9 374	4 148
2013	3 811	4 077	3 904	3 776	3 332	3 288	..	8 898	3 887
2014 (f)	3 735	3 981	3 821	3 531	3 147	3 288	–	8 342	3 771
Number of pharmacies									
Urban									
2010	1 447	1 022	832	430	318	81	63	19	4 212
2011	1 456	1 035	852	429	318	85	64	19	4 258
2012	1 462	1 047	844	441	320	84	68	20	4 286
2013	1 546	1 082	887	455	347	93	72	18	4 500
2014	1 567	1 113	901	466	349	95	72	17	4 580
Rural									
2010	284	162	185	85	96	52	..	11	876
2011	280	169	201	91	100	54	..	12	908
2012	300	179	204	99	103	57	..	12	955
2013	248	165	183	101	85	53	–	15	851
2014	253	169	187	108	90	53	–	16	877
Number of approved GPs — Rural (g)									
2010	11	3	8	23	2	5	..	1	53
2011	9	1	6	17	2	3	..	1	39
2012	11	9	5	11	1	4	..	–	41
2013	10	1	5	11	1	5	..	..	33
2014	8	1	4	7	1	3	–	–	24
Number of approved hospitals — urban (h)									
Public									
2010	–	53	27	8	8	–	–	1	97
2011	–	53	27	10	8	3	–	1	102
2012	–	53	27	12	8	3	–	1	104
2013	1	52	30	12	10	4	..	1	110
2014	1	52	29	13	10	4	–	1	110

Table 10A.20 **Approved providers of PBS medicines, by urban and rural location, at 30 June (a), (b)**

	NSW (c)	Vic (c)	Qld	WA	SA	Tas	ACT	NT (d)	Aust (e)
Private									
2010	23	26	21	5	4	1	3	1	84
2011	22	28	24	5	4	1	4	1	89
2012	22	29	25	5	4	1	4	1	91
2013	26	29	25	4	6	1	3	1	95
2014	31	28	26	3	9	2	4	1	104
Number of approved hospitals — rural (h) (i)									
Public									
2010	–	13	63	–	–	–	..	4	80
2011	–	16	20	6	–	1	..	4	47
2012	–	18	22	6	–	1	..	4	51
2013	..	16	20	6	3	..	..	4	49
2014	–	16	20	6	3	–	–	4	49

- (a) Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2-6. The ACT has no rural PhARIA areas.
- (b) The estimated resident populations (ERP) used to derive rates in the early and latter parts of this time series are based on different ABS Censuses. Rates derived using ERPs based on different Censuses are not comparable.
- (c) For 2013, one public hospital in NSW is a campus of a Victorian hospital participating in the Pharmaceutical Reforms.
- (d) Care should be taken using data for the NT, as 43.9 per cent of the population live in remote and very remote areas and data exclude Aboriginal Medical Services that supply medications in these areas under s.100 of the *National Health Act 1953* (Cwlth).
- (e) Includes other territories
- (f) 118 pharmacies were reclassified as urban at 30 June 2013. Those pharmacies were classified as rural at 30 June 2012.
- (g) GPs in urban areas are not able to demonstrate that they are practising in an area where there is no pharmacist approved and therefore the category 'Number of approved GPs — Urban' is not applicable.
- (h) PBS approved private hospitals supply medicines to patients of the hospital (inpatients and outpatients), while public hospitals provide medicines only to patients on discharge.
- (i) There were no PBS approved private hospitals in rural areas in the years 2009 to 2013.
- .. Not applicable. – Nil or rounded to zero.

Source: Department of Health unpublished, derived from Department of Human Services, ABS unpublished *2006/2011 Census of Population and Housing* and the University of Adelaide's Australian Population and Migration Research Centre.

Table 10A.21 **PBS expenditure per person, by remoteness area (2013-14 dollars) (a), (b), (c), (d), (e)**

	Unit	2012-13	2013-14
<i>Total expenditure</i>			
Major cities	\$m	4 807.2	4 924.3
Inner regional	\$m	1 536.8	1 573.5
Outer regional	\$m	687.3	697.7
Remote	\$m	68.3	69.9
Very remote	\$m	24.7	25.1
Australia (f)	\$m	7 126.5	7 292.6
<i>Expenditure per person</i>			
Major cities	\$	301.2	301.8
Inner regional	\$	370.3	373.1
Outer regional	\$	335.9	337.5
Remote	\$	213.4	216.5
Very remote	\$	118.0	119.8
Australia (f)	\$	314.2	315.2

- (a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.
- (b) Includes PBS general ordinary, general safety net, concessional ordinary, concessional free safety net and unknown free safety net. Excludes RPBS and doctor's bag.
- (c) Locality level data are only available on a cash basis for general and concessional categories. These figures are not directly comparable to those published in the Department of Health annual report which are prepared on an accrual accounting basis and also include doctor's bag and other categories administered under special arrangements (such as medicines supplied in bulk to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth].) Expenditure on medications dispensed to remote and very remote areas under s.100 was \$36.9 million in 2012-13.
- (d) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification.
- (e) Rates are derived using the final ABS 2011 Census based estimated resident population (ERP). Rates in this table use the 30 June ERP preceding the reference year and differ from rates reported in tables 10A.4 and 10A.5 which use the December 31 ERP for the reference year.
- (f) Data for Australia includes Other Territories and expenditure that could not be allocated to a remoteness area.

Source: Department of Health unpublished, PBS Statistics; ABS 2013, *Regional Population Growth, Australia, 2012*, Cat. no. 3218.0.

Table 10A.22 **PBS expenditure per person, by urban and rural location, 2009-10 to 2011-12 (2013-14 dollars) (a), (b), (c), (d)**

	2009-10	2010-11	2011-12
Capital city	331.8	323.4	326.2
Other metropolitan	379.1	373.6	376.7
Rural and remote	369.3	364.4	370.3
All locations	346.2	339.0	342.7

(a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.

(b) Includes PBS general ordinary, general safety net, concessional ordinary, concessional free safety net and unknown free safety net. Excludes RPBS and doctor's bag.

(c) Locality level data are only available on a cash basis for general and concessional categories. These figures are not directly comparable to those published in the Department of Health annual report which are prepared on an accrual accounting basis and also include doctor's bag and other categories administered under special arrangements (such as medicines supplied in bulk under s.100 of the *National Health Act 1953* [Cwlth]).

(d) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification.

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

Table 10A.23 **Availability of GPs by region, 2013-14 (a), (b), (c), (d), (e), (f)**

	NSW (f)	Vic (g)	Qld	WA	SA (h)	Tas (h)	ACT (e)	NT (h)	Aust
Number of GPs									
Major cities	7 232	5 821	4 088	2 302	1 815	..	466	..	21 724
Inner regional	2 083	1 644	1 307	273	276	613	np	..	6 196
Outer regional	654	335	1 195	266	345	205	..	212	3 112
Remote	np	np	159	198	118	37	..	383	683
Very remote	np	..	221	153	np	np	..	np	686
Total	9 969	7 800	6 970	3 192	2 554	855	466	595	32 401
Number of full time workload equivalent GPs									
Major cities	5 997	4 470	3 103	1 519	1 320	..	277	..	16 686
Inner regional	1 522	1 116	962	183	161	329	np	..	4 273
Outer regional	408	242	670	158	206	137	..	107	1 890
Remote	np	np	47	67	51	10	..	68	226
Very remote	np	–	36	27	np	np	..	np	119
Total	7 927	5 828	4 818	1 953	1 739	476	277	175	23 194
Number of full time workload equivalent GPs per 100 000 people									
Major cities	109.1	101.7	107.4	78.6	107.6	..	72.5	..	102.2
Inner regional	106.5	101.8	101.9	80.1	88.8	97.8	np	..	101.3
Outer regional	84.3	96.7	97.9	84.0	102.1	82.8	..	78.9	91.4
Remote	np	np	58.8	64.6	84.5	90.0	..	136.9	69.9
Very remote	np	..	60.6	40.5	np	np	..	np	56.9
Total	107.0	101.5	103.5	77.5	104.1	92.8	72.5	72.9	100.3

(a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which are based on a different classification.

(b) There are no very remote areas in Victoria; no major cities in Tasmania; no outer regional or remote areas in the ACT; and no inner regional or major cities in the NT.

(c) GP and FWE data include vocationally registered GPs and other medical practitioners (OMPs).

(d) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.

(e) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.

(f) For NSW, remote and very remote area data are not reported for confidentiality reasons, but are included in outer regional area data.

(g) For Victoria, remote area data are not reported for confidentiality reasons, but are included in outer regional data.

(h) For SA, Tasmania and the NT, very remote area data are not reported for confidentiality reasons, but are included in remote area data.

(i) For the ACT, inner regional area data are not reported for confidentiality reasons, but are included in major cities data.

.. Not applicable. np Not published.

Table 10A.23 **Availability of GPs by region, 2013-14 (a), (b), (c), (d), (e), (f)**

	<i>NSW (f)</i>	<i>Vic (g)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (h)</i>	<i>Tas (h)</i>	<i>ACT (e)</i>	<i>NT (h)</i>	<i>Aust</i>
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Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.24

Table 10A.24 **Availability of GPs by region, 2004-05 to 2011-12 (a), (b), (c), (d)**

	<i>NSW (e)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (e)</i>	<i>NT</i>	<i>Aust</i>
Number of GPs									
Urban									
2004-05	6 266	4 413	2 794	1 620	1 443	308	np	127	16 971
2005-06	6 327	4 437	2 846	1 651	1 469	317	np	113	17 160
2006-07	6 412	4 508	2 884	1 698	1 463	313	np	116	17 394
2007-08	6 047	4 598	2 978	1 717	1 503	328	383	121	17 675
2008-09	6 184	4 738	3 142	1 797	1 550	340	385	139	18 275
2009-10	6 349	4 896	3 272	1 803	1 568	349	398	142	18 777
2010-11	6 530	5 043	3 340	1 826	1 592	346	416	160	19 253
2011-12	6 725	5 305	3 544	1 895	1 644	362	440	153	20 068
Rural									
2004-05	1 699	1 308	1 850	555	501	301	..	193	6 407
2005-06	1 762	1 365	1 947	589	511	308	..	192	6 674
2006-07	1 816	1 406	1 980	612	527	329	..	208	6 878
2007-08	1 887	1 464	2 074	640	596	333	..	234	7 228
2008-09	1 921	1 502	2 198	661	591	339	..	239	7 451
2009-10	2 040	1 553	2 292	689	633	355	..	274	7 836
2010-11	2 124	1 667	2 464	788	661	373	..	303	8 380
2011-12	2 273	1 728	2 655	849	704	408	..	326	8 943
Number of full time workload equivalent GPs									
Urban									
2004-05	5 227	3 242	2 026	1 121	1 027	166	np	47	12 856
2005-06	5 283	3 335	2 105	1 132	1 060	171	np	48	13 135
2006-07	5 427	3 426	2 171	1 142	1 071	173	np	50	13 459
2007-08	5 274	3 551	2 241	1 166	1 080	179	232	54	13 778
2008-09	5 411	3 662	2 357	1 186	1 118	179	235	56	14 204
2009-10	5 461	3 788	2 459	1 216	1 149	185	238	62	14 558
2010-11	5 567	3 897	2 518	1 222	1 166	186	239	66	14 861
2011-12	5 748	4 059	2 686	1 259	1 204	195	250	73	15 474
Rural									
2004-05	1 195	925	1 363	336	337	212	..	49	4 416
2005-06	1 234	948	1 384	341	343	215	..	48	4 514
2006-07	1 283	981	1 393	358	345	218	..	54	4 632
2007-08	1 327	1 033	1 441	376	375	222	..	61	4 835
2008-09	1 381	1 076	1 504	388	393	225	..	60	5 027
2009-10	1 431	1 113	1 534	399	397	232	..	65	5 171
2010-11	1 500	1 166	1 599	417	404	243	..	67	5 397
2011-12	1 590	1 211	1 658	439	424	254	..	69	5 645
Number of full time workload equivalent GPs per 100 000 people									
Urban									
2004-05	95.2	85.4	84.0	75.7	90.1	83.7	np	53.6	88.0

Table 10A.24 **Availability of GPs by region, 2004-05 to 2011-12 (a), (b), (c), (d)**

	<i>NSW (e)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (e)</i>	<i>NT</i>	<i>Aust</i>
2005-06	95.6	87.0	85.5	75.3	92.5	86.0	np	54.4	89.0
2006-07	97.2	87.3	85.4	73.9	91.5	86.0	np	53.7	89.4
2007-08	99.6	89.0	86.0	73.6	91.2	88.3	67.5	57.1	90.0
2008-09	100.4	89.6	87.9	72.2	93.2	87.3	67.2	58.0	90.7
2009-10	99.0	90.3	89.0	71.7	94.5	89.4	66.7	61.8	90.7
2010-11	99.9	91.7	90.1	71.0	95.0	89.0	65.6	66.4	91.5
2011-12	103.2	95.5	96.1	73.2	98.1	93.6	68.8	73.1	95.3
Rural									
2004-05	73.6	74.8	88.1	63.0	83.9	73.9	..	42.4	76.9
2005-06	75.5	76.0	87.6	62.9	85.0	74.4	..	41.0	77.7
2006-07	77.8	76.8	85.4	64.3	83.7	74.6	..	44.3	78.0
2007-08	79.7	79.6	86.2	65.8	89.9	75.5	..	49.1	80.0
2008-09	81.6	80.9	87.5	65.5	93.1	75.6	..	46.9	81.3
2009-10	82.6	81.5	86.5	65.2	92.8	77.1	..	49.5	81.5
2010-11	85.7	84.3	89.1	67.3	93.4	80.4	..	51.1	84.1
2011-12	90.9	87.6	92.4	70.9	98.1	83.8	..	52.1	88.0

- (a) Geographical locations are based on the 1994 Rural, Remote and Metropolitan Areas classification. Urban areas consist of capital city and other metro areas. Rural areas consist of large rural centres, small rural centres, other rural areas, remote centres, other remote areas and other areas.
- (b) Data are not comparable with data from 2012-13, for which geographical location is based on the Australian Statistical Geography Standard 2011 (ASGS) classification.
- (c) GP and FWE data include vocationally registered GPs and other medical practitioners (OMPs).
- (d) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.
- (e) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.
- (f) From 2007-08, data are reported separately for NSW and the ACT. Historical data for NSW and the ACT are combined for confidentiality reasons. The ACT has no rural areas.
- .. Not applicable. **np** Not published.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.25

Table 10A.25 **Availability of female GPs (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Female GPs										
2004-05	no.	2 751	2 116	1 717	801	671	243	180	151	8 630
2005-06	no.	2 853	2 168	1 799	828	703	254	183	132	8 920
2006-07	no.	2 958	2 247	1 850	877	718	270	181	151	9 252
2007-08	no.	3 010	2 359	1 955	898	775	277	191	171	9 636
2008-09	no.	3 142	2 446	2 117	987	809	294	192	184	10 171
2009-10	no.	3 323	2 569	2 230	1 016	828	306	192	193	10 657
2010-11	no.	3 520	2 720	2 327	1 089	872	318	216	220	11 282
2011-12	no.	3 736	2 925	2 553	1 134	925	357	230	235	12 095
2012-13	no.	4 014	3 071	2 797	1 241	985	368	238	287	13 001
2013-14	no.	4 302	3 366	2 987	1 369	1 058	388	251	292	14 013
Female FWE GPs										
2004-05	no.	1 679	1 096	923	382	329	114	73	38	4 633
2005-06	no.	1 729	1 158	968	394	335	122	76	34	4 815
2006-07	no.	1 822	1 232	1 010	410	348	125	82	37	5 065
2007-08	no.	1 916	1 312	1 083	426	371	131	85	45	5 369
2008-09	no.	2 003	1 389	1 178	455	401	136	87	48	5 697
2009-10	no.	2 087	1 468	1 232	482	423	142	87	54	5 976
2010-11	no.	2 219	1 538	1 299	499	430	147	96	56	6 285
2011-12	no.	2 362	1 643	1 406	512	459	154	104	62	6 702
2012-13	no.	2 519	1 781	1 516	544	481	162	110	66	7 180
2013-14	no.	2 710	1 933	1 633	626	507	171	118	72	7 770
Female FWE GPs as a proportion of all FWE GPs										
2004-05	%	27.0	26.3	27.2	26.2	24.1	30.2	36.3	40.3	26.8
2005-06	%	27.4	27.0	27.7	26.8	23.8	31.5	36.5	34.8	27.3
2006-07	%	28.1	28.0	28.3	27.3	24.6	31.9	36.1	35.4	28.0

TABLE 10A.25

Table 10A.25 **Availability of female GPs (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2007-08	%	29.0	28.6	29.4	27.6	25.5	32.7	36.4	38.8	28.8
2008-09	%	29.5	29.3	30.5	28.9	26.5	33.7	37.0	41.3	29.6
2009-10	%	30.3	30.0	30.8	29.9	27.4	34.1	36.6	42.7	30.3
2010-11	%	31.4	30.4	31.5	30.5	27.4	34.3	40.1	42.2	31.0
2011-12	%	32.2	31.2	32.4	30.2	28.2	34.3	41.3	43.7	31.7
2012-13	%	33.2	32.1	33.2	30.2	28.6	34.9	40.5	41.7	32.5
2013-14	%	34.2	33.2	33.9	32.0	29.2	36.0	42.6	41.0	33.5
Female FWE GPs										
2004-05	per 100 000 females	49.2	43.0	46.5	38.0	42.3	46.4	44.2	40.1	45.3
2005-06	per 100 000 females	50.3	44.7	47.2	38.6	42.1	49.0	44.9	33.2	46.2
2006-07	per 100 000 females	52.3	46.7	48.1	39.2	43.3	49.9	47.4	35.4	47.8
2007-08	per 100 000 females	54.4	48.9	50.4	39.7	45.7	52.1	48.6	42.4	49.8
2008-09	per 100 000 females	55.7	50.6	53.2	41.1	48.8	53.3	49.2	44.0	51.7
2009-10	per 100 000 females	57.1	52.4	54.3	42.5	50.9	55.2	48.5	48.7	53.2
2010-11	per 100 000 females	60.1	54.2	56.6	43.3	51.2	56.8	52.3	50.6	55.2
2011-12	per 100 000 females	64.7	58.3	62.1	43.2	55.2	60.0	55.5	56.1	59.3
2012-13	per 100 000 females	68.1	62.1	65.6	44.5	57.4	63.0	57.9	58.4	62.4
2013-14	per 100 000 females	72.1	66.1	69.4	49.6	60.0	66.4	61.0	62.7	66.3

- (a) From 2011-12, rates are computed by the Secretariat using first preliminary December 31 female ERP based on the 2011 Census. Rates for previous years are derived using ERPs based on the 2001 and 2006 Censuses. Rates derived using ERPs based on different Censuses are not comparable.
- (b) FWE is calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.
- (c) GP and FWE numbers include vocationally registered GPs and other medical practitioners.
- (d) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.26

Table 10A.26 **Availability of male GPs (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Male GPs										
2009-10	no.	5 064	3 881	3 336	1 475	1 375	398	206	221	15 956
2010-11	no.	5 134	3 990	3 483	1 525	1 381	401	200	243	16 357
2011-12	no.	5 262	4 108	3 646	1 610	1 423	413	210	244	16 916
2012-13	no.	5 413	4 273	3 832	1 732	1 463	442	232	293	17 680
2013-14	no.	5 667	4 434	3 983	1 823	1 496	467	215	303	18 388
Male FWE GPs										
2009-10	no.	4 806	3 433	2 762	1 132	1 123	275	151	72	13 754
2010-11	no.	4 847	3 525	2 828	1 140	1 140	282	143	77	13 982
2011-12	no.	4 976	3 627	2 937	1 186	1 169	295	147	80	14 417
2012-13	no.	5 074	3 762	3 056	1 259	1 199	302	162	92	14 906
2013-14	no.	5 217	3 895	3 186	1 328	1 231	305	159	104	15 424
Male FWE GPs as a proportion of all FWE GPs										
2009-10	%	69.7	70.1	69.2	70.1	72.6	66.0	63.4	56.7	69.7
2010-11	%	68.6	69.6	68.5	69.5	72.6	65.7	59.9	57.8	69.0
2011-12	%	67.8	68.8	67.6	69.8	71.8	65.7	58.7	56.3	68.3
2012-13	%	66.8	67.9	66.8	69.8	71.4	65.1	59.5	58.3	67.5
2013-14	%	65.8	66.8	66.1	68.0	70.8	64.0	57.4	59.0	66.5
Male FWE GPs										
2009-10	per 100 000 males	136.3	127.8	126.6	99.2	140.2	109.6	84.9	60.1	126.3
2010-11	per 100 000 males	136.0	129.5	127.7	97.6	141.0	111.1	78.9	63.9	126.7
2011-12	per 100 000 males	138.4	131.6	130.6	98.7	143.6	115.8	79.7	65.4	129.0
2012-13	per 100 000 males	139.1	133.9	132.8	100.8	145.7	118.2	85.7	73.8	130.7
2013-14	per 100 000 males	140.8	135.9	136.3	102.9	148.1	119.1	83.2	81.0	132.9

(a) Rates are computed by the Secretariat using the (first released) preliminary December 31 male ERP based on the 2011 Census.

Table 10A.26 **Availability of male GPs (a), (b), (c), (d)**

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(b)	FWE is calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.								
(c)	GP and FWE numbers include vocationally registered GPs and other medical practitioners.								
(d)	GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.								

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.27

Table 10A.27 Availability of public dentists (per 100 000 people) (a), (b), (c), (d), (e), (f)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (g)</i>	<i>ACT (g)</i>	<i>NT (g)</i>	<i>Aust (i)</i>
FTE dentists per 100 000 population (h)									
2009									
Major cities	7.7	7.6	11.1	7.5	11.8	..	9.5	..	8.6
Inner regional	4.9	4.9	8.6	6.1	5.4	7.6	–	..	6.0
Outer regional	3.9	4.7	8.3	4.0	2.1	1.8	..	16.6	5.9
Remote and very remote	3.2	–	9.9	10.9	2.0	–	..	6.2	7.7
Total	6.9	6.9	10.1	7.2	9.5	5.5	9.5	12.0	7.8
2010									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote and very remote	na	na	na	na	na	na	na	na	na
Total	na	na	na	na	na	na	na	na	na
2011									
Major cities	4.8	4.8	6.4	5.7	8.7	..	7.1	..	5.6
Inner regional	3.6	4.8	6.6	5.4	4.1	5.4	–	..	4.8
Outer regional	2.0	4.2	7.5	3.5	4.9	0.5	..	13.2	5.1
Remote/very remote	1.9	–	1.5	10.1	5.0	–	..	9.1	6.1
Total (i)	4.4	4.7	6.5	5.8	7.6	3.7	7.1	11.3	5.4
2012 (d), (j)									
Major cities	5.6	4.5	5.6	5.9	6.4	..	6.9	..	5.5
Inner regional	4.4	3.3	6.0	4.5	2.4	5.4	–	..	4.5
Outer regional	1.9	3.1	7.9	3.0	4.5	0.7	..	8.2	4.7
Remote/very remote	1.8	–	3.3	6.2	3.0	..	..	7.9	5.0
Total (i)	5.1	4.2	6.0	5.6	5.7	4.0	6.9	8.1	5.2
2013 (j)									

TABLE 10A.27

Table 10A.27 **Availability of public dentists (per 100 000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (g)</i>	<i>ACT (g)</i>	<i>NT (g)</i>	<i>Aust (i)</i>
Major cities	7.3	6.3	7.9	7.6	9.6	..	4.7	..	7.3
Inner regional	5.2	5.8	7.6	5.7	4.1	8.7	np	..	6.2
Outer regional	2.8	5.8	12.2	3.6	6.9	0.7	..	10.7	7.1
Remote/very remote	7.9	–	7.2	8.8	–	..	..	9.0	7.1
Total (i)	6.6	6.2	8.5	7.2	8.3	5.9	5.0	10.0	7.1

FTE = Full Time Equivalent

- (a) Data include dentists working in the public sector only – in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and 'other public' areas. Dentists who work in both the public and private sectors are not included.
- (b) From 2012, allocation to public sector is based on clinical hours worked. For 2011 and previous years, allocation to public sector is based on total hours worked.
- (c) Data are not available for 2010.
- (d) From 2011, allocation to State or Territory and to region is by location of main job where available. Otherwise, location of principal practice is used as a proxy. If that is also not available, location of residence is used. If none of these are available, location is coded 'unstated'.
- (e) Remoteness areas for 2011 and previous years are defined using the Australian Standard Geographical Classification (ASGC), based on the ABS 2006 Census of population and housing. Data for 2012 are revised to remoteness areas defined using the Australian Statistical Geography Standard (ASGS), based on the ABS 2011 Census of population and housing. Data for 2012 may differ to previous reports in which the 2006 Census based ASGC was used.
- (f) Remote/very remote includes Migratory areas.
- (g) There are no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; and no major cities or inner regional areas in the NT.
- (h) FTE based on a 40-hour week.
- (i) Total includes remoteness area 'unstated'.
- (j) Data for 2012 and 2013 exclude provisional registrants.

na Not available. **..** Not applicable. **–** Nil or rounded to zero.

Source: AIHW unpublished, National Health Workforce Data Set.

TABLE 10A.28

Table 10A.28 Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)

	<i>NSW</i>	<i>Vic (h)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT (i)</i>	<i>NT (i)</i>	<i>Aust (j)</i>
2009 (g), (i)									
FTE dental hygienists per 100 000 population (k)									
Major cities	0.2	–	0.2	0.6	0.7	..	0.5	..	0.2
Inner regional	–	–	–	–	–	–	–	..	..
Outer regional	0.1	–	0.5	–	–	–	..	1.4	0.2
Remote and very remote	0.8	–	–	–	–	–	..	–	..
Total (k)	0.1	–	0.2	0.4	0.5	–	0.5	0.8	0.2
FTE dental therapists per 100 000 population (k)									
Major cities	2.0	–	6.4	6.5	5.5	..	3.4	..	3.0
Inner regional	5.3	–	9.3	7.3	6.4	6.6	–	..	5.1
Outer regional	3.2	–	8.8	6.6	7.1	11.1	..	6.1	6.1
Remote and very remote	5.6	–	4.1	3.7	3.4	–	..	8.9	5.0
Total (k)	2.8	–	7.3	6.4	5.7	8.0	3.4	7.4	3.8
2010									
FTE dental hygienists per 100 000 population (k)									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote/very remote	na	na	na	na	na	na	na	na	na
Total	na	na	na	na	na	na	na	na	na
FTE dental therapists per 100 000 population (k)									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote/very remote	na	na	na	na	na	na	na	na	na
Total	na	na	na	na	na	na	na	na	na

TABLE 10A.28

Table 10A.28 Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)

	<i>NSW</i>	<i>Vic (h)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT (i)</i>	<i>NT (i)</i>	<i>Aust (j)</i>
2011									
FTE dental hygienists per 100 000 population (k)									
Major cities	0.1	–	0.1	0.6	0.6	..	0.3	..	0.2
Inner regional	–	–	–	–	–	–	–	..	–
Outer regional	–	0.2	0.1	–	–	–	..	–	0.1
Remote/very remote	–	–	–	–	–	–	..	–	–
Total (l)	0.1	–	0.1	0.5	0.5	–	0.3	–	0.1
FTE dental therapists per 100 000 population (k)									
Major cities	1.7	1.3	5.2	4.9	3.8	..	2.5	..	2.8
Inner regional	3.4	2.3	6.8	7.9	8.8	6.6	–	..	4.6
Outer regional	2.5	1.6	6.0	8.4	6.1	9.1	..	9.4	5.4
Remote and very remote	2.6	–	4.0	7.0	6.5	–	..	4.5	5.1
Total (l)	2.1	1.5	5.6	5.6	4.8	7.2	2.5	7.6	3.4
2012 (e), (m)									
FTE dental hygienists per 100 000 population (k)									
Major cities	0.2	0.1	0.1	0.4	0.8	..	0.2	..	0.2
Inner regional	0.1	–	–	–	–	–	–	..	–
Outer regional	–	0.3	0.1	–	–	–	..	–	0.1
Remote and very remote	–	–	–	–	–	–	..	1.3	0.3
Total (l)	0.1	0.1	0.1	0.3	0.6	–	0.2	0.6	0.2
FTE dental therapists per 100 000 population (k)									
Major cities	1.7	1.4	5.1	5.2	4.0	..	2.7	..	2.8
Inner regional	3.7	2.3	6.2	5.8	4.9	6.0	np	..	4.3
Outer regional	2.8	0.9	6.3	7.9	8.6	6.0	..	8.9	5.4
Remote/very remote	–	–	3.2	4.0	4.9	12.1	..	5.6	4.2
Total (l)	2.1	1.5	5.4	5.4	4.7	6.1	2.9	7.5	3.3

TABLE 10A.28

Table 10A.28 **Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic (h)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT (i)</i>	<i>NT (i)</i>	<i>Aust (j)</i>
2013 (m)									
FTE dental hygienists per 100 000 population (k)									
Major cities	0.1	–	–	0.4	0.5	..	–	..	0.1
Inner regional	–	0.1	–	–	–	–	–	..	–
Outer regional	–	–	–	–	0.4	–	..	0.4	0.1
Remote/very remote	0.3	–	–	–	–	–	..	–	–
Total (l)	0.1	0.1	–	0.3	0.4	–	–	0.2	0.1
FTE dental therapists per 100 000 population (k)									
Major cities	1.9	2.2	4.8	5.3	4.7	..	4.3	..	3.1
Inner regional	3.8	2.1	6.6	6.4	6.5	7.9	–	..	4.6
Outer regional	2.7	2.6	6.5	7.1	9.4	8.1	..	8.7	5.8
Remote/very remote	–	–	4.4	4.4	5.5	7.1	..	7.0	4.7
Total (l)	2.3	2.2	5.4	5.5	5.5	8.0	4.3	7.9	3.7

FTE = Full Time Equivalent

- (a) Dual registered practitioners (practitioners registered as both dental therapists and dental hygienists) are included in dental therapists data and not in dental hygienists data.
- (b) Data include professionals working in the public sector only — in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and “other public” areas. Professionals who work in both the public and private sectors are not included.
- (c) From 2012, allocation to public sector is based on clinical hours worked. For 2011 and previous years, allocation to public sector is based on total hours worked.
- (d) Data are not available for 2010.
- (e) From 2011, allocation to State or Territory and region is by location of main job where available. Otherwise, location of principal practice is used as a proxy. If that is also not available, location of residence is used. If none of these are available, location is coded 'unstated'.
- (f) Remoteness areas for 2011 and previous years are defined using the Australian Standard Geographical Classification (ASGC), based on the ABS 2006 Census of population and housing. Data for 2012 are revised to remoteness areas defined using the Australian Statistical Geography Standard (ASGS), based on the ABS 2011 Census of population and housing. Data for 2012 may differ to previous reports in which the 2006 Census based ASGC was used.

Table 10A.28 **Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic (h)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT (i)</i>	<i>NT (i)</i>	<i>Aust (j)</i>
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(g) Remote/very remote includes Migratory areas.

(h) Data are not available for Victoria for 2009 due to changes in Victoria's data collection form.

(i) There are no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; and no major cities or inner regional areas in the NT.

(j) 2009 data for Australia exclude data for Victoria.

(k) FTE based on a 40-hour week.

(l) Total includes remoteness area 'unstated'.

(m) Data from 2012 exclude provisional registrants.

na Not available. .. Not applicable. – Nil or rounded to zero.

Source: AIHW unpublished, National Health Workforce Data Set.

TABLE 10A.29

Table 10A.29 Availability of public Occupational Therapists and Psychologists (per 100 000 people) (a), (b), (c), (d), (e), (f)

	NSW	Vic	Qld (g)	WA (g)	SA (g)	Tas (h)	ACT (h)	NT (h)	Aust
2011									
FTE psychologists per 100 000 population (i)									
Major cities	35.9	29.7	27.7	37.9	24.7	..	68.3	..	32.9
Inner regional	26.3	14.9	19.6	15.5	6.2	31.6	–	..	20.6
Outer regional	18.2	7.4	25.7	20.9	5.1	11.2	..	43.5	19.5
Remote and very remote	17.5	–	10.5	20.9	5.6	–	..	18.2	14.9
Total (j)	32.0	24.9	24.1	30.2	19.2	24.0	65.8	31.1	28.9
2012 (e), (m)									
FTE occupational therapists per 100 000 population (i)									
Major cities	23.6	29.6	na	na	na	..	np	..	16.6
Inner regional	21.9	26.9	na	na	na	np	np	..	16.3
Outer regional	np	21.5	na	na	na	np	..	33.7	8.2
Remote and very remote	np	–	na	na	na	np	..	14.2	3.8
Total	22.5	28.8	na	na	na	18.8	27.2	25.1	15.5
FTE psychologists per 100 000 population (i)									
Major cities	26.6	19.3	19.2	24.0	18.1	..	41.5	..	22.7
Inner regional	21.9	12.1	13.9	11.0	4.7	29.5	–	..	16.8
Outer regional	13.3	5.3	17.8	14.7	np	np	..	34.8	14.0
Remote/very remote	10.1	–	12.2	15.2	np	np	..	11.5	11.9
Total (j)	24.8	17.3	17.7	21.4	14.3	23.2	41.4	25.8	20.6
2013 (m)									
FTE occupational therapists per 100 000 population (i)									
Major cities	23.8	30.4	25.0	28.2	31.9	..	26.6	..	27.0
Inner regional	23.0	28.4	17.7	16.7	17.0	28.9	–	..	23.0
Outer regional	np	21.2	27.7	24.2	20.1	np	..	34.9	22.0
Remote/very remote	np	–	15.5	15.2	18.6	np	..	15.4	14.5

TABLE 10A.29

Table 10A.29 **Availability of public Occupational Therapists and Psychologists (per 100 000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (g)</i>	<i>WA (g)</i>	<i>SA (g)</i>	<i>Tas (h)</i>	<i>ACT (h)</i>	<i>NT (h)</i>	<i>Aust</i>
Total (j)	23.0	29.6	23.7	25.9	28.3	22.4	26.6	26.3	25.5
FTE psychologists per 100 000 population (i)									
Major cities	39.4	32.6	27.8	37.8	np	..	np	..	35.1
Inner regional	30.6	22.1	20.0	17.4	np	34.3	np	..	24.6
Outer regional	20.2	7.2	28.2	19.8	np	np	..	48.7	21.1
Remote/very remote	22.2	–	8.3	18.2	np	np	..	22.1	15.0
Total (j)	36.4	29.6	25.7	33.3	21.4	27.3	71.0	37.1	31.5

FTE = Full Time Equivalent

- (a) Data are for professionals working in the public sector. For Occupational Therapists, data are based on clinical hours worked in the public sector. For Psychologists:
- data for 2011 are based on total hours worked
 - data for 2012 are based on clinical hours worked in the public sector
 - data for 2013 are based on hours worked in a direct client service role in the public sector.
- (b) Data exclude provisional registrants.
- (c) Occupational therapists joined the National Registration and Accreditation Scheme (NRAS) 1 July 2012. Hence, data are not available for previous years.
- (d) Remoteness areas are defined using the Australian Statistical Geography Standard (ASGS), based on the ABS 2011 Census of population and housing.
- (e) Allocation to State or Territory and region is by location of main job where available. Otherwise, location of principal practice is used as a proxy. If that is also not available, location of residence is used. If none of these are available, location is coded 'unstated'.
- (f) Remote/very remote includes Migratory areas.
- (g) Occupational therapist workforce data are not available for 2012 for Queensland, WA or SA. Due to transitional arrangements to the National Registration and Accreditation Scheme, many occupational therapists were not required to renew their registration and so did not complete a workforce survey.
- (h) There are no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; and no major cities or inner regional areas in the NT.
- (i) FTE based on a 38-hour week.
- (j) Total includes remoteness area 'unstated', with the exception of 2012 data for occupational therapists.

na Not available. .. Not applicable. – Nil or rounded to zero.

Source: AIHW unpublished, National Health Workforce Data Set.

TABLE 10A.30

Table 10A.30 Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	1 466	265	1 544	798	140	23	24	993	5 253
Target population (h)	no.	17 726	3 868	13 432	6 329	2 994	2 168	286	5 133	51 967
Proportion of target population assessed	%	8.3	6.9	11.5	12.6	4.7	1.1	8.4	19.3	10.1
Non-Indigenous older people										
Number of people assessed (i)	no.	111 344	73 138	62 716	21 998	27 423	9 486	2 430	283	308 818
Target population (j)	no.	457 989	343 315	232 677	116 062	120 952	34 610	15 362	2 521	1 323 516
Proportion of target population assessed	%	24.3	21.3	27.0	19.0	22.7	27.4	15.8	11.2	23.3
2009-10										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	1 652	337	2 053	1 021	153	36	46	1 186	6 484
Target population (h)	no.	18 646	4 092	14 257	6 674	3 141	2 278	328	5 360	54 807
Proportion of target population assessed	%	8.9	8.2	14.4	15.3	4.9	1.6	14.0	22.1	11.8
Non-Indigenous older people										
Number of people assessed (i)	no.	116 756	77 946	65 087	24 451	28 049	9 151	2 724	292	324 456
Target population (j)	no.	467 220	350 473	237 999	119 044	122 469	35 271	15 843	2 666	1 351 013
Proportion of target population assessed	%	25.0	22.2	27.3	20.5	22.9	25.9	17.2	11.0	24.0
2010-11										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	3 216	422	3 149	1 509	450	109	36	1 574	10 465
Target population (h)	no.	19 654	4 312	15 114	7 068	3 303	2 399	376	5 609	57 868

TABLE 10A.30

Table 10A.30 Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion of target population assessed	%	16.4	9.8	20.8	21.3	13.6	4.5	9.6	28.1	18.1
Non-Indigenous older people										
Number of people assessed (i)	no.	130 114	90 493	74 576	29 865	31 394	10 976	3 169	302	370 889
Target population (j)	no.	478 253	358 105	244 178	122 815	123 854	35 826	16 360	2 825	1 382 248
Proportion of target population assessed	%	27.2	25.3	30.5	24.3	25.3	30.6	19.4	10.7	26.8
2011-12										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	4 156	558	4 588	1 632	509	185	48	1 764	13 440
Target population (h)	no.	20 775	4 489	16 001	7 541	3 469	2 519	423	5 934	61 185
Proportion of target population assessed	%	20.0	12.4	28.7	21.6	14.7	7.3	11.4	29.7	22.0
Non-Indigenous older people										
Number of people assessed (i)	no.	137 445	96 176	79 933	31 879	32 887	11 499	3 271	314	393 404
Target population (j)	no.	487 126	365 944	250 898	126 677	125 660	36 643	16 919	3 023	1 412 742
Proportion of target population assessed	%	28.2	26.3	31.9	25.2	26.2	31.4	19.3	10.4	27.8
2012-13										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	5 166	718	5 447	2 191	604	262	73	2 266	16 727
Target population (h)	no.	21 979	4 644	16 978	8 032	3 644	2 659	460	6 343	64 773
Proportion of target population assessed	%	23.5	15.5	32.1	27.3	16.6	9.9	15.9	35.7	25.8
Non-Indigenous older people										
Number of people assessed (i)	no.	146 182	101 897	87 240	35 745	35 332	12 887	3 818	373	423 474

TABLE 10A.30

Table 10A.30 Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Target population (j)	no.	499 610	375 719	258 431	130 987	127 857	37 541	17 635	3 268	1 450 718
Proportion of target population assessed	%	29.3	27.1	33.8	27.3	27.6	34.3	21.7	11.4	29.2
2013-14										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	6 523	844	6 768	2 787	798	365	101	2 695	20 881
Target population (h)	no.	23 245	4 841	18 025	8 520	3 830	2 826	495	6 779	68 597
Proportion of target population assessed	%	28.1	17.4	37.5	32.7	20.8	12.9	20.4	39.8	30.4
Non-Indigenous older people										
Number of people assessed (i)	no.	156 390	111 656	94 872	41 535	39 648	13 741	4 265	547	462 654
Target population (j)	no.	510 562	385 295	266 773	135 602	130 089	38 318	18 316	3 481	1 488 095
Proportion of target population assessed	%	30.6	29.0	35.6	30.6	30.5	35.9	23.3	15.7	31.1

- (a) Older people are defined as Aboriginal and Torres Strait Islander people aged 55 years or over and non-Indigenous people aged 75 years or over, excluding people living in residential aged care facilities.
- (b) Indigenous status is determined by self-identification. Aboriginal and Torres Strait Islander people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Aboriginal and Torres Strait Islander people.
- (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) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.
- (e) Allocation of patients to state or territory is based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.
- (f) Rates have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.1 and 2A.13-14) for details.

Table 10A.30 **Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(g)	Includes claims for MBS items 704, 706 and 715, for Aboriginal and Torres Strait Islander people aged 55 years or over.									
(h)	Derived population of Aboriginal and Torres Strait Islander people aged 55 years or over at 31 December, computed by averaging the estimates/projections at 30 June at each end of the reference year. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.1 and 2A.13-14) for details.									
(i)	Includes claims for MBS items 700, 702, 701, 703, 705 and 707, for people aged 75 years or over.									
(j)	Estimated population of non-Indigenous people aged 75 years or over as at 31 December, computed by subtracting the derived population of Aboriginal and Torres Strait Islander people aged 75 or over (see footnote (h)) from the December 31 ERP for all Australians aged 75 years or over. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Aboriginal and Torres Strait Islander population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.									

Source: Department of Health unpublished, MBS data collection; ABS various years, *Australian Demographic Statistics*, Cat. no. 3201.0; ABS 2014, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0.

TABLE 10A.31

Table 10A.31 **Older Aboriginal and Torres Strait Islander people who received an annual health assessment (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (g)</i>
2007-08										
Number of people assessed	no.	1 148	275	1 261	620	127	7	10	855	4 303
Target population	no.	16 856	3 666	12 669	5 996	2 870	2 066	247	4 923	49 324
Proportion of target population assessed	%	6.8	7.5	10.0	10.3	4.4	0.3	4.0	17.4	8.7
2008-09										
Number of people assessed	no.	1 466	265	1 544	798	140	23	24	993	5 253
Target population	no.	17 726	3 868	13 432	6 329	2 994	2 168	286	5 133	51 967
Proportion of target population assessed	%	8.3	6.9	11.5	12.6	4.7	1.1	8.4	19.3	10.1
2009-10										
Number of people assessed	no.	1 652	337	2 053	1 021	153	36	46	1 186	6 484
Target population	no.	18 646	4 092	14 257	6 674	3 141	2 278	328	5 360	54 807
Proportion of target population assessed	%	8.9	8.2	14.4	15.3	4.9	1.6	14.0	22.1	11.8
2010-11										
Number of people assessed	no.	3 216	422	3 149	1 509	450	109	36	1 574	10 465
Target population	no.	19 654	4 312	15 114	7 068	3 303	2 399	376	5 609	57 868
Proportion of target population assessed	%	16.4	9.8	20.8	21.3	13.6	4.5	9.6	28.1	18.1
2011-12										
Number of people assessed	no.	4 156	558	4 588	1 632	509	185	48	1 764	13 440
Target population	no.	20 775	4 489	16 001	7 541	3 469	2 519	423	5 934	61 185
Proportion of target population assessed	%	20.0	12.4	28.7	21.6	14.7	7.3	11.4	29.7	22.0
2012-13										
Number of people assessed	no.	5 166	718	5 447	2 191	604	262	73	2 266	16 727

Table 10A.31 Older Aboriginal and Torres Strait Islander people who received an annual health assessment (per cent) (a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (g)</i>
Target population	no.	21 979	4 644	16 978	8 032	3 644	2 659	460	6 343	64 773
Proportion of target population assessed	%	23.5	15.5	32.1	27.3	16.6	9.9	15.9	35.7	25.8
2013-14										
Number of people assessed	no.	6 523	844	6 768	2 787	798	365	101	2 695	20 881
Target population	no.	23 245	4 841	18 025	8 520	3 830	2 826	495	6 779	68 597
Proportion of target population assessed	%	28.1	17.4	37.5	32.7	20.8	12.9	20.4	39.8	30.4

- (a) Older Aboriginal and Torres Strait Islander people are defined as aged 55 years or over, excluding people living in residential aged care facilities.
- (b) Includes claims for MBS items 704, 706 and 715 for Aboriginal and Torres Strait Islander people aged 55 years or over. Indigenous status is determined by self-identification. Aboriginal and Torres Strait Islander people aged 75 years or over may have received a health assessment available to 'all older people'. This is considered unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Aboriginal and Torres Strait Islander people .
- (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 people. Data for Aboriginal and Torres Strait Islander people are therefore likely to understate the proportion who access health assessments.
- (d) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.
- (e) Allocation of patients to state or territory is based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.
- (f) Target population is the derived population of Aboriginal and Torres Strait Islander people aged 55 years of over at 31 December, computed by averaging the estimates/projections at 30 June at each end of the reference year. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.1 and 2A.13-14) for details.
- (g) Includes Other Territories.

Source: Department of Health unpublished, MBS data collection; ABS 2014, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians Australians 2001 to 2026*, Cat. no. 3238.0.

TABLE 10A.32

Table 10A.32 **Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)**
(a), (b), (c), (d)

<i>Unit</i>		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (e)</i>
2009-10										
Children 0–14 years (f)										
Children assessed	no.	4 159	841	5 913	2 403	392	73	62	2 808	16 651
Target population	no.	75 637	16 552	69 806	30 913	12 846	8 582	1 974	22 764	239 157
Proportion assessed	%	5.5	5.1	8.5	7.8	3.1	0.9	3.1	12.3	7.0
Adults 15–54 years										
People assessed	no.	9 633	1 981	12 639	6 095	1 101	193	202	8 035	39 879
Target population	no.	108 367	24 656	98 192	48 429	20 142	12 605	3 508	39 892	355 929
Proportion assessed	%	8.9	8.0	12.9	12.6	5.5	1.5	5.8	20.1	11.2
Adults 55 years or over										
People assessed	no.	1 652	337	2 053	1 021	153	36	46	1 186	6 484
Target population	no.	18 646	4 092	14 257	6 674	3 141	2 278	328	5 360	54 807
Proportion assessed	%	8.9	8.2	14.4	15.3	4.9	1.6	14.0	22.1	11.8
2010-11										
Children 0–14 years (f)										
Children assessed	no.	6 046	801	8 349	2 371	476	112	68	3 933	22 156
Target population	no.	75 671	16 789	70 518	30 932	13 013	8 629	1 987	22 616	240 239
Proportion assessed	%	8.0	4.8	11.8	7.7	3.7	1.3	3.4	17.4	9.2
Adults 15–54 years										
People assessed	no.	11 073	1 614	11 844	5 020	1 325	315	150	6 599	37 940
Target population	no.	111 226	25 545	101 122	49 543	20 673	12 912	3 680	40 361	365 202
Proportion assessed	%	10.0	6.3	11.7	10.1	6.4	2.4	4.1	16.4	10.4
Adults 55 years or over										
People assessed	no.	3 216	422	3 149	1 509	450	109	36	1 574	10 465

TABLE 10A.32

Table 10A.32 **Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)**
(a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (e)</i>
Target population	no.	19 654	4 312	15 114	7 068	3 303	2 399	376	5 609	57 868
Proportion assessed	%	16.4	9.8	20.8	21.3	13.6	4.5	9.6	28.1	18.1
2011-12										
Children 0–14 years										
Children assessed	no.	8 520	1 150	12 133	2 436	800	137	197	5 270	30 643
Target population	no.	75 697	17 008	71 105	30 934	13 123	8 669	2 007	22 513	241 139
Proportion assessed	%	11.3	6.8	17.1	7.9	6.1	1.6	9.8	23.4	12.7
Adults 15–54 years										
People assessed	no.	14 933	2 148	18 475	5 355	1 767	449	286	7 229	50 642
Target population	no.	114 004	26 419	104 124	50 694	21 205	13 250	3 819	40 967	374 626
Proportion assessed	%	13.1	8.1	17.7	10.6	8.3	3.4	7.5	17.6	13.5
Adults 55 years or over										
People assessed	no.	4 156	558	4 588	1 632	509	185	48	1 764	13 440
Target population	no.	20 775	4 489	16 001	7 541	3 469	2 519	423	5 934	61 185
Proportion assessed	%	20.0	12.4	28.7	21.6	14.7	7.3	11.4	29.7	22.0
2012-13										
Children 0–14 years										
Children assessed	no.	10 733	1 570	15 197	3 959	1 003	234	214	5 598	38 508
Target population	no.	75 863	17 171	71 812	31 038	13 205	8 733	2 006	22 498	242 410
Proportion assessed	%	14.1	9.1	21.2	12.8	7.6	2.7	10.7	24.9	15.9
Adults 15–54 years										
People assessed	no.	17 762	2 717	22 585	8 597	2 342	664	448	9 202	64 317
Target population	no.	116 702	27 292	107 067	51 912	21 734	13 598	3 961	41 703	384 118
Proportion assessed	%	15.2	10.0	21.1	16.6	10.8	4.9	11.3	22.1	16.7

TABLE 10A.32

Table 10A.32 **Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)**
(a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (e)</i>
Adults 55 years or over										
People assessed	no.	5 166	718	5 447	2 191	604	262	73	2 266	16 727
Target population	no.	21 979	4 644	16 978	8 032	3 644	2 659	460	6 343	64 773
Proportion assessed	%	23.5	15.5	32.1	27.3	16.6	9.9	15.9	35.7	25.8
2013-14										
Children 0–14 years										
Children assessed	no.	13 072	1 908	18 204	5 161	1 527	236	211	6 587	46 906
Target population	no.	76 189	17 360	72 773	31 147	13 311	8 823	2 019	22 487	244 192
Proportion assessed	%	17.2	11.0	25.0	16.6	11.5	2.7	10.5	29.3	19.2
Adults 15–54 years										
People assessed	no.	21 373	3 535	26 639	10 967	3 357	845	492	10 819	78 027
Target population	no.	119 324	28 149	109 829	53 172	22 250	13 909	4 099	42 416	393 298
Proportion assessed	%	17.9	12.6	24.3	20.6	15.1	6.1	12.0	25.5	19.8
Adults 55 years or over										
People assessed	no.	6 523	844	6 768	2 787	798	365	101	2 695	20 881
Target population	no.	23 245	4 841	18 025	8 520	3 830	2 826	495	6 779	68 597
Proportion assessed	%	28.1	17.4	37.5	32.7	20.8	12.9	20.4	39.8	30.4

(a) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.

(b) Allocation of patients to state/territory based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment/check rather than number of health assessments/checks provided. Indigenous status is determined by self-identification.

(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 people. Data for Aboriginal and Torres Strait Islander people are therefore likely to understate the proportion who access health assessments.

Table 10A.32 **Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)**
(a), (b), (c), (d)

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (e)</i>
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(d) Target population is the derived population of Aboriginal and Torres Strait Islander people in the age group at 31 December, computed by averaging the estimates/projections at 30 June at each end of the reference year. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.1 and 2A.13-14) for details.

(e) Includes Other Territories.

Source: Department of Health unpublished, MBS data collection; ABS various years, *Australian Demographic Statistics*, Cat. no. 3201.0; ABS 2014, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0.

TABLE 10A.33

Table 10A.33 **Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)**
(a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (k)</i>	<i>Aust (e)</i>
2009-10										
Aboriginal and Torres Strait Islander Child Health Check (f), (g)	%	27.8	21.7	35.2	35.5	17.3	np	np	45.5	31.0
Healthy Kids Check (h)	%	20.3	6.7	28.1	15.1	10.2	20.5	12.4	17.6	17.2
Total	%	20.6	6.9	28.5	16.3	10.5	19.2	12.3	29.2	17.8
2010-11										
Aboriginal and Torres Strait Islander Child Health Check (f), (g)	%	37.7	23.2	47.7	36.2	17.9	5.2	9.9	63.6	40.1
Healthy Kids Check (h)	%	25.7	7.1	34.4	16.3	12.5	22.8	12.8	31.2	20.7
Total	%	26.3	7.3	35.2	17.5	12.7	21.5	12.8	44.6	21.7
2011-12 (a), (i)										
Aboriginal and Torres Strait Islander Child Health Check (f), (g)	no.	2 326	338	3 198	774	204	47	61	1 367	8 315
Target population (e)	no.	5 173	1 188	4 897	2 150	883	609	123	1 545	16 559
Proportion of target population assessed	%	45.0	28.5	65.3	36.0	23.1	7.7	49.8	88.5	50.2
Healthy Kids Check (h)	no.	46 372	16 885	37 595	12 480	7 201	3 219	1 218	805	125 775
Target population (e)	no.	88 936	69 237	56 498	29 660	18 731	5 844	4 543	2 107	275 592
Proportion of target population assessed	%	52.1	24.4	66.5	42.1	38.4	55.1	26.8	38.2	45.6
Total	no.	48 698	17 223	40 793	13 254	7 405	3 266	1 279	2 172	134 090
Target population	no.	94 109	70 425	61 394	31 810	19 614	6 453	4 666	3 652	292 151
Proportion of target population assessed	%	51.7	24.5	66.4	41.7	37.8	50.6	27.4	59.5	45.9

TABLE 10A.33

Table 10A.33 **Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)**
(a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (k)</i>	<i>Aust (e)</i>
2012-13 (a), (j)										
Aboriginal and Torres Strait Islander Child Health Check (f), (g)	no.	2 864	403	3 791	1 106	271	64	48	1 489	10 036
Target population (e)	no.	5 106	1 199	5 050	2 118	917	642	130	1 500	16 664
Proportion of target population assessed	%	56.1	33.6	75.1	52.2	29.6	10.0	37.1	99.3	60.2
Healthy Kids Check (h)	no.	56 223	21 201	42 969	14 021	9 502	3 668	1 823	931	150 338
Target population (e)	no.	90 363	70 506	58 037	30 663	19 013	5 856	4 755	2 162	281 380
Proportion of target population assessed	%	62.2	30.1	74.0	45.7	50.0	62.6	38.3	43.1	53.4
Total	no.	59 087	21 605	46 767	15 130	9 773	3 732	1 871	2 439	160 404
Target population	no.	95 469	71 705	63 087	32 781	19 929	6 497	4 885	3 662	298 044
Proportion of target population assessed	%	61.9	30.1	74.1	46.2	49.0	57.4	38.3	66.6	53.8
2013-14 (a), (j)										
Aboriginal and Torres Strait Islander Child Health Check (f), (g)	no.	3 206	471	4 397	1 290	354	42	57	1 714	11 531
Target population (e)	no.	5 182	1 191	5 131	2 103	919	625	142	1 450	16 746
Proportion of target population assessed (k)	%	61.9	39.5	85.7	61.3	38.5	6.7	40.3	118.2	68.9
Healthy Kids Check (h)	no.	59 486	19 662	45 372	15 377	10 169	3 578	2 063	858	156 565
Target population (e)	no.	91 582	71 916	58 606	31 431	19 119	5 750	4 976	2 232	285 636
Proportion of target population assessed	%	65.0	27.3	77.4	48.9	53.2	62.2	41.5	38.4	54.8

Table 10A.33 Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)
(a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (k)</i>	<i>Aust (e)</i>
Total	no.	62 692.0	20 133.0	49 769.0	16 667.0	10 523.0	3 620.0	2 120.0	2 572.0	168 096.0
Target population	no.	96 763	73 107	63 737	33 534	20 038	6 375	5 117	3 682	302 381
Proportion of target population assessed	%	64.8	27.5	78.1	49.7	52.5	56.8	41.4	69.9	55.6

- a) Computed by the Secretariat from the 2011-12 reference period. Historical data were sourced from the National Healthcare Agreement and do not include underlying data. The considerable increase in proportion of target population assessed compared to previous years is associated with a considerable increase in the number of children receiving fourth year developmental health checks (Department of Health, pers. comm, 25 October 2012).
- b) Reference year is based on the date the service was provided. Data may differ from other reports in which reference year is based on the date the claim was processed.
- c) Patient allocation based on patient postcode at the date their last service was processed in the reference period. This is not necessarily where the service was received. Data are for number of patients receiving a health assessment/check rather than number of health assessments/checks provided.
- d) Children are counted only once in the numerator.
- e) From the 2010-11 reference period, children who received both a healthy kids check and an Aboriginal and Torres Strait Islander people's health assessment during the reference period were counted against the Aboriginal and Torres Strait Islander health assessment.
- f) Derived target populations as at 31 December are computed as the average of the 4 year old population estimates / projections at June 30 at each end of the reference year. For the Healthy Kids Check, the target population of non-Indigenous 4 year olds is computed by subtracting the derived population of Aboriginal and Torres Strait Islander 4 year olds from the derived 4 year old ERP. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.2 and 2A.13-14) for details.
- g) Data for Aboriginal and Torres Strait Islander Child Health Checks are not published for Tasmania or the ACT for 2009-10 due to small numbers, but are included in the total for Australia.
- h) Includes claims for Medicare Benefits Schedule (MBS) Item 708 (Aboriginal and Torres Strait Islander Child Health Check, available to 30 April 2010) and Item 715 (Aboriginal and Torres Strait Islander People's Health Assessment, available from 1 May 2010) for children aged 3, 4 or 5 years for the 2012-13 reference period, and 3 or 4 years for the 2011-12 reference period. 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 for Aboriginal and Torres Strait Islander people are therefore likely to understate the proportion who access health assessments.

Table 10A.33 Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)
(a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (k)</i>	<i>Aust (e)</i>
(i)	Includes claims for MBS items 709 and 711 (Healthy Kids Check, available to 30 April 2010) and items 701, 703, 705, 707 and 10986 (Health Assessment, available from 1 May 2010) for children aged 3, 4 or 5 years from 2011-12, and 3 or 4 years for data to 2010-11. Data do not include developmental health check activity conducted outside Medicare, such as State and Territory early childhood health assessments in preschools and community health centres. This is known to be a particular issue for several jurisdictions. For example, in Victoria, the Victorian Maternal and Child Health Service provided a 3.5 year old Key Ages and Stages consultation to 47 638 children in the 2011-12 financial year. Data include Aboriginal and Torres Strait Islander children who received a Healthy Kids Check and did not also receive a health check under MBS items 708 or 715.									
(j)	From 2011-12, data include Aboriginal and Torres Strait Islander and non-Indigenous children aged 3, 4 or 5 years who received a health assessment under the specified MBS items, provided they had not received such a check in a previous reference period. This constitutes a break in time series for the data. Data from 2011-12 should not be compared with data for previous years, which are limited to children aged 3 or 4 years.									
(k)	For the NT for 2013-14, data for the proportion of Aboriginal and Torres Strait Islander children who received a health check exceeds 100 per cent. This is largely because numerator and denominator are not directly comparable — children are eligible to receive this health assessment at the age of 3, 4 or 5 years. However, a child is eligible to receive it once only (children may also be eligible for other health checks) — hence, the denominator uses population estimates and projections for a single year of age — 4 years. Using this methodology, the total number of children aged 3, 4 and 5 years who received a check in 2013-14 exceeds the derived population of Aboriginal and Torres Strait Islander children aged 4 years.									

np Not published.

Source: Department of Health unpublished, MBS Statistics; ABS unpublished, *Australian demographic statistics*, Cat. no. 3101.0; ABS 2014, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1996 to 2026*, B series, Cat. no. 3238.0.

Table 10A.34 Non-referred attendances that were bulk billed, by region and age (per cent) (a), (b), (c), (d)

	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote</i>	<i>Very remote</i>	<i>Aust (e)</i>
2012-13						
0–15 years	89.4	88.3	88.7	91.6	92.5	89.2
16–64 years	78.6	72.3	73.7	74.4	83.1	77.0
65 years or over	90.5	88.8	89.7	92.0	94.0	90.1
All ages	83.3	79.6	80.5	81.3	86.6	82.3
2013-14						
0–15 years	90.2	89.8	90.3	92.4	94.7	90.2
16–64 years	80.3	74.5	76.0	75.7	86.2	78.9
65 years or over	90.7	88.9	89.8	91.7	95.2	90.2
All ages (f)	84.5	81.2	82.1	82.2	89.3	83.6

(a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which were based on a different classification.

(b) Data include non-referred attendances undertaken by general practice nurses

(c) Patient age at date of service.

(d) Allocation to remoteness area based on patients' Medicare enrolment postcode.

(e) Australia includes attendances where patient postcodes could not be allocated to a remoteness area.

(f) All ages includes attendances where patient age is unknown.

Source: Department of Health unpublished, MBS Statistics.

Table 10A.35 Non-referred attendances that were bulk billed, by region and age, 2006-07 to 2011-12 (per cent) (a), (b), (c), (d), (e)

	<i>Capital city</i>	<i>Other metro centre</i>	<i>Large rural centre</i>	<i>Small rural centre</i>	<i>Other rural area</i>	<i>Remote centre</i>	<i>Other remote area</i>	<i>Aust</i>
2006-07								
0-15 years	86.9	82.1	79.1	82.2	82.4	80.3	87.8	85.4
16-64 years	74.3	71.0	63.9	66.1	65.5	63.0	74.5	71.9
65 years or over	89.4	86.2	83.1	85.6	85.3	87.7	89.4	87.8
All ages	79.8	76.9	71.5	74.3	73.8	70.1	79.9	78.0
2007-08								
0-15 years	87.6	83.3	80.8	84.8	84.6	81.4	89.2	86.4
16-64 years	75.4	72.7	66.1	68.9	67.9	65.0	76.8	73.4
65 years or over	89.7	87.3	84.6	87.3	86.7	87.8	90.9	88.6
All ages	80.7	78.3	73.4	76.7	76.0	71.6	82.0	79.2
2008-09								
0-15 years	88.2	84.7	83.2	87.3	86.1	81.7	89.8	87.3
16-64 years	75.7	73.8	67.1	71.2	68.6	63.8	77.4	73.9
65 years or over	90.2	88.0	85.9	88.6	87.8	87.9	91.8	89.2
All ages	81.1	79.4	74.7	78.8	77.0	70.9	82.6	79.9
2009-10								
0-15 years	88.8	86.4	85.1	88.7	87.0	84.0	91.3	88.2
16-64 years	75.5	75.5	67.8	73.1	69.8	65.5	78.9	74.3
65 years or over	90.4	89.3	87.2	89.7	88.8	88.0	92.1	89.8
All ages	81.3	81.1	76.0	80.5	78.3	72.5	83.9	80.5
2010-11								
0-15 years	88.8	86.4	85.7	88.8	86.9	84.6	91.8	88.2
16-64 years	76.2	76.1	68.8	73.3	69.9	65.4	79.4	74.9
65 years or over	90.4	89.5	87.6	89.9	88.8	87.9	92.5	89.9
All ages	81.7	81.5	76.7	80.8	78.3	72.5	84.4	80.9
2011-12								
0-15 years	89.2	87.1	86.8	89.6	87.8	84.8	92.5	88.8
16-64 years	77.2	76.8	71.1	74.0	70.8	64.9	80.2	75.8
65 years or over	90.3	89.6	87.8	90.3	88.8	86.7	93.1	89.9
All ages	82.3	82.0	78.1	81.4	78.9	71.9	85.2	81.5

(a) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification. Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; large rural centre = statistical local areas (SLAs) where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone.

(b) Data are not comparable to data for 2012-13 and subsequent years which are based on the Australian Statistical Geography Standard 2011 (ASGS) classification.

Table 10A.35 **Non-referred attendances that were bulk billed, by region and age, 2006-07 to 2011-12 (per cent) (a), (b), (c), (d), (e)**

	<i>Other metro Capital city centre</i>	<i>Large rural centre</i>	<i>Small rural centre</i>	<i>Other rural area</i>	<i>Remote centre</i>	<i>Other remote area</i>	<i>Aust</i>
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(c) Data include non-referred attendances undertaken by general practice nurses

(d) Patient age at date of service.

(e) Allocation to state/territory based on patients' Medicare enrolment postcode.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.36

Table 10A.36 **Non-referred attendances that were bulk billed by age (per cent)**
(a), (b), (c), (d)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (e)</i>
2005-06									
0-15 years	87.1	78.2	83.3	86.6	86.0	78.6	52.9	69.7	83.4
16-64 years	78.2	67.5	66.6	60.6	65.9	61.2	35.7	57.8	69.8
65 years or over	87.5	85.8	86.3	89.4	87.8	83.6	64.9	86.1	86.7
All ages	81.9	73.8	74.2	71.8	74.9	69.6	44.2	63.0	76.2
2006-07									
0-15 years	88.5	80.4	85.4	88.4	88.1	81.7	62.7	69.6	85.4
16-64 years	80.0	69.7	68.7	62.0	68.6	63.9	44.2	59.0	71.9
65 years or over	88.7	86.7	87.5	90.0	89.0	85.4	68.6	86.6	87.8
All ages	83.5	75.7	76.1	73.0	77.1	72.2	51.9	64.0	78.0
2007-08									
0-15 years	89.2	81.7	86.5	90.0	89.6	84.2	62.2	70.7	86.4
16-64 years	81.2	71.4	70.5	62.3	71.0	66.5	46.2	61.0	73.4
65 years or over	89.5	87.3	88.2	90.4	90.0	86.7	69.2	87.6	88.6
All ages	84.5	77.0	77.5	73.9	79.0	74.5	53.2	65.7	79.2
2008-09									
0-15 years	89.9	82.9	87.8	90.7	90.7	85.6	62.2	68.1	87.3
16-64 years	81.7	72.4	71.4	61.6	72.1	66.2	46.0	60.0	73.9
65 years or over	90.1	87.9	89.1	90.9	90.8	87.1	68.3	88.0	89.2
All ages	85.1	77.9	78.5	73.7	80.1	74.8	53.0	64.7	79.9
2009-10									
0-15 years	90.4	83.8	89.3	90.5	91.4	87.2	64.4	72.9	88.2
16-64 years	81.0	73.6	73.4	61.7	70.5	67.7	40.5	64.3	74.3
65 years or over	90.6	88.6	90.1	91.3	91.3	88.1	67.7	89.7	89.8
All ages	85.0	79.0	80.3	73.9	79.7	76.3	49.9	68.9	80.5
2010-11									
0-15 years	90.3	84.5	89.3	90.5	91.6	86.7	61.9	76.0	88.2
16-64 years	81.8	74.5	74.2	61.0	70.7	67.5	38.3	66.4	74.9
65 years or over	90.8	88.7	90.3	90.9	91.0	88.0	66.4	89.9	89.9
All ages	85.5	79.7	80.8	73.4	79.6	76.1	48.1	71.1	80.9
2011-12									
0-15 years	90.8	85.7	89.4	90.3	92.1	86.4	65.4	80.4	88.8
16-64 years	82.7	76.0	74.8	60.4	72.9	66.5	40.8	68.9	75.8
65 years or over	91.0	88.8	90.2	90.1	90.7	87.4	66.3	90.6	89.9
All ages	86.1	80.8	81.0	72.8	80.8	75.4	50.2	73.7	81.5
2012-13									
0-15 years	91.0	86.8	89.5	90.2	92.1	86.9	68.1	85.5	89.2

Table 10A.36 Non-referred attendances that were bulk billed by age (per cent)
(a), (b), (c), (d)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (e)</i>
16–64 years	83.7	77.7	75.7	61.0	73.9	67.4	47.9	73.9	77.0
65 years or over	91.3	89.2	90.4	89.7	90.6	88.3	66.5	91.2	90.1
All ages	86.8	82.1	81.7	73.0	81.4	76.4	55.0	78.2	82.3
2013-14									
0–15 years	91.6	88.1	90.6	91.5	92.4	88.1	69.6	89.8	90.2
16–64 years	85.1	79.2	77.7	65.5	75.3	68.9	50.5	79.3	78.9
65 years or over	91.5	89.3	90.6	89.6	90.2	88.5	67.1	91.6	90.2
All ages	87.9	83.2	83.1	75.7	82.2	77.7	57.2	82.8	83.6

(a) Data include non-referred attendances undertaken by general practice nurses.

(b) Patient age at date of service.

(c) Allocation to State/Territory based on patients' Medicare enrolment postcode.

(d) All ages includes attendances where patient age is unknown.

(e) Australia includes attendances where patient postcodes could not be allocated to a State/Territory.

Source: Department of Health unpublished, MBS Statistics.

Table 10A.37 **People deferring access to GPs due to cost (per cent) (a), (b), (c), (d), (e), (f), (g)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (f)	Aust
2012-13										
Proportion	%	4.5	5.0	5.9	7.7	5.4	7.0	8.8	5.2	5.4
RSE	%	8.7	6.3	7.0	7.4	9.5	9.6	12.1	20.5	3.3
95 per cent confidence interval	±	0.8	0.6	0.8	1.1	1.0	1.3	2.1	2.1	0.4
2013-14 (g)										
Proportion	%	3.5	5.0	5.8	6.2	4.5	6.9	6.9	5.6	4.9
RSE	%	7.6	6.9	6.2	7.5	11.7	10.4	11.3	21.8	2.9
95 per cent confidence interval	±	0.5	0.7	0.7	0.9	1.0	1.4	1.5	2.4	0.3

RSE = Relative standard error.

- (a) People aged 15 years or over who delayed or did not visit a GP at any time in the last 12 months due to cost.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Rates with RSEs between 25 per cent and 50 per cent should be used with caution.
- (d) Data from 2012-13 are not comparable to data for previous years due to a change in question sequencing/wording. See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (e) Data are not comparable to data for Aboriginal and Torres Strait Islander people that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.
- (f) Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.
- (g) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.38 **Aboriginal and Torres Strait Islander people deferring access to GPs due to cost, 2012-13 (per cent) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion	%	11.1	12.3	13.0	13.8	7.7	16.3	20.7	11.0	12.2
RSE (c)	%	24.5	28.4	26.9	20.7	43.8	23.9	24.3	40.2	10.2
95 per cent confidence interval	± %	5.3	6.9	6.8	5.6	6.6	7.6	9.9	8.7	2.4

RSE = Relative standard error.

- (a) Aboriginal and Torres Strait Islander people aged 15 years or over who reported needing to see a GP in the last 12 months and delayed doing so or did not do so because of cost, divided by the number of Aboriginal and Torres Strait Islander people aged 15 years or over who reported needing to see a GP in the last 12 months.
- (b) Rates are age-standardised to the 2001 estimated resident population using 5 year ranges.
- (c) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.
- (d) Data are not comparable with data for all Australians that were sourced from the ABS Patient Experience Survey, due to differences in survey design and collection methodology.
- (e) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Source: 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.39 **Waiting time for GPs for an urgent appointment (per cent) (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
2012-13										
Within four hours										
Proportion	%	63.9	63.7	66.2	61.5	65.2	53.9	60.0	51.9	63.8
RSE	%	2.5	3.1	3.2	4.5	2.5	6.3	7.6	10.0	1.3
95 per cent confidence interval	±	3.2	3.8	4.2	5.5	3.2	6.6	8.9	10.2	1.6
Four to less than 24 hours										
Proportion	%	9.5	11.7	11.2	11.8	13.5	15.4	13.2	13.8	11.2
RSE	%	11.1	11.8	13.8	15.3	10.8	12.9	21.3	25.3	5.1
95 per cent confidence interval	±	2.1	2.7	3.0	3.5	2.9	3.9	5.5	6.8	1.1
24 hours or more										
Proportion	%	26.5	24.5	22.6	26.8	21.2	30.7	26.9	34.3	25.0
RSE	%	5.4	7.5	7.5	9.0	8.1	10.4	13.0	13.9	3.1
95 per cent confidence interval	±	2.8	3.6	3.3	4.7	3.4	6.2	6.9	9.4	1.5
2013-14 (g)										
Within four hours										
Proportion	%	64.7	63.4	65.4	65.2	64.7	51.8	58.3	78.4	64.2
RSE	%	3.3	0.6	2.5	4.9	4.8	5.6	9.6	7.3	1.4
95 per cent confidence interval	±	4.1	0.7	3.2	6.2	6.0	5.7	11.0	11.2	1.7
Four to less than 24 hours										
Proportion	%	8.2	10.4	10.4	8.8	12.2	16.0	19.2	12.7	10.0
RSE	%	18.4	14.5	19.8	19.5	16.7	22.1	21.4	33.0	8.2
95 per cent confidence interval	±	2.9	3.0	4.0	3.4	4.0	6.9	8.1	8.2	1.6
24 hours or more										
Proportion	%	26.7	25.9	24.0	27.1	21.5	34.8	26.4	6.4	25.8
RSE	%	5.6	8.9	7.0	10.5	11.5	8.2	17.1	44.8	2.2
95 per cent confidence interval	±	2.9	4.5	3.3	5.6	4.9	5.6	8.8	5.6	1.1

RSE = relative standard error.

- (a) Time waited between making an appointment and seeing the GP for urgent medical care.
- (b) People aged 15 years or over who saw a GP for urgent medical care for their own health in the last 12 months. 'Urgent' as defined by respondent. Discretionary interviewer advice was to include health issues that arose suddenly and were serious (e.g. fever, headache, vomiting, unexplained rash).
- (c) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.

Table 10A.39 **Waiting time for GPs for an urgent appointment (per cent) (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
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(d) Data for 2013-14 are comparable with data for 2011-12 and 2012-13 but are not comparable with data for previous years, due to a change to the question wording in 2011-12. See data quality information at www.pc.gov.au/rogs/2015 for further detail.

(e) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.

(f) Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.

(g) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.40 **Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment (per cent) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
2012-13										
Proportion	%	20.2	21.2	17.5	24.4	20.5	22.5	22.0	22.0	20.5
RSE	%	3.1	3.0	4.6	4.4	4.8	5.3	7.3	9.0	1.9
95 per cent confidence interval	±	1.2	1.3	1.6	2.1	1.9	2.3	3.2	3.9	0.7
2013-14 (e)										
Proportion	%	23.9	22.6	19.2	24.5	21.9	23.4	25.1	26.5	22.6
RSE	%	2.6	3.0	3.7	4.7	3.7	4.8	6.3	8.4	1.5
95 per cent confidence interval	±	1.2	1.3	1.4	2.3	1.6	2.2	3.1	4.3	0.7

RSE = relative standard error.

- (a) Persons aged 15 years or over who saw a GP in the previous 12 months, excluding interviews by proxy.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Data from 2012-13 are not comparable to data for previous years due to a change in question sequencing. See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (d) Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.
- (e) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

TABLE 10A.41

Table 10A.41 **Selected potentially avoidable GP-type presentations to emergency departments (number) (a), (b), (c)**

	<i>NSW</i> (d)	<i>Vic</i> (d)	<i>Qld</i>	<i>WA</i>	<i>SA</i> (e)	<i>Tas</i> (f)	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09	648 937	542 164	380 947	193 353	112 517	55 644	44 535	34 703	2 012 800
2009-10	706 134	550 887	371 539	207 545	117 056	62 534	46 217	37 717	2 099 629
2010-11	692 778	555 140	375 169	263 845	117 525	60 182	48 485	42 303	2 155 427
2011-12	684 991	554 124	378 087	286 820	103 928	59 840	47 807	40 903	2 156 500
2012-13 (g)	692 774	574 874	383 924	271 878	112 801	61 600	46 627	39 813	2 184 291
2013-14 (h)	709 345	572 435	381 378	272 936	113 358	61 176	50 486	39 272	2 200 386

- (a) 'GP-type' emergency department presentations are defined as presentations for which the type of visit was reported as emergency presentation, which did not arrive by ambulance or by police or other correctional vehicle, with a triage category of 4 (semi-urgent) or 5 (non-urgent), and where the episode end status was not: admitted to the hospital, referred to another hospital, or died. This is an interim definition, pending development of new methodology to more closely approximate the population that could receive services in the primary care sector. Data include appropriate presentations to emergency departments that can only retrospectively be categorised as 'GP-type'.
- (b) Data are presented by the state/territory of usual residence of the patient, not by the state/territory of the hospital.
- (c) Limited to peer group A and B public hospitals.
- (d) From 2009-10, data for the Albury Base Hospital (previously reported in NSW hospital statistics) were reported in Victorian hospital statistics. This change in reporting arrangements should be factored into any analysis of data for NSW and Victoria.
- (e) For SA for 2008-09 and 2009-10, data include presentations for which the type of visit was not reported.
- (f) The Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B) for these data.
- (g) Data for 2012-13 have been revised using hospital classification into peer groups A and B based on 2012-13 peer groups and differ from data published in the 2014 Report which utilised hospital classification into peer groups A and B based on 2011-12 peer groups.
- (h) Data for 2013-14 are preliminary. Hospital classification into peer groups A and B is based on 2012-13 peer groups.

Source: AIHW unpublished, National Non-admitted Emergency Department Care Database.

TABLE 10A.42

Table 10A.42 **People attending a hospital emergency department who thought the care could have been provided at a general practice (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
2010-11										
Proportion	%	26.3	17.3	19.2	23.5	18.3	23.7	26.9	19.9	21.5
RSE	%	8.2	8.5	9.5	8.4	11.5	14.4	21.5	17.8	4.6
95% confidence interval	±	4.2	2.9	3.6	3.9	4.1	6.7	11.3	7.0	1.9
2011-12										
Proportion	%	21.2	24.1	26.1	27.4	20.2	21.9	25.3	26.2	23.5
RSE	%	7.3	8.2	10.7	8.3	13.5	12.7	16.4	15.2	3.4
95% confidence interval	±	3.0	3.9	5.5	4.5	5.4	5.5	8.1	7.8	1.6
2012-13										
Proportion	%	23.7	22.7	23.6	24.8	23.7	24.1	24.2	22.5	23.6
RSE	%	6.5	6.1	8.0	8.9	12.7	11.8	14.0	14.7	3.5
95% confidence interval	±	3.0	2.7	3.7	4.3	5.9	5.6	6.6	6.5	1.6

RSE = Relative standard error.

- (a) People aged 15 years or over who reported attending a hospital emergency department and thought at the time that the care received could have been provided at a general practice.
- (b) Rates are age-standardised to the 2001 estimated resident population using 5 year age ranges except for ACT and NT, for which 15 year age ranges are used.
- (c) Excludes persons who responded "Don't know" whether care could have been provided at a GP
- (d) Data from 2011-12 exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions, but include very remote areas. Data for previous years exclude very remote areas which translates into the exclusion of around 23 per cent of the NT population — NT data for 2010-11 should therefore be used with care.

Source: ABS unpublished, *Patient Experience Survey 2010-11, 2011-12, 2012-13*, Cat. no. 4839.0.

Table 10A.43 **People deferring access to prescribed medication due to cost (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (f)	Aust
2012-13										
Proportion	%	7.4	7.9	9.3	6.8	8.2	8.5	6.7	9.0	7.9
RSE	%	5.3	5.3	6.5	9.4	7.8	10.0	15.4	17.1	2.5
95 per cent confidence interval	±	0.8	0.8	1.2	1.2	1.2	1.7	2.0	3.0	0.4
2013-14 (g)										
Proportion	%	7.0	6.3	9.9	8.4	7.5	8.0	6.7	6.2	7.6
RSE	%	7.0	5.9	6.3	7.6	8.3	9.0	14.7	17.4	2.7
95 per cent confidence interval	±	1.0	0.7	1.2	1.2	1.2	1.4	1.9	2.1	0.4

RSE = Relative standard error.

- (a) People aged 15 years and over who received a prescription for medication from a GP in the last 12 months and delayed using or did not get medication at any time in the last 12 months due to the cost.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution.
- (d) Data for 2010-11 and subsequent reference years are comparable over time, but are not comparable with data for 2009 due to a change in the sequencing and wording of the survey question. See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (e) Data are not comparable to data for Aboriginal and Torres Strait Islander people that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.
- (f) Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.
- (g) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.44 **Aboriginal and Torres Strait Islander people deferring access to prescribed medication due to cost, 2012-13 (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion	%	24.4	36.3	47.0	45.2	35.3	46.5	24.1	22.8	34.6
RSE (c)	%	19.7	14.8	15.0	19.3	26.0	14.9	37.2	34.1	8.4
95 per cent confidence interval	±	9.4	10.5	13.8	17.1	18.0	13.5	17.6	15.2	5.7

RSE = Relative standard error.

- (a) Aboriginal and Torres Strait Islander people aged 15 years and over who received a prescription for medication in the last 12 months and delayed getting or did not get the medication due to the cost, divided by the number of Aboriginal and Torres Strait Islander people who received a prescription for medication in the last 12 months.
- (b) Rates are age-standardised to the 2001 estimated resident population (10 year ranges).
- (c) Estimates with RSEs between 25 and 50 per cent should be used with caution.
- (d) Data are not comparable to data for all Australians that were sourced from the ABS Patient Experience Survey, due to differences in survey design and collection methodology.
- (e) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).
- (f) Includes major cities, inner and outer regional areas only, as these survey questions were not asked in remote and very remote areas.

Source: 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.45 **Waiting time for public dentistry (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
2012-13 (d)										
Less than 1 month										
Proportion	%	33.9	30.9	29.8	35.9	16.1	32.2	30.4	41.3	30.8
RSE (c)	%	8.4	11.5	10.7	15.2	25.2	19.4	24.2	26.3	4.1
95% CI	±	5.6	7.0	6.3	10.7	7.9	12.3	14.4	21.3	2.5
1 month or more										
Proportion	%	66.1	69.1	70.2	64.1	83.9	67.8	69.6	58.7	69.2
RSE	%	4.3	5.1	4.5	8.5	4.8	9.2	10.6	18.5	1.8
95% CI	±	5.6	7.0	6.3	10.7	7.9	12.3	14.4	21.3	2.5
2013-14 (d), (g)										
Less than 1 month										
Proportion	%	27.6	17.8	27.2	19.7	18.4	26.2	32.5	24.4	23.4
RSE (c)	%	12.9	10.4	11.9	26.3	23.8	26.4	35.1	40.1	6.1
95% CI	±	6.9	3.6	6.4	10.2	8.6	13.6	22.4	19.2	2.8
1 month or more										
Proportion	%	71.6	82.8	70.9	82.4	83.2	74.7	81.5	73.9	76.5
RSE	%	5.0	5.6	5.4	3.6	7.5	4.6	19.6	14.8	1.5
95% CI	±	7.0	9.1	7.5	5.9	12.2	6.8	31.3	21.4	2.2

RSE = Relative standard error. **CI** = confidence interval.

- (a) Time waited for treatment at a government dental clinic for people 15 years or over who were on a public dental waiting list in the last 12 months.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.
- (d) Data for 2013-14 are not comparable with data for 2012-13 and previous years due to significant changes in question wording and sequencing. For the 2013-14 survey, respondents were for the first time asked to include waiting times for public dental services provided at a private dental clinic. See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (e) Data are not comparable with data for Aboriginal and Torres Strait Islander people that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.
- (f) Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.
- (g) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS (unpublished) *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.46 **Waiting time for public dentistry by remoteness, Australia (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>Major Cities</i>	<i>Other (f)</i>	<i>Inner regional</i>	<i>Outer regional/ remote/very remote</i>	<i>Total</i>
2012-13 (d)						
Less than 1 month						
Proportion	%	31.9	29.3	30.3	27.6	30.8
RSE	%	6.6	10.1	9.9	17.2	4.1
95% CI	±	4.1	5.8	5.9	9.3	2.5
1 month or more						
Proportion	%	68.1	70.7	69.7	72.4	69.2
RSE	%	3.1	4.2	4.3	6.6	1.8
95% CI	±	4.1	5.8	5.9	9.3	2.5
2013-14 (d), (g)						
Less than 1 month						
Proportion	%	25.2	21.3	18.3	25.7	23.4
RSE	%	8.3	7.8	9.8	12.0	6.1
95% CI	±	4.1	3.2	3.5	6.0	2.8
1 month or more						
Proportion	%	74.2	78.8	81.3	74.5	76.5
RSE	%	2.9	1.5	3.5	2.7	1.5
95% CI	±	4.2	2.4	5.6	3.9	2.2

RSE = Relative standard error. **CI** = confidence interval.

- (a) Time waited for treatment at a government dental clinic for people 15 years or over who were on a public dental waiting list in the last 12 months for their own health.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.
- (d) Data for 2013-14 are not comparable to data for 2012-13 and previous years. See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (e) Data are not comparable with data for Aboriginal and Torres Strait Islander people that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.
- (f) 'Other' includes inner and outer regional, remote and very remote areas.
- (g) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.47 **Waiting times for public dentistry, Aboriginal and Torres Strait Islander people, by remoteness, Australia, 2012-13 (per cent) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Aust (c)</i>
Less than 1 month					
Proportion	%	57.8	56.6	63.2	59.0
RSE	%	6.5	8.0	8.1	4.5
95% CI	±	7.4	8.9	10.0	5.2
1 month or more					
Proportion	%	29.5	33.8	21.2	28.0
RSE	%	14.2	13.7	19.8	9.1
95% CI	±	8.2	9.1	8.2	5.0

CI = confidence interval. **RSE** = relative standard error. Estimates with RSEs between 25 percent and 50 percent should be used with caution.

- (a) Aboriginal and Torres Strait Islander people aged 15 years or over who reported seeing a dental professional at a government dental clinic within specified waiting time categories for non-urgent treatment in the last 12 months, divided by the number of Aboriginal and Torres Strait Islander people aged 15 years or over who reported seeing a dental professional at a government dental clinic in the last 12 months.
- (b) Rates are age-standardised to the 2001 estimated resident population using 5 year age ranges.
- (c) Includes persons in non-remote areas only, as the survey questions were not asked of people in remote areas.
- (d) Data are not comparable with data for all Australians that were sourced from the ABS 2012-13 Patient Experience Survey, due to differences in survey design and collection methodology.
- (e) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Source: ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (NATSIHS component), Cat. no. 4727.0.

Table 10A.48 **Proportion of full time workload equivalent (FWE) GPs with vocational registration by region (per cent) (a), (b), (c), (d)**

	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote</i>	<i>Very remote</i>	<i>Aust</i>
2012-13	92.6	82.8	78.8	75.5	83.4	89.4
2013-14	91.7	80.9	78.8	78.3	79.8	88.5

- (a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which were based on a different classification.
- (b) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.
- (c) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period. In the small proportion of cases where data values were not reported, doctors were reallocated based on available information.
- (d) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

Source: Department of Health unpublished, MBS Statistics.

Table 10A.49 Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region, 2003-04 to 2011-12 (per cent) (a), (b), (c), (d)

	<i>Capital city</i>	<i>Other metro centre</i>	<i>Large rural centre</i>	<i>Small rural centre</i>	<i>Other rural area</i>	<i>Remote centre</i>	<i>Other remote area</i>	<i>Aust</i>
2003-04	93.7	93.0	90.0	86.7	83.8	71.2	68.3	91.4
2004-05	93.4	91.7	89.7	85.3	83.4	71.4	67.2	91.0
2005-06	93.1	90.3	90.7	84.2	83.1	68.2	72.9	90.6
2006-07	92.9	90.0	90.3	83.5	83.3	71.3	68.8	90.4
2007-08	92.7	89.9	87.6	82.2	83.1	71.0	65.5	90.0
2008-09	92.6	89.6	87.5	81.8	83.4	70.4	67.3	89.9
2009-10	92.6	89.6	87.1	80.2	83.3	68.9	69.6	89.7
2010-11	93.2	90.6	87.0	80.5	81.5	67.2	72.6	89.9
2011-12	92.8	90.9	86.6	80.3	80.8	67.6	73.5	89.6

- (a) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification. Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone.
- (b) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.
- (c) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period. In the small proportion of cases where data values were not reported, doctors were reallocated based on available information.
- (d) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

Source: Department of Health unpublished, MBS Statistics.

Table 10A.50 Number and proportion of full time workload equivalent (FWE) GPs with vocational registration (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
FWE GPs with vocational registration										
2004-05	no.	5 774	3 789	2 933	1 335	1 262	348	191	81	15 714
2005-06	no.	5 858	3 870	3 004	1 346	1 289	353	199	79	15 997
2006-07	no.	6 007	3 987	3 051	1 362	1 301	356	215	80	16 359
2007-08	no.	6 098	4 131	3 125	1 395	1 322	370	223	82	16 745
2008-09	no.	6 260	4 284	3 265	1 414	1 376	372	223	86	17 279
2009-10	no.	6 346	4 402	3 389	1 455	1 403	385	224	94	17 699
2010-11	no.	6 490	4 528	3 574	1 494	1 418	390	227	96	18 216
2011-12	no.	6 725	4 630	3 810	1 542	1 474	405	234	104	18 924
2012-13	no.	6 928	4 819	4 040	1 636	1 524	428	253	114	19 742
2013-14	no.	7 184	4 981	4 242	1 748	1 557	432	254	122	20 521
Proportion of FWE GPs with vocational registration										
2004-05	%	92.8	90.9	86.6	91.7	92.6	92.1	95.5	84.4	91.0
2005-06	%	92.8	90.4	86.1	91.4	91.8	91.4	95.9	81.8	90.6
2006-07	%	92.7	90.5	85.6	90.8	91.8	91.0	95.2	76.9	90.4
2007-08	%	92.4	90.1	84.9	90.5	90.9	92.1	95.9	70.5	90.0
2008-09	%	92.2	90.4	84.6	89.8	91.1	92.0	95.0	74.2	89.9
2009-10	%	92.1	89.8	84.9	90.1	90.7	92.2	94.2	74.1	89.7
2010-11	%	91.8	89.4	86.6	91.1	90.3	90.9	94.8	71.8	89.9
2011-12	%	91.6	87.9	87.7	90.8	90.5	90.1	93.4	73.5	89.6
2012-13	%	91.3	86.9	88.4	90.7	90.7	92.2	93.0	72.1	89.4
2013-14	%	90.6	85.5	88.0	89.5	89.5	90.8	91.8	69.8	88.5

- (a) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.
- (b) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.
- (c) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.51

Table 10A.51 **General practices that are accredited at 30 June (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008										
Accredited										
AGPAL	no.	1 372	936	795	329	339	113	47	37	3 968
GPA Accreditation <i>plus</i>	no.	267	212	148	73	36	10	23	3	772
Total	no.	1 639	1 148	943	402	375	123	70	40	4 740
General practices	no.	2 782	1 687	1 278	569	567	167	92	119	7 261
Proportion accredited	%	58.9	68.0	73.8	70.7	66.1	73.7	76.1	33.6	65.3
Registered for accreditation (b)										
AGPAL	no.	1 471	972	858	356	357	121	49	47	4 231
GPA Accreditation <i>plus</i>	no.	278	228	163	77	37	10	23	3	819
2009										
Accredited										
AGPAL	no.	1 364	915	782	311	338	115	43	37	3 905
Quality Practice Accreditation	no.	315	262	182	86	42	15	22	5	930
Total	no.	1 679	1 177	964	397	380	130	65	42	4 835
General practices	no.	2 726	1 641	1 247	570	556	160	91	119	7 110
Proportion accredited	%	61.6	71.7	77.3	69.6	68.3	81.3	71.4	35.3	68.0
Registered for accreditation (b)										
AGPAL	no.	1 450	959	833	331	359	118	46	46	4 142
Quality Practice Accreditation	no.	333	286	193	91	44	17	23	7	994
2010										
Accredited										
AGPAL	no.	1 346	883	753	330	330	98	40	38	3 818
Quality Practice Accreditation	no.	329	284	197	86	44	32	19	3	994
Total	no.	1 675	1 167	950	416	374	130	59	41	4 812
General practices	no.	2 731	1 691	1 266	569	525	158	91	120	7 151

TABLE 10A.51

Table 10A.51 **General practices that are accredited at 30 June (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion accredited	%	61.3	69.0	75.0	73.1	71.2	82.3	64.8	34.2	67.3
Registered for accreditation (b)										
AGPAL	no.	1 431	942	818	358	346	103	44	58	4 100
Quality Practice Accreditation	no.	343	291	214	89	44	32	19	4	1 036
2011										
Accredited										
AGPAL	no.	1 318	871	735	327	323	86	38	41	3 739
Quality Practice Accreditation	no.	340	296	206	93	48	33	21	7	1 044
Total	no.	1 658	1 167	941	420	371	119	59	48	4 783
General practices	no.	2 712	1 687	1 241	573	537	158	84	105	7 097
Proportion accredited	%	61.1	69.2	75.8	73.3	69.1	75.3	70.2	45.7	67.4
Registered for accreditation (b)										
AGPAL	no.	1 399	926	784	350	339	92	40	57	3 987
Quality Practice Accreditation	no.	373	334	241	102	49	38	23	9	1 169
2012										
Accredited										
AGPAL	no.	1 308	865	719	323	323	85	39	52	3 714
Quality Practice Accreditation	no.	439	344	280	109	65	42	23	10	1 312
Total	no.	1 747	1 209	999	432	388	127	62	62	5 026
General practices	no.	na	na	na	na	na	na	na	na	na
Proportion accredited	%	na	na	na	na	na	na	na	na	na
Registered for accreditation (b)										
AGPAL	no.	1 403	932	781	345	337	87	41	58	3 984
Quality Practice Accreditation	no.	476	362	311	120	71	46	25	11	1 422
2013 (c)										
Accredited										

TABLE 10A.51

Table 10A.51 **General practices that are accredited at 30 June (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
AGPAL	no.	1 284	892	742	333	331	85	38	52	3 757
Quality Practice Accreditation	no.	625	462	382	160	91	59	34	15	1 828
Total	no.	1 909	1 354	1 124	493	422	144	72	67	5 585
General practices	no.	na	na	na	na	na	na	na	na	na
Proportion accredited	%	na	na	na	na	na	na	na	na	na
Registered for accreditation (b)										
AGPAL	no.	1 352	941	784	347	332	86	46	55	3 943
Quality Practice Accreditation	no.	659	485	407	168	98	62	36	19	1 934
2014 (c)										
Accredited										
AGPAL	no.	1 271	908	748	349	321	84	41	54	3 776
Quality Practice Accreditation	no.	622	460	415	154	107	55	30	26	1 869
Total	no.	1 893	1 368	1 163	503	428	139	71	80	5 645
General practices (c)	no.	na	na	na	na	na	na	na	na	na
Proportion accredited	%	na	na	na	na	na	na	na	na	na
Registered for accreditation (b)										
AGPAL	no.	1 321	946	786	370	337	87	42	57	3 946
Quality Practice Accreditation	no.	663	490	449	167	109	59	30	27	1 994

(a) Includes practices accredited by either of Australia's two accrediting bodies. Quality Practice Accreditation manages the General Practice Australia ACCREDITATION *plus* accreditation program.

(b) Includes practices registered for accreditation but not yet accredited, in addition to accredited practices.

(c) Data for the total number of practices have not been available since 2010-11. Historical data were collected by the Primary Health Care Research and Information Service (PHC RIS) for the Annual Survey of Divisions (ASD), in response to the question "How many general practices were in your Division's catchment area at 30 June". Data were provided by all Divisions of General Practice as required under contractual agreements with Department of Health. The ASD ceased with the transition from Divisions of General Practice to Medicare Locals and no other data source has been identified.

na Not available.

Table 10A.51 **General practices that are accredited at 30 June (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Source:</i>	AGPAL (Australian General Practice Accreditation Limited) unpublished; Quality Practice Accreditation Pty Ltd unpublished; PHCRIS, Department of Health unpublished, ASD (various years).									

Table 10A.52 **General practice activity in PIP practices (per cent)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion of SWPEs that are in PIP practices (a)										
2003-04	%	75.8	83.3	79.8	80.3	84.8	88.3	76.4	51.3	79.7
2004-05	%	76.6	83.9	79.9	80.7	84.3	86.9	80.7	56.5	80.2
2005-06	%	77.2	84.3	80.1	82.2	85.2	88.5	83.4	55.1	80.9
2006-07	%	77.4	84.4	81.3	82.2	85.4	86.0	84.6	53.6	81.2
2007-08	%	77.9	85.0	81.4	82.6	85.1	88.7	86.1	54.9	81.6
2008-09	%	78.5	85.3	82.6	83.7	84.4	88.7	83.4	56.9	82.1
2009-10	%	79.1	85.9	84.0	83.6	84.8	88.4	88.1	59.8	82.9
2010-11	%	79.1	85.8	84.3	83.6	86.0	88.1	88.2	60.5	83.0
2011-12	%	80.6	86.4	85.8	84.8	87.3	89.3	88.3	64.1	84.2
2012-13	%	81.2	86.6	85.7	85.7	87.6	89.2	89.4	66.2	84.6
Proportion of services provided by PIP practices (b)										
2003-04	%	73.3	81.2	79.3	79.5	83.9	87.4	75.3	51.7	78.0
2004-05	%	74.2	82.0	80.0	80.1	83.4	86.5	79.6	58.0	78.7
2005-06	%	75.2	82.7	80.2	81.7	84.8	88.4	82.7	56.6	79.6
2006-07	%	75.6	83.0	81.6	82.0	85.2	86.0	84.4	55.0	80.1
2007-08	%	76.3	83.9	81.8	82.9	85.3	88.8	85.4	56.2	80.8
2008-09	%	76.9	84.3	83.0	84.0	84.6	88.4	83.5	59.5	81.4
2009-10	%	77.9	85.0	84.7	84.0	85.3	88.5	88.1	61.7	82.4
2010-11	%	77.8	84.8	84.6	84.0	86.1	88.2	88.2	61.7	82.4
2011-12	%	79.1	85.4	86.0	84.5	87.3	89.3	88.3	65.6	83.4
2012-13	%	79.7	85.6	85.7	85.5	87.7	89.1	89.7	69.9	83.8

(a) A SWPE is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.

(b) Services may vary in type and quality.

Source: Department of Health unpublished, MBS and PIP data collections.

Table 10A.53 **Filled prescriptions, ordered by GPs, for oral antibiotics that are used most commonly for treatment of upper respiratory tract infections (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2012-13										
All people										
Scripts	no.	2 340 481	1 768 423	1 434 337	472 595	532 288	169 921	67 108	20 855	6 806 008
Population (d)	no.	7 348 899	5 679 633	4 610 932	2 472 717	1 662 169	512 422	379 554	236 869	22 906 352
Rate	per 1000 people	318.5	311.4	311.1	191.1	320.2	331.6	176.8	88.0	297.1
2013-14										
All people										
Scripts	no.	2 381 870	1 880 698	1 371 143	479 066	519 983	161 838	67 432	22 366	6 884 396
Population (d)	no.	7 465 497	5 790 990	4 690 910	2 550 874	1 677 250	513 955	384 147	242 573	23 319 385
Rate	per 1000 people	319.1	324.8	292.3	187.8	310.0	314.9	175.5	92.2	295.2

(a) The oral antibiotics used most commonly in treating upper respiratory tract infection are: phenoxymethylpenicillin (penicillin V); amoxicillin; erythromycin; roxithromycin; cefaclor; amoxicillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names were extracted for each year.

(b) These antibiotics are also used for treatment of diseases other than upper respiratory tract infection. The reason for the antibiotic prescription is not known.

(c) Data include prescriptions ordered by vocationally registered GPs and other medical practitioners (OMPs) and dispensed to PBS concession card holders.

(d) Estimated resident population at 31 December based on the ABS 2011 Census, first preliminary estimates.

Source: Department of Health unpublished, PBS Statistics.

TABLE 10A.54

Table 10A.54 **Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and provided to PBS concession card holders, 2009-10 to 2011-12 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2009-10										
Scripts	no.	2 187 899	1 697 904	1 257 889	426 460	512 394	156 175	58 960	18 865	6 316 546
Concession card holders	no.	1 772 335	1 396 751	1 041 249	456 175	457 481	156 888	52 263	46 588	5 389 025
Rate	per 1000 holders	1 234.5	1 215.6	1 208.1	934.9	1 120.0	995.5	1 128.1	404.9	1 172.1
2010-11										
Scripts	no.	2 280 551	1 853 022	1 353 985	432 750	521 568	163 389	65 432	19 361	6 690 058
Concession card holders	no.	1 793 360	1 410 180	1 067 874	460 274	465 767	159 817	53 085	45 779	5 466 022
Rate	per 1000 holders	1 271.7	1 314.0	1 267.9	940.2	1 119.8	1 022.4	1 232.6	422.9	1 223.9
2011-12										
Scripts	no.	2 349 145	1 761 703	1 400 017	471 336	515 907	171 723	63 802	20 031	6 753 664
Concession card holders	no.	1 810 065	1 434 628	1 082 274	463 942	471 039	163 012	54 111	46 017	5 535 884
Rate	per 1000 holders	1 297.8	1 228.0	1 293.6	1 015.9	1 095.3	1 053.4	1 179.1	435.3	1 220.0

(a) The oral antibiotics used most commonly in treating upper respiratory tract infection are: phenoxymethylpenicillin (penicillin V); amoxicillin; erythromycin; roxithromycin; cefaclor; amoxicillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names were extracted for each year.

(b) These antibiotics are also used for treatment of diseases other than upper respiratory tract infection. The reason for the antibiotic prescription is not known.

(c) Data include prescriptions ordered by vocationally registered GPs and other medical practitioners (OMPs) and dispensed to PBS concession card holders.

(d) Number of concession card holders data were obtained from the Department of Families, Housing, Community Services and Indigenous Affairs.

Source: Department of Health unpublished, PBS Statistics.

TABLE 10A.55

Table 10A.55 **Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2006 to 2011										
Systemic antibiotic prescribed	%	34.7	30.7	33.5	28.1	31.1	24.0	30.3	17.8	32.4
95 per cent confidence interval	±	2.0	2.3	2.6	4.5	4.2	5.9	8.2	9.9	1.2
Encounters for acute URTI management (c)	no.	9 761	6 145	4 388	1 970	1 882	562	641	180	26 025
2007 to 2012										
Systemic antibiotic prescribed	%	35.0	30.1	33.7	28.7	30.1	25.3	33.0	22.8	32.5
95 per cent confidence interval	±	1.9	2.3	2.6	4.3	4.1	5.9	9.9	10.0	1.2
Encounters for acute URTI management (c)	no.	10 384	6 215	4 473	1 979	1 852	542	527	149	26 619
2008 to 2013										
Systemic antibiotic prescribed	%	35.7	29.9	34.1	25.9	28.6	26.5	28.0	21.4	32.5
95 per cent confidence interval	±	2.0	2.3	2.6	3.7	3.7	6.1	8.3	8.8	1.2
Encounters for acute URTI management (c)	no.	10 330	6 003	4 643	2 163	1 673	502	510	140	26 454
2009 to 2014										
Systemic antibiotic prescribed	%	33.0	27.4	33.1	25.6	26.7	26.3	25.7	20.9	30.5
95 per cent confidence interval	±	2.0	2.3	2.5	4.5	3.9	5.8	8.1	9.5	1.2

Table 10A.55 **Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Encounters for acute URTI management (c)	no.	9 691	5 630	4 576	1 953	1 604	533	529	115	25 105

URTI = Upper respiratory tract infection.

- (a) Data are from April of the first year to March of the final year of each 5 year period.
- (b) Participation in the survey is voluntary. Data are not necessarily representative of non-participating GPs.
- (c) A GP encounter is a professional interchange between a patient and a GP.

Source: Britt et al. unpublished, BEACH Statistics.

Table 10A.56 **Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia (a), (b), (c)**

	Unit	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Encounters for acute URTI management (c)	per 100 GP encounters	5.2	5.6	5.5	5.5	4.9	5.6	5.3	4.4
95 per cent confidence interval	±	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Systemic antibiotic prescribed for URTI management	%	32.2	29.9	39.0	29.6	31.0	32.8	29.9	29.0
95 per cent confidence interval	±	2.7	2.5	2.7	2.5	2.4	2.6	2.7	2.6

URTI = Upper respiratory tract infection.

(a) Data are for the period from April to the following March.

(b) Participation in the survey is voluntary. Data are not necessarily representative of non-participating GPs.

(c) A GP encounter is a professional interchange between a patient and a GP.

Source: Britt et al. unpublished, BEACH Statistics.

TABLE 10A.57

Table 10A.57 Uptake by Practices in the Practice Incentives Program (PIP) of the PIP Diabetes Incentive (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PIP practices (May 2014) (b)	no.	1 812	1 255	1 077	452	367	121	71	55	5 210
SWPE (c)	('000)	5 259	4 346	3 383	1 701	1 301	401	284	101	16 774
PIP Diabetes Incentive — uptake	no.	880	528	585	216	130	44	41	40	2 464
Share of PIP practices	%	48.6	42.1	54.3	47.8	35.4	36.4	57.7	72.7	47.3

- (a) Not all practices are involved in PIP, and the proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.51).
- (b) In accordance with the purpose of the PIP Diabetes incentive to encourage general practices to provide earlier diagnosis and effective management of people with established diabetes mellitus, practices are required to maintain an active patient register and recall and reminder system for all known patients with diabetes mellitus, and to agree to implement a cycle of care for patients with diabetes mellitus.
- (c) A SWPE is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.

Source: Department of Health unpublished, MBS and PIP data collections.

Table 10A.58 Proportion of people with known diabetes who had a HbA1c test in the last 12 months, 2011-12 (per cent) (a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
Proportion of people with known diabetes who had a HbA1c test in last 12 months										
Males	%	86.4	72.1	74.7	81.6	84.8	88.2	73.3	84.7	80.4
Females	%	66.9	91.1	58.9	82.6	100.0	85.0	83.2	94.8	73.0
Persons	%	78.4	79.9	69.2	82.1	88.2	86.8	79.1	91.1	77.5
Relative Standard Error (RSE)										
Males	%	12.1	31.7	11.6	15.9	13.2	15.1	42.5	26.7	5.9
Females	%	39.2	13.6	26.0	22.5	0.0	19.5	22.5	7.8	13.4
Persons	%	15.1	14.0	12.5	12.4	9.9	11.1	18.9	8.8	6.3
95% confidence interval										
Males	± %	20.6	44.8	17.0	25.4	22.0	26.1	61.1	44.2	9.2
Females	± %	51.4	24.2	30.0	36.3	0.0	32.6	36.7	14.5	19.1
Persons	± %	23.2	21.9	16.9	19.9	17.1	19.0	29.2	15.7	9.5

Estimates with RSEs between 25 percent and 50 percent should be used with caution.

- (a) Persons aged 18 years to 69 years. Includes pregnant women.
- (b) Known diabetes is derived using a combination of fasting plasma glucose test results and self-reported information on diabetes diagnosis and medication use. See data quality information for further detail.
- (c) Excludes people who did not fast for 8 hours or more prior to the blood test. For Australia in 2011-12, approximately 79% of people aged 18 years and over who participated in the National Health Measures Survey (NHMS) had fasted.
- (d) Rates are non-age standardised.
- (e) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

Source: ABS unpublished, *Australian Health Survey 2011-13* (2011-12 NHMS component), Cat. no. 4364.0.

TABLE 10A.59

Table 10A.59 **Proportion of people aged 18 to 69 years with known diabetes who have a HbA1c (glycated haemoglobin) level less than or equal to 7.0 per cent, by sex, 2011-12 (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust</i>
<i>Proportion</i>										
Males	%	66.2	41.2	48.5	65.3	41.6	67.4	73.9	23.2	53.8
Females	%	44.9	19.1	43.0	55.6	84.6	72.2	26.5	71.9	45.0
Total	%	56.7	35.5	46.4	61.3	52.1	69.9	44.3	47.7	50.5
<i>Relative standard error</i>										
Males	%	14.1	51.5	22.1	19.5	39.5	19.3	27.9	61.8	11.1
Females	%	31.6	88.0	18.5	30.8	13.9	15.6	63.2	27.6	15.8
Total	%	13.4	46.5	15.3	16.7	28.5	11.4	31.0	31.4	8.8
<i>95 per cent confidence interval</i>										
Males	±	18.3	41.7	21.0	24.9	32.2	25.5	40.3	28.1	11.8
Females	±	27.8	32.9	15.6	33.6	23.1	22.1	32.8	38.8	13.9
Total	±	14.9	32.4	13.9	20.1	29.1	15.7	26.9	29.3	8.7

(a) Estimates with a relative standard error (RSE) between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(b) People aged 18 years to 69 years. Includes pregnant women.

(c) Known diabetes is derived using a combination of fasting plasma glucose test results and self-reported information on diabetes diagnosis and medication use.

(d) Excludes people who did not fast for 8 hours or more prior to the blood test. For Australia in 2011-12, approximately 79 per cent of people aged 18 years or over who participated in the National Health Measures Survey (NHMS) had fasted.

(e) Rates are not age standardised (they are crude rates).

(f) Denominator includes a small number of persons for whom test results were not reported.

(g) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

Source: ABS (unpublished) *Australian Health Survey 2011-13*, (2011-12 NHMS component), Cat. no. 4364.0.

TABLE 10A.60

Table 10A.60 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c), (d), (e) Aust</i>
2001									
0–14 years									
Proportion	%	24.2	31.8	16.2	20.0	30.5	19.5	44.4	np 24.7
RSE	%	14.6	12.6	22.5	28.1	18.8	29.0	20.1	np 7.7
95 per cent confidence interval	±	± 6.9	± 7.9	± 7.1	± 11.0	± 11.2	± 11.1	± 17.5	np ± 3.7
15–64 years									
Value	%	19.6	12.7	13.2	np	16.1	np	19.1	np 15.0
RSE	%	12.6	13.7	14.9	np	18.0	np	15.8	np 6.5
95 per cent confidence interval	±	± 4.8	± 3.4	± 3.9	np	± 5.7	np	± 5.9	np ± 1.9
65 years or over									
Proportion	%	14.6	7.7	11.8	np	19.0	np	23.8	np 12.1
RSE	%	32.3	44.6	48.9	np	49.7	np	46.3	np 22.1
95 per cent confidence interval	±	± 9.2	± 6.7	± 11.3	np	± 18.5	np	± 21.6	np ± 5.2
All ages (crude rates)									
Proportion	%	20.3	16.4	13.8	11.4	19.7	11.1	25.4	np 17.0
RSE	%	10.5	10.9	11.3	18.1	12.3	27.0	12.3	np 5.3
95 per cent confidence interval	±	± 4.2	± 3.5	± 3.1	± 4.0	± 4.7	± 5.9	± 6.1	np ± 1.8
2004-05									
0–14 years									
Proportion	%	33.6	52.5	29.9	np	39.2	21.9	np	np 36.7
RSE	%	20.7	16.7	17.3	np	19.8	24.9	np	np 9.6
95 per cent confidence interval	±	± 13.6	± 17.2	± 10.1	np	± 15.2	± 10.7	np	np ± 6.9
15–64 years									
Proportion	%	22.6	21.6	18.2	14.5	17.1	15.6	24.6	np 19.7
RSE	%	14.2	16.0	15.8	19.8	14.3	16.6	18.7	np 6.9
95 per cent confidence interval	±	± 6.3	± 6.8	± 5.6	± 5.6	± 4.8	± 5.1	± 9.0	np ± 2.7
65 years or over									
Proportion	%	17.1	7.6	18.5	np	20.6	19.7	np	np 14.2
RSE	%	29.1	54.1	39.0	np	22.3	32.1	np	np 17.5

TABLE 10A.60

Table 10A.60 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c), (d), (e)</i>	<i>Aust</i>
95 per cent confidence interval	±	± 9.8	± 8.1	± 14.1	np	± 9.0	± 12.4	np	np	± 4.9
All ages (crude rates)										
Proportion	%	24.3	27.0	21.0	15.0	22.6	17.3	27.0	np	22.9
RSE	%	12.8	11.2	10.8	18.4	9.6	12.5	17.9	np	6.0
95 per cent confidence interval	±	± 6.1	± 5.9	± 4.4	± 5.4	± 4.3	± 4.2	± 9.5	np	± 2.7
2007-08										
0-14 years										
Proportion	%	46.5	61.6	41.4	29.0	56.1	41.6	47.3	np	47.8
RSE	%	16.3	9.8	17.1	28.1	17.1	20.6	17.1	np	7.6
95 per cent confidence interval	±	± 14.9	± 11.8	± 13.9	± 16.0	± 18.8	± 16.8	± 15.9	np	± 7.1
15-24 years										
Proportion	%	11.9	9.3	14.7	np	7.4	9.6	35.0	np	12.6
RSE	%	47.1	47.0	37.8	np	53.2	69.2	29.0	np	19.5
95 per cent confidence interval	±	± 11.0	± 8.6	± 10.9	np	± 7.7	13.0	± 19.9	np	± 4.8
25-44 years										
Proportion	%	13.8	6.1	14.1	17.0	8.1	11.8	11.3	np	11.5
RSE	%	27.3	35.6	32.6	36.7	35.9	36.8	26.4	np	15.7
95 per cent confidence interval	±	± 7.4	± 4.3	± 9.0	± 12.2	± 5.7	± 8.5	± 5.8	np	± 3.5
45-64 years										
Proportion	%	14.1	21.9	16.2	11.3	np	9.3	12.5	np	16.5
RSE	%	27.7	26.7	28.4	42.3	np	49.7	43.1	np	14.2
95 per cent confidence interval	±	± 7.7	± 11.5	± 9.0	± 9.4	np	± 9.1	± 10.6	np	± 4.6
65 years or over										
Proportion	%	20.0	18.8	13.9	np	np	12.1	15.1	np	17.9
RSE	%	26.0	33.9	35.3	np	np	47.9	53.2	np	15.9
95 per cent confidence interval	±	± 10.2	± 12.5	± 9.6	np	np	± 11.4	± 15.7	np	± 5.6
All ages (ASR) (f)										
Proportion	%	20.4	22.9	19.7	17.4	21.9	17.1	21.8	40.9	20.8

TABLE 10A.60

Table 10A.60 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c), (d), (e)</i>	<i>Aust</i>
RSE	%	11.2	10.9	11.4	17.6	13.4	18.8	12.1	47.0	5.6
95 per cent confidence interval	±	± 4.5	± 4.9	± 4.4	± 6.0	± 5.7	± 6.3	± 5.2	± 37.7	± 2.3
2011-12										
0-14 years										
Proportion	%	35.1	46.9	32.6	48.4	58.3	36.6	37.4	65.5	40.9
RSE	%	20.0	14.0	20.8	21.6	13.2	26.1	18.9	18.9	7.8
95 per cent confidence interval	±	± 13.7	± 12.9	± 13.3	± 20.5	± 15.1	± 18.7	± 13.9	± 24.2	± 6.2
15-24 years										
Proportion	%	15.5	20.4	np	31.0	27.2	np	np	np	18.6
RSE	%	47.3	35.9	np	32.4	38.7	np	np	np	18.8
95 per cent confidence interval	±	± 14.3	± 14.3	np	± 19.7	± 20.6	np	np	np	± 6.9
25-44 years										
Proportion	%	24.4	11.8	11.8	15.7	19.0	23.1	17.5	26.1	16.8
RSE	%	22.7	25.6	30.9	34.4	29.0	25.2	31.9	29.9	12.6
95 per cent confidence interval	±	± 10.8	± 5.9	± 7.2	± 10.6	± 10.8	± 11.4	± 10.9	± 15.3	± 4.1
45-64 years										
Proportion	%	22.6	27.9	21.9	15.7	20.5	15.7	19.0	16.5	22.6
RSE	%	23.9	20.8	23.1	33.4	26.7	32.9	30.9	40.6	10.8
95 per cent confidence interval	±	± 10.6	± 11.4	± 9.9	± 10.3	± 10.7	± 10.1	± 11.5	± 13.1	± 4.8
65 years or over										
Proportion	%	37.0	23.2	16.0	16.7	21.9	20.1	33.1	42.2	26.4
RSE	%	20.3	22.5	30.3	38.3	32.9	34.9	39.6	43.0	12.5
95 per cent confidence interval	±	± 14.7	± 10.2	± 9.5	± 12.6	± 14.1	± 13.7	± 25.6	± 35.6	± 6.5
All ages (ASR) (f)										
Proportion	%	26.6	25.3	18.4	24.5	29.3	22.6	24.3	33.7	24.6
RSE	%	9.7	9.9	13.8	15.2	9.5	14.2	14.6	17.0	4.5
95 per cent confidence interval	±	± 5.1	± 4.9	± 5	± 7.3	± 5.5	± 6.3	± 7	± 11.3	± 2.2

ASR = age standardised rate. **RSE** = relative standard error.

Table 10A.60 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c), (d), (e)</i>	<i>Aust</i>
(a)	Separate estimates for the NT are not available for the 2001 or 2004-05 surveys, and are available only for 'all ages' for the 2007-08 survey. However, NT data are included in national estimates.									
(b)	Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published. However, these data contribute to national estimates.									
(c)	Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.									
(d)	Data for the NT are not published for 2001 or 2004-05 as sample sizes were insufficient to provide reliable estimates, but are included in the Australian total. For the same reason, 2007-08 data for the NT are published only for all ages, although data by age are included in the Australian total.									
(e)	Data for 2011-12 for the NT are not comparable to data for previous years due to the increased sample size.									
(f)	For 'all ages', 2007-08 and 2011-12 data are age standardised to the Australian population at 30 June 2001. These data differ from previous reports which reported crude rates.									
	np Not published.									

Source: ABS 2009, *National Health Survey: Summary of Results, 2007-2008*, Cat. no. 4364.0; ABS 2009, *National Health Survey: Summary of Results; State Tables, 2007-08*, Cat. no. 4362.0; ABS unpublished, *National Health Survey 2001, 2004-05, 2007-08*, Cat. no. 4364.0; ABS unpublished, *Australian Health Survey 2011-13* (2011-12 NHS component), Cat. no. 4364.0.

TABLE 10A.61

Table 10A.61 **Proportion of people with asthma with a written asthma plan, by Indigenous status, by age, 2011–13 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Aboriginal and Torres Strait Islander people										
0-14 years										
Proportion	%	56.5	58.0	42.6	37.1	42.4	43.5	51.7	55.7	50.9
RSE	%	14.0	13.7	15.1	27.5	23.5	19.0	27.0	32.3	8.7
95 per cent confidence interval	±	15.5	15.6	12.6	20.0	19.5	16.2	27.4	35.2	8.7
15-34 years										
Proportion	%	11.2	28.2	12.4	23.6	27.8	19.3	22.2	26.4	16.3
RSE	%	31.0	26.3	42.6	30.5	34.2	31.2	42.4	69.7	14.1
95 per cent confidence interval	±	6.8	14.6	10.3	14.1	18.7	11.8	18.5	36.1	4.5
35-54 years										
Proportion	%	21.9	26.3	19.0	11.4	39.2	np	np	29.5	21.1
RSE	%	31.3	29.6	30.7	45.5	22.4	np	np	50.3	15.2
95 per cent confidence interval	±	13.4	15.2	11.4	10.2	17.2	np	np	29.1	6.3
55 yrs or over										
Proportion	%	28.1	32.8	24.6	24.5	28.4	np	np	51.4	28.6
RSE	%	33.8	30.4	55.5	56.2	48.8	np	np	26.3	19.0
95 per cent confidence interval	±	18.6	19.6	26.7	27.0	27.1	np	np	26.5	10.6
All ages (Crude rates)										
Proportion	%	30.5	37.2	24.3	24.2	34.9	25.1	27.5	40.5	29.4
RSE	%	13.3	12.1	16.7	18.4	14.1	15.7	21.9	19.3	7.3
95 per cent confidence interval	±	7.9	8.8	7.9	8.7	9.7	7.7	11.8	15.3	4.2
All ages (ASR) (e)										
Proportion	%	26.6	34.8	23.4	22.9	34.0	22.6	21.6	36.9	27.3
RSE	%	14.1	13.0	19.4	19.0	16.1	16.9	24.1	22.7	7.9
95 per cent confidence interval	±	7.3	8.8	8.9	8.5	10.8	7.5	10.2	16.4	4.2
Non-Indigenous people										
0-14 years										
Proportion	%	34.7	46.9	32.5	48.2	55.3	35.4	32.9	47.0	40.3
RSE	%	20.9	14.0	20.9	22.8	14.6	27.4	23.5	40.0	8.3
95 per cent confidence interval	±	14.2	12.9	13.3	21.5	15.8	19.0	15.1	36.9	6.5
15-34 years										
Proportion	%	18.8	15.5	12.3	25.9	18.5	17.7	20.8	24.6	17.3
RSE	%	23.2	24.7	40.0	30.0	38.4	43.0	31.3	43.9	14.5

Table 10A.61 **Proportion of people with asthma with a written asthma plan, by Indigenous status, by age, 2011–13 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
95 per cent confidence interval	±	8.6	7.5	9.7	15.2	13.9	14.9	12.8	21.2	4.9
35-54 years										
Proportion	%	25.1	19.6	15.6	12.1	27.0	26.1	np	np	20.1
RSE	%	20.3	25.2	29.1	30.4	19.5	21.3	np	np	9.9
95 per cent confidence interval	±	10.0	9.7	8.9	7.2	10.3	10.9	np	np	3.9
55 yrs or over										
Proportion	%	30.4	23.8	16.7	18.8	20.4	11.4	np	np	23.8
RSE	%	16.5	19.1	23.9	29.9	26.7	35.6	np	np	9.0
95 per cent confidence interval	±	9.9	8.9	7.8	11.0	10.7	7.9	np	np	4.2
All ages (Crude rates)										
Proportion	%	26.6	24.4	18.1	21.7	27.3	22.3	23.5	20.6	23.7
RSE	%	9.9	9.9	14.7	17.1	11.2	14.2	15.0	24.8	4.6
95 per cent confidence interval	±	5.2	4.8	5.2	7.3	6.0	6.2	6.9	10.0	2.1
All ages (ASR) (e)										
Proportion	%	26.5	25.1	18.4	24.6	29.0	22.4	23.5	23.2	24.2
RSE	%	10.4	10.0	14.1	16.3	10.0	14.9	16.0	24.3	4.7
95 per cent confidence interval	±	5.4	4.9	5.1	7.9	5.7	6.5	7.4	11.0	2.2

(a) Persons who have been told by a doctor they have asthma, and the asthma is current and long-term.

(b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(c) Excludes remote and very remote areas. Data on whether the respondent has a written asthma action plan was collected for non-remote respondents only in the National Aboriginal and Torres Strait Islander Health Survey.

(d) Data for Aboriginal and Torres Strait Islander people and for non-Indigenous people use different survey questions to define asthma as current. However, data are comparable.

(e) Rates are age standardised to the Australian estimated resident population at 30 June 2001.

np not published

Source: 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; ABS unpublished, *Australian Health Survey 2011-13* (2011-12 NHS component), Cat. no. 4364.0.

Table 10A.62 **Proportion of people with asthma with a written asthma plan, by Indigenous status (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2004-05										
Aboriginal and Torres Strait Islander people										
Proportion	%	30.2	22.5	17.2	11.9	20.4	29.8	20.5	7.9	20.4
RSE	%	15.6	43.3	28.9	21.0	24.1	30.5	39.7	19.9	9.7
95 per cent confidence interval	±	± 9.2	± 19.1	± 9.8	± 4.9	± 9.6	± 17.8	± 16.0	± 3.1	± 3.9
Non-Indigenous people										
Proportion	%	23.6	26.3	20.5	15.8	21.9	17.5	28.3	–	22.5
RSE	%	11.8	9.2	10.7	15.8	10.2	12.6	15.6	–	5.4
95 per cent confidence interval	±	± 5.5	± 4.8	± 4.3	± 4.9	± 4.4	± 4.3	± 8.6	–	± 2.4
2011–13										
Aboriginal and Torres Strait Islander people										
Proportion	%	26.6	34.8	23.4	22.9	34.0	22.6	21.6	36.9	27.3
RSE	%	14.1	13.0	19.4	19.0	16.1	16.9	24.1	22.7	7.9
95 per cent confidence interval	±	7.3	8.8	8.9	8.5	10.8	7.5	10.2	16.4	4.2
Non-Indigenous people										
Proportion	%	26.5	25.1	18.4	24.6	29.0	22.4	23.5	23.2	24.2
RSE	%	10.4	10.0	14.1	16.3	10.0	14.9	16.0	24.3	4.7
95 per cent confidence interval	±	5.4	4.9	5.1	7.9	5.7	6.5	7.4	11.0	2.2

RSE = relative standard error.

- (a) Persons who have been told by a doctor they have asthma, and the asthma is current and long-term.
 (b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution.
 (c) Rates are age standardised to the Australian estimated resident population at 30 June 2001.
 – Nil or rounded to zero.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no. 4715.0; ABS unpublished, *National Health Survey, 2004-05*, Cat. no. 4364.0; ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey (National Aboriginal and Torres Strait Islander Health Survey component)*, Cat. no. 4727.0; ABS unpublished, *Australian Health Survey 2011-13 (2011-12 NHS component)*, Cat. no. 4364.0.

Table 10A.63 **Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
Major cities										
Proportion	%	20.9	22.7	21.4	14.6	19.4	..	21.8	..	20.7
RSE	%	13.7	12.9	16.4	21.5	14.1	..	12.1	..	5.8
95 per cent confidence interval	%	± 5.6	± 5.8	± 6.9	± 6.2	± 5.3	..	± 5.2	..	± 2.3
Inner regional										
Proportion	%	14.9	np	21.6	27.8	np	19.2	..	..	21.5
RSE	%	26.6	np	22.2	31.0	np	23.1	..	..	10.7
95 per cent confidence interval	%	± 7.8	np	± 9.4	± 16.9	np	± 8.7	..	..	± 4.5
Outer regional										
Proportion	%	33.1	np	np	np	28.3	np	..	50.0	20.9
RSE	%	45.4	np	np	np	41.2	np	..	43.4	19.2
95 per cent confidence interval	%	± 29.4	np	np	np	± 22.9	np	..	± 42.5	± 7.9
Remote										
Proportion	%	–	–	np	np	np	np	..	–	13.4
RSE	%	–	–	np	np	np	np	..	–	51.1
95 per cent confidence interval	%	–	–	np	np	np	np	..	–	± 13.4
Very remote (f)										
Proportion	%	na	na	na	na	na	na	na	na	na
RSE	%	na	na							
95 per cent confidence interval	%	na	na	na	na	na	na	na	na	na
Total										
Proportion	%	20.4	22.9	19.7	17.4	21.9	17.1	21.8	40.9	20.8
RSE	%	11.2	10.9	11.4	17.6	13.4	18.8	12.1	47.0	5.6
95 per cent confidence interval	%	± 4.5	± 4.9	± 4.4	± 6.0	± 5.7	± 6.3	± 5.2	± 37.7	± 2.3

RSE = relative standard error.

(a) Persons who have been told by a doctor they have asthma, and the asthma is current and long-term.

(b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published.

(c) Rates are age standardised to the Australian estimated resident population at 30 June 2001.

(d) Regions are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS 2006 Census of population and housing. The accuracy of the classifications decreases over time due to changes in demographics within postcode boundaries in the intercensal periods. Not all remoteness areas are represented in each state or territory. There were: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.

Table 10A.63 **Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)**

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
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(e) Data for the NT should be used with care as exclusion of very remote areas translates to exclusion of around 23 per cent of the NT population.

(f) Very remote data were not collected in the 2007-08 National Health Survey.

na Not available. .. Not applicable. – Nil or rounded to zero. **np** Not published.

Source: ABS unpublished, *National Health Survey, 2007-08*, Cat. no. 4364.0.

Table 10A.64 GP use of chronic disease management Medicare items for care planning or case conferencing (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09										
GPs using CDM items	no.	6 276	4 758	3 671	1 706	1 534	462	259	111	18 777
Total GPs	no.	6 488	4 931	3 937	1 807	1 638	492	292	122	19 707
GPs using CDM items	%	96.7	96.5	93.2	94.4	93.7	93.9	88.7	91.0	95.3
2009-10										
GPs using CDM items	no.	6 439	4 925	3 820	1 764	1 605	487	263	120	19 423
Total GPs	no.	6 617	5 061	4 064	1 858	1 683	511	286	135	20 215
GPs using CDM items	%	97.3	97.3	94.0	94.9	95.4	95.3	92.0	88.9	96.1
2010-11										
GPs using CDM items	no.	6 643	5 151	3 962	1 808	1 631	514	280	125	20 114
Total GPs	no.	6 806	5 277	4 168	1 875	1 712	526	299	132	20 795
GPs using CDM items	%	97.6	97.6	95.1	96.4	95.3	97.7	93.6	94.7	96.7
2011-12										
GPs using CDM items	no.	6 939	5 420	4 170	1 900	1 691	514	301	135	21 070
Total GPs	no.	7 084	5 538	4 378	1 963	1 761	531	319	143	21 717
GPs using CDM items	%	98.0	97.9	95.2	96.8	96.0	96.8	94.4	94.4	97.0
2012-13										
GPs using CDM items	no.	7 208	5 682	4 413	1 977	1 718	525	323	139	21 985
Total GPs	no.	7 354	5 818	4 601	2 055	1 794	543	349	148	22 662
GPs using CDM items	%	98.0	97.7	95.9	96.2	95.8	96.7	92.6	93.9	97.0
2013-14										
GPs using CDM items	no.	7 519	5 993	4 671	2 135	1 787	570	322	142	23 139
Total GPs	no.	7 705	6 149	4 874	2 203	1 859	578	340	154	23 862
GPs using CDM items	%	97.6	97.5	95.8	96.9	96.1	98.6	94.7	92.2	97.0

- (a) The chronic disease management (CDM) items include GP only care plans, multidisciplinary care plans (A15 subgroup 1) and case conferences (A15 subgroup 2, excluding items relating to consultant physicians and psychiatrists). Services that qualify under the DVA National Treatment Account or are provided in public hospitals are not included.
- (b) Additional chronic disease management MBS items are introduced from time-to-time and may impact on GP use of care planning or case conferencing MBS items.
- (c) GPs are defined as those General Practitioners and Other Medical Practitioners who have claimed at least 1500 non-referred attendances in the relevant financial year. GPs are counted only in the state/territory where they claimed the most services — this prevents double counting.

Source: Department of Health unpublished, MBS Statistics.

Table 10A.65 Pathology tests requested by GPs, real benefits paid (2013-14 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e), (f), (g), (h)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
Benefits paid										
2012-13	\$m	499.9	358.6	319.7	139.4	108.7	31.7	22.4	14.5	1 494.8
2013-14	\$m	516.4	369.6	338.9	149.5	112.9	31.8	23.1	15.3	1 557.6
Benefits paid per person (ASR)										
2012-13	\$	64.3	59.9	67.5	55.5	59.7	56.1	59.2	66.5	62.3
2013-14	\$	65.3	60.4	70.1	57.6	61.3	55.8	60.2	68.5	63.6
MBS pathology items rebated										
2012-13	'000	27 177	20 092	17 469	7 788	6 431	1 829	1 176	774	82 737
2013-14	'000	28 199	20 808	18 310	8 333	6 657	1 857	1 214	829	86 213
MBS pathology items rebated per person (ASR)										
2012-13	no.	3.5	3.3	3.7	3.1	3.5	3.2	3.1	3.6	3.4
2013-14	no.	3.5	3.4	3.8	3.2	3.6	3.2	3.2	3.8	3.5

ASR = age standardised rate.

- (a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.
- (b) Data are directly age standardised to the 2001 Australian standard population. Data are not comparable to previous years for which crude rates are reported (see table 10A.66).
- (c) GPs are defined as vocationally recognised GPs and other medical officers (OMPs).
- (d) Includes Department of Veterans' Affairs (DVA) data.
- (e) In general, Medicare benefits are payable for a maximum of three MBS pathology items per specimen (generally, the three most expensive items). Data do not include additional tests that are performed but not rebated.
- (f) Includes Patient Episode Initiated (PEI) Items. From 1 November 2009 benefits for PEI Items were reduced and bulk billing incentives for PEI Items commenced. This contributed to a change in the mix and amount of benefits for tests ordered by GPs and OMPs.
- (g) Estimated resident populations used to derive rates are first preliminary estimates based on the 2011 Census.
- (h) Data for 2012-13 exclude tests ordered by eligible midwives and nurse practitioners. Data for 2013-14 include tests ordered by eligible nurse practitioners.

Source: Department of Health unpublished, MBS and DVA data collections; table 2A.51.

TABLE 10A.66

Table 10A.66 **Pathology tests requested by GPs, real benefits paid, 2009-10 to 2011-12 (2013-14 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e), (f), (g), (h), (i)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2009-10										
Benefits paid										
Benefits paid	\$m	504.2	360.3	317.9	137.6	110.8	31.8	23.1	13.2	1 498.9
Per person	\$	69.6	64.8	70.1	59.6	67.4	62.7	64.4	57.1	66.9
MBS pathology items rebated										
Number	'000	25 774	18 690	15 935	7 164	6 055	1 693	1 128	671	77 110
Per person	no.	3.56	3.36	3.51	3.10	3.68	3.33	3.15	2.91	3.44
2010-11										
Benefits paid										
Benefits paid	\$m	465.5	329.0	291.5	128.8	101.8	29.4	21.0	12.4	1379.3
Per person	\$	64.8	59.9	65.7	55.5	62.4	57.6	57.5	53.7	62.2
MBS pathology items rebated										
Number	'000	25 364	18 372	15 940	7 201	6 026	1 669	1 098	676	76 347
Per person	no.	3.53	3.34	3.59	3.11	3.69	3.27	3.01	2.94	3.44
2011-12										
Benefits paid										
Benefits paid	\$m	487.8	342.2	309.9	134.1	104.4	30.3	22.3	13.8	1444.8
Per person	\$	67.3	61.4	68.7	56.2	63.5	59.2	60.1	59.4	64.3
MBS pathology items rebated										
Number	'000	26 520	19 235	16 900	7 487	6 217	1 733	1 172	748	80 012
Per person	no.	3.66	3.45	3.74	3.14	3.78	3.39	3.16	3.22	3.56

(a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.

(b) Per person data for 2011-12 and previous years are crude rates and are not comparable to data for 2012-13 and subsequent years which are age standardised (see table 10A.65).

Table 10A.66 Pathology tests requested by GPs, real benefits paid, 2009-10 to 2011-12 (2013-14 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e), (f), (g), (h), (i)

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(c)	GPs are defined as vocationally recognised (specialist) GPs and other medical officers (OMPs).								
(d)	Includes Department of Veterans' Affairs (DVA) data.								
(e)	From 2011-12, DVA data exclude tests ordered by local medical officers who are not specialist GPs. DVA data for previous years include all data for tests ordered by all local medical officers, including but not limited to specialist GPs.								
(f)	In general, Medicare benefits are payable for a maximum of three MBS pathology items per specimen (generally, the three most expensive items). Data do not include additional tests that are performed but not rebated.								
(g)	Includes Patient Episode Initiated (PEI) Items. From 1 November 2009 benefits for PEI Items were reduced and bulk billing incentives for PEI Items commenced. This contributed to a change in the mix and amount of benefits for tests ordered by GPs and OMPs.								
(h)	Population data used to derive rates are revised to the ABS' final 2011 Census rebased estimates. See chapter 2 (tables 2A.2) for details.								
(i)	Data for 2012-13 exclude tests ordered by eligible midwives and nurse practitioners. Data for 2013-14 include tests ordered by eligible nurse practitioners.								

Source: Department of Health unpublished, MBS and DVA data collections; table 2A.51.

Table 10A.67 Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid (2013-14 dollars) and number of rebated MBS imaging items (a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
Benefits paid										
2012-13	\$m	532.8	326.1	300.1	120.7	91.0	28.5	17.9	7.2	1 424.2
2013-14	\$m	583.2	356.4	338.8	133.1	99.3	31.1	19.3	8.9	1 570.2
Benefits paid per person (ASR)										
2012-13	\$	67.8	54.4	63.2	48.2	49.6	49.6	48.5	35.6	59.1
2013-14	\$	72.9	58.2	69.8	51.5	53.4	53.6	51.1	42.9	63.8
MBS diagnostic imaging items										
2012-13	'000	4 613	3 037	2 692	1 095	860	263	160	69	12 789
2013-14	'000	4 941	3 255	2 953	1 185	917	280	169	85	13 785
MBS diagnostic imaging items per person (ASR)										
2012-13	no.	0.59	0.51	0.57	0.44	0.48	0.47	0.43	0.33	0.54
2013-14	no.	0.63	0.54	0.61	0.46	0.50	0.49	0.45	0.40	0.56

ASR = age standardised rate.

- (a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.
- (b) Data are directly age standardised to the 2001 Australian standard population. Data are not comparable to previous years for which crude rates are reported (see table 10A.68).
- (c) GPs are defined as vocationally recognised (specialist) GPs and other medical officers (OMPs).
- (d) Includes Department of Veterans' Affairs (DVA) data.
- (e) Estimated resident populations used to derive rates are first preliminary estimates based on the 2011 Census.
- (f) Data for 2012-13 exclude tests ordered by eligible midwives and nurse practitioners. Data for 2013-14 include tests ordered by eligible nurse practitioners.

Source: Department of Health unpublished, MBS and DVA data collections.

TABLE 10A.68

Table 10A.68 Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid, 2008-09 to 2011-12 (2013-14 dollars) and number of rebated MBS imaging items (a), (b), (c), (d), (e), (f), (g)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2009-10										
Benefits paid										
Benefits paid	\$m	495.2	308.1	272.9	113.8	89.5	27.5	17.3	5.8	1330.1
Per person	\$	68.3	55.4	60.2	49.3	54.4	54.1	48.2	25.2	59.4
MBS diagnostic imaging items rebated										
Number	'000	4 087	2 691	2 324	982	798	240	143	53	11 320
Per person	no.	0.56	0.48	0.51	0.43	0.49	0.47	0.40	0.23	0.51
2010-11										
Benefits paid										
Benefits paid	\$m	476.6	288.4	266.7	109.3	84.8	25.6	15.7	5.4	1272.5
Per person	\$	66.4	52.5	60.1	47.1	52.0	50.1	43.0	23.6	57.4
MBS diagnostic imaging items rebated										
Number	'000	4 096	2 660	2 384	981	796	235	140	53	11 344
Per person	no.	0.57	0.48	0.54	0.42	0.49	0.46	0.38	0.23	0.51
2011-12										
Benefits paid										
Benefits paid	\$m	509.0	309.2	289.9	116.3	87.9	26.6	16.9	6.0	1361.8
Per person	\$	70.2	55.5	64.2	48.7	53.4	52.0	45.7	25.8	60.6
MBS diagnostic imaging items rebated										
Number	'000	4 377	2 867	2 583	1 044	824	245	149	58	12 145
Per person	no.	0.60	0.51	0.57	0.44	0.50	0.48	0.40	0.25	0.54

(a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.

Table 10A.68 Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid, 2008-09 to 2011-12 (2013-14 dollars) and number of rebated MBS imaging items (a), (b), (c), (d), (e), (f), (g)

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(b)	Per person data for 2011-12 and previous years are crude rates and are not comparable to data for 2012-13 and subsequent years which are age standardised (see table 10A.67).								
(c)	GPs are defined as vocationally recognised (specialist) GPs and other medical officers (OMPs).								
(d)	Includes Department of Veterans' Affairs (DVA) data.								
(e)	From 2011-12, DVA data exclude tests ordered by local medical officers who are not specialist GPs. DVA data for previous years include all data for tests ordered by all local medical officers, including but not limited to specialist GPs.								
(f)	Data for 2012-13 exclude tests ordered by eligible midwives and nurse practitioners. Data for 2013-14 include tests ordered by eligible nurse practitioners.								
(g)	Population data used to derive rates are revised to the ABS' final 2011 Census rebased estimates. See chapter 2 (tables 2A.2) for details.								
<i>Source:</i> Department of Health unpublished, MBS and DVA data collections; table 2A.51.									

TABLE 10A.69

Table 10A.69 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PIP practices (May 2010)	no.	1 700	1 209	981	409	354	123	67	38	4 881
SWPE (c)	no.	4 765 033	4 063 295	3 060 662	1 500 216	1 225 101	389 553	269 970	79 148	15 352 978
PIP eHealth Incentive — uptake	no.	1 280	971	793	333	274	102	57	20	3 830
Share of PIP practices	%	75.3	80.3	80.8	81.4	77.4	82.9	85.1	52.6	78.5
PIP practices (May 2011)	no.	1 664	1 178	957	409	338	123	66	46	4 781
SWPE (c)	no.	4 792 245	4 100 376	3 129 970	1 508 314	1 239 216	396 459	277 984	86 021	15 530 585
PIP eHealth Incentive — uptake	no.	1 412	1 050	856	364	299	109	62	37	4 189
Share of PIP practices	%	84.9	89.1	89.4	89.0	88.5	88.6	93.9	80.4	87.6
PIP practices (May 2012)	no.	1 710	1 211	1 005	424	353	126	66	54	4 949
SWPE (c)	no.	4 948 168	4 213 416	3 260 160	1 562 809	1 276 083	402 315	279 439	90 413	16 032 803
PIP eHealth Incentive — uptake	no.	1 481	1 087	897	378	310	113	60	42	4 368
Share of PIP practices	%	86.6	89.8	89.3	89.2	87.8	89.7	90.9	77.8	88.3
PIP practices (May 2013)	no.	1 798	1 229	1 046	433	363	127	65	56	5 117
SWPE (c)	no.	5 129 251	4 207 334	3 319 305	1 619 421	1 300 886	399 791	270 671	90 909	16 337 568
PIP eHealth Incentive — uptake	no.	1 247	937	776	296	264	96	52	27	3 695
Share of PIP practices	%	69.4	76.2	74.2	68.4	72.7	75.6	80.0	48.2	72.2
PIP practices (May 2014) (b)	no.	1 812	1 255	1 077	452	367	121	71	55	5 210
SWPE (c)	no.	5 258 991	4 345 602	3 383 012	1 700 870	1 300 873	400 531	283 522	100 855	16 774 256
PIP eHealth Incentive — uptake	no.	1 553	1 117	926	375	318	104	60	43	4 496
Share of PIP practices	%	85.7	89.0	86.0	83.0	86.7	86.0	84.5	78.2	86.3

Table 10A.69 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(a)	Proportion of PIP practices registered for the PIP eHealth Incentive. Not all practices are involved in PIP, and the proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.51).									
(b)	In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements, as reflected in the sharp decrease in the share of PIP practices registered as having taken up the eHealth incentive in May 2013 and the recovery in May 2014. Under the previous requirements, practices were required to: have a secure messaging capability provided by an eligible supplier; have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and, provide practitioners from the practice with access to a range of key electronic clinical resources.									
(c)	A SWPE is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.									

Source: Department of Health unpublished, MBS and PIP data collections.

Table 10A.70 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region (a), (b), (c)

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote</i>	<i>Very remote</i>	<i>Australia</i>
PIP practices (May 2013)	no.	3 425	981	536	104	71	5 117
PIP eHealth Incentive — uptake	%	72.3	77.5	68.8	55.8	43.7	72.2
PIP practices (May 2014)	no.	3 484	1 012	546	99	69	5 210
PIP eHealth Incentive — uptake	%	86.9	88.9	82.8	72.7	62.3	86.3

- (a) Proportion of PIP practices registered for the PIP eHealth Incentive. Not all practices are involved in PIP, and the proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.51).
- (b) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which were based on a different classification.
- (c) In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements and this is reflected in a drop in the share of PIP practices registered as having taken up the eHealth incentive in May 2013 compared to historical data under previous requirements (see table 10A.70). Previously, practices were required to: have a secure messaging capability provided by an eligible supplier; have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and, provide practitioners from the practice with access to a range of key electronic clinical resources.

Source: Department of Health unpublished, MBS and PIP data collections.

Table 10A.71 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region, 2010 to 2012 (a), (b)**

	<i>Unit</i>	<i>Capital city</i>	<i>Other metro centre</i>	<i>Large rural centre</i>	<i>Small rural centre</i>	<i>Other rural</i>	<i>Remote centre</i>	<i>Other remote</i>	<i>Aust</i>
PIP practices (May 2012)	no.	3 002	378	318	364	701	63	123	4 949
SWPE (c)	no.	10 057 467	1 358 563	1 145 718	1 315 196	1 890 771	147 831	117 257	16 032 803
PIP eHealth Incentive — uptake (d), (e)									
Share of PIP practices (May 2010)	%	77.8	79.7	83.1	80.2	81.0	66.1	63.9	78.5
Share of PIP practices (May 2011)	%	87.7	88.5	90.6	85.7	89.5	72.9	76.7	87.6
Share of PIP practices (May 2012)	%	88.4	90.0	89.6	87.6	90.3	74.6	74.0	88.3

(a) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification. Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone.

(b) Not all practices are involved in PIP, and the proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.51).

(c) A SWPE is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.

(d) In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements and this is reflected in a drop in the share of PIP practices registered as having taken up the eHealth incentive in May 2013 (see tables 10A.68 and 10A.69).

Under the previous requirements, practices were required to: have a secure messaging capability provided by an eligible supplier; have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and, provide practitioners from the practice with access to a range of key electronic clinical resources.

Source: Department of Health unpublished, MBS and PIP data collections.

TABLE 10A.72

Table 10A.72 **Client experience of GPs by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
2012-13										
GP always or often listened carefully										
Major cities										
Proportion	%	90.8	89.3	89.5	89.2	89.4	..	89.3	..	89.9
RSE	%	0.6	0.7	0.6	0.8	0.8	..	1.3	..	0.3
95% CI	± %	1.0	1.3	1.1	1.4	1.4	..	2.3	..	0.5
Other (d)										
Proportion	%	89.3	90.1	87.5	86.1	86.9	89.4	-	86.4	88.6
RSE	%	1.3	1.0	1.0	1.5	1.5	1.0	-	1.5	0.5
95% CI	± %	2.2	1.8	1.7	2.5	2.5	1.7	-	2.6	0.9
Total										
Proportion	%	90.4	89.5	88.8	88.5	88.8	89.4	89.3	86.4	89.5
RSE	%	0.5	0.6	0.5	0.6	0.8	1.0	1.3	1.5	0.2
95% CI	± %	0.8	1.1	0.9	1.1	1.3	1.7	2.3	2.6	0.4
GP always or often showed respect										
Major cities										
Proportion	%	93.8	93.2	92.4	92.6	92.9	..	93.0	..	93.2
RSE	%	0.4	0.6	0.4	0.6	0.6	..	1.1	..	0.2
95% CI	± %	0.8	1.0	0.7	1.1	1.1	..	1.9	..	0.4
Other (d)										
Proportion	%	92.8	92.2	90.9	90.6	90.3	92.0	-	90.6	91.8
RSE	%	0.8	0.8	1.1	1.4	1.3	0.9	-	1.2	0.4
95% CI	± %	1.4	1.5	1.9	2.5	2.4	1.7	-	2.2	0.7
Total										
Proportion	%	93.5	93.0	91.8	92.2	92.3	92.0	93.0	90.6	92.8
RSE	%	0.3	0.5	0.4	0.5	0.6	0.9	1.1	1.2	0.2
95% CI	± %	0.6	0.9	0.8	1.0	1.0	1.7	1.9	2.2	0.4
GP always or often spent enough time										
Major cities										
Proportion	%	89.8	88.0	88.4	87.5	88.1	..	85.9	..	88.6
RSE	%	0.7	0.8	0.7	0.8	1.1	..	1.5	..	0.3
95% CI	± %	1.2	1.3	1.2	1.3	1.9	..	2.5	..	0.6

TABLE 10A.72

Table 10A.72 **Client experience of GPs by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
Other (d)										
Proportion	%	89.9	88.2	85.5	86.2	88.0	88.0	-	84.7	87.8
RSE	%	1.0	1.3	1.5	2.1	1.4	0.9	-	1.7	0.6
95% CI	± %	1.8	2.2	2.6	3.6	2.5	1.6	-	2.8	1.0
Total										
Proportion	%	89.9	88.0	87.3	87.2	88.1	88.0	85.9	84.7	88.4
RSE	%	0.5	0.6	0.6	0.7	1.0	0.9	1.5	1.7	0.3
95% CI	± %	0.9	1.0	1.1	1.3	1.7	1.6	2.5	2.8	0.5
2013-14 (e)										
GP always or often listened carefully										
Major cities										
Proportion	%	91.8	91.9	90.1	88.9	91.5	..	88.8	..	91.1
RSE	%	1.3	0.5	0.9	1.1	0.2	..	1.5	..	0.3
95% CI	± %	2.3	1.0	1.6	2.0	0.3	..	2.6	..	0.6
Other (d)										
Proportion	%	89.5	89.9	89.6	87.3	89.2	91.3	-	84.8	89.4
RSE	%	1.3	1.4	0.9	2.7	1.7	0.7	-	1.5	0.9
95% CI	± %	2.3	2.4	1.6	4.7	3.0	1.2	-	2.5	1.6
Total										
Proportion	%	91.2	91.3	89.8	88.6	90.9	91.3	89.1	84.8	90.6
RSE	%	0.5	0.7	0.8	0.9	0.5	0.7	1.5	1.5	0.3
95% CI	± %	0.9	1.3	1.3	1.5	0.8	1.2	2.6	2.5	0.6
GP always or often showed respect										
Major cities										
Proportion	%	94.2	94.6	92.9	91.8	94.9	..	92.3	..	93.7
RSE	%	1.2	0.6	0.7	0.8	1.5	..	1.0	..	0.3
95% CI	± %	2.2	1.0	1.4	1.5	2.8	..	1.7	..	0.5
Other (d)										
Proportion	%	91.2	93.0	92.7	90.6	92.3	93.5	-	89.6	92.1
RSE	%	1.2	1.1	0.9	2.2	1.5	0.6	-	1.0	0.6
95% CI	± %	2.2	2.0	1.6	3.8	2.8	1.1	-	1.8	1.2
Total										
Proportion	%	93.4	94.2	92.6	91.5	94.4	93.5	92.4	89.6	93.3
RSE	%	0.4	0.6	0.4	0.7	-	0.6	1.0	1.0	0.2
95% CI	± %	0.8	1.1	0.8	1.2	-	1.1	1.8	1.8	0.4

Table 10A.72 **Client experience of GPs by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
GP always or often spent enough time										
Major cities										
Proportion	%	91.0	89.3	89.6	87.3	90.7	..	87.2	..	89.7
RSE	%	1.3	0.8	0.6	1.0	0.6	..	1.9	..	0.5
95% CI	± %	2.3	1.4	1.1	1.8	1.2	..	3.2	..	0.8
Other (d)										
Proportion	%	88.2	88.1	88.0	88.7	89.3	89.7	-	86.3	88.3
RSE	%	1.0	0.9	1.0	2.2	1.5	0.8	-	1.8	0.7
95% CI	± %	1.7	1.6	1.7	3.9	2.6	1.5	-	3.1	1.2
Total										
Proportion	%	90.3	89.1	88.9	87.6	90.3	89.7	87.2	86.3	89.3
RSE	%	0.5	0.8	0.5	0.8	0.6	0.8	1.9	1.8	0.4
95% CI	± %	0.8	1.4	0.8	1.4	1.0	1.5	3.2	3.1	0.7

RSE = Relative standard error. **CI** = confidence interval.

- (a) Proportion of people 15 years or over who saw a GP in the last 12 months for their own health (excluding interviews by proxy) reporting the GP always or often: listened carefully, showed respect, and spent enough time with them.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.
- (d) 'Other' includes inner and outer regional, remote and very remote areas.
- (e) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.
- .. Not applicable. – Nil or rounded to zero.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.73 **Client experience of GPs by remoteness, Australia (a), (b), (c), (d)**

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote/Very remote</i>	<i>Total</i>
2012-13						
GP always or often listened carefully						
Proportion	%	89.9	88.9	88.4	85.4	89.5
RSE	%	0.3	0.6	0.8	2.8	0.2
95% CI	± %	0.5	1.0	1.4	4.7	0.4
GP always or often showed respect						
Proportion	%	93.2	92.4	90.9	88.5	92.8
RSE	%	0.2	0.5	0.7	1.8	0.2
95% CI	± %	0.4	0.9	1.2	3.1	0.4
GP always or often spent enough time						
Proportion	%	88.6	88.2	87.5	84.3	88.4
RSE	%	0.3	0.7	1.0	2.6	0.3
95% CI	± %	0.6	1.2	1.7	4.4	0.5
2013-14 (d)						
GP always or often listened carefully						
Proportion	%	91.1	90.1	88.7	86.1	90.6
RSE	%	0.3	0.9	0.7	3.4	0.3
95% CI	± %	0.6	1.6	1.3	5.7	0.6
GP always or often showed respect						
Proportion	%	93.7	92.7	91.7	88.7	93.3
RSE	%	0.3	0.7	0.8	2.7	0.2
95% CI	± %	0.5	1.2	1.5	4.8	0.4
GP always or often spent enough time						
Proportion	%	89.7	88.7	88.1	86.0	89.3
RSE	%	0.5	0.7	1.6	4.5	0.4
95% CI	± %	0.8	1.2	2.7	7.6	0.7

RSE = Relative standard error. **95% CI** = confidence interval.

- (a) Proportion of people 15 years or over who saw a GP in the last 12 months for their own health (excluding interviews by proxy) reporting the GP always or often: listened carefully, showed respect, and spent enough time with them.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Data are not comparable with data for Aboriginal and Torres Strait Islander people that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.
- (d) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.74 **Client experience of GPs by remoteness, Aboriginal and Torres Strait Islander people, Australia, 2012-13 (a), (b), (c), (d)**

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Total (e)</i>
2012-13 (e)					
GP always or usually listened carefully					
Proportion	%	89.8	88.8	86.4	88.5
RSE	%	1.4	1.9	2.3	1.0
95% CI	± %	2.5	3.3	3.9	1.8
GP always or usually showed respect					
Proportion	%	90.5	88.0	87.5	89.0
RSE	%	1.7	1.9	1.4	1.0
95% CI	± %	3.0	3.3	2.4	1.7
GP always or usually spent enough time					
Proportion	%	86.2	85.0	83.2	85.0
RSE	%	1.8	2.1	2.3	1.1
95% CI	± %	3.0	3.4	3.7	1.9

RSE = Relative standard error. **95% CI** = confidence interval.

- (a) Persons 15 years and over who saw a GP in the last 12 months for their own health (excluding interviews by proxy), reporting the GP always or usually listened carefully, showed respect, and spent enough time with them.
- (b) Rates are age standardised to the 2001 estimated resident population (5 year ranges).
- (c) Data are not comparable with data for all Australians that were sourced from the ABS 2012-13 Patient Experience Survey, due to differences in survey design and collection methodology.
- (d) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).
- (e) Includes major cities, inner and outer regional areas only, as these survey questions were not asked in remote and very remote areas.

Source: 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.75 **Client experience of dental professionals by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
2012-13										
Dental professional always or often listened carefully										
Major cities										
Proportion	%	96.3	94.6	94.5	95.5	95.3	..	95.1	..	95.3
RSE	%	0.5	0.6	0.5	0.6	0.6	..	0.9	..	0.3
95% CI	± %	1.0	1.1	1.0	1.1	1.1	..	1.7	..	0.5
Other (d)										
Proportion	%	94.0	92.7	93.1	95.3	91.9	94.5	-	92.4	93.5
RSE	%	0.9	1.3	0.8	1.3	2.5	0.8	-	1.6	0.5
95% CI	± %	1.6	2.3	1.5	2.3	4.5	1.4	-	2.8	0.9
Total										
Proportion	%	95.8	94.2	94.0	95.5	94.5	94.5	95.1	92.4	94.8
RSE	%	0.5	0.5	0.4	0.5	0.7	0.8	0.9	1.6	0.2
95% CI	± %	1.0	1.0	0.7	1.0	1.2	1.4	1.7	2.8	0.4
Dental professional always or often showed respect										
Major cities										
Proportion	%	97.0	96.3	95.6	96.5	96.8	..	96.0	..	96.5
RSE	%	0.4	0.5	0.6	0.5	0.5	..	0.8	..	0.3
95% CI	± %	0.8	1.0	1.2	1.0	1.0	..	1.5	..	0.6
Other (d)										
Proportion	%	95.4	93.6	95.2	96.9	94.9	96.1	-	94.8	95.1
RSE	%	0.6	1.2	0.8	1.1	1.5	0.5	-	1.3	0.3
95% CI	± %	1.2	2.2	1.5	2.1	2.7	1.0	-	2.3	0.7
Total										
Proportion	%	96.7	95.7	95.4	96.6	96.4	96.1	96.0	94.8	96.1
RSE	%	0.4	0.4	0.5	0.4	0.5	0.5	0.8	1.3	0.2
95% CI	± %	0.7	0.8	0.9	0.8	0.9	1.0	1.5	2.3	0.5
Dental professional always or often spent enough time										
Major cities										
Proportion	%	96.8	95.2	95.0	96.3	96.6	..	95.4	..	95.9
RSE	%	0.4	0.5	0.6	0.7	0.6	..	0.9	..	0.2
95% CI	± %	0.7	1.0	1.1	1.3	1.0	..	1.8	..	0.4
Other (d)										
Proportion	%	94.5	93.8	96.3	97.8	96.8	96.9	-	94.4	95.4
RSE	%	0.9	1.4	0.8	0.7	0.9	0.7	-	1.1	0.5
95% CI	± %	1.7	2.6	1.4	1.3	1.8	1.3	-	2.0	0.9

TABLE 10A.75

Table 10A.75 **Client experience of dental professionals by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
Total										
Proportion	%	96.2	94.9	95.4	96.6	96.7	96.9	95.4	94.4	95.8
RSE	%	0.4	0.5	0.5	0.6	0.4	0.7	0.9	1.1	0.2
95% CI	± %	0.7	0.9	1.0	1.1	0.8	1.3	1.8	2.0	0.4
2013-14 (e)										
Dental professional always or often listened carefully										
Major cities										
Proportion	%	94.6	95.3	93.0	96.3	97.5	..	95.6	..	95.0
RSE	%	0.9	0.9	0.4	0.3	2.3	..	3.6	..	0.4
95% CI	± %	1.6	1.6	0.8	0.6	4.4	..	6.7	..	0.7
Other (d)										
Proportion	%	95.0	91.2	92.6	96.6	92.9	93.7	100.0	94.5	93.3
RSE	%	0.6	2.0	0.8	1.5	1.1	1.1	-	1.9	0.5
95% CI	± %	1.2	3.6	1.5	2.8	2.0	2.1	-	3.5	1.0
Total										
Proportion	%	94.8	94.5	92.9	96.5	96.5	93.7	95.4	94.5	94.6
RSE	%	0.6	0.7	0.8	0.6	1.6	1.1	3.6	1.9	1.0
95% CI	± %	1.2	1.3	1.4	1.1	3.0	2.1	6.8	3.5	1.9
Dental professional always or often showed respect										
Major cities										
Proportion	%	95.9	96.2	94.5	96.6	97.2	..	96.7	..	96.0
RSE	%	0.7	0.6	3.1	2.3	2.3	..	3.5	..	0.4
95% CI	± %	1.4	1.2	5.7	4.4	4.4	..	6.6	..	0.8
Other (d)										
Proportion	%	94.9	92.7	93.6	95.6	94.3	96.2	100.0	95.4	94.2
RSE	%	-	2.2	0.5	1.9	7.0	0.9	-	2.0	0.3
95% CI	± %	-	3.9	1.0	3.5	12.9	1.7	-	3.8	0.5
Total										
Proportion	%	95.8	95.3	94.2	96.7	96.5	96.2	96.3	95.4	95.5
RSE	%	0.6	0.6	0.5	0.3	1.6	0.9	3.5	2.0	0.2
95% CI	± %	1.1	1.1	0.9	0.5	3.0	1.7	6.6	3.8	0.5
Dental professional always or often spent enough time										
Major cities										
Proportion	%	95.6	96.9	94.0	96.9	98.1	..	96.6	..	96.0
RSE	%	0.6	0.7	3.2	2.3	0.2	..	3.6	..	0.3
95% CI	± %	1.1	1.3	5.9	4.4	0.4	..	6.8	..	0.5

Table 10A.75 **Client experience of dental professionals by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
Other (d)										
Proportion	%	95.6	94.7	93.5	97.9	93.2	95.5	100.0	96.3	94.9
RSE	%	0.6	1.6	5.3	1.4	0.5	1.6	-	1.7	0.5
95% CI	± %	1.1	2.9	9.7	2.7	0.9	3.0	-	3.1	0.9
Total										
Proportion	%	95.7	96.3	93.9	97.1	97.0	95.5	97.1	96.3	95.7
RSE	%	0.5	0.6	0.5	0.4	1.7	1.6	3.6	1.7	0.1
95% CI	± %	1.0	1.1	0.9	0.8	3.2	3.0	6.9	3.1	0.2

RSE = Relative standard error. **CI** = confidence interval.

- (a) Proportion of people who saw a dental professional for their own health in the last 12 months (excluding interviews by proxy) reporting the dental professional always or often: listened carefully, showed respect, and spent enough time with them.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.
- (d) 'Other' includes inner and outer regional, remote and very remote areas.
- (e) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

na Not available. ... Not applicable. – Nil or rounded to zero.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.76 **Client experience of dental professionals by remoteness, Australia (a), (b), (c)**

	<i>Unit</i>	<i>Major Cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote/Very remote</i>	<i>Total</i>
2012-13						
Dental professional always or often listened carefully						
Proportion	%	95.3	93.2	93.8	95.0	94.8
RSE	%	0.3	0.6	1.0	1.3	0.2
95% CI	± %	0.5	1.1	1.8	2.5	0.4
Dental professional always or often showed respect						
Proportion	%	96.5	94.6	96.0	96.8	96.1
RSE	%	0.3	0.5	0.6	1.2	0.2
95% CI	± %	0.6	0.9	1.1	2.3	0.5
Dental professional always or often spent enough time						
Proportion	%	95.9	95.0	96.2	95.8	95.8
RSE	%	0.2	0.6	0.7	1.4	0.2
95% 95% CI	± %	0.4	1.1	1.3	2.6	0.4
2013-14 (c)						
Dental professional always or often listened carefully						
Proportion	%	95.0	93.3	93.5	94.8	94.6
RSE	%	0.4	3.0	1.1	3.5	1.0
95% CI	± %	0.7	5.5	2.1	6.5	1.9
Dental professional always or often showed respect						
Proportion	%	96.0	94.1	94.3	95.2	95.5
RSE	%	0.4	0.3	1.2	3.5	0.2
95% CI	± %	0.8	0.6	2.3	6.5	0.5
Dental professional always or often spent enough time						
Proportion	%	96.0	95.1	94.5	95.8	95.7
RSE	%	0.3	3.0	1.4	2.7	0.1
95% 95% CI	± %	0.5	5.6	2.6	5.0	0.2

RSE = Relative standard error. **95% CI** = confidence interval.

(a) Proportion of persons who saw a dental professional for their own health in the last 12 months (excluding interviews by proxy) reporting the dental professional always or often: listened carefully, showed respect, and spent enough time with them.

(b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.

(c) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

TABLE 10A.77

Table 10A.77 Annual health assessments for older people (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2006-07										
Older people assessed	no.	97 804	64 885	52 209	18 266	25 014	7 914	1 752	790	268 634
Older people	no.	457 509	333 152	235 712	116 423	120 858	35 603	14 772	7 126	1 321 206
Proportion assessed	%	21.38	19.48	22.15	15.69	20.70	22.23	11.86	11.09	20.33
2007-08										
Older people assessed	no.	104 776	66 478	57 405	19 384	26 741	8 301	2 337	1 039	286 461
Older people	no.	466 836	340 221	241 060	119 456	122 578	36 154	15 228	7 409	1 348 993
Proportion assessed	%	22.44	19.54	23.81	16.23	21.82	22.96	15.35	14.02	21.24
2008-09										
Older people assessed	no.	112 810	73 403	64 260	22 796	27 563	9 509	2 454	1 276	314 071
Older people	no.	475 715	347 182	246 109	122 391	123 946	36 778	15 647	7 654	1 375 483
Proportion assessed	%	23.71	21.14	26.11	18.63	22.24	25.86	15.68	16.67	22.83
2009-10										
Older people assessed	no.	118 408	78 283	67 140	25 472	28 202	9 187	2 770	1 478	330 940
Older people	no.	485 866	354 565	252 255	125 718	125 610	37 549	16 171	8 026	1 405 819
Proportion assessed	%	24.37	22.08	26.62	20.26	22.45	24.47	17.13	18.42	23.54
2010-11										
Older people assessed	no.	133 330	90 915	77 725	31 374	31 844	11 085	3 205	1 876	381 354
Older people	no.	497 907	362 416	259 291	129 883	127 157	38 225	16 736	8 434	1 440 116
Proportion assessed	%	26.78	25.09	29.98	24.16	25.04	29.00	19.15	22.24	26.48
2011-12										
Older people assessed	no.	141 601	96 734	84 521	33 511	33 396	11 684	3 319	2 078	406 844
Older people	no.	507 900	370 433	266 899	134 218	129 129	39 162	17 341	8 957	1 473 927
Proportion assessed	%	27.88	26.11	31.67	24.97	25.86	29.84	19.14	23.20	27.60
2012-13										
Older people assessed	no.	151 348	102 615	92 687	37 936	35 936	13 149	3 891	2 639	440 201
Older people	no.	521 589	380 362	275 409	139 019	131 501	40 200	18 095	9 611	1 515 491

TABLE 10A.77

Table 10A.77 Annual health assessments for older people (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion assessed	%	29.02	26.98	33.65	27.29	27.33	32.71	21.50	27.46	29.05
2013-14										
Older people assessed	no.	162 913	112 500	101 640	44 322	40 446	14 106	4 366	3 242	483 535
Older people	no.	533 806	390 136	284 798	144 121	133 919	41 144	18 811	10 259	1 556 691
Proportion assessed	%	30.52	28.84	35.69	30.75	30.20	34.28	23.21	31.60	31.06

- (a) Older people are defined as Aboriginal and Torres Strait Islander people aged 55 years or over and non-Indigenous people aged 75 years or over, excluding people living in residential aged care facilities.
- (b) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.
- (c) Allocation of patients to state or territory is based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.
- (d) Rates have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.1 and 2A.13-14) for details.
- (e) Derived target populations as at 31 December are computed as the average of the population estimates / projections at June 30 at each end of the reference year. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.2 and 2A.13-14) for details.

Source: Department of Health unpublished, MBS data collection; 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.78

Table 10A.78 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2009–2014 (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
Valid vaccinations provided										
GPs	no.	5 927 073	3 172 889	3 982 990	1 686 901	999 973	398 833	216 598	724 026	16 429 263
Council	no.	211 262	2 070 561	274 577	88 261	253 425	27 545	–	–	2 925 631
State or territory health department	no.	–	–	447	119 468	285	–	4 486	1 513	126 199
Public hospital	no.	61 176	61 562	132 613	31 622	9 562	1 672	1 019	24 276	324 672
Aboriginal health service	no.	34 977	9 086	12 121	10 248	10 271	52	–	68 879	145 634
Community health centre	no.	433 355	14 617	283 378	499 981	95 838	280	141 437	189 578	1 659 050
Other (e)	no.	3 383	2 047	23 258	1 283	733	–	–	552	34 383
Total	no.	6 671 226	5 330 762	4 709 384	2 437 764	1 370 087	428 382	363 540	1 008 824	21 644 832
Proportion of total valid vaccinations										
GPs	%	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 health service	%	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
Other (e)	%	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) 1 July 2009 to 30 June 2014.

(b) Totals may not add as a result of rounding.

(c) Data reported by the State or Territory in which the immunisation provider is located.

(d) Includes data for unknown State or Territory.

Table 10A.78 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2009–2014 (a), (b), (c)**

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
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(e) Other includes Divisions of GP, Flying Doctors Services, Aboriginal Health Workers, Community nurses, Private hospitals and unknown providers.

– Nil or rounded to zero. **np** Not published.

Source: Department of Health unpublished, Australian Childhood Immunisation Register (ACIR) data collection.

Table 10A.79 Children aged 12 months to less than 15 months who were fully immunised (per cent) (a), (b), (c), (d)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Fully immunised (e)									
2007-08	91.6	91.9	91.1	89.4	91.0	92.3	93.6	90.7	91.3
2008-09	91.7	91.9	90.9	89.5	91.6	91.5	93.9	90.1	91.4
2009-10	91.8	92.1	91.8	89.7	91.2	92.5	93.1	89.9	91.6
2010-11 (f)	90.1	92.0	91.6	89.5	91.4	91.5	93.5	90.6	91.2
2011-12	91.6	92.6	91.6	90.3	92.3	92.5	93.2	91.8	91.8
2012-13	90.8	91.7	92.0	90.2	91.3	92.2	92.8	91.5	91.3
2013-14 (g)	89.7	90.8	91.2	90.1	90.2	89.8	93.0	90.8	90.4
Immunised against (2013-14)									
Diphtheria, tetanus and pertussis	90.6	91.8	91.8	91.3	90.9	90.6	93.8	91.4	91.3
Polio	90.4	91.7	91.8	91.2	90.8	90.5	93.8	91.4	91.2
<i>Haemophilus influenzae</i> type b	90.3	91.5	91.7	91.0	90.7	90.3	93.5	91.3	91.1
Pneumococcal (g)	90.2	91.9	91.1	90.7	90.8	90.8	95.1	88.8	91.0

- (a) Coverage measured for children immunised at the age of 12 months to less than 15 months, by the State or Territory in which the child resided.
- (b) The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).
- (c) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.
- (d) NT immunisation records differ from published ACIR data due to a review of a rule change implemented in 2009. As a result, all reports affected by the change were recalculated accounting for the anomaly.
- (e) 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.
- (f) Coverage rates were relatively low for the June 2011 quarter, associated with parents not receiving immunisation reminders due to administrative error. This may be reflected in relatively low coverage rates for 2010-11.
- (g) From the quarter ending 31 December 2013, immunisation against pneumococcal is included for assessment of children as fully immunised at 12 months.

Source: Department of Health unpublished, ACIR data collection.

Table 10A.80 Children aged 24 months to less than 27 months who were fully immunised (per cent) (a), (b), (c), (d)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Fully immunised (e)									
2007-08	92.6	93.7	92.3	91.2	94.3	94.5	94.1	94.1	92.8
2008-09	92.6	93.7	92.1	90.9	92.6	93.7	94.2	93.8	92.6
2009-10	92.2	92.9	91.5	90.9	91.7	93.4	93.8	92.7	92.1
2010-11	92.4	93.5	92.9	91.0	92.6	94.2	93.5	94.1	92.7
2011-12	92.3	93.3	92.8	90.8	92.6	93.8	93.6	94.5	92.6
2012-13	92.3	93.1	92.6	90.6	92.5	94.2	93.2	93.4	92.4
2013-14	91.9	92.8	93.2	91.0	92.2	93.1	93.1	93.6	92.4
Immunised against (2013-14)									
Diphtheria, tetanus and pertussis	94.7	95.4	95.1	94.0	94.9	95.6	95.5	95.3	94.9
Polio	94.6	95.4	95.1	94.1	94.8	95.6	95.5	95.3	94.9
<i>Haemophilus influenzae</i> type b	93.9	94.5	94.5	93.1	93.9	94.6	94.8	95.0	94.1
Measles, mumps and rubella	93.7	94.4	94.5	93.0	94.1	94.4	94.6	95.1	94.0

- (a) Coverage measured for children immunised at the age of 24 months to less than 27 months, by the State or Territory in which the child resided.
- (b) The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).
- (c) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.
- (d) NT immunisation records differ from published ACIR data due to a review of a rule change implemented in 2009. As a result, all reports affected by the change were recalculated accounting for the anomaly.
- (e) Children assessed as fully immunised at 24 months are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type b, hepatitis B and measles, mumps and rubella.

Source: Department of Health unpublished, ACIR data collection.

Table 10A.81 Children aged 60 months to less than 63 months who were fully immunised (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT NT (d)</i>	<i>Aust</i>	
Fully immunised (e)									
2007-08	81.4	85.8	84.0	79.6	78.9	82.9	88.2	82.9	82.8
2008-09	77.9	84.1	81.5	79.1	75.3	80.9	85.3	82.8	80.3
2009-10	83.7	87.2	84.5	82.3	81.9	86.4	86.9	82.8	84.6
2010-11	89.1	91.0	89.9	86.0	87.0	91.3	91.0	86.9	89.3
2011-12	90.0	91.4	90.3	86.8	87.6	90.8	91.5	89.3	90.0
2012-13	91.6	92.6	91.5	89.4	90.9	92.9	92.3	90.7	91.5
2013-14	92.2	92.5	92.3	89.8	91.0	92.7	92.7	91.4	92.0
Immunised against (2013-14)									
Diphtheria, tetanus and pertussis	92.7	93.1	92.7	90.4	91.5	93.4	93.3	91.9	92.4
Polio	92.6	92.9	92.6	90.3	91.4	93.2	93.2	91.7	92.4
Measles, mumps and rubella	92.6	92.9	92.7	90.3	91.6	93.5	92.9	92.0	92.4

- (a) Coverage measured for children immunised at the age of 60 months to less than 63 months, by the State or Territory in which the child resided.
- (b) The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).
- (c) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.
- (d) NT immunisation records differ from published ACIR data due to a review of a rule change implemented in 2009. As a result, all reports affected by the change were recalculated accounting for the anomaly.
- (e) Children assessed as fully immunised at 60 months are immunised against diphtheria, tetanus, pertussis (whooping cough), polio and measles, mumps and rubella.

Source: Department of Health unpublished, ACIR data collection.

TABLE 10A.82

Table 10A.82 **Notifications of measles, children aged 0–14 years (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Notifications										
2006-07	no.	np	–	np	np	–	–	–	–	4
2007-08	no.	18	np	4	np	np	–	–	np	27
2008-09	no.	3	18	20	np	–	np	–	–	44
2009-10	no.	5	np	np	np	np	–	–	–	11
2010-11	no.	40	6	7	5	–	–	np	np	61
2011-12	no.	20	np	–	np	–	–	4	–	27
2012-13	no.	85	np	np	3	3	–	–	np	95
2013-14	no.	29	26	20	10	10	–	–	18	113
Notifications per 100 000 children (0–14 years) (d)										
2006-07	per 100 000 children	np	–	np	np	–	–	–	–	0.1
2007-08	per 100 000 children	1.4	np	np	np	np	–	–	np	0.7
2008-09	per 100 000 children	np	1.8	2.3	np	–	np	–	–	1.1
2009-10	per 100 000 children	0.4	np	np	np	np	–	–	–	0.3
2010-11	per 100 000 children	2.9	0.6	0.8	1.1	–	–	np	np	1.4
2011-12	per 100 000 children	1.5	np	–	np	–	–	np	–	0.6
2012-13	per 100 000 children	6.1	np	np	np	np	–	–	np	2.2
2013-14	per 100 000 children	2.1	2.5	2.2	2.1	3.4	–	–	33.4	2.6

(a) Notification of the relevant State/Territory authority is required when measles is diagnosed. Available diagnostic tools make it uncommon for cases to go undiagnosed and therefore the 'notified fraction' for measles — the proportion of total cases for which notification is made — is expected to be high, with little variation between states and territories as well as over time.

(b) Cases defined based on Communicable Diseases Network Australia (CDNA) National Notifiable Diseases Surveillance System (NNDSS) case definitions.

(c) Data are suppressed for number of notifications where number is less than 3 and for rates where numerator is less than 5.

(d) Rates are derived using the ERP as at December 31. Rates have been revised to the ABS' final 2011 Census rebased ERP and may differ from previous reports. See chapter 2 (table 2A.2) for details.

– Nil or rounded to zero. **np** Not published.

Table 10A.82 **Notifications of measles, children aged 0–14 years (a), (b), (c)**

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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Source: Department of Health unpublished, NNDSS; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE 10A.83

Table 10A.83 Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Notifications										
2006-07	no.	303	92	112	33	39	7	8	np	596
2007-08	no.	677	181	95	36	41	9	5	82	1 126
2008-09	no.	8 161	681	955	205	586	205	59	162	11 014
2009-10	no.	3 275	1 094	1 496	242	1 841	108	32	60	8 148
2010-11	no.	8 784	2 832	3 147	744	2 183	68	335	129	18 222
2011-12	no.	6 719	1 716	3 178	2 564	279	384	87	280	15 207
2012-13	no.	2 144	928	2 369	529	305	660	88	52	7 075
2013-14	no.	977	857	1 163	489	349	59	63	14	3 971
Notifications per 100 000 children (0–14 years) (d)										
2006-07	per 100 000 children	22.9	9.5	13.6	8.0	13.7	7.3	12.6	np	14.8
2007-08	per 100 000 children	50.8	18.5	11.3	8.6	14.3	9.3	7.8	158.2	27.7
2008-09	per 100 000 children	607.1	68.8	110.6	47.4	203.4	211.2	91.3	309.7	266.6
2009-10	per 100 000 children	241.6	109.3	170.6	55.0	635.6	111.4	48.8	113.9	195.0
2010-11	per 100 000 children	644.2	280.5	355.3	166.2	751.7	70.6	504.9	245.8	432.5
2011-12 (d)	per 100 000 children	492.8	169.0	355.1	561.1	96.1	403.5	129.3	534.2	358.9
2012-13	per 100 000 children	155.1	89.2	258.9	111.6	103.7	694.9	126.1	97.7	163.6
2013-14	per 100 000 children	69.5	80.9	125.1	100.4	117.9	62.2	88.3	26.0	90.3

- (a) Notification of the relevant State/Territory authority is required when whooping cough is diagnosed. Diagnosis cannot always be confirmed using available tools. Therefore, the 'notified fraction' is likely to be only a proportion of the total number of cases. The notified fraction may vary between states and territories and over time.
- (b) Cases defined based on Communicable Diseases Network Australia (CDNA) National Notifiable Diseases Surveillance System (NNDSS) case definitions.
- (c) Data are suppressed for number of notifications where number is less than 3 and for rates where numerator is less than 5.
- (d) Rates are derived using the ERP as at December 31. Rates have been revised to the ABS' final 2011 Census rebased ERP and may differ from previous reports. See chapter 2 (table 2A.2) for details.
np Not published.

Table 10A.83 **Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b), (c)**

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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Source: Department of Health unpublished, NNDSS; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE 10A.84

Table 10A.84 Notifications of invasive *Haemophilus influenzae* type b, children aged 0–14 years (a), (b), (c)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Notifications										
2006-07	no.	4	3	8	np	–	–	–	–	17
2007-08	no.	7	–	np	–	np	np	–	np	12
2008-09	no.	3	np	3	np	–	–	–	np	11
2009-10	no.	np	–	np	np	np	–	–	np	6
2010-11	no.	6	np	np	np	–	–	–	–	12
2011-12	no.	–	–	np	np	np	–	–	np	7
2012-13	no.	3	3	3	–	–	–	–	–	9
2013-14	no.	4	np	5	np	–	–	–	np	12
Notifications per 100 000 children (0–14 years) (d)										
2006-07	per 100 000 children	0.3	np	1.0	np	–	–	–	–	0.4
2007-08	per 100 000 children	0.5	–	np	–	np	np	–	np	0.3
2008-09	per 100 000 children	np	np	np	np	–	–	–	np	0.3
2009-10	per 100 000 children	np	–	np	np	np	–	–	np	0.1
2010-11	per 100 000 children	0.4	np	np	np	–	–	–	–	0.3
2011-12 (e)	per 100 000 children	–	–	np	np	np	–	–	np	0.2
2012-13	per 100 000 children	np	np	np	–	–	–	–	–	0.2
2013-14	per 100 000 children	np	np	0.5	np	–	–	–	np	0.3

- (a) Notification of the relevant State/Territory authority is required when invasive *Haemophilus influenzae* type b (Hib) is diagnosed. Available diagnostic tools make it uncommon for cases to go undiagnosed and therefore the 'notified fraction' for Hib — the proportion of total cases for which notification is made — is expected to be high, with little variation between states and territories as well as over time.
- (b) Cases defined based on Communicable Diseases Network Australia (CDNA) National Notifiable Diseases Surveillance System (NNDSS) case definitions.
- (c) Data are suppressed for number of notifications where number is less than 3 and for rates where numerator is less than 5.
- (d) Rates are derived using the Estimated Resident Populations (ERP) as at December 31. Rates have been revised to the ABS' final 2011 Census rebased ERP and may differ from previous reports. See chapter 2 (table 2A.2) for details.

Table 10A.84 **Notifications of invasive *Haemophilus influenzae* type b, children aged 0–14 years (a), (b), (c)**

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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– Nil or rounded to zero. **np** Not published.

Source: Department of Health unpublished, NNDSS; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE 10A.85

Table 10A.85 **Participation rates for women in BreastScreen Australia
(24 month period) (a), (b), (c)**

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (e)</i>	<i>Tas</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust (g)</i>
2008–2009									
40–44 years	6.5	5.1	25.2	11.0	10.0	22.9	6.2	3.3	11.0
45–49 years	11.5	9.8	38.7	21.7	20.0	35.7	10.1	12.3	18.8
50–54 years	49.1	48.3	55.7	52.8	55.9	50.5	42.6	36.0	51.1
55–59 years	56.1	54.4	60.5	57.2	58.8	58.9	54.5	42.0	57.1
60–64 years	58.6	58.5	62.8	60.0	63.5	63.3	58.5	46.4	60.3
65–69 years	56.9	56.6	61.4	59.2	61.5	62.2	56.3	43.5	58.6
70–74 years	15.2	24.1	55.4	20.6	25.3	21.3	21.9	9.6	26.5
75–79 years	7.0	8.5	20.7	11.4	13.6	9.8	9.6	5.2	10.9
80–84 years	2.8	2.9	5.5	4.3	5.2	3.6	3.1	2.1	3.7
85+ years	0.6	0.6	1.6	0.9	1.1	0.7	0.7	0.5	0.8
40+ years (ASR)	29.4	29.3	43.4	33.6	34.9	38.3	28.5	22.4	33.3
Ages 50–69 (ASR)	54.4	53.6	59.5	56.6	59.3	57.6	51.6	41.2	56.0
2009–2010									
40–44 years	6.2	4.9	23.7	10.5	9.0	22.7	6.8	3.0	10.4
45–49 years	10.8	9.8	37.8	21.6	19.1	37.2	10.9	11.3	18.4
50–54 years	46.9	49.9	54.5	53.9	53.0	51.9	42.1	35.5	50.5
55–59 years	55.0	54.9	59.1	57.8	57.1	59.9	53.6	42.5	56.5
60–64 years	58.4	59.8	62.1	61.8	61.4	65.0	58.2	46.9	60.4
65–69 years	56.7	56.8	60.5	60.1	59.9	62.1	57.2	45.0	58.3
70–74 years	16.1	19.5	54.9	20.9	25.0	18.6	23.4	9.6	25.6
75–79 years	7.0	8.1	20.0	11.8	13.9	9.3	9.9	4.3	10.8
80–84 years	2.8	2.9	5.4	4.5	5.5	3.6	2.9	2.6	3.7
85+ years	0.6	0.6	1.4	1.0	1.1	0.7	0.7	0.2	0.8
40+ years (ASR)	28.8	29.4	42.5	34.1	33.6	38.8	28.8	22.3	32.8
Ages 50–69 (ASR)	53.3	54.6	58.4	57.8	57.1	58.6	51.3	41.5	55.6
2010–2011									
40–44 years	5.7	5.0	21.7	10.1	8.6	22.3	7.2	2.7	9.8
45–49 years	9.8	10.6	36.6	21.5	18.6	36.8	11.9	10.2	18.0
50–54 years	43.1	51.1	53.5	53.8	53.2	50.0	41.1	34.8	49.3
55–59 years	51.5	54.6	57.9	57.9	58.3	58.5	53.0	43.5	55.1
60–64 years	55.9	59.6	61.5	62.3	63.3	64.7	59.2	48.3	59.6
65–69 years	54.6	57.6	59.9	60.4	61.9	60.5	57.3	43.9	57.9
70–74 years	15.6	17.3	54.3	21.1	25.4	16.7	20.7	9.1	24.8
75–79 years	6.8	8.0	19.7	12.2	14.1	9.0	9.4	4.6	10.7
80–84 years	2.7	2.9	5.5	4.8	6.0	3.6	3.0	2.9	3.8
85+ years	0.5	0.6	1.3	1.1	1.1	0.7	0.7	0.7	0.8
40+ years (ASR)	27.0	29.5	41.4	34.1	34.0	37.9	28.7	22.1	32.1
Ages 50–69 (ASR)	50.1	55.0	57.5	57.9	58.3	57.3	51.1	41.6	54.6

Table 10A.85 **Participation rates for women in BreastScreen Australia (24 month period) (a), (b), (c)**

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (e)</i>	<i>Tas</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust (g)</i>
2011–2012									
40–44 years	6.1	6.3	21.1	10.3	9.0	22.4	8.7	2.5	10.2
45–49 years	10.0	12.9	36.0	22.1	18.6	37.3	13.8	9.9	18.6
50–54 years	42.6	50.4	52.5	53.7	54.2	50.5	43.0	35.8	48.7
55–59 years	51.8	53.7	57.8	57.6	58.5	58.3	56.3	41.8	54.7
60–64 years	56.2	58.4	60.8	61.6	62.9	64.0	63.2	46.6	59.0
65–69 years	55.8	57.0	59.8	60.6	62.3	62.7	59.0	45.8	58.0
70–74 years	16.3	20.0	54.3	21.7	26.3	17.2	21.4	10.2	25.8
75–79 years	7.5	9.0	20.2	13.1	15.8	9.1	10.6	5.3	11.5
80–84 years	2.9	3.4	5.6	5.3	6.8	3.6	3.3	2.0	4.1
85+ years	0.6	0.7	1.4	1.3	1.3	0.6	0.9	0.9	0.9
40+ years (ASR)	27.3	30.0	41.0	34.3	34.5	38.2	30.6	22.1	32.2
Ages 50–69 (ASR)	50.3	54.2	57.0	57.7	58.7	57.6	53.8	41.5	54.2
2012–2013									
40–44 years	6.8	8.9	21.7	11.3	9.6	24.2	10.6	8.6	11.6
45–49 years	10.7	14.9	36.1	22.6	18.1	38.6	16.9	16.1	19.6
50–54 years	44.3	51.1	52.7	53.0	49.2	51.1	44.2	36.8	49.3
55–59 years	51.5	53.9	57.4	56.7	52.1	57.2	55.9	41.4	54.3
60–64 years	56.5	58.3	61.9	60.6	57.0	63.9	63.2	44.8	59.1
65–69 years	56.1	57.6	60.5	59.7	56.7	64.1	61.1	43.9	58.3
70–74 years	25.5	25.3	54.3	22.6	28.1	19.0	27.9	15.3	30.9
75–79 years	8.6	11.0	21.0	14.3	17.0	10.2	11.5	7.1	12.8
80–84 years	3.1	4.4	6.0	5.9	7.2	4.0	3.7	3.1	4.6
85+ years	0.7	1.0	1.6	1.4	1.5	0.6	0.8	1.1	1.0
40+ years (ASR)	28.7	31.6	41.4	34.3	32.2	38.9	32.3	24.5	33.2
Ages 50–69 (ASR)	50.9	54.6	57.3	56.8	53.0	57.8	54.4	41.0	54.3

ASR = age standardised rate.

- (a) The participation rate is the number of women screened during the reference period as a percentage of the eligible female population, calculated as the average of the Australian Bureau of Statistics (ABS) ERP in each of the calendar years in the reference period. Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (b) Participation rates for women 40 years or over and 50–69 years are age standardised to the 2001 Australian population standard.
- (c) Data include only women who were residents of the jurisdiction in which they were screened, with the exception of NSW where data include all women screened, whether or not they were residents of the jurisdiction. Data may differ from participation rates data published elsewhere that allocate women to jurisdictions based on the jurisdiction in which screening took place.
- (d) Residents of Victorian postcodes allocated to the Albury/Wodonga catchment (NSW jurisdiction) are included in Victoria's population estimate, accounting for the slight decrease in participation rates compared to those published by BreastScreen Victoria.

Table 10A.85 **Participation rates for women in BreastScreen Australia
(24 month period) (a), (b), (c)**

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (e)</i>	<i>Tas</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust (g)</i>
(e)	The fall in the participation rate for SA in 2012–2013 reflects a temporary reduction in the total number of women screened, instigated to best manage a Digital Mammography System Wide Review and implementation of the review recommendations, concurrent with the introduction of a new client information system. Going forward, BreastScreen SA anticipates a return to forecasted participation								
(f)	In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, 2.2 per cent of women screened in the 24 months 2012–2013 were not ACT residents, a decline from 7–9 per cent of women screened in previous 24 month periods. The decline reflects a change in arrangements between the ACT and NSW, whereby from November 2013 a limited number of ACT screening appointments are available for NSW residents who work in the ACT. Previously, the ACT provided screening services to residents in some southern parts of NSW.								
(g)	Australia includes women screened in a jurisdiction not their jurisdiction of residence.								
<i>Source:</i>	State and Territory governments unpublished; ABS various years, <i>Population by Age and Sex, Australian States and Territories</i> , Cat. no. 3201.0.								

TABLE 10A.86

Table 10A.86 **Participation rates for women in BreastScreen Australia by residential status, 2012 and 2013 (24 month period)**

	<i>Unit</i>	<i>NSW (a)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (b)</i>	<i>NT</i>
40+ years									
Residents screened	no.	530 480	439 957	449 966	197 158	141 673	53 911	27 928	10 943
Non-residents screened	no.	5142	2210	1999	141	177	46	620	93
Non-residents screened (proportion)	%	1.0	0.5	0.4	0.1	0.1	0.1	2.2	0.8
Ages 50–69									
Residents screened	no.	440 454	355 201	301 171	153 786	110 291	39 740	22 286	8 596
Non-residents screened	no.	4643	1733	1352	126	135	32	474	87
Non-residents screened (proportion)	%	1.0	0.5	0.4	0.1	0.1	0.1	2.1	1.0

(a) Data for NSW exclude women who are not residents of NSW. However, data are not available for non-residents of NSW screened in NSW.

(b) In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, 2.2 per cent of women screened in the 24 months 2012–2013 were not ACT residents, a decline from 7–9 per cent of women screened in previous 24 month periods. The decline reflects a change in arrangements between the ACT and NSW, whereby from November 2013 a limited number of ACT screening appointments are available for NSW residents who work in the ACT. Previously, the ACT provided screening services to residents in some southern parts of NSW.

Source: State and Territory governments unpublished.

Table 10A.87

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) (a), (b), (c)

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA (e)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
2008–2009									
Aged 40–49 years	5.7	3.0	21.3	10.5	8.3	14.2	6.4	3.7	10.6
Aged 50–59 years	27.8	19.8	42.0	23.6	26.2	31.8	29.3	24.9	30.3
Aged 60–69 years	34.2	29.1	46.1	29.5	29.8	39.4	63.1	29.3	35.9
Aged 70–79 years	9.3	9.5	29.9	14.0	15.8	13.6	31.6	5.6	14.9
Aged 80+ years	2.1	2.4	5.6	3.9	3.0	np	–	1.6	3.4
Age 40+ years (ASR)	17.1	13.1	31.5	17.5	17.7	np	25.8	14.2	20.6
Age 50–69 years (ASR)	30.3	23.5	43.6	25.9	27.6	34.8	42.6	26.6	32.5
2009–2010									
Aged 40–49 years	5.9	3.2	19.8	11.2	7.3	15.3	7.1	3.1	10.3
Aged 50–59 years	26.2	20.3	39.7	25.7	25.8	33.3	28.2	24.6	29.4
Aged 60–69 years	34.1	29.0	45.7	31.3	31.2	41.8	62.9	27.8	36.1
Aged 70–79 years	8.9	10.1	30.8	13.6	13.3	11.9	23.1	5.0	14.8
Aged 80+ years	2.2	3.3	4.3	3.5	2.0	np	–	2.0	3.1
Age 40+ years (ASR)	16.7	13.5	30.3	18.6	17.1	np	24.6	13.6	20.3
Age 50–69 years (ASR)	29.3	23.7	42.1	27.9	27.9	36.6	41.9	25.8	32.1
2010–2011									
Aged 40–49 years	5.8	4.6	19.3	12.1	6.7	14.4	6.9	3.0	10.3
Aged 50–59 years	25.2	22.7	38.8	27.9	26.8	27.7	29.2	25.4	29.3
Aged 60–69 years	33.1	29.2	45.5	34.3	28.8	39.0	52.4	28.1	35.8
Aged 70–79 years	8.7	8.4	32.0	13.5	12.4	13.7	33.3	6.1	15.1
Aged 80+ years	1.6	4.1	3.3	5.6	np	np	–	2.8	2.9
Age 40+ years (ASR)	16.1	14.5	30.0	20.1	np	np	24.3	14.1	20.2
Age 50–69 years (ASR)	28.3	25.2	41.4	30.4	27.6	32.1	38.3	26.5	31.9
2011–2012									
Aged 40–49 years	6.5	5.9	19.9	13.3	7.0	15.9	6.6	3.6	11.1
Aged 50–59 years	26.4	22.6	39.8	31.5	27.6	27.8	28.8	24.0	30.3
Aged 60–69 years	35.2	31.0	46.5	36.1	28.8	30.8	40.4	29.3	37.4
Aged 70–79 years	9.3	8.1	32.9	16.5	16.0	np	106.7	5.1	16.3
Aged 80+ years	2.4	2.6	4.0	6.0	0.6	–	–	2.3	3.0
Age 40+ years (ASR)	17.2	15.1	30.8	22.3	17.4	np	32.1	13.9	21.2
Age 50–69 years (ASR)	29.9	25.9	42.5	33.3	28.1	29.0	33.4	26.1	33.1
2012–2013									
Aged 40–49 years	7.2	7.4	22.3	13.6	6.7	18.1	8.6	10.5	12.9
Aged 50–59 years	27.9	26.8	41.8	32.2	25.3	30.5	27.9	27.3	32.0
Aged 60–69 years	36.6	36.0	49.9	37.8	30.5	26.2	28.7	31.1	39.7
Aged 70–79 years	12.8	12.9	33.8	16.8	15.1	np	np	10.3	18.7
Aged 80+ years	3.4	2.1	5.0	6.5	1.8	np	np	4.5	3.9
Age 40+ years (ASR)	18.7	18.2	33.0	23.0	16.9	np	np	18.4	23.1
Age 50–69 years (ASR)	31.3	30.4	45.0	34.4	27.4	28.8	28.2	28.8	35.1

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) (a), (b), (c)

	NSW	Vic (d)	Qld	WA (e)	SA	Tas	ACT (f)	NT	Aust
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ASR = age standardised rate.

- (a) Rates are derived using populations that are revised to the ABS 2011 Census rebased population estimates and projections and may differ from previous reports.
- (b) The participation rate is the number of women resident in the catchment area screened in the reference period, divided by the number of women resident in the catchment area in the reference period based on Australian Bureau of Statistics (ABS) ERP data. Where service boundaries cross State localised areas, calculation of resident women is made on a proportional basis. If a woman is screened more than once during the reference period then only the first screen is counted. Catchment area: a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or Statistical Local Area (SLA). Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (c) Aboriginal and/or Torres Strait Islander women are women who self-identified as being of Aboriginal and/or Torres Strait Islander descent.
- (d) Residents of Victorian postcodes allocated to the Albury/Wodonga catchment (NSW jurisdiction) are included in Victoria's population estimate, accounting for the slight decrease in participation rates compared to those published by BreastScreen Victoria.
- (e) Data for WA may include some Aboriginal and/or Torres Strait Islander women usually resident in the NT in WA catchment areas.
- (f) In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, 2.2 per cent of women screened in the 24 months 2012–2013 were not ACT residents, a decline from 7–9 per cent of women screened in previous 24 month periods. The decline reflects a change in arrangements between the ACT and NSW, whereby from November 2013 a limited number of ACT screening appointments are available for NSW residents who work in the ACT. Previously, the ACT provided screening services to residents in some southern parts of NSW.
- Nil or rounded to zero. **np** Not published.

Source: State and Territory governments unpublished; ABS 2014, *Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 2001 to 2026*, Cat. no. 3238.0.

TABLE 10A.88

Table 10A.88 Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
2008–2009									
Aged 40–49 years	7.6	3.1	30.6	14.3	12.6	12.3	2.9	5.4	9.5
Aged 50–59 years	47.1	28.5	59.7	58.2	51.2	28.1	20.4	33.6	43.1
Aged 60–69 years	52.0	39.8	67.5	67.3	66.8	41.2	26.8	44.2	50.9
Aged 70–79 years	7.7	11.2	40.6	13.9	14.3	8.6	4.4	7.4	12.6
Aged 80+ years	1.1	0.8	3.3	2.2	1.9	1.6	0.6	1.5	1.3
Aged 40+ years (ASR)	26.0	17.6	44.7	34.9	32.4	20.5	12.0	20.1	26.0
Aged 50–69 years (ASR)	49.0	33.0	62.8	61.8	57.3	33.3	22.9	37.8	46.2
2009–2010									
Aged 40–49 years	7.1	3.3	29.9	14.3	11.8	17.9	3.0	4.5	9.2
Aged 50–59 years	46.9	30.1	60.0	60.1	49.1	37.6	20.2	33.4	43.6
Aged 60–69 years	52.6	40.5	66.9	69.2	62.2	50.4	26.4	43.6	51.2
Aged 70–79 years	7.7	8.9	41.3	14.5	14.3	10.2	4.6	5.9	11.9
Aged 80+ years	1.1	0.7	3.3	2.1	1.8	1.9	0.5	2.1	1.3
Aged 40+ years (ASR)	25.8	17.9	44.5	35.9	30.7	26.9	12.0	19.5	26.0
Aged 50–69 years (ASR)	49.1	34.2	62.7	63.7	54.3	42.7	22.7	37.4	46.6
2010–2011									
Aged 40–49 years	7.6	4.9	29.0	14.3	11.6	19.7	3.1	4.1	9.8
Aged 50–59 years	46.4	40.7	59.3	59.4	48.3	37.9	20.6	34.6	46.5
Aged 60–69 years	52.9	48.9	65.7	69.7	60.4	50.9	27.3	43.0	54.0
Aged 70–79 years	7.6	8.7	41.1	14.7	14.2	11.0	4.1	6.6	11.8
Aged 80+ years	1.1	0.9	2.8	2.2	1.8	1.7	0.7	2.7	1.3
Aged 40+ years (ASR)	25.9	22.8	43.7	35.8	30.1	27.8	12.2	19.7	27.5
Aged 50–69 years (ASR)	49.0	43.9	61.8	63.4	53.1	43.0	23.3	38.0	49.4
2011–2012									
Aged 40–49 years	6.9	7.3	29.4	15.2	12.2	19.1	3.5	4.6	10.5
Aged 50–59 years	43.3	47.8	59.6	59.2	48.2	39.3	21.3	34.7	47.4
Aged 60–69 years	51.9	55.0	65.9	71.3	57.8	51.2	28.3	42.1	55.6
Aged 70–79 years	7.3	10.6	40.3	15.2	13.6	9.8	4.4	6.2	12.3
Aged 80+ years	0.9	1.2	3.2	2.5	2.2	2.1	0.8	1.6	1.5
Aged 40+ years (ASR)	24.6	27.0	43.9	36.4	29.7	27.9	12.8	19.6	28.3
Aged 50–69 years (ASR)	46.7	50.6	62.1	64.0	52.0	44.0	24.0	37.7	50.6
2012–2013									
Aged 40–49 years	7.2	8.9	30.4	16.0	12.1	19.9	5.7	13.0	11.4
Aged 50–59 years	44.4	49.5	60.2	58.6	43.4	43.2	22.8	37.9	48.2
Aged 60–69 years	53.5	56.4	66.8	70.5	50.2	50.9	30.2	42.3	56.3
Aged 70–79 years	13.0	12.8	39.3	15.9	14.6	11.5	6.4	10.6	15.3
Aged 80+ years	1.0	1.5	3.4	3.0	2.5	1.7	0.8	2.5	1.7
Aged 40+ years (ASR)	26.1	28.6	44.4	36.5	27.2	29.4	14.5	24.0	29.4
Aged 50–69 years (ASR)	48.0	52.2	62.8	63.3	46.1	46.2	25.7	39.6	51.4

Table 10A.88 Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
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ASR = age standardised rate. **NESB** = Non English speaking background.

- (a) The participation rate is the number of NESB women residents in the catchment area screened in the reference period, divided by the estimated number of NESB women resident in the catchment area in that period. The female NESB population estimate is derived by applying the NESB age distribution from the 2011 Census to the Australian Bureau of Statistics (ABS) female ERP data for the relevant year. Where service boundaries cross State localised areas, calculation of resident women is made on a proportional basis. If a woman is screened more than once during the reference period then only the first screen is counted. Catchment area: a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or Statistical Local Area (SLA). Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (b) Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs and rates may differ from those published in previous reports. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from June 2012 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1) for details.
- (c) NESB is defined as persons who speak a language other than English at home.
- (d) Residents of Victorian postcodes allocated to the Albury/Wodonga catchment (NSW jurisdiction) are included in Victoria's population estimate, accounting for the slight decrease in participation rates compared to those published by BreastScreen Victoria.
- (e) An apparent drop in participation of NESB women in Tasmania occurred from the 2005–2006 screening period and coincided with a significant reduction in self-reporting of NESB status that followed a change in the client registration form in 2006. Since revision of the form in May 2009, both self-reporting of NESB status and participation rates are returning to earlier levels. The observed drop in participation, therefore, appears to reflect the drop in self reporting of NESB status rather than reduced participation.
- (f) In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, 2.2 per cent of women screened in the 24 months 2012–2013 were not ACT residents, a decline from 7–9 per cent of women screened in previous 24 month periods. The decline reflects a change in arrangements between the ACT and NSW, whereby from November 2013 a limited number of ACT screening appointments are available for NSW residents who work in the ACT. Previously, the ACT provided screening services to residents in some southern parts of NSW.

Source: State and Territory governments unpublished; ABS various years, *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; ABS unpublished, *2011 Census of Population and Housing*.

Table 10A.89 Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
2009–2010									
Major Cities									
Aged 40–49 years	7.8	7.0	29.7	16.3	13.5	..	9.2	..	12.8
Aged 50–59 years	49.0	50.9	54.4	57.2	53.5	..	48.8	..	51.7
Aged 60–69 years	55.3	57.1	59.3	61.9	58.3	..	59.6	..	57.5
Aged 70–79 years	10.7	13.2	37.7	15.5	17.7	..	18.0	..	17.0
Aged 80+ years	1.5	1.5	3.3	2.3	2.7	..	1.8	..	2.0
Age 40+ years (ASR)	27.5	28.4	40.9	34.5	32.3	..	29.6	..	31.2
Age 50–69 years (ASR)	51.3	53.2	56.2	59.0	55.3	..	52.8	..	53.9
Inner Regional									
Aged 40–49 years	9.1	7.9	27.3	14.2	13.7	29.6	np	..	15.0
Aged 50–59 years	52.4	55.1	55.1	53.2	55.5	56.3	np	..	54.2
Aged 60–69 years	60.1	61.5	61.8	61.9	65.5	64.0	np	..	61.5
Aged 70–79 years	13.4	16.6	39.5	20.7	23.6	13.3	np	..	20.5
Aged 80+ years	1.7	2.2	3.5	3.8	3.6	1.8	np	..	2.4
Age 40+ years (ASR)	30.0	31.2	40.8	33.4	35.0	38.6	np	..	33.8
Age 50–69 years (ASR)	55.2	57.5	57.6	56.4	59.3	59.1	np	..	56.9
Outer Regional									
Aged 40–49 years	13.2	10.2	34.5	13.7	17.2	31.0	..	6.6	21.4
Aged 50–59 years	52.7	55.7	61.5	51.8	59.2	54.4	..	42.4	55.8
Aged 60–69 years	60.3	61.6	65.3	59.6	65.0	62.6	..	50.6	62.1
Aged 70–79 years	16.7	18.9	43.1	22.6	25.7	16.0	..	6.5	24.7
Aged 80+ years	3.0	3.5	4.1	5.0	5.7	2.8	..	np	3.8
Age 40+ years (ASR)	32.1	32.5	46.2	32.8	37.4	38.6	..	23.8	37.1
Age 50–69 years (ASR)	55.5	58.0	62.9	54.7	61.3	57.4	..	45.6	58.2
Remote									
Aged 40–49 years	23.7	np	34.5	20.5	14.6	np	..	9.6	22.2
Aged 50–59 years	53.5	np	55.3	51.9	48.7	np	..	38.0	50.3
Aged 60–69 years	65.7	np	63.7	62.5	55.9	np	..	42.1	59.5
Aged 70–79 years	23.9	np	41.7	24.1	26.0	np	..	np	28.1
Aged 80+ years	np	np	6.3	np	6.1	np	..	np	6.1
Age 40+ years (ASR)	38.1	37.5	44.1	36.1	32.2	36.3	..	22.8	36.1
Age 50–69 years (ASR)	58.2	np	58.5	56.1	51.5	51.0	..	39.5	53.9
Very remote									
Aged 40–49 years	np	..	32.5	20.5	np	np	..	5.7	21.3
Aged 50–59 years	np	..	54.9	46.6	np	np	..	28.4	46.3
Aged 60–69 years	np	..	57.1	44.5	np	np	..	30.4	48.6
Aged 70–79 years	np	..	36.7	na	np	np	..	np	25.4
Aged 80+ years	np	..	np	np	np	np	..	np	5.0

Table 10A.89 Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
Age 40+ years (ASR)	49.0	..	41.6	30.5	30.5	np	..	16.1	32.4
Age 50–69 years (ASR)	np	..	55.7	45.8	45.6	np	..	29.0	47.2
2010–2011									
Major Cities									
Aged 40–49 years	na	na	na	na	na	na	na	na	12.3
Aged 50–59 years	na	na	na	na	na	na	na	na	50.8
Aged 60–69 years	na	na	na	na	na	na	na	na	57.0
Aged 70–79 years	na	na	na	na	na	na	na	na	16.7
Aged 80+ years	na	na	na	na	na	na	na	na	2.0
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	30.7
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	53.1
Inner Regional									
Aged 40–49 years	na	na	na	na	na	na	na	na	14.9
Aged 50–59 years	na	na	na	na	na	na	na	na	53.6
Aged 60–69 years	na	na	na	na	na	na	na	na	61.3
Aged 70–79 years	na	na	na	na	na	na	na	na	20.2
Aged 80+ years	na	na	na	na	na	na	na	na	2.4
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	33.5
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	56.5
Outer Regional									
Aged 40–49 years	na	na	na	na	na	na	na	na	20.7
Aged 50–59 years	na	na	na	na	na	na	na	na	55.0
Aged 60–69 years	na	na	na	na	na	na	na	na	61.4
Aged 70–79 years	na	na	na	na	na	na	na	na	24.9
Aged 80+ years	na	na	na	na	na	na	na	na	4.1
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	36.6
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	57.4
Remote									
Aged 40–49 years	na	na	na	na	na	na	na	na	21.7
Aged 50–59 years	na	na	na	na	na	na	na	na	52.2
Aged 60–69 years	na	na	na	na	na	na	na	na	59.9
Aged 70–79 years	na	na	na	na	na	na	na	na	30.7
Aged 80+ years	na	na	na	na	na	na	na	na	6.9
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	37.0
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	55.2
Very remote									
Aged 40–49 years	na	na	na	na	na	na	na	na	19.3
Aged 50–59 years	na	na	na	na	na	na	na	na	43.3

Table 10A.89 **Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
Aged 60–69 years	na	na	na	na	na	na	na	na	49.5
Aged 70–79 years	na	na	na	na	na	na	na	na	28.0
Aged 80+ years	na	na	na	na	na	na	na	na	7.7
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	31.6
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	45.8

ASR = age standardised rate.

- (a) Rates are the number of women screened as a proportion of the eligible female population, calculated as the average of the Australian Bureau of Statistics (ABS) estimated resident population (ERP) in each of the calendar years in the reference period. Rates for '40+ years' and '50–69 years' are age standardised to the Australian population at 30 June 2001.
- (b) Periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (c) Data are suppressed where numerator is less than 5 or denominator is less than 1000.
- (d) Remoteness areas are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS *Census of population and housing* for 2006. The accuracy of remoteness classifications decreases over time since the census year due to demographic changes within postcode boundaries. Sources of inaccuracy particularly affect rates based on small numbers and these should be interpreted with caution. Areas where rates are based on small numbers include very remote areas in NSW, SA and Tasmania, remote areas in Victoria and Tasmania, and inner regional areas in the ACT. Minor differences can result in apparently large variations where numerators are small numbers.
- (e) Women were allocated to a remoteness area based on postcode of usual residence. Some women's postcodes could not be matched to a remoteness area; these women were excluded from the state and territory calculations, but included in the state and territory and Australia totals. Some postcodes supplied by women may not accurately reflect their usual residence.
- (f) Data are not available for the 24 month periods 2007 and 2008, and 2011 and 2012. Data are not available for states and territories for the 24 month periods from 2010 and 2011.
- (g) In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, 2.2 per cent of women screened in the 24 months 2012–2013 were not ACT residents, a decline from 7–9 per cent of women screened in previous 24 month periods. The decline reflects a change in arrangements between the ACT and NSW, whereby from November 2013 a limited number of ACT screening appointments are available for NSW residents who work in the ACT. Previously, the ACT provided screening services to residents in some southern parts of NSW.

na Not available. **..** Not applicable. **np** Not published.

Source: AIHW unpublished, derived from State and Territory data and ABS Census of population and housing.

TABLE 10A.90

Table 10A.90 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
Target age group (20–69 years)									
Crude rates									
2005 and 2006	57.3	62.7	57.1	59.0	62.9	60.4	61.1	53.8	59.3
2006 and 2007	58.8	62.7	58.5	58.6	62.3	59.1	61.0	53.1	60.0
2007 and 2008	58.9	61.9	58.9	57.7	61.4	57.4	60.2	55.8	59.6
2008 and 2009	57.7	61.6	58.1	57.9	60.8	57.3	59.0	57.0	59.0
2009 and 2010	56.1	61.1	56.3	56.9	59.9	57.2	57.6	55.1	57.8
2010 and 2011	55.8	59.8	55.3	55.5	59.5	55.4	56.6	53.7	56.9
2011 and 2012	56.4	60.4	55.5	55.6	59.1	56.3	56.2	54.0	57.3
2012 and 2013	56.9	60.9	56.0	55.5	58.7	57.0	57.0	55.2	57.7
Age standardised rates									
2005 and 2006	57.3	62.9	57.1	58.8	63.0	60.5	61.5	53.1	59.3
2006 and 2007	58.9	63.0	58.5	58.5	62.5	59.3	61.3	52.3	60.1
2007 and 2008	59.1	62.2	59.0	57.6	61.6	57.6	60.6	55.1	59.8
2008 and 2009	58.0	62.1	58.3	57.9	61.1	57.5	59.6	56.5	59.3
2009 and 2010	56.5	61.7	56.6	57.1	60.2	57.4	58.5	54.9	58.2
2010 and 2011	56.2	60.5	55.6	55.7	59.9	55.6	57.7	53.6	57.3
2011 and 2012	56.8	61.1	55.8	55.9	59.4	56.6	57.2	53.8	57.7
2012 and 2013	57.4	61.6	56.4	55.9	59.0	57.4	58.0	55.1	58.2
By age group (years)									
2005 and 2006									
20–24	43.5	47.7	49.2	51.4	51.4	56.8	48.4	50.5	47.5
25–29	54.9	59.2	57.4	58.8	61.7	62.3	58.5	54.5	57.5
30–34	61.8	65.3	60.8	63.3	66.6	64.4	64.2	56.1	63.0
35–39	62.9	67.1	61.1	64.1	67.4	64.4	65.8	56.4	64.1
40–44	62.6	67.8	61.1	63.6	67.4	64.6	66.1	56.2	64.1
45–49	62.6	68.8	61.5	62.9	67.4	63.1	64.7	55.7	64.3
50–54	60.4	67.2	58.3	59.2	65.3	61.7	64.3	53.6	61.9
55–59	56.7	64.4	54.7	56.0	62.3	57.0	63.0	50.3	58.6
60–64	52.7	61.2	51.4	50.9	58.8	52.8	60.6	45.3	54.9
65–69	45.3	55.1	45.1	46.7	53.7	46.0	55.1	41.6	48.7
20–69 years	57.3	62.7	57.1	59.0	62.9	60.4	61.1	53.8	59.3
20–69 years (ASR)	57.3	62.9	57.1	58.8	63.0	60.5	61.5	53.1	59.3
2006 and 2007									
20–24	45.3	48.1	51.4	52.1	51.1	54.7	50.6	51.2	48.7
25–29	56.7	58.9	59.0	59.4	61.2	60.4	58.7	54.4	58.4
30–34	62.9	64.5	61.7	62.2	65.1	62.4	63.5	54.8	63.0
35–39	64.2	66.8	62.2	62.9	66.3	62.7	64.9	55.4	64.3
40–44	63.9	67.6	62.1	62.5	66.6	62.7	64.7	54.8	64.4

TABLE 10A.90

Table 10A.90 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
45–49	64.8	69.4	63.0	62.7	67.1	62.5	64.3	55.3	65.4
50–54	62.0	67.4	59.7	59.1	65.2	60.3	63.8	51.7	62.7
55–59	58.8	65.1	56.6	56.3	62.3	56.9	63.5	50.0	59.9
60–64	54.8	61.7	52.8	51.2	59.2	53.0	60.3	45.2	56.1
65–69	46.8	55.4	46.3	45.8	53.9	46.9	54.6	40.4	49.4
20–69 years	58.8	62.7	58.5	58.6	62.3	59.1	61.0	53.1	60.0
20–69 years (ASR)	58.9	63.0	58.5	58.5	62.5	59.3	61.3	52.3	60.1
2007 and 2008									
20–24	44.5	46.6	51.5	51.3	49.4	53.5	49.7	52.7	47.9
25–29	56.0	57.1	58.4	57.7	59.5	58.0	58.0	56.5	57.2
30–34	62.6	63.2	61.8	60.3	63.7	60.9	62.0	57.1	62.3
35–39	64.3	66.1	62.3	61.8	64.8	61.8	64.6	59.0	64.0
40–44	64.2	67.1	62.5	61.5	65.7	60.6	63.4	57.7	64.2
45–49	65.0	68.7	63.6	61.6	66.8	61.0	64.3	57.7	65.2
50–54	62.6	67.0	61.0	59.0	65.1	57.8	63.4	56.0	63.0
55–59	59.8	65.3	58.0	55.9	62.6	55.7	64.4	53.7	60.5
60–64	55.8	61.8	54.1	52.0	59.1	51.5	59.2	48.5	56.7
65–69	47.1	54.8	47.4	45.2	53.8	44.5	52.5	41.2	49.4
20–69 years	58.9	61.9	58.9	57.7	61.4	57.4	60.2	55.8	59.6
20–69 years (ASR)	59.1	62.2	59.0	57.6	61.6	57.6	60.6	55.1	59.8
2008 and 2009									
20–24	42.1	44.2	48.8	50.2	47.4	51.6	46.6	52.4	45.6
25–29	53.5	55.5	56.2	56.8	57.8	56.2	55.3	56.5	55.3
30–34	61.1	63.3	60.9	60.6	62.8	60.5	60.8	58.6	61.6
35–39	63.2	66.2	61.7	62.1	64.9	61.2	62.7	59.3	63.6
40–44	63.2	67.3	62.1	62.3	65.4	60.5	63.5	61.2	64.0
45–49	64.0	69.0	63.1	62.1	66.3	61.5	64.0	60.0	64.9
50–54	61.9	67.8	61.2	60.1	65.2	59.1	62.8	59.1	63.2
55–59	59.9	66.3	58.4	56.7	62.8	57.0	63.9	53.8	61.0
60–64	56.1	63.2	54.7	53.5	59.8	53.0	61.1	50.4	57.6
65–69	47.9	55.5	47.8	45.4	53.5	45.7	52.8	43.3	50.0
20–69 years	57.7	61.6	58.1	57.9	60.8	57.3	59.0	57.0	59.0
20–69 years (ASR)	58.0	62.1	58.3	57.9	61.1	57.5	59.6	56.5	59.3
2009 and 2010									
20–24	39.8	42.8	46.3	48.4	45.9	50.5	43.4	50.2	43.6
25–29	51.0	53.9	53.8	55.2	56.0	55.3	53.8	53.5	53.2
30–34	58.8	62.2	58.1	59.3	61.3	59.9	60.0	56.4	59.8
35–39	61.0	65.2	59.4	60.6	64.2	60.5	60.4	57.3	61.9
40–44	61.7	67.0	60.3	61.1	64.4	60.7	62.6	58.8	62.8

TABLE 10A.90

Table 10A.90 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
45–49	62.8	69.2	61.6	61.9	65.7	61.5	62.4	58.8	64.1
50–54	61.1	68.4	60.4	59.7	64.4	59.5	62.6	57.2	62.8
55–59	59.4	66.3	57.8	57.0	62.7	57.7	63.1	54.0	60.7
60–64	56.4	64.1	54.9	53.9	60.4	54.3	61.7	50.9	58.1
65–69	48.2	55.8	47.3	45.5	53.1	46.8	54.0	43.4	50.0
20–69 years	56.1	61.1	56.3	56.9	59.9	57.2	57.6	55.1	57.8
20–69 years (ASR)	56.5	61.7	56.6	57.1	60.2	57.4	58.5	54.9	58.2
2010 and 2011									
20–24	39.3	41.7	44.9	46.9	45.0	49.8	40.9	49.0	42.6
25–29	50.4	52.3	52.1	53.2	55.1	54.6	52.9	52.2	52.0
30–34	57.9	59.8	56.3	57.1	61.3	57.6	57.7	54.6	58.2
35–39	60.1	63.4	57.8	58.6	63.1	58.4	60.0	56.3	60.4
40–44	61.2	65.6	58.8	59.2	64.1	59.1	60.4	55.9	61.7
45–49	62.3	68.2	60.8	60.7	65.6	58.6	61.8	57.6	63.4
50–54	61.8	67.7	60.0	58.8	64.2	57.0	63.9	55.4	62.6
55–59	59.4	65.8	57.6	56.5	63.1	56.4	62.4	54.8	60.5
60–64	57.3	64.4	55.6	54.0	61.1	52.9	62.5	50.9	58.6
65–69	48.9	55.7	47.5	45.8	53.3	44.7	55.2	42.7	50.3
20–69 years	55.8	59.8	55.3	55.5	59.5	55.4	56.6	53.7	56.9
20–69 years (ASR)	56.2	60.5	55.6	55.7	59.9	55.6	57.7	53.6	57.3
2011 and 2012									
20–24	39.7	42.1	44.8	46.7	45.2	49.6	40.5	50.6	42.8
25–29	50.6	52.6	52.4	53.2	55.0	56.1	52.3	52.4	52.2
30–34	58.1	59.7	56.6	56.9	60.5	57.3	57.0	54.9	58.2
35–39	60.4	63.7	58.1	58.4	62.1	59.4	59.8	55.0	60.6
40–44	61.5	66.1	58.8	59.2	63.0	59.7	60.6	56.2	61.9
45–49	63.0	68.8	61.1	61.1	65.2	60.8	62.1	58.4	63.9
50–54	62.8	68.7	60.2	59.7	63.5	58.3	62.4	55.9	63.3
55–59	60.2	66.8	58.2	56.7	62.8	57.4	61.6	54.1	61.2
60–64	58.4	65.9	55.8	55.1	61.1	54.0	62.5	50.7	59.5
65–69	50.6	57.1	48.0	47.0	53.2	46.4	54.7	43.5	51.5
20–69 years	56.4	60.4	55.5	55.6	59.1	56.3	56.2	54.0	57.3
20–69 years (ASR)	56.8	61.1	55.8	55.9	59.4	56.6	57.2	53.8	57.7
2012 and 2013									
20–24	39.5	42.3	44.7	45.8	44.8	49.9	41.3	52.4	42.7
25–29	50.6	52.4	52.4	52.7	54.1	56.5	51.3	53.0	52.0
30–34	58.1	59.4	56.8	56.6	59.8	58.7	57.9	56.6	58.1
35–39	61.2	63.7	58.6	58.7	61.5	60.6	60.7	55.7	61.0
40–44	62.6	66.8	59.8	59.1	62.6	60.3	61.9	58.0	62.6

Table 10A.90 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
45–49	63.8	69.5	61.9	61.3	64.5	61.3	63.4	59.6	64.5
50–54	63.6	69.8	61.2	59.6	63.5	59.9	62.6	58.0	64.0
55–59	61.0	67.8	59.1	57.0	62.6	57.2	63.5	55.3	61.9
60–64	59.4	67.0	56.9	55.1	61.5	55.5	63.0	51.7	60.4
65–69	51.7	59.0	49.5	47.7	53.9	47.0	56.5	43.0	52.7
20–69 years	56.9	60.9	56.0	55.5	58.7	57.0	57.0	55.2	57.7
20–69 years (ASR)	57.4	61.6	56.4	55.9	59.0	57.4	58.0	55.1	58.2

ASR = age standardised rate.

- (a) Rates are the number of women screened as a proportion of the eligible female population calculated as the average of the Australian Bureau of Statistics estimated resident population based on the 2011 Census in each of the calendar years in the reference period. Age-standardised rates are standardised to the Australian population at 30 June 2001.
- (b) The eligible female population has been adjusted for the estimated proportion of women who have had a hysterectomy, using age-specific hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database. Historical data may differ from data in previous reports for which hysterectomy fractions were estimated using a different methodology.
- (c) Data exclude women who have opted off the cervical cytology register.
- (d) Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (e) Number of women screened includes all women screened in each jurisdiction, except for Victoria and the ACT. Data may differ from data published elsewhere in which allocation of women to jurisdictions is by residential postcode.
- (f) Data for Victoria include only residents of Victoria and, from the the period 2008 and 2009, immediate border residents.
- (g) Data for the ACT include only residents of the ACT and, from the period 2008 and 2009, immediate border residents.

Source: AIHW unpublished, State and Territory Cervical Cytology Registry data.

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)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2004-05										
Age standardised rate (a)	%	41.5	44.6	53.1	42.6	48.0	52.7	53.2	68.5	49.5
RSE	%	7.3	14.4	7.1	6.4	9.1	9.8	12.2	7.9	3.3
95 per cent confidence interval	%	± 8.9	± 16.5	± 6.8	± 7.6	± 9.7	± 9.5	± 11.7	± 5.9	± 3.4
2012-13										
Age standardised rate (a)	%	53.2	59.0	53.0	49.0	58.5	54.7	54.2	53.8	53.4
RSE	%	5.2	6.0	6.2	6.4	6.4	7.3	11.7	6.6	2.8
95 per cent confidence interval	%	± 5.5	± 6.9	± 6.5	± 6.2	± 7.4	± 7.9	± 12.4	± 7.0	± 2.9

RSE = Relative standard error.

(a) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no. 4715.0; 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.92

Table 10A.92 **Influenza vaccination coverage, people aged 65 years or over (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2003										
People vaccinated	'000	663	499	328	172	186	52	23	5	1 928
Target population	'000	869	642	448	219	225	67	29	8	2 508
People vaccinated	%	76.3	77.7	73.1	78.4	82.8	76.7	80.7	68.1	76.9
2004										
People vaccinated	'000	716	541	353	181	188	53	24	6	2 062
Target population	'000	907	664	465	230	231	69	30	9	2 605
People vaccinated	%	78.9	81.6	75.8	78.7	81.4	77.3	80.0	67.5	79.1
2006										
People vaccinated	'000	710	565	364	194	200	57	25	6	2 121
Target population	'000	945	693	498	246	238	72	32	10	2 735
People vaccinated	%	75.1	81.4	73.1	78.7	83.9	79.2	77.8	63.3	77.5
2009										
People vaccinated	'000	720	550	410	200	200	60	28	8*	2,200
Target population	'000	990	740	550	270	250	77	36	12	2 900
People vaccinated	%	72.7	75.0	74.6	72.9	81.3	77.5	78.0	69.3*	74.6

(a) A '*' indicates a relative standard error (RSE) of more than 25 per cent. Estimates with RSEs greater than 25 per cent should be used with caution.

(b) The Adult Vaccination Survey was not conducted in 2005, 2007, 2008 or 2010.

Source: AIHW 2004, 2005, 2011, *Adult Vaccination Survey: Summary Results*, Cat. no. PHE 51, PHE 56, PHE 135; Department of Health unpublished, 2006 Adult Vaccination Survey.

TABLE 10A.93

Table 10A.93 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Major city										
Proportion	%	48.9	50.6	52.0	46.2	55.0	..	50.4	..	50.2
RSE	%	4.4	4.5	4.8	7.2	5.2	..	6.0	..	2.4
95 per cent confidence interval	%	± 4.2	± 4.5	± 4.9	± 6.5	± 5.6	..	± 5.9	..	± 2.3
Inner regional										
Proportion	%	48.9	51.7	50.4	57.6	64.3	56.0	np	..	51.6
RSE	%	5.7	6.9	7.8	10.1	9.7	6.4	233.2	..	3.3
95 per cent confidence interval	%	± 5.4	± 7.0	± 7.7	± 11.5	± 12.2	± 7.0	np	..	± 3.4
Outer regional										
Proportion	%	49.9	53.5	46.2	51.5	39.8	47.9	..	41.7	48.9
RSE	%	9.0	13.5	11.5	17.7	17.5	9.9	..	7.3	4.2
95 per cent confidence interval	%	± 8.8	± 14.1	± 10.4	± 17.9	± 13.6	± 9.3	..	± 6.0	± 4.0
Remote, very remote (e)										
Proportion	%	56.3	np	66.4	np	46.3	40.8	..	58.3	57.3
RSE	%	35.7	124.6	17.3	53.0	36.0	44.9	..	16.0	10.9
95 per cent confidence interval	%	± 39.3	np	± 22.5	np	± 32.6	± 35.9	..	± 18.2	± 12.2
Total (f)										
Proportion	%	49.1	51.3	51.5	48.5	54.7	52.9	50.4	43.1	50.6
RSE	%	3.3	3.7	3.9	5.7	4.5	6.0	6.0	6.7	1.7
95 per cent confidence interval	%	± 3.2	± 3.7	± 3.9	± 5.4	± 4.8	± 6.2	± 5.9	± 5.7	± 1.7

Table 10A.93 Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009 (a), (b), (c), (d)

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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RSE = Relative standard error.

- (a) Estimates are for people aged 65 years or over who are fully vaccinated against both influenza and pneumococcal disease. To be 'fully vaccinated' against pneumococcal disease requires a follow-up vaccination up to 5 years after the initial vaccination. This contributes to potential error in the estimates. Influenza vaccinations have been available free to older adults since 1999 while vaccinations against pneumococcal disease became available free in 2005.
- (b) Remoteness areas are defined using the Australian Standard Geographical Classification (AGSC), based on the *ABS 2006 Census of population and housing*. Not all remoteness areas are represented in each state or territory. There were: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.
- (c) Rates are age-standardised to the Australian population at 30 June 2001.
- (d) Estimates with relative standard errors (RSEs) between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published.
- (e) Remote and very remote categories have been aggregated due to small numbers.
- (f) Total includes people for whom a remoteness category could not be assigned as the place of residence was unknown or not stated.
- .. Not applicable. **np** Not published.

Source: AIHW unpublished, 2009 Adult Vaccination Survey.

TABLE 10A.94

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 (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2004-05										
Proportion	%	18.8	23.0	36.6	29.6	35.9	32.7	8.6	54.7	31.1
Relative standard error	%	19.7	23.8	11.1	13.1	19.8	14.9	54.0	8.9	6.2
2012-13										
Proportion	%	23.3	24.4	27.1	24.4	25.7	17.5	14.4	33.7	25.3
Relative standard error	%	11.9	16.6	13.6	14.7	18.4	20.5	41.3	14.5	6.3

- (a) Vaccinations against influenza and pneumococcal disease have been available free to Aboriginal and Torres Strait Islander people aged 50 years or over since 1999.
- (b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no. 4715.0; 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.95

Table 10A.95 **Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people) (a), (b), (c), (d)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
Vaccine-preventable conditions									
2007-08	0.6	0.7	0.7	0.7	0.9	0.4	0.7	2.7	0.7
2008-09	0.6	0.7	0.6	0.6	0.7	0.5	0.5	2.8	0.6
2009-10	0.6	0.6	0.8	0.7	0.7	0.6	0.5	2.9	0.7
2010-11	0.5	0.7	0.7	0.6	0.8	0.4	0.3	3.0	0.7
2011-12	0.6	0.7	0.8	0.6	0.8	0.5	0.5	3.2	0.7
2012-13	0.7	0.8	1.1	1.0	1.1	1.0	0.8	3.7	0.9
Acute conditions excluding dehydration and gastroenteritis									
2007-08	10.5	11.4	11.8	11.3	12.0	9.0	9.0	18.2	11.2
2008-09	10.2	11.2	12.2	11.3	11.9	8.2	9.7	20.2	11.2
2009-10	10.2	11.3	12.4	11.3	12.1	8.5	8.1	19.7	11.2
2010-11	10.7	11.9	12.9	12.7	12.6	8.3	9.1	20.2	11.8
2011-12	10.9	12.1	12.9	13.7	12.9	8.4	9.6	21.2	12.1
2012-13	10.8	10.2	13.8	13.6	13.6	9.9	9.3	20.5	11.8
Chronic conditions excluding diabetes complications (additional diagnoses only)									
2007-08	12.6	14.6	15.6	13.3	14.6	13.6	9.4	24.6	14.0
2008-09	12.3	14.0	14.8	13.2	14.2	12.3	11.0	24.0	13.5
2009-10	12.2	14.1	14.5	13.3	13.4	11.8	9.8	23.7	13.4
2010-11	10.2	12.1	12.5	11.2	11.7	9.2	8.7	23.3	11.4
2011-12	10.5	11.9	12.7	11.1	11.5	9.2	8.6	21.6	11.4
2012-13	10.4	10.8	12.9	11.3	11.9	10.1	8.3	22.1	11.3
All potentially preventable hospitalisations excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only) (f)									
2007-08	23.6	26.6	28.0	25.2	27.4	22.8	19.1	45.0	25.8
2008-09	23.0	25.9	27.6	25.0	26.7	20.9	21.1	46.6	25.3

Table 10A.95 **Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people) (a), (b), (c), (d)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
2009-10	23.0	25.9	27.6	25.2	26.1	20.8	18.2	45.8	25.2
2010-11	21.4	24.6	26.0	24.4	25.0	17.8	18.1	45.9	23.8
2011-12	22.0	24.6	26.3	25.4	25.1	18.0	18.7	45.6	24.1
2012-13	21.9	21.7	27.7	25.7	26.4	20.8	18.2	45.8	23.9

- (a) Rates are age-standardised to the Australian estimated resident population at 30 June 2001.
- (b) Data have been revised in line with a nationally agreed revised definition of selected potentially preventable hospitalisations and may differ from previous reports. See data quality information (DQI) at www.pc.gov.au/rogs/2015 for more detail.
- (c) Separation rates are based on state or territory of usual residence, not state or territory of hospitalisation. Separations for patients usually resident overseas are excluded. Totals include Australian residents of external Territories.
- (d) Caution should be used in comparing data over time as there have been changes between the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM) editions and the associated Australian Coding Standards. See DQI for more information.
- (e) Tasmanian data are not comparable over time as 2008-09 data exclude two private hospitals that account for approximately one eighth of Tasmania's total hospital separations, while data for subsequent reference years include these hospitals.
- (f) More than one category may be reported during the same hospitalisation. Therefore, the total is not necessarily equal to the sum of the components.

Source: AIHW unpublished, National Hospital Morbidity Database; ABS unpublished, Estimated Resident Population, 30 June preceding the reference period.

Table 10A.96

Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)

	NSW	Vic	Qld	WA	SA	Tas (f), (g)	ACT (f)	NT	Aust (d)
Vaccine preventable conditions									
Aboriginal and Torres Strait Islander people									
2007-08	1.1	1.1	1.6	3.7	3.0	0.6	1.4	7.2	2.3
2008-09	1.1	1.1	1.4	2.8	2.8	0.2	1.0	7.3	2.1
2009-10	1.4	1.0	3.1	4.5	3.0	0.6	0.1	8.3	3.0
2010-11	1.1	1.1	2.5	3.2	2.8	0.3	0.4	9.4	2.7
2011-12	1.1	1.5	2.0	3.8	2.9	0.4	1.3	9.6	2.7
2012-13	1.4	1.3	2.8	4.7	3.7	1.4	3.3	11.6	3.4
Other Australians (h)									
2007-08	0.6	0.7	0.7	0.6	0.9	0.4	0.7	1.1	0.7
2008-09	0.6	0.7	0.6	0.5	0.6	0.5	0.5	1.0	0.6
2009-10	0.6	0.6	0.7	0.6	0.7	0.6	0.5	0.9	0.6
2010-11	0.5	0.7	0.7	0.5	0.8	0.4	0.3	0.9	0.6
2011-12	0.6	0.7	0.8	0.5	0.8	0.5	0.5	1.1	0.7
2012-13	0.7	0.8	1.1	0.9	1.0	0.9	0.7	1.3	0.9
Acute conditions excluding dehydration and gastroenteritis									
Aboriginal and Torres Strait Islander people									
2007-08	17.2	13.4	25.8	39.4	27.7	6.1	12.7	38.0	24.4
2008-09	16.4	14.3	26.0	35.4	27.0	5.6	12.4	43.0	24.2
2009-10	16.2	14.3	24.9	35.0	27.6	7.5	8.9	43.3	23.9
2010-11	18.0	18.0	27.2	40.3	29.3	7.6	12.4	42.9	26.2
2011-12	19.6	19.6	27.2	42.0	31.4	7.9	17.4	45.1	27.4
2012-13	20.8	13.9	28.8	41.5	30.7	6.5	19.7	43.1	27.5
Other Australians (h)									
2007-08	10.4	11.5	11.4	10.4	11.8	9.1	9.0	10.6	10.9
2008-09	10.2	11.3	11.8	10.5	11.8	8.3	9.6	10.8	10.9
2009-10	10.2	11.4	12.0	10.6	11.9	8.6	8.0	10.3	10.9

Table 10A.96

Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)

	NSW	Vic	Qld	WA	SA	Tas (f), (g)	ACT (f)	NT	Aust (d)
2010-11	10.6	11.9	12.4	11.8	12.4	8.3	9.0	11.2	11.5
2011-12	10.8	12.2	12.4	12.7	12.6	8.4	9.5	11.7	11.7
2012-13	10.7	10.3	13.3	12.7	13.4	10.0	9.1	11.4	11.4
Chronic conditions excluding diabetes complications (<i>additional diagnoses only</i>)									
Aboriginal and Torres Strait Islander people									
2007-08	29.9	21.3	44.1	57.2	50.2	11.7	23.9	52.4	39.1
2008-09	29.6	23.1	44.5	52.8	45.9	13.4	24.5	54.0	38.7
2009-10	28.2	25.0	41.2	50.5	39.1	10.9	16.6	57.7	37.1
2010-11	25.0	22.5	34.5	43.6	34.4	10.7	26.6	54.0	32.6
2011-12	29.3	26.7	35.2	43.0	35.3	14.3	24.3	54.0	34.8
2012-13	27.7	20.5	36.8	41.0	35.1	14.7	14.8	52.9	33.8
Other Australians (h)									
2007-08	12.5	14.8	15.0	12.4	14.5	13.6	9.3	16.6	13.7
2008-09	12.2	14.2	14.2	12.4	14.2	12.3	10.8	15.5	13.2
2009-10	12.1	14.2	13.9	12.4	13.3	11.8	9.6	13.8	13.1
2010-11	10.1	12.3	12.0	10.5	11.6	9.2	8.5	13.4	11.1
2011-12	10.3	12.0	12.1	10.4	11.5	9.1	8.5	11.9	11.1
2012-13	10.2	10.9	12.3	10.5	11.8	9.9	8.0	11.7	10.9
All potentially preventable hospitalisations <i>excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only)</i> (i)									
Aboriginal and Torres Strait Islander people									
2007-08	48.0	35.7	70.9	98.8	80.3	18.2	38.0	95.8	65.2
2008-09	46.9	38.3	71.2	89.6	75.1	19.1	37.9	102.6	64.3
2009-10	45.6	40.0	68.4	88.9	69.2	18.7	25.6	107.4	63.3
2010-11	44.0	41.4	63.6	86.4	66.1	18.6	39.5	104.3	60.9
2011-12	49.9	47.5	63.8	88.2	69.0	22.4	43.1	107.0	64.4
2012-13	49.7	35.5	67.7	86.4	68.8	22.2	36.6	105.3	64.0

Table 10A.96

Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)

	NSW	Vic	Qld	WA	SA	Tas (f), (g)	ACT (f)	NT	Aust (d)
Other Australians (h)									
2007-08	23.5	26.9	27.0	23.4	27.1	23.0	18.9	28.2	25.2
2008-09	22.9	26.1	26.6	23.3	26.5	21.1	20.9	27.2	24.6
2009-10	22.8	26.1	26.5	23.6	25.8	20.9	18.0	24.8	24.5
2010-11	21.2	24.8	25.0	22.7	24.8	17.8	17.8	25.4	23.2
2011-12	21.7	24.7	25.1	23.6	24.8	17.9	18.4	24.6	23.4
2012-13	21.5	21.8	26.4	24.0	26.0	20.8	17.8	24.4	23.1

- (a) Rates are age-standardised to the Australian estimated resident population at 30 June 2001.
- (b) Data have been revised in line with nationally agreed revisions to the definition of selected potentially preventable hospitalisations and may differ from previous reports. Further, population estimates and projections used to derive rates have been revised based on the 2011 Census. See data quality information (DQI) at www.pc.gov.au/rogs/2015 for more detail.
- (c) Cells have been suppressed to protect confidentiality where a patient or service provider could be identified or where rates are likely to be highly volatile, for example, where the denominator is very small.
- (d) Separation rates are based on state or territory of usual residence, not state or territory of hospitalisation. Separations for patients usually resident overseas are excluded. Totals include Australian residents of external Territories.
- (e) Caution should be used in comparing data over time as there have been changes between the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM) editions and the associated Australian Coding Standards. See DQI for more information.
- (f) From 2010-11, Indigenous status data are of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.
- (g) Tasmanian data are not comparable over time as 2008-09 data exclude two private hospitals that account for approximately one eighth of Tasmania's total hospital separations, while data for subsequent reference years include these hospitals.
- (h) Other Australians includes separations where Indigenous status was not stated.
- (i) More than one category may be reported during the same hospitalisation. Therefore, the total is not necessarily equal to the sum of the components.

Source: AIHW unpublished, National Hospital Morbidity Database; ABS unpublished, Estimated Resident Population, 30 June preceding the reference period. ABS 2014, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*, Series B, Cat. no. 3238.0.

TABLE 10A.97

Table 10A.97 **Separations for selected potentially preventable hospitalisations by remoteness, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (e)</i>
<i>Vaccine preventable conditions</i>									
Major cities	0.7	0.8	1.2	0.9	1.1	..	0.8	..	0.4
Inner regional	0.7	0.7	1.0	0.7	0.9	1.0	1.4	..	0.4
Outer regional	0.8	0.7	1.1	1.1	1.0	0.9	..	1.8	0.5
Remote	0.6	0.2	1.9	2.1	1.4	0.4	..	5.2	1.1
Very remote	1.5	..	1.7	2.2	2.7	0.6	..	7.7	1.6
<i>Acute conditions excluding dehydration and gastroenteritis</i>									
Major cities	10.2	9.7	12.7	12.9	13.0	..	9.3	..	5.5
Inner regional	12.3	11.6	14.5	12.3	13.6	9.6	11.7	..	6.2
Outer regional	13.9	13.2	15.8	14.4	16.4	10.2	..	12.5	7.1
Remote	21.1	17.6	21.1	20.6	13.4	12.5	..	30.2	10.4
Very remote	26.2	..	27.2	24.8	23.9	13.3	..	30.7	13.2
<i>Chronic conditions excluding diabetes complications (additional diagnoses only)</i>									
Major cities	9.4	10.6	12.1	10.5	11.2	..	8.3	..	5.2
Inner regional	11.8	11.1	13.7	11.6	11.1	10.1	8.4	..	5.9
Outer regional	14.7	12.5	14.0	13.8	15.4	10.0	..	15.6	6.9
Remote	22.3	12.1	16.6	15.9	12.7	10.2	..	26.3	8.8
Very remote	26.3	..	24.4	19.7	22.5	13.4	..	36.4	12.8
<i>All potentially preventable hospitalisations excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only) (g)</i>									
Major cities	20.3	21.0	25.7	24.1	25.2	..	18.2	..	11.1
Inner regional	24.7	23.3	29.1	24.5	25.6	20.6	20.0	..	12.5
Outer regional	29.4	26.3	30.7	29.1	32.6	21.0	..	29.8	14.4
Remote	44.0	30.0	39.5	38.4	27.4	23.1	..	60.8	20.1
Very remote	53.8	..	52.9	46.3	48.6	26.8	..	73.7	27.3

Table 10A.97 **Separations for selected potentially preventable hospitalisations by remoteness, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (e)</i>
(a)	Rates are age-standardised to the Australian estimated resident population at 30 June 2001.								
(b)	Remoteness areas are defined using the ABS 2011 Census based Australian Standard Geographical Classification (ASGS). Not all remoteness areas are represented in each state or territory. Caution should be used in comparing 2012-13 data with earlier years in which remoteness areas were defined using a different geographical classification. See data quality information (DQI) at www.pc.gov.au/rogs/2015 for further detail.								
(c)	There are: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.								
(d)	Cells have been suppressed to protect confidentiality where a patient or service provider could be identified or where rates are likely to be highly volatile, for example, where the denominator is very small.								
(e)	Separation rates are based on state or territory and remoteness area of usual residence, not hospitalisation. Separations for patients usually resident overseas are excluded. Totals include Australian residents of external Territories.								
(f)	Caution should be used in comparing data over time as there have been changes between the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM) editions and the associated Australian Coding Standards. See DQI for more information.								
(g)	More than one category may be reported during the same hospitalisation. Therefore, the total is not necessarily equal to the sum of the components.								
	.. Not applicable. np Not published.								

Source: AIHW unpublished, National Hospital Morbidity Database; ABS unpublished, Estimated Resident Population, 30 June preceding the reference period.

Table 10A.98 Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)

	<i>Major cities</i>	<i>Inner regional/ Outer regional</i>	<i>Remote/ Very remote</i>
Vaccine-preventable conditions			
Aboriginal and Torres Strait Islander people			
2012-13	2.2	2.4	7.2
Other Australians (g)			
2012-13	0.9	0.8	1.2
Acute conditions <i>excluding dehydration and gastroenteritis</i> (c)			
Aboriginal and Torres Strait Islander people			
2012-13	18.5	23.3	49.3
Other Australians (g)			
2012-13	11.0	12.5	14.3
Chronic conditions <i>excluding diabetes complications as additional diagnoses</i> (c)			
Aboriginal and Torres Strait Islander people			
2012-13	22.4	34.2	49.3
Other Australians (g)			
2012-13	10.5	11.8	12.8
All potentially preventable hospitalisations <i>excluding dehydration and gastroenteritis and diabetes complications as additional diagnoses</i> (c)			
Aboriginal and Torres Strait Islander people			
2012-13	42.7	59.5	104.4
Other Australians (g)			
2012-13	22.3	25.0	28.2

(a) Rates are age-standardised to the Australian estimated resident population at 30 June 2001.

(b) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification.

(c) Cells have been suppressed to protect confidentiality where a patient or service provider could be identified or where rates are likely to be highly volatile, for example, where the denominator is very small. See data quality information (DQI) at www.pc.gov.au/rogs/2015 for further detail.

(d) Caution should be used in comparing data over time as there have been changes between the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM) editions and the associated Australian Coding Standards. See DQI for more information.

(e) Separation rates are based on patient's usual residence (not hospital location).

(f) Separations for patients usually resident overseas are excluded.

(g) 'Other Australians' includes separations where Indigenous status was not stated.

Source: AIHW unpublished, National Hospital Morbidity Database; ABS unpublished, Estimated Residential Population, 30 June 2012; ABS 2014, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*, 30 June 2012, Series B, Cat. no. 3238.0.

TABLE 10A.99

Table 10A.99 **Separations for selected vaccine preventable conditions by Indigenous status, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust (h)</i>
Vaccine preventable conditions per 1000 Aboriginal and Torres Strait Islander people									
Pneumonia and Influenza (vaccine-preventable)	1.0	1.0	2.1	3.7	2.2	1.0	3.3	5.9	2.2
Other vaccine preventable conditions	0.4	0.3	0.7	1.0	1.6	0.3	–	5.8	1.2
Total	1.4	1.3	2.8	4.7	3.7	1.4	3.3	11.6	3.4
Vaccine preventable conditions per 1000 other Australians (i)									
Pneumonia and Influenza (vaccine-preventable)	0.5	0.5	0.8	0.7	0.8	0.7	0.5	0.7	0.6
Other vaccine preventable conditions	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.6	0.3
Total	0.7	0.8	1.1	0.9	1.0	0.9	0.7	1.3	0.9

(a) Data for 2012-13 are based on specifications that have been revised in alignment with the National Healthcare Agreement and are not comparable with data reported elsewhere (such as the AIHW's *Australian hospital statistics*) or with data in previous editions of this Report. Conditions are defined by ICD-10-AM codes that are available on request.

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the Australian population at 30 June 2001.

(d) Separation rates are based on state or territory of usual residence.

(e) Rates are derived using population estimates and projections based on the 2011 Census.

(f) Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes from the 2011-12 reporting year.

(g) NT data are for public hospitals only.

(h) Data for Australia include all States and Territories and Australian residents of external Territories.

(i) Data for non-Indigenous Australians include separations where Indigenous status was not stated.

(j) – Nil or rounded to zero.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 10A.100

Table 10A.100 **Separations for selected acute conditions by Indigenous status, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust (h)</i>
Acute conditions per 1000 Aboriginal and Torres Strait Islander people									
Pneumonia (not vaccine-preventable)	0.1	0.3	0.1	0.2	0.1	–	0.1	0.1	0.1
Cellulitis	4.6	2.7	7.4	9.7	5.0	1.8	4.1	10.8	6.5
Convulsions and epilepsy	5.1	2.5	5.6	8.9	9.9	1.1	3.6	9.0	6.1
Eclampsia	–	–	–	–	–	–	–	–	–
Dental conditions	3.0	3.0	3.6	4.4	3.6	1.5	2.8	5.2	3.5
Ear, nose and throat infections	2.4	1.7	3.1	5.0	3.8	0.5	1.8	5.0	3.1
Gangrene	0.4	0.4	1.2	2.4	0.8	0.2	0.6	2.0	1.1
Pelvic inflammatory disease	0.4	0.3	0.6	1.0	0.6	0.2	0.4	1.2	0.6
Perforated/bleeding ulcer	0.2	0.2	0.2	0.3	0.4	0.2	0.2	0.4	0.3
Urinary tract infections, including pyelonephritis (i)	4.5	2.8	7.1	9.5	6.5	0.9	6.1	9.5	6.2
Total	20.8	13.9	28.8	41.5	30.7	6.5	19.7	43.1	27.5
Acute conditions per 1000 other Australians (j)									
Pneumonia (not vaccine-preventable)	0.1	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1
Cellulitis	2.1	1.7	2.7	1.9	2.4	1.7	1.6	3.5	2.1
Convulsions and epilepsy	1.4	1.2	1.7	1.3	1.6	1.4	1.3	1.2	1.4
Eclampsia	–	–	–	–	–	–	–	–	–
Dental conditions	2.3	2.7	2.8	3.9	3.8	3.4	2.1	2.1	2.8
Ear, nose and throat infections	1.6	1.3	1.9	1.8	2.2	1.2	1.0	1.5	1.6

Table 10A.100 **Separations for selected acute conditions by Indigenous status, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust (h)</i>
Gangrene	0.2	0.5	0.4	0.4	0.3	0.4	0.2	0.5	0.3
Pelvic inflammatory disease	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Urinary tract infections, including pyelonephritis (i)	2.6	2.4	3.3	2.9	2.8	1.6	2.5	2.2	2.7
Total	10.7	10.3	13.3	12.7	13.4	10.0	9.1	11.4	11.4

(a) Data for 2012-13 are based on specifications that have been revised in alignment with the National Healthcare Agreement and are not comparable with data reported elsewhere (such as the AIHW's *Australian hospital statistics*) or with data in previous editions of this Report. Conditions are defined by ICD-10-AM codes that are available on request.

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the Australian population at 30 June 2001.

(d) Separation rates are based on state or territory of usual residence.

(e) Rates are derived using population estimates and projections based on the 2011 Census.

(f) Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes from the 2011-12 reporting year.

(g) NT data are for public hospitals only.

(h) Data for Australia include all States and Territories and Australian residents of external Territories.

(i) Pyelonephritis is kidney inflammation caused by bacterial infection.

(j) Data for non-Indigenous Australians include separations where Indigenous status was not stated.

– Nil or rounded to zero.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 10A.101

Table 10A.101 **Separations for selected chronic conditions by Indigenous status, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust (h)</i>
Chronic conditions per 1000 Aboriginal and Torres Strait Islander people									
Angina	3.4	2.6	5.8	5.2	4.6	2.3	1.4	5.0	4.4
Asthma	2.2	1.9	2.5	3.8	2.9	0.6	1.1	2.9	2.5
Chronic obstructive pulmonary disease	11.2	7.2	10.9	8.1	10.6	4.7	3.7	15.1	10.6
Congestive heart failure	3.8	2.5	5.8	7.0	4.9	3.6	2.6	8.4	5.2
Diabetes complications (i)	4.2	3.4	7.8	10.9	8.0	1.6	3.6	8.9	6.5
Hypertension	0.7	0.5	1.0	1.0	0.7	0.2	–	0.7	0.8
Iron deficiency anaemia	1.8	2.3	2.1	3.5	2.0	1.9	1.6	3.2	2.3
Nutritional deficiencies	0.1	–	–	–	–	–	0.6	0.3	0.1
Rheumatic heart disease (j)	0.1	0.1	0.5	0.8	0.5	–	0.2	3.2	0.7
Bronchiectasis	0.3	0.0	0.4	0.6	0.8	–	–	5.2	0.9
Total (i), (k)	27.7	20.5	36.8	41.0	35.1	14.7	14.8	52.9	33.8
Chronic conditions per 1000 other Australians (l)									
Angina	1.6	1.3	2.2	1.8	1.8	1.2	1.1	2.8	1.7
Asthma	1.2	1.1	1.4	0.9	1.4	0.9	0.8	0.8	1.2
Chronic obstructive pulmonary disease	2.4	2.1	2.7	2.0	2.6	2.1	2.0	3.4	2.4
Congestive heart failure	1.9	2.1	2.0	1.8	1.9	1.7	1.6	1.8	2.0
Diabetes complications (i)	1.4	1.7	1.8	1.7	1.9	1.5	1.0	1.4	1.6
Hypertension	0.3	0.3	0.5	0.3	0.3	0.2	0.2	0.2	0.3
Iron deficiency anaemia	1.2	1.9	1.2	1.7	1.6	2.0	1.1	1.0	1.5
Nutritional deficiencies	–	–	–	–	–	–	0.1	0.1	–
Rheumatic heart disease (j)	0.1	0.1	0.1	0.1	0.1	–	0.1	0.1	0.1

Table 10A.101 **Separations for selected chronic conditions by Indigenous status, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust (h)</i>
Bronchiectasis	0.2	0.2	0.3	0.2	0.1	0.2	0.1	0.2	0.2
Total (i), (k), (l)	10.2	10.9	12.3	10.5	11.8	9.9	8.0	11.7	10.9

- (a) Data for 2012-13 are based on specifications that have been revised in alignment with the National Healthcare Agreement and are not comparable with data reported elsewhere (such as the AIHW's *Australian hospital statistics*) or with data in previous editions of this Report. Conditions are defined by ICD-10-AM codes that are available on request.
- (b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.
- (c) Separation rates are directly age standardised to the Australian population at 30 June 2001.
- (d) Separation rates are based on state or territory of usual residence.
- (e) Rates are derived using population estimates and projections based on the 2011 Census.
- (f) Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes from the 2011-12 reporting year.
- (g) NT data for Aboriginal and Torres Strait Islander people and other Australians are for public hospitals only.
- (h) Data for Australia include all States and Territories and Australian residents of external Territories.
- (i) Excludes separations with an additional diagnosis of diabetes complications.
- (j) Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease.
- (k) Total may not sum to the individual categories as more than one chronic condition can be reported for a separation.
- (l) Data for non-Indigenous Australians include separations where Indigenous status was not stated.
- .. not applicable. – Nil or rounded to zero.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 10A.102 **Ratio of separations for Aboriginal and Torres Strait Islander people to all Australians, diabetes, 2012-13 (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT (b)</i>	<i>NT (b)</i>	<i>Total</i>
Diabetes as a principle diagnosis (h)	no.	622	127	1 245	585	214	35	20	629	3 477
	SHSR	3.94	2.48	5.68	7.02	4.88	1.31	5.44	6.51	5.16
All diabetes — excluding diabetes complications as an additional diagnosis (i)	no.	3 756	778	4 656	3 497	1 188	187	75	2 690	16 827
	SHSR	2.47	2.09	2.91	4.03	3.23	1.14	2.47	3.45	2.90
All diabetes (j)	no.	7 640	1 667	12 463	13 464	2 453	372	179	7 896	46 134
	SHSR	3.01	2.53	4.22	9.23	4.11	1.38	2.96	5.61	4.62

SHSR = Standardised Hospital Separation Ratio

(a) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(b) Data are available for Tasmania and the ACT for the first time. NT data are for public hospitals only.

(c) Caution should be used in the interpretation of these data because of jurisdictional differences in data quality.

(d) Ratios are directly age standardised to the Australian estimated resident population at 30 June 2001.

(e) Patients aged 75 years or over are excluded.

(f) Separation rates are based on state of usual residence.

(g) Reporting of diabetes increased by on average 29.6 per cent for diabetes as a principal diagnosis and 247 per cent for diabetes as an additional diagnosis, between 2011-12 and 2012-13 — in large part due to changes in Australian Coding Standards. Accordingly, data for 2012-13 are not comparable with data for previous years.

(h) Includes ICD-10-AM codes of Principal diagnosis in: 'E10', 'E11', 'E13', 'E14' or 'O24'.

(i) Includes ICD-10-AM codes of Principal diagnosis in: 'E10', 'E11', 'E13', 'E14' or 'O24' or Additional diagnosis in 'E109', 'E119', 'E139' or 'E149'.

(j) All diabetes refers to separations with either a principal or additional diagnosis of diabetes. Includes ICD-10-AM codes in: 'E10', 'E11', 'E13', 'E14' or 'O24'.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 10A.103 **Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2012-13 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g), (h)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (f)</i>
Circulatory	13.2	11.7	10.1	20.7	10.8	np	np	np	12.5
Renal	3.4	2.5	4.7	3.5	4.4	np	np	np	3.5
Ophthalmic	4.9	8.6	10.7	22.4	7.1	np	np	np	9.1
Other specified	37.8	40.3	53.6	43.5	59.1	np	np	np	44.0
Multiple	20.2	40.4	39.1	36.6	35.3	np	np	np	32.9
No complications	5.5	4.8	4.4	5.1	4.4	np	np	np	4.9
Total (g)	85.0	108.5	122.5	131.7	121.0	np	np	np	107.0

- (a) Rates are age standardised to the Australian resident population at 30 June 2001.
- (b) Excludes separations with a care type of Newborn without qualified days, and records for hospital boarders and posthumous organ procurement.
- (c) Results for individual complications may be affected by small numbers, and need to be interpreted with care.
- (d) Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations.
- (e) Morbidity data are coded under coding standards that may differ over time and across jurisdictions.
- (f) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.
- (g) Totals may not add as a result of rounding.
- (h) 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 Australian Coding Standards. Therefore, data for 2012-13 are not comparable with data for previous years.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 10A.104 Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2012-13 (per cent) (a), (b), (c), (d), (e), (f), (g), (h)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (g)</i>
Circulatory	13.6	11.8	15.4	32.7	10.2	np	np	np	16.2
Renal	14.8	17.5	18.3	22.2	22.7	np	np	np	18.6
Ophthalmic	80.6	88.4	92.4	90.0	87.9	np	np	np	88.8
Other specified	10.4	13.1	20.2	15.3	23.1	np	np	np	15.1
Multiple	9.3	35.4	22.4	6.6	19.7	np	np	np	21.6
No complications	38.0	40.1	32.3	31.5	44.2	np	np	np	37.5
Total	16.5	28.5	27.0	29.4	25.4	np	np	np	24.6

- (a) Data are for the number of same day separations with the specified principal diagnosis, as a per cent of all separations with the specified principal diagnosis.
- (b) Rates are age-standardised to the Australian resident population at 30 June 2001.
- (c) Excludes separations with a care type of Newborn without qualified days, and records for hospital boarders and posthumous organ procurement.
- (d) Results for individual complications may be affected by small numbers, and need to be interpreted with care.
- (e) Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations.
- (f) Morbidity data are coded under coding standards that may differ over time and across jurisdictions.
- (g) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.
- (h) 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 Australian Coding Standards. Therefore, data for 2012-13 are not comparable with data for previous years.

– Nil or rounded to zero. **np** Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 10A.105 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2012-13 (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
ASR	per 100 000 people	14.3	16.1	16.5	18.5	19.6	np	np	np	16.4
Separations	no.	1187	988	777	448	395	np	np	np	4 039

ASR = Age standardised rate

- (a) ASR rates are age standardised to the Australian estimated resident population at 30 June 2001.
- (b) Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370-00, 44373-00, 44367-00, 44367-01 and 44367-02 for lower limb amputation.
- (c) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.
- (d) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.
- (e) Reporting of diabetes increased by on average 29.6 per cent for diabetes as a principal diagnosis and 247 per cent for diabetes as an additional diagnosis, between 2011-12 and 2012-13 — in large part due to changes in Australian Coding Standards. Accordingly, data for 2012-13 are not comparable with data for previous years.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 10A.106

Table 10A.106 Separation rates for older people for injuries due to falls (a), (b), (c)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
2005-06									
Separations per 1000 older people	48.5	46.2	40.6	43.3	34.6	32.0	48.8	45.7	44.3
Number	46 425	32 911	20 058	10 409	8 780	2 348	1 516	340	122 787
2006-07									
Separations per 1000 older people	51.6	48.5	43.0	43.8	35.8	32.7	52.2	47.8	46.7
Number of separations	50 938	35 649	22 078	10 954	9 358	2 455	1 697	375	133 504
2007-08									
Separations per 1000 older people	51.6	48.6	42.9	43.7	36.4	34.1	60.1	43.2	46.8
Number of separations	52 463	36 855	22 851	11 319	9 762	2 616	2 051	366	138 283
2008-09									
Separations per 1000 older people	52.4	47.6	45.7	44.6	39.0	32.9	65.0	43.2	47.7
Number	54 998	37 337	25 092	12 009	10 759	2 580	2 318	383	145 476
2009-10									
Separations per 1000 older people	55.9	49.5	47.1	46.2	43.0	32.8	68.2	43.3	50.1
Number of separations	60 117	39 885	26 759	12 877	12 059	2 638	2 546	408	157 289
2010-11									
Separations per 1000 older people	60.4	53.0	51.7	52.1	43.0	32.7	65.6	np	54.0
Number of separations	np	np	np	np	np	np	np	np	np
2011-12 (d)									
Separations per 1000 older people	61.6	55.2	56.2	56.8	46.0	33.7	73.0	54.0	56.5
Number of separations	68 833	45 953	32 782	16 539	13 297	2 845	2 858	513	183 620
2012-13									
Separations per 1000 older people	62.1	51.8	60.1	58.2	47.8	34.3	66.5	53.9	56.8
Number of separations	71 946	44 709	36 424	17 719	14 261	2 992	2 757	575	191 383

(a) Excludes separations records for Hospital Boarders and Posthumous organ procurement.

Table 10A.106 **Separation rates for older people for injuries due to falls (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
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(b) Older people are defined as people aged 65 years or over.

(c) Separation rates are age standardised to the the Australian population aged 65 years or over at 30 June 2001.

(d) The Australian total for 2010-11 does not include NT data.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Community health services programs

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Fifth Community Pharmacy Agreement (5CPA)	5CPA provides more than \$15.6 billion over five years (1 July 2010 to 30 June 2015) for the dispensing of PBS medicines and to ensure vital medicines are accessible to the Australian community. The 5CPA includes \$663.4m over the life of the 5CPA for Professional Services and Programmes delivered by pharmacists, which promote access to services that assist patient medication management and support the quality use of medicine and through this, improve consumer health outcomes. A number of these programmes target particular population groups (such as the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander people) and geographical settings (such as the Rural Pharmacy Workforce Programme).	Over \$14b for the dispensing of PBS medicines. \$950m for the Community Service Obligation funding pool, which supports the timely supply of medicines to all Australians. \$663.4m for a range of Programmes and Services that improve patient health outcomes.	<ul style="list-style-type: none"> • Data via PBS. • The Pharmacy Guild of Australia reports on a number of 5CPA programmes. • Department of Human Services reports on two programmes. • Reporting data or activity for 5CPA programmes by funding recipients.
Blood-borne Viruses and Sexually Transmissible Infection Prevention and Control	<p>The Commonwealth funds programs to support a coordinated national effort to address the risk and spread of viral hepatitis, sexually transmissible infections and HIV/AIDS.</p> <p>The Commonwealth Government works with partners including state and territory governments, research institutions and community-based organisations to reduce the risk and transmission of blood-borne viruses (BBV) and sexually transmissible infections (STI) as well as to improve the health outcomes of people living with or at risk of these diseases.</p>	State and Commonwealth Co-funded and coordinated at the national level to achieve program objectives and targets	<ul style="list-style-type: none"> • Routine reporting <ul style="list-style-type: none"> – quarterly – progress and annual reports • Additional <ul style="list-style-type: none"> - activity and program evaluation.

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Closing the Gap – PBS Co-payment Measure	The Closing the Gap (CTG) Pharmaceutical Benefits Scheme Co-Payment Measure is funded through the Indigenous Australians' Health Programme. The CTG Measure improves access to Pharmaceutical Benefits Scheme medicines, by providing co-payment relief for Aboriginal and Torres Strait Islanders living with, or at risk of, chronic disease. Eligible general practices participating in the Practice Incentive Programme (PIP) under the Indigenous Health Incentive (IHI) and non-remote Indigenous Health Services (IHS) may participate in the Measure which commenced on 1 July 2010.	Commonwealth Department of Health	<ul style="list-style-type: none"> • The Department of Human Services records registration of PIP accredited GP practices and non-remote IHS, and eligible registered patients. • Expenditure data is reported monthly through DHS.
Royal Flying Doctor Service	The Australian Government funds the Royal Flying Doctor Service of Australia (RFDS) to provide essential primary health care service 'traditional services', that is emergency primary aeromedical evacuations, primary GP and nursing health clinics, remote consultations and medical chests in remote and very remote areas which are beyond the normal medical infrastructure in areas of market failure.	Commonwealth Department of Health	Reporting is quarterly for health, financial data and qualitative information.
Rural Womens GP Service Programme	The Rural Women's GP Service (RWGPS) aims to improve access to primary health care services for women in rural and remote Australia, who currently have little or no access to a female GP, by facilitating the travel of female GPs to these communities.	Commonwealth Department of Health to the Royal Flying Doctor Service to deliver the RWGPS.	Reporting quarterly by exception. Six monthly for full health, financial data and qualitative reporting.

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Rural Health Outreach Fund	<p>The Rural Health Outreach Fund (RHOF) improves access to medical specialist, allied health and GP and other health services for people living in rural and remote locations, by removing the financial disincentives incurred by health professionals who provide outreach services. This is achieved by meeting costs associated with delivering outreach services such as travel, accommodation, and venue hire.</p> <p>The RHOF addresses four health priorities - maternity and paediatric health; eye health; mental health; and support for chronic disease management. A range of health professionals are supported, including specialists such as paediatricians, psychiatrists, and surgeons; allied health professionals such as dietitians and occupational therapists; as well as GPs; nurses; and midwives.</p>	<p>Commonwealth Department of Health</p> <p>Delivered by jurisdictional fundholders.</p>	<p>Quarterly financial and service activity reports</p>
Stronger Futures in the Northern Territory	<p>Stronger Futures in the Northern Territory National Partnership Agreement – Health.</p> <p>This 10 year agreement includes an investment of over \$700 million and aims to address persistent challenges experienced accessing health care services for Aboriginal people in the Northern Territory. Funding supports improved access, coordination and health care service delivery in remote areas, including facilitating delivery of specialist, dental and audiology health services for high disease burden conditions such as oral health and hearing health.</p>	<p>Commonwealth Department of Health</p> <p>The programme is delivered by a range of Aboriginal Community Controlled Health Services, Non-Government Organisations and the Northern Territory Government.</p>	<p>Services undertake a quarterly review of progress against agreed plans. Organisations provide an annual report of service activity. Clinical primary health care service providers report biannually on national key performance indicators.</p>
Visiting Optometrist Scheme (VOS)	<p>The VOS improves access to optometric services for people living and working in rural and remote communities. This is achieved by addressing some of the financial disincentives incurred by participating optometrists providing outreach services, including travel, accommodation and facility fees.</p>	<p>Commonwealth Department of Health</p> <p>Delivered by optometrists.</p>	<p>Six monthly financial and activity reports.</p>

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Eye and Ear Health	<p>Ear Health The Healthy Ears – Better Hearing, Better Listening Programme improves access to ear and hearing health services for Indigenous Australian children and youth, with a focus on rural and remote locations, by providing multidisciplinary outreach services. This is achieved by meeting the costs associated with delivering outreach services, such as travel, accommodation and venue hire. A range of health professionals are supported, such as medical specialists, GPs, nurses, audiologists and speech pathologists.</p> <p>Eye Health The Trachoma National Partnership Agreement aims to eliminate trachoma by 2020 by improving trachoma screening and treatment activities. Trachoma occurs primarily in remote and very remote Aboriginal communities in the Northern Territory, South Australia and Western Australia.</p>	<p>Commonwealth Department of Health Delivered by jurisdictional fundholders.</p> <p>Commonwealth Department of Health and health departments in New South Wales, Northern Territory, Queensland, South Australia and Western Australia. Delivered by state governments.</p>	<p>Quarterly financial and service activity reports</p> <p>6 monthly reporting on activities and data collection through the Kirby Institute, University of NSW.</p>
Primary Health care Funding	<p>The Indigenous Australians' Health Programme supports Aboriginal community controlled health organisations and other Aboriginal medical services to provide Indigenous-specific comprehensive primary health care services including population health activities and clinical services, such as the treatment of acute illness, emergency care, management of chronic conditions, crisis intervention and referral. Funded organisations deliver services across the country, including in remote Aboriginal and Torres Strait Islander communities ensuring access to essential health services.</p>	<p>Funding is provided by the Department of Health. The programme is delivered by a range of Aboriginal community controlled health services, non-government organisations and some State and Territory health departments.</p>	<p>Organisations provide an annual report of service activity. Services providing clinical primary health care report biannually against agreed national key performance indicators.</p>

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Australian Nurse Family Partnership Programme	<p>The Australian Nurse Family Partnership Programme (ANFPP) is an evidence-based programme that aims to improve pregnancy outcomes by: helping women engage in good preventive health practices; supporting parents to improve their child's health and development; and helping parents develop a vision for their own future, including continuing education and finding work.</p> <p>The Programme is based on the US Nurse-Family Partnership® (NFP) model developed over the last 30 years by Professor David Olds and his team at the University of Colorado. In the 2014 Budget, the Australian Government provided additional funding from 2015-16 through the Better Start to Life approach for an additional 10 ANFPP sites to a total of 13 sites by 2018.</p>	Department of Health to three Aboriginal Community Controlled Health Organisations to deliver the programme - Wellington Aboriginal Corporation Health Service (Wellington, NSW), Wuchopperen Health Service (Cairns, QLD), and Central Australian Aboriginal Congress (Alice Springs, NT).	Australian Nurse Family Partnership Programme - Quarterly fidelity and progress reports as well as six monthly financial reports.

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
National Partnership Agreement: Indigenous Early Childhood Development	<p>The National Partnership Agreement on Indigenous Early Childhood Development (NPA IECD) was one of a range of measures agreed to by the Council of Australian Governments (COAG) to achieve the target of Closing the Gap in Indigenous disadvantage. The NPA IECD provided funding over 6 years to June 2014, to specifically address the needs of Aboriginal and Torres Strait Islander Children in their early years.</p> <p>The NPA IECD comprised of three interrelated Elements:</p> <ul style="list-style-type: none"> • The Department of Prime Minister and Cabinet was responsible for Element 1 of the NPA IECD. • The Department of Health was responsible for the health components (Elements 2 and 3) of the NPA IECD. <p>- Element 2: (\$107m over 5 years) aimed to increase access to antenatal care, pre-pregnancy and teenage sexual and reproductive health services.</p> <p>- Element 3: (\$90.3m of Commonwealth Own Purpose Expenditure and \$75m of State Own Purpose Expenditure over 5 years) - to increase access to, and use of, maternal and child health services by Aboriginal and Torres Strait Islander families.</p> <p>Building on the achievements of the NPA IECD, the 2014-15 Commonwealth Budget commits \$25.9 million in 2014-15 for a new Indigenous Teenage Sexual and Reproductive Health and Young Parent Support measure to continue Indigenous teenage sexual and reproductive health and antenatal care services previously funded through the NPA IECD.</p>	<p>Funding was provided by the Australian Government and state and territory governments.</p> <p>Element 2: Funding is through payment transfers to states and territories who manage/deliver the programmes/services.</p> <p>Element 3: The Department of Health funds Aboriginal community controlled health organisations (ACCHOs) and primary health care organisations to deliver the New Directions programme.</p> <p>States and territories provide funding for Indigenous maternal and child health services.</p>	<p>A national evaluation was undertaken by Urbis Pty Ltd and the Final Report will be released in late 2014.</p> <p>An Annual Data Report on health performance indicators, commissioned by the Department of Health, is provided by the Australian Institute of Health and Welfare.</p>

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
New Directions: Mothers and Babies	<p>The New Directions: Mothers and Babies Services programme provides Aboriginal and Torres Strait Islander children and their mothers with access to antenatal care, standard information about baby care, practical advice and assistance with breastfeeding, nutrition and parenting; monitors developmental milestones, immunisation status and infections; and undertakes health checks for Indigenous children before starting school.</p> <p>The programme is being implemented in 85 sites across Australia. There are 15 organisations funded in urban locations, 38 in regional locations and the remaining 32 are in remote locations, 12 of which are remote service delivery sites. These services will expand from 85 to 136 sites by 2018 under the Australian Government's Better Start to Life approach.</p> <p>The New Directions: Mothers and Babies Services programme was the Commonwealth's contribution to Element 3 of the NPA IECD.</p>	Funding for New Directions: Mothers and Babies is provided by the Department of Health under Element 3 of the NPA IECD to ACCHOs and primary health care organisations.	Under the NPA IECD, the Commonwealth prepares an Annual Report for the preceding Financial year by 31 August each year
Indigenous Australians Health Programme	<p>The Aboriginal and Torres Strait Islander Chronic Disease Fund ceased on 30 June 2014 with activities continuing under the Indigenous Australians Health Programme (IAHP) from 1 July 2014.</p> <p>The chronic disease theme of the IAHP aims to improve the prevention, detection and management of chronic disease in Aboriginal and Torres Strait Islander peoples to close the gap in life expectancy. It provides funding for prevention programmes and community education to reduce the key risk factors that contribute to chronic disease; improved access to best practice chronic disease management and follow up care; and improved health services for use by Aboriginal and Torres Strait Islander people with, or at risk of, chronic disease.</p>	Commonwealth Department of Health -	Department of Health Annual Report

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Australian General Practice Training (AGPT) Program	<p>The AGPT program is the main pathway for achieving GP specialist qualifications in Australia. The AGPT program is a three to four year postgraduate vocational training program for medical graduates wishing to pursue a career in general practice. Registrars train to meet the standards for fellowship of either the Royal Australian College of General Practice (RACGP) or the Australian College of Rural and Remote Medicine (ACCRM).</p> <ul style="list-style-type: none"> • In 2014, all 1192 places on the AGPT were filled and 58% of doctors who applied were women. These doctors provide services to the local community while they train. • At least 50% of all AGPT training must occur in rural and remote areas 	<p>Commonwealth Department of Health and managed by General Practice Education Training</p> <p>The program is delivered by 17 Regional Training Providers (RTPs).</p>	<ul style="list-style-type: none"> • Financial and activity reports submitted to the Department in line with funding agreements between the Department and the RTPs. .
Remote Vocational Training Scheme	<p>The Remote Vocational Training Scheme (RVTS) is a four year programme delivering structured distance education and supervision to doctors providing general medical services in rural and remote locations throughout Australia.</p> <ul style="list-style-type: none"> • The RVTS vocational training supports doctors in rural/remote areas to gain Fellowship: of the RACGP and/or the ACRRM, and/or in Advanced Rural General Practice. The RVTS funds locum relief to allow doctors to attend face-to-face training. This ensures that solo doctor towns or small communities are not affected by doctors leaving for training requirements. • The funding supports 22 new training places each year for registrars training in RA 2-5 categories, with entry for an additional 10 registrars to train in Aboriginal and Community Controlled Health Services in 2014 and 2015. 	<p>Commonwealth Department of Health</p> <p>The program is delivered by RVTS Ltd through a funding agreement with the Department.</p>	<ul style="list-style-type: none"> • Financial and activity reports submitted to the Department four times a year in line with the funding agreement between the Department and RVTS Ltd. .

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Voluntary Dental Graduate Year Program	<p>The Voluntary Dental Graduate Year Programme (VDGYP) provides dental graduates with a structured programme for enhanced practice experience and professional development opportunities, whilst increasing the dental workforce capacity, particularly in the public sector.</p> <ul style="list-style-type: none"> • In 2014 placements are based across 43 locations. Of these locations, 21 are metropolitan areas, 16 are regional areas, 5 remote areas and 1 provide services across remoteness areas. • The VDGYP commenced first intake of 50 graduates in 2013. • Graduate placements are directed towards the public sector and areas of need, including rural areas 	The program is delivered by a national administrator Australian Information Technology Engineering Centre.	<ul style="list-style-type: none"> • Financial and activity reports submitted to the Department twice a year in line with the funding agreement between the Department and administrator.
Oral Health Therapist Graduate Year Program	<p>The Oral Health Therapist Graduate Year Programme (OHTGYP) provides oral health therapist graduates with a structured programme for enhanced practice experience and professional development opportunities, whilst increasing the dental workforce capacity, particularly in the public sector.</p> <ul style="list-style-type: none"> • The first cohort of 50 oral health therapist graduates commenced participation in the OHTGYP on 20 January 2014. • The first cohort commenced in January 2014. Placements are based across 43 locations. Of these locations, 20 are metropolitan areas, 19 are regional areas, 2 remote areas and 3 provide services across remoteness areas. • Graduate placements are directed towards the public sector and areas of need, including rural areas 	The program is delivered by a national administrator Australian Information Technology Engineering Centre.	<ul style="list-style-type: none"> • Financial and activity reports submitted to the Department twice a year in line with the funding agreement between the Department and administrator.

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Aboriginal and Torres Strait Islander Health Workforce Services	<p>Funding is provided to four Aboriginal and Torres Strait Islander peak health organisations:</p> <ul style="list-style-type: none"> • Australian Indigenous Doctors Association; • Congress of Aboriginal and Torres Strait Islander Nurses and Midwives; • National Aboriginal and Torres Strait Islander Health Worker Association; and • Indigenous Allied Health Australia <p>Aboriginal and Torres Strait Islander peak health organisations provide representation, advocacy, advice and support for the health workforce they represent and participate in the development and implementation of Aboriginal and Torres Strait Islander health workforce policy, priorities and programs.</p> <p>The support provided by Aboriginal and Torres Strait Islander peak health organisations assists in the recruitment and retention of Aboriginal and Torres Strait Islander health professionals, which has the potential to improve primary health care outcomes for those Aboriginal and Torres Strait Islanders who feel more comfortable seeing Indigenous health professionals when accessing some mainstream health services.</p>	Commonwealth Department of Health	Financial and activity reports submitted regularly to the Department in line with funding agreements between the Commonwealth and individual organisations.
General Practice Rural Incentive Programme	<p>The General Practice Rural Incentives Programme (GPRIP) provides financial incentives to encourage doctors to move to and/or remain in regional, rural and remote Australia. Payments are scaled to provide the greatest incentive to those living and working in the most isolated regions. Doctors and registrars receive a retention payment based on their length of service in a rural community, clinical workload and location of the practice.</p> <p>For more information go to www.ruralhealthaustralia.gov.au</p>	<p>Commonwealth Department of Health</p> <p>The programme is administered by the Department of Human Services- Medicare Australia</p>	Quarterly activity and financial reporting as well as annual activity and expenditure reports.

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Nursing and Allied Health Rural Locum Scheme	The Nursing and Allied Health Rural Locum Scheme (NAHRLS) is a retention incentive strategy established in 2011. The NAHRLS addresses workload issues for nursing and allied health professionals working in rural and remote locations, by enabling leave for holiday and/or professional development. For more information go to www.nahrsls.com.au	Commonwealth Department of Health The programme is administered by Aspen Medical.	Quarterly activity and six monthly progress reports against deliverables. As well as annual activity and audited financial report. An annual work plan is submitted.
Dental Relocation and Infrastructure Support Scheme	The Dental Relocation and Infrastructure Support Scheme (DRISS) supports the distribution of dental services into regional and remote communities by providing relocation incentives and infrastructure support grants to dentists. The programme supports dentists to relocate to a more regional or remote location. For more information go to www.rhwa.org.au	Commonwealth Department of Health The programme is administered by Rural Health Workforce Australia.	An annual work plan plus a six month performance and financial report. Annual activity and financial reports.
International Recruitment Strategy	The International Recruitment Strategy (IRS) comprises four activities to support doctors in rural areas: 1. International Recruitment – a case managed recruitment service for overseas trained doctors (OTDs). 2. Additional Assistance Scheme – financial support for Australian and overseas trained doctors to assist their achievement of Fellowship qualifications. 3. The Rural Locum Relief Program – provides access to A2 Medicare rebates for doctors restricted by s19AA of the <i>Health Insurance Act 1973</i> (the Act). 4. The Five Year OTD Scheme – a retention service that offers the ability for OTDs to reduce the period of their restriction under s19AB of the Act.	Commonwealth Department of Health The programme is administered by Rural Health Workforce Australia.	A six month progress report on each component as well as annual activity and audited financial statement. In addition, the Five Year OTD scheme reports fortnightly.

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Rural Obstetric and Anaesthetic Locum Schemes	The Rural and Obstetric and Anaesthetic Scheme (ROALS) supports the rural specialist and general practitioner obstetric and anaesthetic workforce. The programme aims to improve rural workforce retention through the provision of subsidised locum services. The ROALS objective is to help maintain and improve access to quality obstetric and anaesthetic care for rural communities by supporting affordable locum relief to the rural obstetric and anaesthetic workforce. Specialist obstetricians and anaesthetists and GP obstetricians and anaesthetists located in Australian Standard Geographical Classification Remoteness Areas 2-5 locations are eligible to apply. For more information go to www.roals.org.au	Commonwealth Department of Health The program is administered by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.	Quarterly data and progress reports as well as annual activity and audited financial report. Steering Committee has policy oversight on the administration of the scheme.
Rural Locum Education Assistance Programme and Rural Procedural Grants Programme	The Rural Locum Education Assistance Programme (Rural LEAP) provides financial assistance to urban GPs who undertake emergency medicine training and commit to a 4 week (or 20 working days) paid general practice locum placement in rural location within a two (2) year period. Participants are required to undertake practice based GP locum positions located in ASGC-RA 2-5. These locum placements may be organised by the participant or through a locum agency. Rural Procedural Grants Programme (RPGP) aims to ensure the GP proceduralists in rural and remote areas sufficient financial support to access relevant training, up skilling and skills maintenance activities More information is available at www.acrrm.org.au or www.racgp.org.au	Commonwealth Department of Health The programme is administered jointly by the ACRRM and the RACGP who are responsible for assessing the eligibility of GPs and the training on offer. The Department of Human Services maintains a register of eligible GPs and tracking participation.	Rural Leap - twice yearly progress reports and an annual activity and financial report. A collaboration committee has policy oversight on the administration of the scheme. RPGP – twice yearly progress reports and an annual activity and financial report.

Source: Australian Government unpublished.

Table 10A.108 **New South Wales, community health services programs***Programs funded by the NSW Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child Adolescent and Family Services	Covers services such as youth health, paediatric allied health (physiotherapy, occupation therapy, social work and counselling, speech pathology, psychology, audiology), specialist medical services, early childhood nursing, immunisation, post natal programs, early intervention and school surveillance services. Personal Health Record (PHR) - The NSW PHR (also known as 'the Blue Book') is distributed to all families with a newborn in NSW and provides a schedule of nine recommended child health checks from birth to four years of age. The PHR uses a joint parental-professional approach to detect or anticipate problems. Early Childhood Health Services provide a range of services to support good health outcomes of children, including parenting support and education, breastfeeding support, universal health home visiting, screening for postnatal depression and referral if necessary, and health and development advice for families with young children.	Local Health Districts (LHDs) receive block funding from the Department of Health to provide health services to their population. Each LHD determines how much money is allocated to this program.	These services are measured as Non Admitted Patient Occasions of Service. The number of occasions on which one or more health care professional provides services to a Non-admitted Patient is reported by LHDs to the Ministry of Health on a quarterly basis.

Table 10A.108 **New South Wales, community health services programs***Programs funded by the NSW Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Children's health and wellbeing	Children's Health and Wellbeing services include universal services provided to the whole population and targeted services. Universal services including Postnatal child and family health services such as early childhood health services and Universal Home Health Visiting.		Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require quarterly reports on tests offered and conducted.
	Universal Health Home Visiting (UHHV) – is the offer of a home visit by a Child and Family Health Nurse to all families in NSW after the birth of their baby. At the UHHV the nurse assesses the baby's health and development, and identifies the level of support the family needs. The nurse can then link parents identified as requiring additional support to appropriate support and/or secondary services.	LHD funds	Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.
	Sustaining NSW Families is a program of nurse led structured evidenced based sustained health home visiting provided to vulnerable children at risk of poor developmental outcomes and their families in selected low socio-economic areas. The program actively supports parents' aspirational goals for themselves and their child and builds parenting capacity and secure parent/ child relationships. It is prevention and early intervention strategy which commences in the antenatal period and continues until child is 2 years of age with the aim of optimising child health and development outcomes. Services include bi-lingual nurses (English/Arabic and English/Mandarin) and services in a rural area with a focus on engaging vulnerable Aboriginal families.	Most funding is Keep Them Safe dedicated funding	Quarterly data reporting to Ministry of Health. Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.project Annual Reporting and six monthly financial acquittal.

Table 10A.108 **New South Wales, community health services programs***Programs funded by the NSW Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Children's health and wellbeing contd.	Health care needs of children in Out Of Home Care - coordination and provision of health development and wellbeing assessments, reviews and interventions of children and young people in OOHC. This state-wide project is being implemented in phases commencing with children/young people entering Statutory Out of Home care who are expected to remain in care for more than 90 days.	Keep Them Safe funding	
	Building Strong Foundations for Aboriginal Children Families and Communities is a culturally safe early childhood health service for Aboriginal children birth to school entry age and their families. It aims to support parents and communities to provide an environment that will optimise the health, development and wellbeing of their child so that children are ready able to engage fully in life and learning. It has close links to Aboriginal maternity services including NSW Aboriginal Mothers and Infants Health Services and New Directions as well as mains team services. Teams comprising Aboriginal Health Workers and Child and Family Health nurses provide the main frontline service. Seven new sites were funded late 2011/12 bringing total to 15 across NSW.	State program funding to selected sites.	Annual Reporting and six monthly financial acquittal.
Health Child Wellbeing Units	Health Child Wellbeing Units provide support and assistance to health mandatory reporters to assist them to identify and provide appropriate responses for children and young people at risk of significant harm and to determine what other supports should be put in place for vulnerable children and young people below this statutory reporting threshold.	Keep Them Safe 'protected item' funding.	Milestone reporting to Department of Premier and Cabinet. Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget

Table 10A.108 **New South Wales, community health services programs***Programs funded by the NSW Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Maternal and child health	<p>Maternity services are part of the core services provided by LHDs to their population. Community antenatal and postnatal care is provided including through shared care arrangements with GPs.</p> <p>Targeted programs for vulnerable populations include:</p> <ul style="list-style-type: none"> - Aboriginal Maternal and Infant Health Service (AMIHS) provides culturally appropriate antenatal and postnatal care up to 8 weeks, to Aboriginal mothers and babies. Mental health and drug and alcohol secondary services are being delivered in selected AMIHS sites across the state as part of the Indigenous Early Childhood Development National Partnership Agreement (IECD NP). Quit for new life, a smoking cessation intervention specifically for Aboriginal pregnant women is also being rolled out across AMIHS programs. 	LHD block funding and some IECD NP funds (Commonwealth)	<p>Varies by program. Some services measured as Non Admitted Patient Occasions of Service.</p> <p>Regular reports on activity, outcomes against indicators</p>

Table 10A.108 **New South Wales, community health services programs***Programs funded by the NSW Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Screening	<p>Domestic Violence Routine Screening - Women are routinely screened for recent or current domestic violence in antenatal and early childhood health services, and women aged 16 and over are screened in mental health and alcohol and other drugs services. Screening is an early identification and education strategy</p> <p>Covers screening and assessment programs particularly directed towards children to identify problems early so treatment options are optimized. Program includes the Statewide Eyesight Preschooler Screening (StEPS) program, Statewide Infant Screening Hearing (SWISH) program, universal health home visiting for mothers and babies.</p> <p>Statewide Eyesight Preschooler Screening (StEPS) - is a free vision screening program for all four year old children in NSW. The program is designed to identify childhood vision problems early which cannot be detected by observation, behaviour, family history or vision surveillance. By identifying and treating vision problems during the critical visual development period, treatment outcomes can be maximised.</p>	<p>LHDs receive global funding from the Ministry of Health via annual Service Agreements to provide health services to their population. Domestic Violence Routine Screening funding is implemented within service agreement allocations.</p> <p>A mix of LHD and Australian Government funding.</p>	<p>A one-month data collection snapshot from all LHDs is conducted in November of each year. This provides information on outcomes such as screening and identification rates, and referrals. Domestic Violence Routine Screening is also included within the Service Schedule of the Ministry of Health and LHD annual Service Agreements.</p> <p>Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require quarterly reports on tests offered and conducted.</p>

Table 10A.108 **New South Wales, community health services programs***Programs funded by the NSW Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Services for Children under 10 years with Problematic or Harmful Sexual Behaviour	Under Keep Them Safe (KTS) NSW Health committed to expanding services for children aged under 10 years who display problematic or harmful sexualised behaviour, including Aboriginal children. To increase service delivery, the Ministry of Health allocated KTS funding to enhance the Sparks program in the Hunter New England LHD, which is the only NSW Health specialist service responding to this client group. The Ministry is also developing a statewide policy directive and guidelines on best practice service delivery, including training requirements for staff, were necessary to resolve current issues and assist LHDs in their local responses to the target group.	LHD funding and Keep Them Safe 'protected item' funding	Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.
Sexual Assault Services	NSW Health's 55 Sexual Assault Services provide holistic specialist assistance to adult and child victims of sexual assault including supporting their psycho-social, emotional and cultural wellbeing. Free counselling, court support, medical and forensic examinations and medical treatment are available to anyone who has recently been sexually assaulted in NSW.	LHDs receive global funding from the Ministry of Health via annual Service Agreements to provide health services to their population. Sexual Assault Service funding is implemented within service agreement allocations.	Sexual Assault Services are included within the Service Schedule of the Ministry of Health and LHD annual Service Agreements.
Youth health and wellbeing	Provides education and health promotion programs, clinical services and planning of youth friendly services. Also provides specific health services for homeless and at risk young people.	A mix of LHD and Australian Government funding is allocated for Innovative Health Services for Homeless Youth (IHSHY).	These services are measured as Non Admitted Patient Occasions of Service. The number of occasions on which one or more health care professional provides a services to a Non-admitted Patient and reported by the LHDs to the Ministry of Health on a quarterly basis.

Source: NSW Government unpublished.

Table 10A.109 **Victoria, community health services programs***Programs funded by the Victorian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Primary Care Partnerships (PCPs) Strategy	<p>Primary Care Partnerships (PCPs) are cross government funded voluntary alliances of health, human services providers and other organisations. There are 28 PCPs in Victoria which engage over 600 organisations. PCPs deliver local service system reforms to:</p> <ul style="list-style-type: none"> • improve the coordination of services • improve the way health promotion is planned, implemented and evaluated; and • improve the management of chronic disease. <p>The strategy to improve the coordination of services is supported by a state-wide policy and operational framework and includes:</p> <ul style="list-style-type: none"> • state-wide practice standards and a continuous improvement manual • tools for screening, referral and coordinated care planning • data standards for sharing client health and care information embedded in agency client management software applications • e-referral systems to securely share client information with client consent. <p>PCPs identify local health and well being priorities and ways to address these priorities. 'Place based' partnership approaches are used to assess and engage with communities that experience significant disadvantage. Interventions may be targeted to particular population groups, for example, farmers, people with a refugee background and ethnic communities.</p>	Core funding provided by the Victorian Department of Health.	Suite of reports as part of the 2013-17 PCP Program Logic. This includes a four year strategic plan and impact oriented reports against each area of the PCP program logic.
Refugee Health Nurse Program	<p>The Refugee Health Nurse Program (RHNP) seeks to optimise the long-term health of refugees and asylum seekers by promoting accessible and culturally appropriate health care services that are innovative and responsive to their unique needs. The program supports a coordinated model of care, and acknowledges the importance of early identification and intervention in health issues in the early stages of settlement.</p>	The Victorian Government funds the RHNP through the Department of Health. Community health services are funded to deliver the RHNP.	Community health services funded under the RHNP report hours of service on a quarterly basis.

Table 10A.109 **Victoria, community health services programs***Programs funded by the Victorian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Refugee Health Nurse Program contd.	<p>The RHNP has three aims — to:</p> <ul style="list-style-type: none"> • increase refugee access to primary health services • improve the response of health services to refugees' needs • enable refugee individuals, families and communities to improve their health and wellbeing. <p>The RHNP builds the capacity of individuals, families and refugee communities to improve their health through: disease management and prevention; the development of referral networks and collaborative relationships with general practitioners and other health providers; connection with social support and orientation programs.</p>	<p>The Victorian Government funds the RHNP through the Department of Health. Community health services are funded to deliver the RHNP.</p>	<p>Community health services funded under the RHNP report hours of service on a quarterly basis.</p>
Dental Health Program	<p>Public dental services are provided to eligible Victorians through the Royal Dental Hospital of Melbourne, community health centres and rural hospitals.</p> <p>The following groups are eligible for state-funded public dental services:</p> <ul style="list-style-type: none"> • All children aged 0-12 years. • Young people aged 13-17 years who are, or are dependents of, health care or pensioner concession card holders. • Children and young families up to 18 years of age in out-of-home care provided by the Department of Human Services. • Youth justice clients in custodial care, up to 18 years of age. • Adults who are, or are dependents of, health care or pensioner concession card holders. • Refugees and Asylum Seekers. <p>Eligible clients presenting for care are assessed and those requiring routine care are placed on one of three waiting lists (general care, denture care and priority denture care). Priority clients are offered the next available appointment and are NOT reflected in waiting list numbers.</p>	<ul style="list-style-type: none"> • State funded public dental services are output funded and supported by an activity based funding model. • From 1 July 2013, with the implementation of the National Partnership Agreement on Treating More Public Dental Patients, the funding unit is a Dental Weighted Activity Unit (DWAU), calculated using the Australian Dental Association (ADA) three digit item codes and a weighting. 	<ul style="list-style-type: none"> • Performance targets are set by the department and monitored through various reporting mechanisms to demonstrate program delivery. Examples of targets are people treated, waiting times and quality measures. • Funded agencies delivering dental services are set DWAU targets based on their total service delivery funding. For performance monitoring, all activity (treatment items) are converted to DWAUs.

Table 10A.109 **Victoria, community health services programs***Programs funded by the Victorian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Dental Health Program contd.	<p>Priority groups are:</p> <ul style="list-style-type: none"> • Aboriginal and Torres Strait Islanders • Children and young people • Homeless people and people at risk of homelessness • Pregnant women • Refugees and asylum seekers • Registered clients of mental health and disability services. <p>People requiring urgent care are assessed, triaged and managed using the Emergency Care Demand Management System, and are offered an appointment.</p> <p>Fees for public dental services apply to people 18 years or over who are, or are dependents of, health care or pensioner concession card holders and to children 0–12 years who are not dependents of nor themselves health care or pensioner concession card holders. Inability to pay cannot be used as a basis for refusing a dental service to an eligible person. Exemption from fees for public dental services applies to :</p> <ul style="list-style-type: none"> • Aboriginal and Torres Strait Islander people • Homeless people and people at risk of homelessness • Refugees and Asylum Seekers • Children/young people 0-17 years who are, or are dependents of, health care or pensioner concession card holders • Children and young people up to 18 years of age who are in Department of Human Services provided out-of-home care • Youth justice clients up to 18 years of age in custodial care • Registered clients of mental health and disability services, supported by a letter of recommendation from their case manager or staff of special developmental schools • Those receiving care from undergraduate students • Those experiencing financial hardship. 		

Table 10A.109 **Victoria, community health services programs***Programs funded by the Victorian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
NURSE-ON-CALL	NURSE-ON-CALL is a statewide telephone-based health line that provides residents with timely access to health information, assistance and advice for the cost of a local phone call. The service operates 24 hours, 7 days a week and takes about 1000 calls per day. Registered nurses triage callers' symptoms and health issues so as to advise on health care needs. NURSE-ON-CALL also provides callers with health information and information about local health providers. In the after-hours period, approximately 160 eligible callers to NURSE-ON-CALL per day are transferred to the Commonwealth government's After Hours GP helpline.	NURSE-ON-CALL is delivered by Medibank Health Solutions under contract to the Department of Health.	Medibank Health Solutions provides the department with a number of monthly reports.
IHSY Program	The Innovative Health Services for Homeless Youth (IHSY) program is a Commonwealth/State funded initiative that promotes health care for young people who are homeless or at risk of homelessness. Funding is provided to community health services to deliver innovative and flexible health services for the target population. The services respond to the complex health needs and improve their access to mainstream health services. IHSY provides a means of engaging young people who may not otherwise access health services.	<ul style="list-style-type: none"> • Joint state/Commonwealth funded. IHSY is provided under the National Healthcare Agreement. • Community health services are funded to deliver the IHSY program. 	Community health services funded under the IHSY program report hours of service on a quarterly basis.
Maternal & Child Health	The Healthy Mothers, Healthy Babies program aims to reduce the burden of chronic disease and reduce health inequity by addressing maternal risk behaviours and providing support during pregnancy. The program is delivered by community health services in areas that have high numbers of births and higher rates of relative socioeconomic disadvantage.	<ul style="list-style-type: none"> • The Victorian Government funds the program through the Department of Health. • The 2014-15 budget provided \$2.5 million recurrent funding for this program. 	<ul style="list-style-type: none"> • Quantitative performance targets are set by the Department of Health and monitored quarterly. • The program was monitored through a formal evaluation completed in November 2014

Table 10A.109 **Victoria, community health services programs***Programs funded by the Victorian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Maternal & Child Health contd.	<p>The objectives of the program are to:</p> <ul style="list-style-type: none"> • improve women's access and attendance at antenatal and post natal services • improve women's access to a range of support services which may include health, welfare, housing and education services • deliver health promotion messages that aim to reduce risk behaviours, and promote healthy behaviours. <p>Women eligible for the program are those women who are not able to access antenatal care services or require additional support because of their:</p> <ul style="list-style-type: none"> • socioeconomic status • culturally and linguistically diverse backgrounds • Aboriginal and Torres Strait Islander descent • age, or • residential distance to services. 		
Children's Health & Wellbeing	<p>Services for children and families within community health are based on evidence which identifies the significance of the early years. Through supporting early identification and treatment of health and developmental problems, community health services respond to the needs of young children and their families.</p> <p>Child health teams provide multidisciplinary care through a mix of group and individual interventions. Services promote positive health, growth and functioning within the community. Their focus is the provision of early interventions as well as to improve the capacity of parents and families to understand and manage the health and development needs of their child. Community health practitioners also support families to access additional services they may require in the community.</p>	The Victorian Government funds the program through the Department of Health.	Community health services providing child health services report hours of service as part of their overall community health program reporting on a quarterly basis

Table 10A.109 **Victoria, community health services programs***Programs funded by the Victorian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Community Health Program	<p>The Community Health Program provides funding to approximately 100 Community Health Services (CHSs) operating from approximately 350 sites across Victoria. This strong connection to communities enables community health services to develop models of care that are responsive to their consumers and reflect the diverse underlying determinants of health. In this way, community health services combine the social model of health with clinical care to maximise outcomes for their consumers.</p> <p>CHSs play an important role in preventive, rehabilitative, maintenance and support services for people at risk of, or with complex conditions and chronic illnesses. In addition, community health prioritises services to population groups that are known to have poor health status, are subject to disadvantage or are at risk. These include people who are homeless or at risk of homelessness, refugees, Aboriginal people, people with an intellectual disability or a serious mental illness. Funding is provided for the provision of direct care, and for health promotion.</p> <p>CHSs are also major providers of Home and Community Care Services, Dental, General Practice, Drugs Program, Disability and other State and Commonwealth programs.</p>	The Victorian Government funds the program through the Department of Health.	<ul style="list-style-type: none"> • Community health services report hours of service on a quarterly basis • CHSs report annually to their consumers, carers, community and other stakeholders through the Quality of Care report. • Agencies funded for health promotion are required to develop four year health promotion plans and report on those plans on an annual basis.

Table 10A.109 **Victoria, community health services programs***Programs funded by the Victorian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Family Planning	Family planning services assist Victorians to make individual choices on sexual and reproductive health matters by providing services that are accessible, culturally relevant and responsive to people who experience difficulty accessing mainstream services. Family planning health promotion focuses on promoting the sexual and reproductive health of Victorians, with a focus on groups at higher risk of ill-health. Funding for family planning services is provided to community health services, and to a statewide service, Family Planning Victoria (FPV).	The Victorian Government funds the Family Planning program through the Department of Health.	<ul style="list-style-type: none"> • Community health services report hours of service on a quarterly basis • In line with broader Integrated Health Promotion Program requirements, agencies funded for family planning health promotion are required to submit a health promotion plan every four years and report on this plan annually.
Early Intervention in Chronic Disease (EliCD)	EliCD focuses upon community based early intervention services for people with chronic diseases. The aim of the initiative is to enhance existing capacity of community health services in supporting people with chronic disease in managing the impact of their condition including the physical, emotional and psychological impact of having a chronic disease. Services aim to reduce the impacts of chronic disease, slow disease progression and reduce potential/future hospitalisation. Models of care are multidisciplinary and provide self management support, care coordination, education, allied health and nursing.	These services are funded under the Primary Health Funding Approach	Quantitative performance targets are set by the department for direct service provision, and monitored quarterly.

Source: Victorian Government unpublished.

Table 10A.110 **Queensland, community health services programs***Programs funded by the Queensland Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Blood Borne Viruses and Sexually Transmissible Infections (BBVs and STIs)	<p>The program implements five national strategies:</p> <ol style="list-style-type: none"> 1. The Seventh National HIV Strategy 2014-2017; 2. The Second National Hepatitis B Strategy 2014-2017; 3. The Fourth National Hepatitis C Strategy 2014-2017; 4. The Third National Sexually Transmissible Infections Strategy 2014-2017; 5. The Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2014-2017. <p>Services and public health programs are delivered through public, non-government and private organisations including 16 Hospital and Health Services (HHSs) Sexual Health Clinics (are the SH clinics part of the HHSs?) providing preventative and clinical BBV and STI services.</p> <p>What are the outputs (missed brief ref above)? ie presume public health mostly educn? services – detection / treatment / notification?</p> <p>Clinical and funded non-government programs target groups most at risk of BBVs and STIs (e.g. men who have sex with men, injecting drug users, culturally and linguistically diverse people, Aboriginal and Torres Strait Islander people and young people).</p> <p>The Queensland HIV Strategy 2013-2015 outlines the strategic direction for HIV prevention and management in Queensland. The draft Queensland Viral Hepatitis Strategy 2014-2017 and Queensland STI Strategy 2014-2017 will outline the strategic direction and priority actions for viral hepatitis and STI prevention, treatment and management.</p> <p>The HIV Foundation Queensland is tasked with leading the Queensland HIV prevention and testing response in conjunction with other Non-Government Organisations (NGOs) and the Department of Health.</p>	<p>Funded through the National Healthcare Agreement (NHA) and a combination of other Commonwealth and State Output Revenue.</p> <p>In 2013–14 HHS reported expenditure of \$48,446,512 for sexual health which encompasses programs for BBV and STIs.</p> <p>Delivered through public, non-government and private organisations including 16 Hospital and Health Services (HHSs) Sexual Health Clinics providing preventative and clinical BBV and STI services.</p>	<p>Six monthly performance reports on activities by funded NGO programs. Quarterly report provided to the BBV and STI Standing Committee (BBVSS).</p> <p>Commonwealth Indigenous funding reports.</p> <p>Notification data for BBVs and STIs provided for the NHA report.</p> <p>Annual reports on Queensland notification data produced by Department of Health.</p>

Table 10A.110 **Queensland, community health services programs***Programs funded by the Queensland Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Preventive Health Unit (PHU)	<p>PHU provides the Queensland Department of Health with expertise, leadership and innovative ideas to improve policy, systems, research, programs and services to encourage healthy behaviours and create environments supportive of health.</p> <p>PHU collaboratively works across the Department, with other agencies, non-government organisations and the private sector on a range of campaigns, and initiatives to deliver services aimed at empowering individuals, communities and institutions to create and live healthier lives. The strategies target the chronic disease risk factors of alcohol, tobacco, overweight and obesity, nutrition, physical inactivity and high blood pressure across population groups and in key settings, such as workplaces and schools.</p>	Queensland Department of Health Budget and National Partnership Agreement (NPA) on Preventive Health under the Healthy Workers and Healthy Children's Initiatives.	Reporting is through contractual performance reports; data collection; independent evaluations, NPA and internal reporting processes.
Retrieval Services and Counter Disaster (RSCD)	<p>The emergency retrieval and aero-medical transport of critically ill or injured patients across Queensland and the north coast of New South Wales (NSW) is coordinated by RSCD to improve access to, and the quality of available transport resources to support patients ranging from acute, urgent, high dependency care to non-urgent, low dependency care.</p> <p>These transport services are provided under state-wide service agreements in partnership with non-government organisations including: Royal Flying Doctor Service (RFDS), community helicopter providers and CareFlight Medical Services; and with Emergency Management Queensland and the Queensland Ambulance Service, Department of Community Safety and Australian Helicopters Pty Ltd.</p> <p>For patients who can travel by themselves and are required to travel away from their home to access specialist medical services, financial assistance is provided to eligible patients through the Patient Travel Subsidy Scheme (PTSS).</p>	<p>Funding source - State Output Revenue (except for the RFDS aero-medical services provided from the Cairns, Mt Isa and Charleville bases which are partially funded by the Commonwealth. RFDS also provides primary health care services funded by the Commonwealth).</p> <p>Budget oversight - RSCD Governance oversight - RSCD Delivered - RSCD</p>	<p>No patient transport reports are provided externally.</p> <p>Internally, activity reports are provided to the HHSs to assist in the monitoring of usage of road ambulance, fixed-and rotary wing aero-medical transport at HHS and facility level.</p> <p>PTSS activity and expenditure reports are provided monthly to HHSs and will be provided to Cabinet Budget Review Committee (CBRC) in the mid-year financial review 2014-15.</p>

Table 10A.110 **Queensland, community health services programs***Programs funded by the Queensland Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Enhanced Maternal and Child Health Service	The Queensland Department of Health is implementing the Enhanced Maternal and Child Health Service to ensure all families have access to two home visits in the first month post birth and community clinics at key stages during the first year of a child's life.	State government Delivered by state government, may be delivered in partnership with other providers. Maternal health expenditure was \$7,776,865 in 2013-14.	Quarterly reporting.
Child health services	A range of child health services are provided to children and young people aged 0-18 years and their families in the community. These services may include interventions such as child development checks, lactation support, parent information sessions; as well secondary and/or tertiary health services such as parenting and behaviour support, nutrition support, or referrals to other service providers. Services are available to all children and young people aged 0-18 years and their families as well as targeted services to particular or 'at risk' populations such as young parents, Aboriginal and Torres Strait Islander families, and refugee families.	State and Commonwealth government funding. Delivered by state government, may be delivered in partnership with other providers. HHSs reported \$116,768,840 expenditure for Child and Youth services in 2013-14.	Local HHS reporting arrangements are in place.
Alcohol, Tobacco and Other Drug Services	Alcohol and Other Drugs treatment services in Queensland are delivered through approximately 85 public and NGOs across the State. Residential and outclient treatment services are provided to people (from 12 years of age) who experience problematic alcohol and other drugs use. Services may include screening; clinical assessment and review; early and brief intervention; crisis intervention; withdrawal management and support; one-to-one counselling; group work; day programs; case management; relapse prevention; and aftercare. Clients may be referred from a Queensland HHSs, court or justice agency, health and community services, or self-referral. Alcohol and other drugs services are underpinned by the principles and priorities outlined in the National Drug Strategy 2010-2015.	Funded through State Output Revenue and Commonwealth funds. In 2013-14 HHSs reported expenditure of \$65,347,009 for Alcohol, Tobacco and Other Drugs.	National reporting through National Minimum Data Set (NMDS) processes - national publication is prepared from the NMDS.

Table 10A.110 **Queensland, community health services programs***Programs funded by the Queensland Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Oral health services	Oral health services are provided to eligible children and adults via community and school-based mobile and fixed public dental clinics. Services include general and specialist dental care, and health promotion and disease prevention activities.	Services are primarily funded by the Queensland Department of Health, with some Commonwealth funding. Services are delivered by HSSs.	Performance targets and overall financial reporting are published in Queensland Health's annual report and Service Delivery Statement.
Get Healthy Services	<p>Under an agreement with NSW Ministry of Health, Queensland has made the Get Healthy Information and Coaching Service (GHS) available to Queensland adults through 13Health (13 432584) or via www.gethealthy.qld.gov.au.</p> <p>The Service has been promoted through a range of channels to the broader community, community organisations, health service providers, workplaces and state and local government.</p>	<p>Funding for the Get Health Information and Coaching Service is provided through the NPA on Preventive Health, Healthy Workers initiative. This agreement was due to expire in June 2018 but the 2014–15 Commonwealth Budget proposed ceasing the NPA early, from 1 July 2014. The Queensland Minister for Health has committed to provide funding in 2014-15 to continue the initiatives funded under this NPA.</p>	Reports are received as per contractual requirements between Queensland Department of Health and NSW Ministry of Health.

Table 10A.110 **Queensland, community health services programs***Programs funded by the Queensland Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Queensland Aboriginal and Torres Strait Islander health investment strategy	<p>A range of primary and community health services are delivered across Queensland to improve the health outcomes of Aboriginal and Torres Strait Islander people and achieve the life expectancy and child mortality targets agreed through the Council of Australian Governments (COAG), including initiatives to strengthen the continuity of care between the acute and primary care settings.</p> <p>In 2013–14, 140 Aboriginal and Torres Strait Islander health initiatives and services were delivered by 16 HHSs and 19 Aboriginal and Torres Strait Islander community controlled health services and NGOs across Queensland. The range of initiatives and services included:</p> <ul style="list-style-type: none"> • Hospital liaison support, case coordination and assistance for Aboriginal and Torres Strait Islander people entering and exiting acute care • Community-based and outreach antenatal, postnatal and infant care services • Targeted sexual and reproductive health prevention, early intervention, detection and education for young people and adults • Multidisciplinary primary healthcare services for the early detection, treatment and management of chronic diseases • Respiratory, diabetes and renal outreach services for Aboriginal and Torres Strait Islander people living in rural and remote areas • Alcohol, tobacco and substance misuse harm prevention, early intervention and treatment targeting Aboriginal and Torres Strait Islander young people, and • Mental health services. 	Queensland Government and Australian Government funding responsibility (primary funding source Queensland Government—some funds provided by the Australian Government under the former Indigenous Early Childhood Development National Partnership Agreement—NPA).	Six monthly performance and financial reporting from the HHSs. Six monthly performance and quarterly financial reporting from the non-government sector.

Source: Queensland Government unpublished.

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Closing the Gap in Indigenous Health Outcomes	<p>Closing the Gap programs previously funded under an NPA are now State funded and centred around the same five priority areas through the delivery of services to Indigenous communities throughout WA:</p> <p>Area 1 – Tackling Smoking Area 2 – Healthy Transition to Adulthood Area 3 – Making Indigenous Health Everyone’s business Area 4 – Primary Health Care Services that can deliver Area 5 – Fixing the gaps and improving the patient journey</p> <p>Area 1 Outcomes – Reduction in smoking prevalence and in the burden of tobacco related disease for Indigenous communities. Area 1 Outputs - Under this area, 10 State funded Tackling Smoking programs were successfully implemented throughout the state and all are delivering a range of strategies and activities for smoking cessation and/or prevention. Interventions include education, social marketing, brief intervention and smoking cessation quit groups. Area 2 Outcomes – Increased sense of social and emotional well being; Reductions in uptake of alcohol, tobacco and illicit drugs, rates of sexually transmissible infections, hospitalisations for violence and injury and reduce morbidity and mortality amongst Aboriginal men. Area 2 Outputs - Under this area, 23 programs continue to increase the access and uptake of services supporting social and emotional wellbeing among young Aboriginal people. Initiatives include self-esteem, sexual health and drugs and alcohol education, social marketing, training, counselling and peer mentorship and leadership strategies. Area 3 Outcomes - Increase health outcomes for Indigenous people in prison settings and Aboriginal men’s health.</p>	<ul style="list-style-type: none"> • Area 1 – State funded • Area 2 – State funded • Area 3 – State funded • Area 4 - State funded • Area 5 – State funded • Budget oversight WACHS Aboriginal Health Improvement Unit • Governance oversight WACHS Aboriginal Health Improvement Unit • Programs delivered by a mixture of government (WACHS and Metropolitan Area Health services) and non-government organisations (Aboriginal Community Controlled Health Organisations) 	<ul style="list-style-type: none"> • WACHS requires biannual reporting from all Closing the Gap programs. Service providers report on contract outputs and outcomes using a defined template. • Templates are reviewed to monitor performance. Quantitative and qualitative data is also collated to provide an overview of levels of service provision. • WACHS AHMU reports annually through AHMAC for CtG funded programs.

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Closing the Gap in Indigenous Health Outcomes contd.	<p>Area 3 Outputs - Under this area, 14 programs continue to increase health outcomes for Aboriginal men and Aboriginal people in the prison settings and post-release. Ten of these are Aboriginal Health Community Re-Entry programs.</p> <p>Area 4 Outcomes - Improve access to quality primary health care; Increase the uptake of MBS-funded services; Implement best practice standards and accreditation and increase cultural competence of primary care services.</p> <p>Area 4 Outputs - Under this area, a suite of 25 state funded primary health care services continue to be delivered through culturally secure community health care settings with a focus on the prevention, early detection, treatment and self management of chronic disease.</p> <p>Area 5 Outcomes - Reduce average length of stay; Improve level of engagement to deliver better follow up and referrals; Improve patient satisfaction and health journey and reduce admissions and incomplete treatments.</p> <p>Area 5 Outputs - Under this area, 22 state funded programs continue to support access to patient transport services and improvements in continuum of care particularly for Aboriginal people living in rural and remote WA.</p>		

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
NPA Indigenous Early Childhood Development (IECD)	<p>The IECD NPA is centred around elements two and three.</p> <p>Element 2 Outcomes - Increase access to antenatal care, pre-pregnancy and teenage sexual and reproductive health for Indigenous women.</p> <p>Element 2 Outputs - Under this element, 14 programs continue to provide antenatal care services targeted at young Aboriginal women. These services include health promotion/prevention, early intervention (screening) and treatment services. Services provide education and support to reduce the harm associated with alcohol use during pregnancy and education, support and treatment for sexual and reproductive health.</p> <p>Element 3 Outcomes - Increase access to, and use of, maternal and child health services by Indigenous families.</p> <p>Element 3 Outputs - Under this element a further 13 programs continue to provide postnatal services and outreach programs with a focus on adolescent mothers and provide clinical policies, guidelines and standards of practice, and work force support and development to maternal and child health services delivering care to Aboriginal women. These services also include the provision of child health checks and immunisation services.</p>	<ul style="list-style-type: none"> • Element 2 - Commonwealth funded • Element 3 – State funded • Budget oversight WACHS Aboriginal Health Improvement Unit • Governance oversight WACHS Aboriginal Health Improvement Unit. • Programs delivered by a mixture of government (WACHS and Metropolitan Area Health services) and non-government organisations (Aboriginal Community Controlled Health Organisations) 	<ul style="list-style-type: none"> • WACHS requires biannual reporting from all COAG IECD programs. Service providers report on contract outputs using a defined template. • Templates are reviewed to monitor performance. Quantitative and qualitative data is also collated to provide an overview of levels of service provision. • WACHS AHU reports biannually to DoHA for IECD programs.

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Primary health/chronic disease programs for Aboriginal communities	<p>WACHS Aboriginal Health Improvement Unit has carriage of several other (approximately 18 programs) contracted programs that provide primary health/chronic disease programs across the State in a community health care setting with a focus on the prevention, early detection, treatment and self management of chronic disease.</p> <p>Outcomes – the majority of these services aim to increase access to culturally appropriate primary health care services for Aboriginal people in WA.</p> <p>Outputs – Service outputs include the provision of 24hr accident and emergency, outpatient's clinics, management of chronic conditions, immunisation, health promotion, screening and associated treatment, maternal and child health and integration of service delivery.</p>	<ul style="list-style-type: none"> • Department of Health WACHS funding • Budget oversight WACHS contracting • Governance oversight WACHS Aboriginal Health Improvement Unit. • Programs delivered through Aboriginal Community Controlled Health Organisations (non-government). 	<ul style="list-style-type: none"> • WACHS requires biannual reporting from all Primary Health Care programs. Service providers report on contract outputs using a defined template. • Templates are reviewed to monitor performance. Quantitative and qualitative data is also collated to provide an overview of levels of service provision.

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child and Adolescent Community Health – Community health services	<p>Community health services encompasses both child health services and school health services statewide across Western Australia, focussing on child health, growth and development in the early years and promoting wellbeing during childhood and adolescence. Universal and targeted services complement each other and families move between streams as their needs and circumstances dictate.</p> <p>Community health services serve as a gateway to a range of other early childhood services, such as child development services, parent and carer support, primary health care and social protection.</p> <p>Child health services aim to promote improved health outcomes for babies, young children and their families, through the provision of a range of universal and targeted prevention, early identification and intervention. Services are delivered in various settings including child health centres, in homes, parenting groups and other community venues.</p> <p>The WA universal Birth to School Entry community child health service offers child health nurse contacts to all mothers of new babies within 10 days of birth and an additional six contacts at critical points in the child's development throughout the first four years of life. Follow up checks are offered to individual families and groups according to need. Information and support is offered regarding parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, lactation, breastfeeding and nutrition.</p>	<p>State funding is provided for both child and school health services. Health services are responsible for delivering child health services.</p> <p>Agreement between the Department of Education and Department of Health which underpins the delivery of School Health Services.</p> <p>The Department of Education part funds School Health Services in WA, as agreed in the MOU between the Departments.</p>	<p>Services are reported as Occasions of Service (for non-admitted patients). Reports are produced as required for service planning, governance, management and reviews.</p> <p>Quarterly reports against key performance indicators are provided to the Government.</p> <p>Service delivery reports are not accessible to the public.</p>

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child and Adolescent Community Health – Community health services contd.	<p>Targeted services focus on engaging vulnerable children and families who are at greater risk of health and developmental issues, including Refugees, Aboriginal families and young parents with identified risks. Targeted programs include Best Beginnings which is delivered in collaboration with the Department for Child Protection and Family Support, and the Enhanced Aboriginal Child Health Schedule (EACHS). These programs provide a modified and expanded version of the Universal Child Health Contact Schedule. Families eligible to receive the EACHS are offered 15 scheduled contacts, from pregnancy to five years of age, in a culturally appropriate manner. Other targeted metropolitan services include Lactation Consultancy and Aboriginal ear health clinics, which provide children with otitis media or known suspected hearing problems with access to an Aboriginal Health Worker, Audiologist, Speech Pathologist and Ear, Nose and Throat specialist. This is to mitigate factors which might lead to ongoing poor health and education outcomes.</p> <p>School health services support school communities in enhancing the health and development of all students through selected health promotion strategies, early detection and specialist health expertise. Services are provided on school sites in collaboration with education providers.</p>		

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child and Adolescent Community Health – Community health services contd.	<p>Key elements of the program are universal health assessments at school entry to all students in government and non-government schools, follow-up checks, support to children in school with particular health needs, and health promotion for all students. In secondary government schools, the focus is more on health promotion (e.g. mental health, sexual health) and providing students with the opportunity to access a health professional who can advise, assess and refer, according to the presenting health issue. In Education Support Schools, nurses provide direct health care services for students with disabilities, many of which have multiple, severe disabilities.</p> <p>The Health Promoting Schools Framework provides a comprehensive, whole school approach in which the curriculum is supported by the environment and ethos of the school. Key components include curriculum, teaching and learning; school policies and approaches to health and wellbeing and school environment; and, partnerships with the wider school community.</p>		
Child and Adolescent Community Health – Child Development Service	<p>The metropolitan Child Development Service in Perth, Western Australia, provides community-based assessment and intervention services for children 0-18 years with (or at risk of) developmental delays and disorders.</p> <p>The Child Development Service also plays a key role in community education and professional development.</p> <p>The Child Development Service clinical workforce consists of a range of allied health and medical disciplines, including Speech Pathologists, Physiotherapists, Occupational Therapists, Clinical Psychologists, Social Workers and Paediatricians.</p>	<p>State funding is provided. Health Services are responsible for delivering child development services.</p>	<p>Services are reported as occasions of service (for non-admitted patients). Reports are produced as required for service planning, governance, management and reviews. Quarterly reports against key performance indicators are provided to the Government. Service delivery reports are not accessible to the public.</p>

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
School Dental Service	The School Dental Service provides free dental care to school children throughout the state ranging from pre-primary through to Year 11 and to Year 12 in remote localities. Care is provided by dental therapists under the supervision of dental officers from fixed and mobile dental clinics located at schools throughout WA. The program incorporates preventive strategies, which include oral health education for school children. Non-general and specialist services are referred. Costs may apply for this treatment.	The Department of Health WA negotiates with Dental Health Services branch to provide funding directly to maintain the program.	Program measures include: <ul style="list-style-type: none"> • Number of children enrolled and under care. • Dental health status i.e. number of decayed / missing / filled teeth. • Average cost of service per child.
Subsidised Dental Care Program	Dental care is provided to eligible financially disadvantaged people (pensioners and other recipients of a benefit/allowance from Centrelink or Department of Veterans' Affairs) via: <ul style="list-style-type: none"> • Public Dental Clinics Metropolitan and Country. • Private practitioners participating in the Metropolitan and Country Patients' Dental Subsidy Scheme. • In addition, a Domiciliary Unit provides dental care for housebound patients. Dental care is also provided for special groups and institutionalised people. Aged Care Dental Program. This program provides dental care to residents of Registered Aged Care Facilities. Residents are eligible to receive free annual screening dental examinations and a care plan. Further treatment needs are advised and the patient is referred to an appropriate provider. Ongoing treatment is through one of the Government programs for eligible residents.	The Department of Health WA negotiates with Dental Health Services branch to provide funding directly to maintain the program.	Program measures include: <ul style="list-style-type: none"> • Access to dental treatment for eligible people. • Average waiting times. • Average cost of completed courses of adult dental care.

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Familial Hypercholesterolaemia	<p>Familial Hypercholesterolaemia (FH) is the most common and serious form of inherited hyperlipidaemia. If untreated could lead to chronic illness and premature death from heart disease. FHWA is a cascade screening program to identify index cases of FH through the Lipid Disorders Clinic at Royal Perth Hospital. The program has been expanded to commence transition of care management of FH patients to Primary Care Providers according to an agreed protocol that ensures safety of the patients is maintained. It includes provision of education and training to primary care practitioners in FH cascade screening and management of FH.</p> <ul style="list-style-type: none"> • Specialised FH services, including specialised lipids nurses, administrative staff, consultants, specialised testing and treatment equipment; • Ongoing development and maintenance of a state-wide database of FH patients; • A central point of information access for GP's ongoing knowledge development; • Support and direction for a Patient Support Group. • Targeted screening and GP identification • Recruitment and training • Communication and education of GP's • Review of the current processes for identifying index cases and cascade screening to deliver an efficient public health service in contrast to having a process for research purposes • Centralised FH database • performance monitoring strategy and criteria to provide a benchmark for GP's and practice nurses to manage detection, testing and occasional referral to the FH specialist services. 	<p>Funding: Department of Health (DOH) WA Contract : Health Strategy Networks DOH WA Program delivery: Prof Gerald Watts, School of Medicine and Pharmacology, University of WA</p>	<p>Six monthly reports Contract reports not available to the public Publication of research reports associated with the project</p>

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Metropolitan Health Lifestyle Project	<p>The Metropolitan Healthy Lifestyles Project Model is a coordinated patient-centred approach involving early patient identification, care co-ordination through general practice, trained clinic staff, supported allied health and community providers, clear referral pathways, and monitored patients to support lifestyle and risk modification for the target groups.</p> <p>The overall aim of the project is to provide practical support for people at risk of developing chronic disease, or those who have chronic disease to make informed lifestyle choices and healthy behaviour change within the Perth metropolitan area.</p> <p>The primary target populations are those newly diagnosed with type 2 diabetes and those with microalbuminuria. The secondary target population is people with multiple risk factors for coronary heart disease.</p> <ul style="list-style-type: none"> • Implementation of an integrated and regionally responsive model - Metropolitan Healthy Lifestyle Program (MHLP) to facilitate the referral of targeted population into healthy lifestyle programs. • Increase the identification and monitoring of the target population in primary health care. • Improved response and capacity of general practice to refer targeted population into lifestyle support programs. • Process and Outcome evaluation of the program to demonstrate the impact of the program on the community; • Economic evaluation of the program on cost effectiveness <p>Develop a long term funding model that outlines a viable alternative funding source(s) to meet ongoing funding requirements beyond the life of the contract</p>	<p>Funding: WA Department of Health</p> <p>Contract : Health Strategy Networks DOH WA</p> <p>Program delivery - Fremantle Medicare Local</p>	<p>Six monthly reports</p> <p>Evaluation report</p> <p>Contract reports not available to the public</p> <p>Publication of research evaluation component of the report available</p>

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Self-Management	<p>Develop, deliver and evaluate programs to coordinate diabetes services and multidisciplinary care for persons with diabetes.</p> <ul style="list-style-type: none"> • Enhance care, access to care closer to home and navigation of the local health system for people living with diabetes • Support the role of Medicare Locals to enhance service coordination in the community • Build the capacity of GPs, practice nurses and other appropriate existing service providers in the community to effectively deliver multidisciplinary care, including through promoting and assisting with the use of Chronic Disease Management Medicare Items and Medicare diabetes incentives • facilitating and encouraging access to self-management education, care and support with multidisciplinary input from appropriate health professionals • deliver self-management education programs and services • creating access to and linking with other local services/programs to provide holistic care and improve health outcomes for people living with diabetes, such as local government recreational services and support groups • integrating with WA Health services, including the development of referral pathways between tertiary, secondary and community based services, including coordinating clients referred from GPs, hospitals and Health Services to appropriate diabetes clinics/services in the metropolitan and regionals areas for ongoing management • identify service gaps in the local community and where viable, work to fill in those service gaps using existing service providers in the local community in the first instance • incorporate relevant WA Health Models of Care as appropriate. 	<p>Funding: DOH WA Contract : Health Strategy Networks DOH WA Program delivery –</p> <ul style="list-style-type: none"> • Medicare Locals • Diabetes WA 	<p>Six monthly reporting Evaluation report Contract reports not available to the public</p>

Source: WA Government unpublished.

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Aboriginal Health Programs	<p>A number of primary health services are accessible across South Australia aimed at providing health care checks and improving the health outcomes of the Aboriginal community across metropolitan, regional and rural areas of SA. Services provided include:</p> <ul style="list-style-type: none"> • Aboriginal Primary Health Care Access Program • Kanggawodli providing short term pre and post-acute clinical support for rural and remote Aboriginal people. • Trachoma and Trichiasis screening service for Aboriginal residents living in the north and the west of the State. • Watto Purrinna Aboriginal Primary Health Care Service • Rheumatic Heart Disease Control Program • Sexual and reproductive health programs for Aboriginal young people. <p>Additionally, SA Health invests in specific programs contributing to closing the gap in Aboriginal life expectancy including:</p> <ul style="list-style-type: none"> • Primary Health Care program improving access for Aboriginal people to effective health care services including parenting programs, well health checks, transport to primary health care programs and allied health services. • Tackling Smoking initiative addressing smoking among Aboriginal people. The initiative includes the promotion of tobacco related health messages through the 'Give up smokes for good' social marketing campaign and the delivery of smoking cessation support through a network of dedicated staff in Aboriginal community controlled health services. 	<p>State and Commonwealth Government funding. COAG National Partnership Agreement and Project Agreement funding.</p>	<p>Monthly activity and financial data reporting. Quarterly activity and financial reporting, including annual and ongoing evaluation. Six monthly activity and financial data reporting.</p>

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Allied Health Services	A range of non-hospital based allied health services (including: speech pathology; physiotherapy; exercise physiology; occupational therapy; social work; psychology; dietetic/nutrition; and podiatry) are provided through the Local Health Networks (LHNs), providing individual therapy, health information, health promotion, group work and advocacy. Within these services are programs specifically targets at children's health and development, including the Allied Health Services in Children's Centres Program.	State Government funding.	Quarterly and annual client activity reports.
Child Health and Development Services	A number of services aimed at child development services are offered across South Australia, which include: <ul style="list-style-type: none"> • Early Childhood Development and Disability Services provide multi-disciplinary therapy and health interventions for children 0-5years of age (to school entry) with or at risk of developmental delays or with a disability. • Child Development Unit Program provides specialist paediatricians and allied health staff assess children in community and country locations with specific and more complicated physical, behavioural and cognitive issues which are impacting on the child's development. 	State Government funding. Grant funding from the Department of Communities and Social Inclusion (DCSI) & an in-kind contribution to the National Disability Insurance Scheme. Grant funding from the Ministerial Advisory Council for Students with Disabilities (MACSWD).	Monthly activity and financial data reporting. Reporting to DCSI and MACSWD.

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child Health and Development Services contd.	<ul style="list-style-type: none"> • Autism Diagnostic Service providing specialist paediatricians and allied health staff to undertake comprehensive assessments of children on the Autism Spectrum Disorder. • Registered Nurse Delegation of Care Program assesses children with complex health needs who mostly have a disability, develops health plans, trains, assesses and delegates care to health support workers to care for children in a variety of community settings. • Access Assistant Program provides children with complex health needs and disability with support to enable access to education in government and non-government schools. • Fragile Airways Program provides a State-wide in-home active overnight support for children with artificial airways (tracheostomy +/- ventilation) who may also have chronic/complex health care needs. • Child Protection services assess and treat children up to 18 years and their families where there are suspicions of child abuse and neglect, providing telephone consultations with Families SA, Police and health workers, providing forensic medical assessment and crisis psychosocial response, psychological and parenting assessments and therapy for children and families. 	<p>State Government funding.</p> <p>Grant funding from the Department of Communities and Social Inclusion (DCSI) & an in-kind contribution to the National Disability Insurance Scheme.</p> <p>Grant funding from the Ministerial Advisory Council for Students with Disabilities (MACSWD).</p>	<p>Monthly activity and financial data reporting.</p> <p>Reporting to DCSI and MACSWD.</p>

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child and Family Health Service	<p>From over 120 sites across the state, the Child and Family Health Service provide a range of child wellbeing, development and parenting supports for families of children 0-5 years of age. These include early parenting groups, 1:1 consultations, a residential feeding and settling service, and access to information via the telephone and internet. Specific services provided include:</p> <ul style="list-style-type: none"> • Universal Contact Visit offering a visit by a community Child and Family Health Nurse following the birth of a baby, enabling early identification of child health and developmental issues. • Family Home Visiting Program providing a nurse led preventative home visiting program undertaken over a period of two years focusing on supporting positive child development, enhancing the parent-infant relationship and ensuring the health and safety of infants. • Early Childhood Intervention Program where consultants work within the local community to assist parent access to support services for children aged 0-8 years with a disability and/or developmental delay. • Parenting SA providing information on quality parenting practices for parents and carers of children aged 0-18 years, through free printed Parent Easy Guides for mainstream, Aboriginal and migrant families, free public seminars, and grants to local parent groups. • Newborn and Children's Hearing Service providing the Universal Neonatal Hearing Screening and the Hearing Assessment service. • Early Child Parent Services providing therapeutic and family support services to families of children aged 0-3 years to improve infant wellbeing, enhance parental capacity and problem solving ability. 	Recurrent State Government funding.	Monthly activity and financial data reporting.

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Chronic Disease Health Services	<p>A range of services are delivered aimed at managing and improving the health of chronic disease patients, including:</p> <ul style="list-style-type: none"> • inSCOPE Asthma and Chronic Obstructive Pulmonary Disease provides support and education for GPs to help manage patients more independently and provide alternate services to hospital for complex patients, identifying self-management plans & education and clear referral pathways for ED & Inpatient to ensure a transition to improved self-care. • Exercise Physiology for Heart Failure patients is a referral service for patients identified as having Chronic Heart Failure or Cardiomyopathies aiming to assist patients in improving function and fitness parameters, with a strong focus on self-management. • Multidisciplinary Ambulatory Care is an innovative multi-disciplinary consulting service that supports people with multiple and complex chronic conditions, who are at risk of being hospitalised, in a shared care approach with General Practitioners. • Better Care in the Community - Chronic Disease program provides more coordinated and targeted care for people with chronic disease living in country SA thereby avoiding the need for hospitalisation or an extended stay in hospital. 	State Government funding.	<p>Monthly activity and financial data reporting.</p> <p>Quarterly reporting to Department of Health (DH) about estimated admissions avoided.</p>

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Community Nursing	<p>A range of community nursing services are provided across metropolitan and country areas in settings including chronic disease and risk factor programs, mental health, pregnancy and antenatal care, palliative care, Diabetes Nurse Educators, breast care nursing and domiciliary care services. Other specific services include:</p> <ul style="list-style-type: none"> • Virtual Nursing Service provides specialist nursing care to assist patients with Tuberculosis who have complex medication management and compliance issues to prevent a prolonged public hospital admission. • Community Nursing Service provides longer term specialised nursing care, education, management and monitoring of clients in extended community care and palliative care. • Hospital and Health Care at Home providing short term flexible, rapid response service for clients in their homes/community or residential care facilities. • Community Geriatric Evaluation and Management Service facilitates transition/transfer from an acute setting to an alternative community setting or multidisciplinary short term in-home care for vulnerable older adults with complex health issues, and community care providers with comprehensive assessment, intervention and care planning. • Regional Falls Prevention Program provides a regional approach to falls prevention and support for complex fallers with the aim of reducing disability and hospital presentations 	State Government funding.	Monthly activity and financial data reporting.

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Drug and Alcohol Service South Australia (DASSA)	<p>The Drug and Alcohol Service South Australia (DASSA) delivers a number of drug and alcohol related initiatives state-wide including:</p> <ul style="list-style-type: none"> • Drug and alcohol support for the Reunification Initiative providing services which aim to reduce the alcohol and other drug intake of parents involved in the program thereby contributing to a reduction in the numbers of children entering alternative care. • Withdrawal Management Service, offering assessment and inpatient medical detoxification for people withdrawing from alcohol and a range of other drugs. • Drug and Alcohol Services Program providing funding to non-government organisations to deliver counselling, residential and non-residential rehabilitation, sobering up services, Mobile Assistance Patrol services and family support services. • The Drug and Alcohol Services South Australia Consultation Liaison Service is a specialist medical and nursing service providing consultation and liaison clinicians in the acute care setting of major tertiary referral (public) hospitals. • Tobacco Cessation Service, providing the Quit SA service, smoking cessation support through telephone counselling, and internet based information. <p>Similarly community based drug and alcohol services provided include:</p> <ul style="list-style-type: none"> • Alcohol and drug information service, providing a telephone information, counselling, and referral service • Community service centres, providing counselling, assessment and referral services, and across Adelaide (4 clinics) and regional centres (13 clinics) 	Funding is provided through a mix of Commonwealth and State Government funding.	<p>Monthly activity and financial data reporting.</p> <p>Quarterly data and activity reports, appointment summary data and financial data reporting.</p> <p>Annual activity reporting.</p> <p>Annual attendance / non-attendance reports to Courts Administration Authority.</p> <p>National Minimum Data Set – Alcohol and Other Drug Treatment Services (NMDS-AODTS).</p>

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Drug and Alcohol Service South Australia (DASSA) contd.	<ul style="list-style-type: none"> • The Woolshed, a therapeutic community for 18 years+ with significant alcohol and drug related problems aiming to develop living, work and interpersonal skills. • Day centres at Ceduna and Port Augusta provide diversionary activities and non-residential rehabilitation and support. • The Clean Needle Program, a public health initiative aimed at reducing the spread of blood borne viruses <p>Drug and alcohol services with a specific focus on the interaction with the criminal justice system include:</p> <ul style="list-style-type: none"> • The Police Drug Diversion Initiative, a service for people detected by police for simple possession drug offences to be diverted from the criminal justice system into a health intervention for education, assessment and treatment. • The Driver Assessment Clinic, assessing drivers for alcohol and/or other drug dependency who have been referred by the Courts Administration Authority. • The City Watch House Community Nursing Service, providing assessment, treatment, management and referral of people held in police custody at the City Watch House. <p>Services with a focus on drug and alcohol issues within the Aboriginal Community include:</p> <ul style="list-style-type: none"> • The Aboriginal Population Health Programs, which identify, develop and evaluate strategies that effectively respond to the needs of Aboriginal people and communities affected by substance misuse • The Aboriginal Connection Program, a dedicated drug and alcohol treatment service for Aboriginal clients with complex needs and who are at risk of homelessness, primarily based in metropolitan Adelaide • The APY Lands Substance Misuse Services provide a range of specialist treatment interventions for Anangu with problematic alcohol and other drug use. 		

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Homelessness Health Services	<p>Programs aimed to support the health of people experiencing homelessness include:</p> <ul style="list-style-type: none"> • Homeless nursing program provides specialised nursing care in the CBD for people experiencing homelessness in a walk in clinic setting providing multi-disciplinary care. • Street to Home provides outreach services for rough sleepers, comprehensive access and connection to health Services, intensive case management, GP and Psychiatry outreach, then transitioning to mainstream health and housing services. 	State Government funding. Partnership funding from the Department of Communities and Social Inclusion (DCSI).	Quarterly and annual activity and financial reporting. Commonwealth H2H National Data Collection Agency.
Maternal Health Programs	<p>A number of programs are accessible across South Australia aimed at providing support and services to pregnant women and their families, these include:</p> <ul style="list-style-type: none"> • Aboriginal Family Birthing Program providing culturally respectful and clinically safe continuity of care for Aboriginal women and their families during their pregnancy, birthing and for up to six weeks post natal by Aboriginal Maternal Infant Care (AMIC) workers in collaboration with maternity services personnel. • Community Midwifery Program providing antenatal, birthing and postnatal services to women across Country Health SA. • Pregnancy to Parenting Program offering support and education to families in the early pregnancy to early parenting period including counselling and support particularly in relation to antenatal care, emotional well-being, psycho social issues, early parenting and child development. 	Combination of Commonwealth and State Government funding.	Monthly activity and financial data reporting.
O'Brien St Practice	O'Brien St Practice offers both HIV medicine and Allied Health practise in HIV, HEP C and gay men's health services, as well as GP services to vulnerable inner city populations.	Combination of State Government and Medicare funding.	Monthly activity and financial data reporting.

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Oral Health Services	<p>A significant number of oral health programs are undertaken state-wide by the South Australian Dental Service (SADS) with such initiatives including:</p> <ul style="list-style-type: none"> • The Community Dental Service and Clinical Placements Program, providing emergency and general dental care (including dentures) for adult holders of a concession card and their dependents in public dental clinics • The Population Oral Health Program, identifying and referral of high risk preschool children with evidence of early dental disease. • The School Dental Service, general and preventively focused dental care for all children under 18 years of age. <p>Additionally, oral health services are provided with a particular focus on vulnerable groups, including:</p> <ul style="list-style-type: none"> • Aged Care Oral Health Projects • Aboriginal Oral Health program • Homelessness and Oral Health Program • Services for newly arrived migrants with a refugee background. • Supported Residential Facilities Program 	<p>State Government funding.</p> <p>Commonwealth grant funding under the Encouraging Better Practice in Aged Care (EBPAC) initiative.</p> <p>Commonwealth funding under the National Partnership on Treating More Public Dental Patients.</p> <p>Commonwealth revenue under the Child Dental Benefits Schedule.</p>	<p>Monthly activity, waiting list and financial data reporting.</p> <p>Six monthly milestone reports to the Commonwealth.</p>
Palliative Care Services	<p>Palliative care services involving integrated care across in-hospital and out-of -hospital settings, linking with other primary care providers for people on an end of life care pathway, with a focus on supporting people to die in their place of choice.</p>	<p>State Government funding</p>	<p>Monthly activity and financial reporting.</p>

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Rehabilitation Services	<p>Specific rehabilitation services provided across South Australia include:</p> <ul style="list-style-type: none"> • The Northern Rehabilitation Service provides maintenance of an individual's independence, function and ability through the provision of inpatient, Rehabilitation in the Home, and outpatient rehabilitation services. • Paediatric Rehabilitation Program provides Rehabilitation Consultant services to community clinics providing specialist medical assessment and intervention by multidisciplinary teams. 	State and Commonwealth Government funding.	Monthly and Annual reporting activity and financial reporting. Daily activity reporting re bed capacity.
Rural and Remote Services	<p>Services provided aiming to assist with patients in rural and remote areas of South Australia include:</p> <ul style="list-style-type: none"> • Country Access to Cardiac Health program provides improved access to cardiac rehabilitation services with a central referral point and telephone based program where no face-to-face program exists. • Country Home Link and Rapid Intensive Brokerage Support (RIBS) programs provide access to flexible services and equipment for country consumers to avoid the need for hospital admission to metropolitan hospital (Country Home Link) and country hospitals (RIBS). 	State Government funding.	Monthly activity and financial data reporting.
Screening Services	Port Pirie Lead Implementation Program monitors blood in lead levels of the Port Pirie community with a particular focus on pregnant women and children 0-5 years, provides intervention to reduce blood lead levels in children and pregnant women and provides ongoing community education around lead safe practices.	State Government funding.	Quarterly lead in blood data used as the basis of the Technical Paper produced by the Public Health Department of DH.

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Transition Care Program (TCP)	Provision of short term restorative residential aged care or community place for patients aged 65 + or 50 years for Indigenous patients, to assist with the transition from an acute hospital stay back to their own homes and/or to lower level residential aged care home, with an emphasis on restorative care and reducing functional decline.	Recurrent Commonwealth Government funding. State Government funding Contribution.	Monthly and Quarterly activity and financial data reporting.
Women's Health Services	Specialised women's health services are provided to Aboriginal and Torres Strait Islander women; newly arrived refugee and migrant women and vulnerable women with complex health and social circumstances who would not otherwise access health services. Services include engagement activities to create referral pathways and a culturally safe service, clinical health assessments and care planning, information and referral, self-management programs and psychosocial therapy, specialised clinical health treatment, co-ordination of care pathways.	State Government funding. Commonwealth government contribution through MBS (section 19(2) exemption).	Monthly activity and financial data reporting. Quarterly performance reporting.
Youth Health Services	Provides specialised health services to young people aged 12 – 25 years from key and vulnerable population groups providing services which include engagement pathways and a culturally safe service; clinical health assessments and care planning; information and referral; medical treatment, health programs and counselling to support young people to build their capacity to manage their own health.	State Government funding. Commonwealth government contribution through MBS (section 19(2) exemption).	Monthly activity and financial data reporting. Quarterly performance reporting.

Source : SA Government unpublished.

Table 10A.113 **Tasmania, community health services programs***Programs funded by the Tasmanian Government during 2013-14*

<i>Program area</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p>Primary Health brings together a wide range of community and rural health services to meet the needs of both individuals and local communities.</p> <p>Community Health Centres offer a variety of services including counselling and support, health promotion, medical, nursing, allied health services and accommodation and meeting spaces for visiting services including housing, disability and family and child health services.</p> <p>Services vary from site to site based on community need and accessibility to similar services provided by government or non-government providers.</p> <p>The size of sites also varies: small sites provide a limited range of services generally based around community nursing.</p>	<p>The majority of funding is allocated from the State budget. During 2013-14 Tasmanian Health Organisations (North, South and North West) were responsible for area spending and overseeing program delivery.</p> <p>Services are provided in accordance with the Tasmanian Government's Output Budgeting Framework.</p> <p>Services are funded through identified outputs within the DHHS budget.</p>	<p>Performance information is collected and reported at the State level through the Budget Papers, Annual Report and the quarterly Your Health and Human Services Progress Chart.</p> <p>National reporting through: National Minimum Data Sets; Report on Government Services; Australian Institute of Health and Welfare (AIHW); Australian Council of Healthcare Standards.</p>
	<p>Rural Health Facilities provide core primary health and community care services within a local community in addition to some inpatient sub-acute beds. In addition, some rural sites provide residential aged care and/or emergency services.</p>	<p>Australian Government funds</p>	<p>Reporting in accordance with specific program requirements.</p>
	<p>Palliative Care Services - specialist palliative care clinicians work within a consultancy framework across the health sector to support primary health service providers in urban and rural areas to provide quality palliative care.</p>		

Table 10A.113 **Tasmania, community health services programs***Programs funded by the Tasmanian Government during 2013-14*

<i>Program area</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	Other Primary Health services include Aged Care Assessment Teams; Community Equipment Scheme; Community Rehabilitation Services; Community Therapy Services (Physiotherapy, Speech Pathology, Occupational Therapy and Podiatry); Contenance Services; Day Centres and Health Promotion activities. These may be provided at a Community Health Centre, Rural Health Facility or as a visiting service across an entire region.	Australian Government and State funding	Reporting in accordance with specific program requirements.
	The Australian Government funds the Rural Health Outreach Fund (RHOF) and the Medical Outreach – Indigenous Chronic Disease Program (MO-ICDP) to provide a broad range of outreach medical, nursing and allied health services to rural and remote areas of Tasmania.	Australian Government funding.	
	Overcoming cultural/language barriers – The Tasmanian DHHS provides access to Interpreter Services for CALD clients in all health settings as required.	Services purchased on an ‘as needs’ basis	As above
	Overcoming geographical barriers – emergency services are provided at some rural sites and three sites also operate an ambulance service.		
	A range of services are provided on an outreach basis to rural communities from an urban hub – including allied health services, Aged Care Assessment Teams and Contenance Services.	Australian Government and State funding	As above

Table 10A.113 **Tasmania, community health services programs***Programs funded by the Tasmanian Government during 2013-14*

<i>Program area</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p>Telehealth is available at 140 facilities in Tasmania to facilitate clinical, administrative and professional education, supervision and development for State, Federal, NGOs and external organisations.</p> <p>In addition to Australian Government contributions, the State provides funding to Health Recruitment Plus to assist recruitment and retention of rural general practitioners and to support rural medical practitioners to provide services to rural health facilities around Tasmania.</p>		
	<p>Overcoming socioeconomic barriers- a range of transport services to access health care is available to people who are transport disadvantaged either because of socioeconomic circumstances or because health and disability preclude use of their own or public transport.</p> <p>Any services that charge fees are means tested such that those in receipt of pensions and are health care card holders either pay a reduced fee or are exempt from fees.</p>	As above	As above
	<p>Overcoming social isolation barriers- day centres around the state provide social support and activities for the frail, aged and people with a disability.</p> <p>Community Health provides coordination of community recovery responsibilities covering the human and social elements of disaster recovery.</p>	As above	As above

Source: Tasmanian Government unpublished.

Table 10A.114 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Immunisation	<p>The Health Protection Service (HPS) is responsible for the Communicable Disease Control program which is responsible for responding to notifiable diseases in the ACT. HPS also coordinates and implements the National Immunisation Program (NIP) (reported in Chapter 11) and ACT vaccination programs across both public and private sectors in the ACT. HPS develops strategic and operational communicable disease control and immunisation policies for the ACT; provides outbreak control advice and clinical advice about immunisation to members of the public, immunisation providers and health care professionals; and provides education to health care professionals and immunisation providers.</p> <p>Vaccine is ordered and distributed to immunisation providers. Within the HPS, the Vaccine Management Unit (VMU) delivers NIP and ACT funded vaccine to Child Health clinics, general practices, hospitals and other immunisation providers. The VMU staff have an active role in ensuring that vaccines are stored within the recommended temperature range and remain viable. The temperature of all immunisation providers' fridges are continuously monitored using data loggers. Each fridge is inspected at least monthly and regular inventories and stock rotation of providers' fridges is undertaken by staff of the VMU. Vaccine use is monitored and policies implemented to ensure high immunisation coverage in eligible groups in the ACT.</p>	<p>Through a designated budget (program coordination and vaccine delivery). NIP vaccines are funded or provided by the Department of Health and Ageing (DoHA) as part of the National Partnership Agreement on Essential Vaccines.</p> <p>Designated budget for the purchase of vaccines and post exposure treatments.</p>	<p>Immunisation coverage in children – quarterly and annual reporting against targets and budgets. NIP vaccine usage levels are reported to the Department of Health and Ageing (DoHA) quarterly as part of the National Partnership Agreement on Essential Vaccines.</p> <p>HPS reports RIG usage to Communicable Disease Network Australia (CDNA).</p> <p>Evaluation of the General Practice influenza vaccination program conducted in 2013.</p> <p>At least monthly inventories of vaccines. Temperature readings recorded. Vaccine wastage reported.</p>

Table 10A.114 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Immunisation contd.	<p>HPS investigates notifiable disease outbreaks and provides advice to the community on measures to reduce the spread of communicable diseases. This includes the purchases stocks of rabies vaccine and immunoglobulin (RIG) for the post exposure treatment of: returning travellers bitten or scratched by animals in countries where rabies is prevalent; or people bitten or scratched by bats in Australia (Australian Bat Lyssavirus (ABL). HPS also stocks quantities of Hepatitis A vaccine for use in post exposure treatment of people exposed to Hepatitis A. Stocks of Normal Human Immunoglobulin, Zoster Immunoglobulin and measles, mumps and rubella (MMR) vaccine are also held by HPS for measles and varicella post exposure treatment.</p> <p>Hepatitis B is funded for intravenous drug users and sexual and household contacts of hepatitis B positive persons. The hepatitis B vaccine is distributed to all immunisation providers including corrections facilities, Aboriginal Medical Services, Youth Health Services and alcohol and drug units.</p> <p>MMR vaccine is funded and provided for all persons who do not have documented evidence of having received 2 doses of measles containing vaccine.</p> <p>To increase the level of immunity of frontline health care staff against circulating influenza viruses the ACT Government funds influenza vaccine for staff in General Practices.</p>		

Table 10A.114 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Community Health Intake	<p>Community Health Intake facilitates access to community health services by providing a single point of entry to services.</p> <p>The public can phone Community Health Intake for information about health services or to arrange appointments with health professionals in community settings.</p> <p>Health professionals can fax referral forms to Community Health Intake for processing.</p> <p>Community Health Intake also has a dedicated GP phone line which provides information about community health services, provides information about clients with existing referrals, and transfers GP calls to other services and programs.</p>	Funded by the ACT Government.	Monthly reporting to operational management

Table 10A.114 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Justice Health Services	<p>The Justice Health Service provides:</p> <ol style="list-style-type: none"> 1. The Justice Health Service represents a combination of the Justice Health Primary Team and Forensic Mental Health Services delivered at the Alexander Maconochie Centre (Adults), the Bimberi Youth Justice Centre (Adolescents and Youth) and the Periodic Detention Centre (Adults). The Forensic Mental Health Services also delivers services to the Courts and in the general Community. This program provides improved access to services by delivering at a minimum community equivalence in service availability via and integrated multidisciplinary care approach. 2. The Primary Health Team provides and coordinates clinical services at secondary and tertiary level to people in the Alexander Maconochie Centre (AMC) and Bimberi Youth Justice Centre (BYJC) respectively. 3. The Forensic Mental Health Services (FMHS) provides specialist forensic mental health services within the AMC and BYJC for people with moderate and severe mental illness. FMHS also provides Mental Health services at the Courts and to high risk and complex consumers in the Community via their Forensic Community Outreach Service (FCOS). 	Through a designated budget	Monthly/Annual reports against output targets and budget

Table 10A.114 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Women, Youth and Children Community Health Programs	<p>Provides:</p> <ul style="list-style-type: none"> • Maternal and Child Health nursing services including universal first home visit, child health checks, early childhood immunisation, parenting education and support and intensive support in the home through a Parenting Enhancement Program. • Child Health Medical Officers and Community Paediatricians offering a secondary child health and development service. • Child at Risk Health Unit delivering specialist health services to children and young people, affected by abuse and neglect, along with their families and/or carers. Related to this, the CHP oversees child protection training for Canberra Hospital and Health Services. • IMPACT Program supporting pregnancy and families who have children up to 2yrs and are clients of Mental Health and/or are receiving Opioid Replacement Therapy. • School based programs including immunisation programs; kindergarten health checks, school youth health nurses; Healthcare Access at School supporting children with complex health issues in schools. • Asthma education, nurse audiometrists and orthoptic screening, social work physiotherapy, and nutrition services. • Women's Health Service providing nursing, medical and counselling services, including cervical screening, for women who experience significant barriers to accessing health services. 	Through a designated budget	Monthly/Annual reports against output targets and budget

Table 10A.114 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Community Care, Division of Rehabilitation, Aged and Community Care	Provides multidisciplinary continuum of care services (nursing, podiatry, physiotherapy, occupational therapy, nutrition and social work), acute, post acute and rapid response services, specialist nursing assessments and self management of chronic conditions program.	Through a designated budget: <ul style="list-style-type: none"> • Some services HACC funded • Remainder ACT Government funded 	<p>Monthly and annual reports against a range of indicators including output targets, budget and quality indicators.</p> <p>The ACT Government Health Directorate's Annual Report includes Accountability Indicators related to the achievement of occasions of service targets for nursing and allied health services.</p> <p>HACC outputs data is reported quarterly and submitted six</p>

Source: ACT Government unpublished.

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Oral Health Services	Oral Health Services provide free assessment and treatment to all children up to school-leaving age and to adults holding a current Healthcare or Pensioner Concession Card. Services are delivered from community and school based clinics (urban areas) and health centres and mobile trucks (remote communities). Services are also provided through the Special Needs clinic and treatment under general anaesthetic is provided in both urban and regional centres. Community level/ individual oral health promotion activities are also conducted. Training is provided to remote primary health care workers to facilitate early detection and prevention of dental disease.	Funding sources: • NT Department of Health • Australian Government via National Partnership Agreements (NPAs) Budget management/oversight by Director Oral Health. Governance oversight by Executive Director Territory-wide Services	Routine reporting: • Executive Monthly Performance Reports (internal) • Department of Health Annual Report, (public). Quarterly reporting (public) against: • NPA – Treating More Public dental patients • Stronger Futures NPA
Men's Health	The Men's Health Strategy Unit (MHSU) provides expert advice, leadership and strategic directions in men's health with a particular focus on Aboriginal male health. The MSHU leads the development of a men's health strategy and strategic planning of programs and services to improve health outcomes of men living in the NT, especially vulnerable populations of men. The MHSU works to develop partnerships with key stakeholders from the Department, other government and non-government organisations, peak men's health bodies and Aboriginal community-controlled organisations, to improve men's knowledge, access and use of preventative health services. The MHSU plays a support role for Aboriginal Male Health Coordinators working in remote communities to engage men and undertake health promotion activities. It coordinates the delivery of urban based male health awareness activities through the 'Pitstop' program. It is involved in staff training on male health aimed at improving service capability for males. The MHSU also encourages and promotes the development of a research effort around gender and health to improve access and use of gendered data to inform program development.	Funding source: Northern Territory Government via Department of Health budget Budget spending/oversight by Director Health Development Branch. Program delivery (limited direct funding) by NT Department of Health and NGO service providers Governance oversight by Executive Director Territory-wide Services	Routine reporting: Department of Health Annual Report.

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Health Promotion Strategy Unit	<p>The core function of the Health Promotion Strategy Unit (HPSU) is to build and strengthen capacity for affective health promotion and prevention in the Department of Health (DoH) and its partners across government and non-government sectors.</p> <p>This involves:</p> <ul style="list-style-type: none"> • facilitating a uniform understanding of health promotion across government and non-government health and related sectors; • providing strategic and policy support to key stakeholders, staff and organisations and • a commitment to planning for health promotion through investment in research, program planning and evaluation, continuous quality improvement, social marketing, health promoting settings and developing sustainable education and training pathways. <p>A key focus is to:</p> <ul style="list-style-type: none"> • facilitate the implementation of the Northern Territory Health Promotion Framework; • support Health Promotion Training and Education offered by NT tertiary providers; • offer professional and workforce development options in health promotion for primary health care and NGO staff; • support health promotion settings approaches such as health promoting workplaces and health services; • provide health promotion information to professionals, communities and individuals in the NT; • work with research organisations on identifying affective strategies and enablers to develop a health literate system; • administer a planning and evaluation system (QIPPS) for health promotion programs in the DOH and its partners; • work with Menzies School of Health Research to roll out Health Promotion CQI tools for primary health care. 	<p>Funding source -NT Department of Health.</p> <p>Responsibility for managing and delivering:</p> <ul style="list-style-type: none"> - Program Leader Health Promotion is responsible for delivering the HPSU functions and program - Responsibility for providing health promotion activity in the NT is that of primary health care teams and NGOs - Budget spending/oversight by Director Health Development Branch. - Governance oversight by Executive Director Territory-wide Services 	<p>DoH Annual report</p> <ul style="list-style-type: none"> - 6 monthly QIPPS report to internal stakeholders - Evaluation reports of any professional development provided to organisations sending participants

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Women's Health	<p>The Women's Health Strategy Unit (WHSU) engages in strategic planning and policy development for women's health at the national and Territory level in partnership with government and community stakeholders and coordinates and leads Department of Health responses to this work.</p> <p>WHSU instigates, leads and project manages key strategic pieces of work to progress priority women's health issues such as those for Aboriginal and Torres Strait Islander Women, Migrant and Refugee Women and Domestic and Family Violence responses.</p> <p>The Unit takes a strategic approach to gender as a key determinant of health both in the Department of Health, with other key stakeholders and services providers. In particular the Unit has an ongoing relationship with the Men's Health Unit, the Office of Women's and Men's Advancement, the Department of Attorney General and Justice and the Office of Multicultural Affairs in regards strategic approaches to access equity and outcomes for women's health and wellbeing in the Territory.</p> <p>The Unit has worked with maternity and women's health staff to support the development of consistent program approaches to women's health service delivery.</p> <p>The Unit has been the Department's representative on a whole of government Domestic and Family Violence Working Group and provided departmental feedback and input into the development of a Northern Territory Domestic and Family Violence Strategy.</p>	<p>Funding source Northern Territory Government via an identified program within the Department of Health budget.</p> <p>Budget spending/oversight by Director Health Development Branch.</p> <p>Governance oversight by Executive Director Territory-wide Services</p> <p>Program delivery via strong collaboration with NTG and NGO partners.</p>	<p>Routine reporting: Department of Health Annual Report, annual public.</p>

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child and Youth Health Strategy Unit	<p>The Healthy Under Five Kids Program is a universal well-child program that begins within 10 days of birth up to five years of age. The program provides health professionals with a standard set of child health and wellbeing assessments and scripted anticipatory guidance at each of the 10 to 13 visits. This allows health professionals to work with children, parents and families to detect early problems that may affect health or wellbeing, assess physical growth and development as well as the social environment and provide consistent evidence-based information to parents about SIDS, hygiene, communication, play, nutrition, child growth and development. Staff providing the assessments link families to other available community services. This program aligns with the NT Childhood Vaccination Schedule.</p> <p>The Child and Family Health Service is provided in NT urban areas by qualified Child Health Nurses. A very similar program is provided in remote areas by Remote Area Nurses and Aboriginal Health Practitioners, supported by visiting qualified child health nurses. From 2015 there will be a single NT schedule. Healthy Under 5 Kids – Partnering Families.</p> <p>The School Health Service works in NT urban government-funded Middle Schools (school years 7-9). Registered nurses work onsite within a Health Promoting Schools Framework and provide health promotion and education in line with the school curriculum and general school ethos to empower youth to make healthy choices. This program supports the NT Childhood Vaccination Schedule. Objective targeted: promoting health and preventing ill health. Population Group: NT Urban dwelling youth attending government funded Middle schools.</p>	<ul style="list-style-type: none"> • NT DOH - Child and Youth Health Strategy Unit provide overall program management • Funding is predominantly through NT Government Department of Health • New Directions Mothers and Babies (Commonwealth) funds a number of positions in specified remote communities • The Top End Area Health and Central Australian Area Health Service provide service delivery. • NT DOH has contracts with two Aboriginal Medical Services in the Katherine region to deliver this program. <ul style="list-style-type: none"> • NT DOH - Child and Youth Health Strategy Unit provide overall program management • NT Government Department of Health 	<ul style="list-style-type: none"> • NT DOH reports to NT Treasury on an Annual basis on this program • NT DOH Annual Report reports on this program annually • Monthly program coverage reporting from service providers to NT DOH <ul style="list-style-type: none"> • Financial reporting obligations within NT Department of Health

Table 10A.115 Northern Territory, community health services programs

Programs funded by the NT Government during 2013-14

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child and Youth Health Strategy Unit contd.	<p>The Healthy School-Age Kids Program is a health promotion and screening program provided to all school-age children in remote communities. The program includes an integrated approach to screening and health promoting activities from a number of different health service providers, non-government organisations as well as the schools. With the advent of improved medical records management and consistent health service delivery the scope of this program is likely to change over the next few years. This program supports the NT Childhood Vaccination Schedule.</p> <p>Objectives targeted:</p> <ul style="list-style-type: none"> • promoting health and preventing ill health • providing early detection and intervention <p>Population Group: NT remote dwelling school-age children.</p>	<ul style="list-style-type: none"> • NT DOH - Child and Youth Health Strategy Unit provide overall program management • Funding is predominantly through NT Government Department of Health • The Top End Area Health and Central Australian Area Health Service provide service delivery. • NT DOH has contracts with two Aboriginal Medical Services in the Katherine region to deliver this program 	<ul style="list-style-type: none"> • Program activity reports by community by event.
Public Health Nutrition and Physical Activity	<p>Services are delivered both by public health nutritionists usually located within multi-disciplinary teams, and policy officers based in the Strategy Unit.</p> <p>Public health nutritionists (PHNs) provide training and support to primary health care teams to promote healthy nutrition and regular physical activity to the community and assist with the management of people with nutrition related conditions. They also offer individual and group dietetic consultations through community care centres and health clinics in both urban and remote areas.</p>	<p>Funding sources</p> <p>NT Government</p> <ul style="list-style-type: none"> - Australian Government via NPAs - NT Medicare Local <p>Budget spending/oversight by Health Development Branch Directorate</p> <p>Governance oversight by Executive Director Territory-wide Services</p>	<p>Department of Health Annual Report, Urban and Remote Health Services Output reports (public).</p> <ul style="list-style-type: none"> - Quarterly (internal) and annual (public) reports to Australian Government - Monthly activity reporting to NT Medicare Local (internal/public)

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Chronic Conditions Strategy Unit (CCSU)	<p>The core function of CCSU is to support the chronic disease network across the Northern Territory to provide evidence-based practice within the framework outlined in the Northern Territory Chronic Conditions Prevention and Management Strategy 2010-2020 (NT CCPMS).</p> <p>CCSU holds annual Chronic Disease Network Conference to showcase and share current (best practice) approaches to care and to improve communication, coordination and collaboration around the provision of chronic condition programs and services across the network. This conference attracts on average 250 health practitioners from the NT and other jurisdictions.</p> <p>The current Implementation Plan (2014-2016) of the NT CCPMS has a strong focus on progressing social determinants of health (SDoH), which will include upskilling the health and non-health professionals to work within the SDoH framework.</p> <p>CCSU provides leadership by working closely with its partners within and outside the government health sector, which includes non-government and Aboriginal community controlled health services, to ensure a consistent approach to chronic care.</p>	<ul style="list-style-type: none"> • NTG funding via DoH budget • Australian Government – NPA (podiatry services) 	<ul style="list-style-type: none"> • Annual DoH Report • Annual Reporting of the Implementation Plan of NT CCPMS.

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Hearing Services	<p>The consequence of chronic ear disease in Indigenous people manifests as endemic hearing loss, which impacts on language and social learning and can flow on to academic underachievement, limitation in vocation and increased contact with the justice system. Access to services reflects this and from the total of 5665 hearing assessments provided, 68% were to Indigenous consumers.</p> <p>The systematic approach to hearing health involves integrating all resources to deliver connected pathways of care to communities. Hearing health services support community based primary health, early childhood and education strategies.</p> <p>Compelling evidence of effectiveness supports this model of care (see AIHW Stronger Futures in the Northern Territory: Hearing Health Service 2012-2013).</p> <p>Services are mostly provided in specialised hearing centres located in remote and urban community health centres, or hospital facilities. Hearing Health utilises Teleotology (a telehealth service) to improve access to specialist Ear, Nose and Throat services in remote areas with demonstrated cost and productivity benefits. Currently 80 per cent of ENT consultations to remote communities are provided through Teleotology.</p> <p>A Hearing Health Information Management System to provide clinical decision support and guidance to primary health practitioners, increase efficiencies in existing Teleotology processes and integrate all clinical data to support a shared care plan is currently being implemented.</p> <p>The Neonatal Hearing Screening program for permanent hearing loss is provided through all urban birthing hospitals. From 3220 births in public hospitals there was 99% coverage for this screening program.</p>	<p>Funding sources</p> <ul style="list-style-type: none"> - NTG Department of Health, and - Australian Government for additional ear health and hearing services for Indigenous children. <p>Budget spending/oversight by Directors of Health Development (remote areas) and Community Health Branches (urban areas)</p> <p>Governance oversight by Executive Director Territory-wide Services.</p> <p>Service delivery by Department of Health NT Hearing Program (Community Health) and Hearing Health Program (Health Development).</p>	<p>Routine reporting:</p> <ul style="list-style-type: none"> - Department of Health Annual Report (public). - Performance targets for Australian Government-funded programs and consented service event data shared with AIHW are published annually.

Table 10A.115 Northern Territory, community health services programs

Programs funded by the NT Government during 2013-14

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Primary Health Care – Top End Health Service (PHC – TEHS) and Central Australia Health Service (PHC-CAHS)	<p>Remote Health delivers evidence based, best practice primary health care services to Aboriginal and non-Aboriginal people in remote areas from a network of 54 department-managed community health centres and collaborates with non-government Aboriginal community controlled health services. Remote Health's workforce consists of rural medical practitioners, remote area nurses, Aboriginal health practitioners, Aboriginal community workers and allied health professionals providing direct care to clients as a collaborative multidisciplinary team.</p> <p>Services include primary health care, 24 hour emergency care, medical evacuations, care and treatment for chronic disease and public health programs. In the remote setting, primary health care professionals work collaboratively with other departmental program professionals to deliver integrated and coordinated care, targeting preventable chronic disease, maternal child and youth health, oral and ear health, sexual health, mental health, alcohol and other drugs and aged and disability services.</p> <p>Remote Health manages the relationships between the Northern Territory and Australian Government agencies and non-government organisations involved in primary health care, and for developing sustainable systems for effective and efficient service delivery. Consultation also occurs with the community to foster and develop community capacity, facilitate community decision making, promote and support the employment of local people and establish effective governance systems so that health services can successfully and confidently make the full transition to community controlled entities.</p>	<p>FUNDING SOURCES:</p> <ol style="list-style-type: none"> Northern Territory Government via Department of Health budget Australian Government Department of Health (AG DoH) <ul style="list-style-type: none"> Primary Health Care base Northern Territory Stronger Futures <ul style="list-style-type: none"> Primary Health Care Child and Maternal Health Substance use Medicare Local NT Primary Health Care Initiative <p>Budget spending/oversight by Director Remote Health Branch.</p> <p>Governance oversight by Executive Director Territory-wide Services.</p> <p>Program delivered by</p> <ul style="list-style-type: none"> Remote Health services and Remote Health grant funded non-government Aboriginal community controlled organisations. 	<p>ROUTINE REPORTING:</p> <p>Bi-annual:</p> <ul style="list-style-type: none"> Financial report to AG DoH Written report to AG DoH Written report to Medicare Local NT ATSI nKPI reporting AG DoH NTAHKPI reporting to NT Department of Health and AG DoH Financial report to AG DoH <p>Annual:</p> <ul style="list-style-type: none"> NT Department of Health Annual Report (public). OSR Reporting to AG DoH

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Urban Health	<p>Child youth and family program operating within the urban setting delivers evidence-based best practice family-centred care. Child youth and family work force consists of clinical nurse specialists Nurse 3, with Child and Family Health nursing qualifications. There are two N5 Clinical Nurse Managers. The Child and Family nurses work under a family partnership model. Referrals are through the individual, hospitals and GPs, with linkages to government and non-government organisations including Family and Children services.</p> <p>Range of services:</p> <ul style="list-style-type: none"> • Universal home visits • Key age assessment (growth and development) • Extended visiting for vulnerable families • Early birds (new mothers) support program • Territory parent support (education program) • Breast feeding /nutrition support • EPDS screening (links to perinatal mental health) • Parenting support and advice • Referral to relevant services i.e. hearing, allied health, GP • Immunisations • Health promoting school nurses are Nurse 4s and operate out of middle schools. • Provide health promotion within the classroom • Immunisation program <p>Community health objectives targeted:</p> <ul style="list-style-type: none"> • promoting health and preventing illness • providing timely and high quality healthcare that meets individual needs, throughout the lifespan 	<p>FUNDING SOURCES: Northern Territory Government via Department of Health budget</p>	<p>Reporting, as requested; monthly from service centres internal</p>

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Urban Health contd.	<ul style="list-style-type: none"> • coordinating service provision to ensure continuity of care where more than one service type, and/or ongoing service provision, is required to meet individuals' healthcare needs. Population groups served: The urban population of diverse cultures including English and non-English speaking families, also including refugees and new immigrants.		
Prison Health Care	<p>Prison Health delivers evidence based, best practice primary health care services to the inmates of Darwin Correctional Centre, Don Dale Centre and the Alice Springs Correctional Centre. The Prison Health workforce consists of medical practitioners, nurses, Aboriginal health practitioners and allied health professionals providing direct care to clients as a collaborative multidisciplinary team.</p> <p>Services include primary health care, 24 hour on call emergency care, medical evacuations, care and treatment for chronic disease and public health programs. In the prison setting, primary health care professionals work collaboratively with other departmental program professionals to deliver integrated and coordinated care, targeting preventable chronic disease, youth health, oral and ear health, sexual health, mental health, alcohol and other drugs and aged and disability services.</p> <p>Prison Health manages the relationships between itself and private allied health providers involved in primary health care service in the prisons. Consultation also occurs with the community, inmate advocate groups and the Department of Correctional Services to foster and develop effective governance systems.</p>	<p>FUNDING SOURCES:</p> <ol style="list-style-type: none"> 1. Northern Territory Government via Department of Health budget 2. Budget spending/oversight by Director Remote Health Branch. <p>Governance oversight by Executive Director Territory-wide Services.</p> <p>Program delivered by Remote Health services</p>	<p>ROUTINE REPORTING:</p> <p>Annual:</p> <ul style="list-style-type: none"> • NT Department of Health Annual Report (public).

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Sexual Health and Blood Borne Viruses Program	<p>The Sexual Health and Blood-Borne Viruses (SHBBVU) Program is a NT wide program aimed at prevention, treatment, surveillance and control of sexually transmitted infections and blood borne viruses such as HIV/AIDS and Hepatitis C. Services include</p> <ul style="list-style-type: none"> • surveillance and public health response to notifiable sexually transmitted infections (STIs) and blood-borne viruses (BBVs) • sexual health education and health promotion • direct early detection and treatment clinical services • the needle syringe program • supporting delivery of culturally appropriate, gender-balanced and accessible educational and clinical services across the NT by services including primary health care services <p>Population groups served include young people and Aboriginal and Torres Strait Islander people as well as gay men, sex workers, travellers and mobile workers, people in custodial settings.</p>	<ul style="list-style-type: none"> • Funding sources NT Department of Health. OATSIH, Australian Government • Responsibility for managing/delivering program NT Department of Health (DoH) 	<p>OATSIH reporting requirements</p> <ul style="list-style-type: none"> • Annual Action Plan and Budget • 6 Month and 12 Month Financial Reports • Annual Progress Report - OATSIH Service Report <p>Biannual Australian Government report</p>
The Adolescent Sexuality Education Project (ASEP)	<p>The Adolescent Sexuality Education Project (ASEP) is a collaboration between the Northern Territory Department of Education and Department of Health in association with the Central Australia Aboriginal Congress. The ASEP is funded for one year (2014-15) by the Australian Government under the project agreement (PA) for Indigenous teenage sexual and reproductive health and young parents support to provide sexual and reproductive health education to young Indigenous adolescents in school and community settings across NT.</p>	<p>Funding Source:</p> <ul style="list-style-type: none"> • Australian Government <p>Responsibility for managing and delivering the program</p> <ul style="list-style-type: none"> • NT Department of Health 	<p>Routine reporting:</p> <p>6 monthly reporting to the Australian Government against project agreement milestones</p>

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Australian Bat Lyssavirus Pre and Post Exposure Prophylaxis (and rabies post exposure) Service	CDC provides education and (privately purchased) rabies vaccine for pre-exposure prophylaxis against Australian Bat Lyssavirus (ABL) to persons at risk of occupational exposure. Post-exposure rabies immunoglobulin and vaccine is administered in Darwin and some regional centres to those potentially exposed to both rabies virus and ABL. Education programs are provided to the community and to occupational groups to ensure people avoid contact with bats and seek appropriate treatment if bitten or scratched by bats or mammals overseas.	Funding sources: 1) NT Department of Health. 2) DoHA refunds 50% of the cost of rabies immunoglobulin administered to people who are bitten or scratched by bats only. Responsibility for managing and delivering the program • NT DoH,	Routine reporting: • NT Department of Health Annual Report, • information on post exposure prophylaxis use is reported to the Australian Government.
Tuberculosis	The Centre of Disease Control (CDC) is responsible for the management of tuberculosis (TB), leprosy and non-tuberculous mycobacteria in the NT. • home visits and interpreter services • education for at risk groups in the community - directly observed therapy (DOT) by a registered nurse is provided to prevent the development of drug resistant disease and client information sheets are available in many languages • medical clinics to monitor clients and contacts identify at risk people and screen for tuberculosis exposure in the prison, alcohol rehabilitation centres, renal units and age care • remote area visits with medical officers, registered nurses and radiologist • regular case meetings with acute care and remote support teams	Funding Sources: • NT Department of Health • Department of Immigration and Boarder Protection for the Illegal Foreign Fisherman (IFF) and Irregular Maritime Arrivals (IMAs). Responsibility for managing and delivering the program • NT DoH	Routine reporting: • NTG Estimates data reports, • NT Department of Health, Annual Report

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Trachoma	<p>The NT Trachoma Program undertakes trachoma control activities in all remote communities across the NT, with the aim of eliminating trachoma by 2020. Services are include:</p> <ul style="list-style-type: none"> • screening and treatment of all 5-9 year old Indigenous children in remote communities for active trachoma infection, including treating entire communities where required and screening (and where required, treatment) of Indigenous adults >40 for trichiasis, which can cause blindness • promotion of facial cleanliness and improving environments to prevent the transmission of infections. <p>Extensive community consultation, employment of community based workers and collaboration with the Indigenous Eye Health Unit are undertaken to ensure services are culturally appropriate and accessible.</p>	<p>Funding Source: Australian Government Partnership Agreement</p> <p>Responsibility for managing and delivering the program</p> <ul style="list-style-type: none"> • NT DoH; • NT Aboriginal Medical Services 	<p>Routine reporting: 6 monthly reporting to the Australian Government against PA milestones</p>
Rheumatic Heart Disease Control Program	<p>The Rheumatic Heart Disease (RHD) Control Program is a NT wide program that aims to reduce the burden of rheumatic heart disease among the Aboriginal population by reducing the occurrence of acute rheumatic fever (ARF) in remote and urban community settings. Health professionals and community members are provided best practice support, education, resource development and supply and patient care.</p> <p>The program works with community elders and interpreters to develop culturally appropriate resources and improve accessibility.</p> <p>The high turnover of remote area nursing staff and the reduction of a consistent GP service in remote areas are addressed by maintaining strong communication with regional health service management.</p>	<p>Funding Source: Australian Government PA</p> <p>Responsibility for managing and delivering the program NT DoH</p>	<p>Routine reporting: 12 monthly reporting against PA</p>

Source: NT Government unpublished.

Data quality information — Primary and community health, chapter 10

Data quality information

Data quality information (DQI) provides information against the seven ABS data quality framework dimensions, for a selection of performance indicators in the Primary and community health chapter. DQI for additional indicators will be progressively introduced in future reports.

Technical DQI has been supplied or agreed by relevant data providers. Additional Steering Committee commentary does not necessarily reflect the views of data providers.

DQI Contents

Availability of PBS medicines	3
Measure 1: People per pharmacy by region	3
Measure 2: PBS expenditure per person by region	4
Measure 3: Equity of access to PBS medicines	5
Measure 1: Availability of GPs by region	6
Measure 2: Availability of GPs by sex	8
Early detection and early treatment for Indigenous people	10
Proportion of children receiving a fourth year developmental health check	13
Effectiveness of access to GPs	15
Measure 1: Bulk billing rates	15
Measure 2: People deferring visits to GPs due to financial barriers	17
Measure 3: GP Waiting times	21
Measure 4: Selected potentially avoidable GP-type presentations to emergency departments	25
Financial barriers to PBS medicines	28
Public dentistry waiting times	32
GPs with vocational registration	36
Management of upper respiratory tract infections	38
Chronic disease management	40

Measure 1: Management of diabetes — HbA1c level	40
Measure 2: Management of asthma	43
Use of pathology tests and diagnostic imaging	46
Patient satisfaction	49
Health assessments for older people	53
Cost to government of general practice per person	55
Child immunisation coverage	57
Notifications of selected childhood diseases	59
Participation rates for women in cervical screening	61
Selected potentially preventable hospitalisations	63
Measure 1: Selected potentially preventable hospitalisations for vaccine preventable, acute and chronic conditions	63
Measure 2: Selected potentially preventable hospitalisations for diabetes	68
Measure 3: Potentially preventable hospitalisations of older people for falls	71

Availability of PBS medicines

Data quality information for this indicator has been developed by the Health Working Group with additional Steering Committee comments.

Measure 1: People per pharmacy by region

Indicator definition and description

Element	Equity — Access
Indicator	Equity of access to PBS medicines
Measure/s (computation)	Definition <ul style="list-style-type: none">The estimated resident population (ERP) divided by the number of pharmacies, in urban areas and in rural areas Numerator: ERP for urban areas and for rural areas Denominator: Number of pharmacies in urban and in rural areas Computation: Numerator ÷ Denominator.
Data source/s	University of Adelaide's National Centre for Social Applications of Geographic Information Systems, using Department of Human Services, Medicare pharmacies data and ABS ERP data.

Data Quality Framework Dimensions

Institutional environment	Australian Government Department of Health, PBS data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists:
Relevance	Data are presented by State/Territory by urban and rural location. Urban and rural location for ERP is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification as at 30 June preceding the reference year from 2012-13. For previous years, geographical location is based on the ABS Australian Standard Geographical Classification 2006 as at 30 June preceding the reference year. 'Urban' constitutes ASGS 'Major cities'. Rural constitutes inner regional, outer regional, remote and very remote areas combined. Urban and rural location for pharmacies is based on the Pharmacy Access/Remoteness Index of Australia (PhARIA) classification. PhARIA is a composite index that incorporates measurements of general remoteness based on the ASGS and previously the ASGC with a professional isolation component represented by the road distance to the five closest pharmacies. 'Urban' is equivalent to the ASGS 'Major cities'. Rural constitutes the remaining PhARIA categories (2 to 6) combined.
Timeliness	Reliable PBS data are available 16 weeks after the close of the reference period.
Accuracy	
Coherence	Estimates are compiled the same way across regions and over time. The ERPs used to derive rates differ across years. For data up to 2010-11 rates are derived using preliminary ERPs based on the 2006 Census. For data from 2011-12 rates are derived using ERPs based on the 2011 Census. Rates derived using ERPs based on different Censuses are not comparable.
Accessibility	Information is available for PBS data from www.pbs.gov.au/info/browse/statistics .
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home .

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: <ul style="list-style-type: none">Data do not include Aboriginal Medical Services that can supply medications to people in remote and very remote areas under s.100 of the <i>National Health Act 1953</i>
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[Cwlth] for the purpose of improving access to medicines for people in those areas. This has particular relevance for the NT, as 43.9 per cent of the population live in remote and very remote areas.

- Disaggregation of data by region is limited to 'Urban' (equivalent to major cities) and 'Rural' (all other areas). Further disaggregation of rural data would be of value.

Measure 2: PBS expenditure per person by region

Indicator definition and description

Element	Equity — Access
Indicator	Equity of access to PBS medicines
Measure/s (computation)	<p>Definition:</p> <ul style="list-style-type: none"> • Expenditure on Pharmaceutical Benefits Scheme (PBS) medicines divided by the ERP, by remoteness area <p>Numerator: Expenditure on PBS medicines</p> <p>Denominator: ERP</p> <p>Computation: Numerator ÷ Denominator.</p>
Data source/s	<p>Numerator: Australian Government Department of Health, PBS Statistics</p> <p>Denominator: ABS ERP as at 30 June preceding the reference year from 2012-13.</p>

Data Quality Framework Dimensions

Institutional environment	PBS expenditure data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists.
Relevance	<p>Expenditure data are reported on a cash basis and are available by region only for general and concessional categories. Therefore, data exclude expenditure on doctor's bag and other categories administered under special arrangements, such as, medications dispensed to Aboriginal Medical Services in remote and very remote areas under s.100 of the <i>National Health Act 1953</i> (Cwlth) for the purpose of improving access to PBS medicines for Indigenous people and others located in those areas. This expenditure, \$38.5 million in 2013-14, is not suitable for computation of expenditure per person as 'catchment' areas for Aboriginal Medical Services cross regional boundaries.</p> <p>Geographical location is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification from 2012-13. For previous years, geographical location is based on the Rural, Remote and Metropolitan Area (RRMA) classification. This constitutes a break in time series; data from 2012-13 are not comparable with data for previous years.</p>
Timeliness	Reliable PBS data are available 16 weeks after the close of the reference period.
Accuracy	The supply data has an accuracy of approximately 98 per cent after 16 weeks.
Coherence	<p>Estimates are compiled the same way across regions.</p> <p>The change to ASGS based geographical location from 2012-13 from RRMA based geographical location for previous years constitutes a break in time series. Data from 2012-13 are not comparable with data for previous years.</p> <p>Data are not directly comparable to data published in the Australian Government Department of Health annual report, which are prepared on an accrual accounting basis and include doctor's bag and other categories administered under special arrangements (such as medications dispensed to remote and very remote areas under s.100 of the <i>National Health Act 1953</i> [Cwlth].)</p>
Accessibility	Information is available for PBS data from www.pbs.gov.au/info/browse/statistics .
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home .

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none">• Data are reported only at the national level; reporting by State/Territory is a priority• Data exclude medications supplied to Aboriginal Medical Services in remote and very remote areas under s.100 of the <i>National Health Act 1953</i> [Cwlth] for the purpose of improving access for Indigenous people and others located in those areas.• Geographical location is based on the ASGS 2011 classification system from 2012-13, a key improvement over the classification system used for previous years that was developed in 1994.
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Measure 3: Equity of access to PBS medicines

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to PBS medicines
Measure/s (computation)	<p>Proportion of PBS prescriptions filled at a concessional rate</p> <p>Definition:</p> <ul style="list-style-type: none">• The number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled. <p>Numerator: The number of PBS prescriptions filled at a concessional rate</p> <p>Denominator: The total number of prescriptions filled</p> <p>Computation: Numerator ÷ Denominator</p>
Data source/s	Australian Government Department of Health, PBS Statistics.

Data Quality Framework Dimensions

Institutional environment	PBS expenditure data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists.
Relevance	Data are reported by State/Territory.
Timeliness	Reliable PBS supply data are available 16 weeks after the close of the reference period
Accuracy	The supply data has an accuracy of approximately 98 per cent after 16 weeks.
Coherence	Estimates are compiled the same way across jurisdictions and over time.
Accessibility	Information is available for PBS data from www.pbs.gov.au/info/browse/statistics
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none">• Data do not capture medicines supplied by Aboriginal Medical Services in remote and very remote areas under s.100 of the <i>National Health Act 1953</i> [Cwlth] for the purpose of improving access to medicines for Indigenous people and others located in these areas. This has particular relevance for the NT as around 43 per cent of the population live in these areas.
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Equity of access to GPs

Data quality information for this indicator has been developed by the Health Working Group with additional Steering Committee comments.

Measure 1: Availability of GPs by region

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to GPs
Measure/s (computation)	Availability of general practitioners (GPs) by region. Definition: <ul style="list-style-type: none">• The number of Full-time Workload Equivalent (FWE) GPs per 100 000 people, by region. Numerator: Number of FWE GPs Denominator: Estimated Resident Population (ERP) by region. Computation: $100\,000 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	Numerator: Australian Government Department of Human Services (DHS), Medicare data. Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December in the reference year.

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of the DHS, Medicare fee for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> (previously <i>Medicare Australia Act 1973</i>) and regularly provides the data to Australian Government Department of Health.
Relevance	<p>Geographical location based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification as at 30 June preceding the reference year from 2012-13.</p> <p>For previous years, geographical location is based on the Rural, Remote and Metropolitan Area (RRMA) classification — urban includes ‘Capital city’ and ‘Other metropolitan area’; rural includes ‘Large rural centres’, ‘Small rural centres’, ‘Other rural areas’, ‘Remote centres’ and ‘Other remote areas’. The RRMA classification was developed in 1994 based on population figures and Statistical Local Area (SLA) boundaries as at the 1991 census. It has not been officially updated and does not reflect population growth or redistribution since 1991 — metropolitan, rural and remote areas are defined as they existed in 1991.</p> <p>GP headcount and FWE figures include vocationally recognised as well as non vocationally recognised general practitioners.</p> <p>GP headcount is a count of all GPs who have provided at least one DHS, Medicare service during the reference period and have had at least one claim for a DHS, Medicare service processed during the same reference period.</p> <p>GP headcount is generally an unreliable measure of workforce supply in Australia due to the high proportion of casual and part-time practitioners accessing DHS, Medicare. FWE is a standardised measure adjusted for the partial contribution of casual and part-time doctors and is a more reliable estimate of the GP workforce.</p> <p>FWE is calculated by dividing each doctor's DHS, Medicare billing by the average billing of full time doctors for the reference period.</p> <p>Example 1: A busy GP billing 50 per cent more services than the average full-time GP will be recorded as 1 in the headcount figure and 1.5 in the FWE figure. Example 2: A part-time GP billing half the services of the average for full time GPs will be recorded as 1 in the headcount figure and 0.5 in the FWE figure.</p>

	<p>A GP can work at more than one location. Allocation of GP headcount to state or territory and region is based on the practice location at which the GP provided the most DHS, Medicare services during the reference period. FWE allocates activity based on the practice location at which services were rendered within the reference period.</p> <p>From 2007-08 to 2011-12 under the RRMA based geographical classification, data are reported separately for NSW and the ACT. Data for previous years for NSW and the ACT are combined for confidentiality reasons. The ACT has no rural areas.</p>
Timeliness	GP headcount and FWE figures are available 10 weeks after the close of the reference period.
Accuracy	<p>GP headcount figures include only those GPs that both claimed and provided a service in the reference period. A small number of GPs may provide services in one year for which all claims are not processed until the next year. As additional months or DHS, Medicare claims data are processed, a small number of providers will become eligible for inclusion in the headcounts. Revision of headcount figures will result in very small differences to published figures each year. FWE figures are not revised each year.</p> <p>Since the commencement of DHS, Medicare, practitioners have provided demographic information to DHS, Medicare including date of birth and gender. Demographic details are updated when practitioners review, renew or change their registration details with DHS, Medicare Australia. While the demographic data for current practitioners is generally very accurate and complete, there are some instances of missing data.</p> <p>To overcome the problems and biases posed by missing data, similar practitioners were grouped based on known demographic information and missing demographic field/s were imputed using a standardised method to maintain data integrity. As a result, some minor changes to the distribution of GPs based on GP age or gender may occur when newly released figures are compared with previous versions.</p>
Coherence	<p>The change in geographical location classification constitutes a break in time series. Data from 2012-13 are not comparable with data for previous years.</p> <p>Estimates are compiled the same way across jurisdictions.</p>
Accessibility	Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9 .
Interpretability	General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • The classification system used to allocate GPs to regions from the reference year 2012-13 is current, a major improvement over data for previous years which were based on a system developed in 1994 • Data are reported for 5 regional categories from 2012-13, compared to only 2 broad regional categories for previous years.
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Measure 2: Availability of GPs by sex

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to GPs by sex
Measure/s (computation)	Availability of general practitioners (GPs) by sex. Definition: <ul style="list-style-type: none">• The number of Full-time Workload Equivalent (FWE) female GPs per 100 000 females• The number of FWE male GPs per 100 000 males Numerator: Number of FWE GPs by sex. Denominator: Estimated Resident Population (ERP) by sex. Computation: $100\,000 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	Numerator: Australian Government Department of Human Services (DHS), Medicare data. Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP).

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> and regularly provides the data to Australian Government Department of Health.
Relevance	FWE GP figures include vocationally recognised as well as non-vocationally recognised general practitioners. FWE is a standardised measure used to estimate the workforce activity of GPs, adjusting for the partial contribution of casual and part-time doctors. FWE is calculated by dividing each doctor's DHS, Medicare billing by the average billing of full-time doctors for the reference period. Example 1: A busy GP billing 50 per cent more services than the average full-time GP will be recorded as 1 in the headcount figure and 1.5 in the FWE figure. Example 2: A part-time GP billing half the services of the average for full time GPs will be recorded as 1 in the headcount figure and 0.5 in the FWE figure.
Timeliness	FWE figures are available 10 weeks after the close of the reference period.
Accuracy	FWE figures are not revised each year. Since the commencement of DHS, Medicare, demographic information has been provided by practitioners to DHS, Medicare including date of birth and gender. The demographic details are updated when practitioners review, renew or change their registration details with DHS, Medicare. While the demographic data for current practitioners is generally very accurate and complete, there are some instances of missing data. To overcome the problems and biases posed by missing data, similar practitioners were grouped based on the known demographic information and missing demographic field/s were imputed using a standardised method to maintain data integrity. As a result, some minor changes to the distribution of GPs based on GP age or gender may occur when newly released figures are compared with previous versions.
Coherence	Estimates are compiled the same way across jurisdictions and over time. For data to 2010-11, rates are derived using the ABS 2006 Census based ERP as at 30 June preceding the reference year. From 2011-12, rates are derived using the preliminary ABS 2011 Census based ERP as at 31 December in the reference year. Rates derived using ERPs based on different Censuses are not comparable.

Accessibility Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.

Interpretability General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues The Steering Committee notes the following issues:

- Data are of acceptable accuracy.
- Data are reported for the first time for male as well as female GPs.

Early detection and early treatment for Indigenous people

Data quality information has been developed for this indicator by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Early detection and early treatment for Indigenous people
Measure/s (computation)	
Measure 1	<p>Definition:</p> <ul style="list-style-type: none">The proportion of older people who received a health assessment by Indigenous status. <p>Numerator:</p> <ul style="list-style-type: none">The number of people aged 75 years or over with an MBS claim for Items 700, 701, 702, 703, 705 or 707 (Health assessment) and the number of people aged 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period <p>Denominator:</p> <ul style="list-style-type: none">The population of Indigenous people aged 55 years or over and the estimated population of non-Indigenous people aged 75 years or over (computed by subtracting the projected population of Indigenous people aged 75 or over from the ERP aged 75 years or over) in the reference period. <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Measure 2	<p>Definition:</p> <ul style="list-style-type: none">The proportion of older Indigenous people who received a health assessment, time series. <p>Numerator: The number of people aged 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period.</p> <p>Denominator: The population of Indigenous people aged 55 years or over in the reference period.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Measure 3	<p>Definition:</p> <ul style="list-style-type: none">The proportion of Indigenous people who received a health assessment, by age group. <p>Numerator:</p> <ul style="list-style-type: none">The number of people aged 0–14 years, 15–54 years, or 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period <p>Denominator:</p> <ul style="list-style-type: none">The population of Indigenous people aged 0–14 years, 15–54 years, and 55 years or over in the reference period. <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Data sources (all measures)	<p>Numerator: Australian Government Department of Human Services (DHS), Medicare data.</p> <p>Denominator: computed by the Secretariat using ERP data from the ABS.</p> <ul style="list-style-type: none">Total population: ABS various years, <i>Australian demographic statistics</i>, Cat. no. 3101.0.For data by Indigenous status: ABS 2014, <i>Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026</i>, Cat. no. 3238.0 (B Series).

Data Quality Framework Dimensions

Institutional environment	<p>MBS claims data are an administrative by-product of the DHS, Medicare fee for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> and regularly provides the data to Australian Government Department of Health.</p> <p>The indicator was calculated by the Secretariat using numerator data supplied by the Department of Health (Australian Government) and denominator data from the ABS.</p>
Relevance	<p>These measures relate to specific DHS, Medicare services for which claims data are available.</p> <p>Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to affect overall proportions significantly because the life expectancy of Indigenous people is, on average, relatively low.</p> <p>Allocation of clients to state or territory is based on client postcode of residence as recorded by DHS, Medicare at time of processing the final claim in the reference period. This might differ from the client's residential postcode at the time the service was received, and might not be where the service was provided.</p> <p>For services provided from 1 May 2010, disaggregation by age is based on client date of birth in DHS, Medicare records at the date the service was received. Prior to 1 May 2010 unique MBS item numbers applied to each age group.</p> <p>Eligible populations exclude people who are hospital in-patients or living in a residential aged care facility.</p>
Timeliness	<p>MBS claims data are available within 14 days of the end of a month.</p>
Accuracy	<p>Data include all claims processed up to 12 months after the service is received. Current year data are preliminary and subject to revision in subsequent reports.</p> <p>Allocation to state and territory does not necessarily reflect the client residence at the time of receiving the service if a change of address prior to receiving the service was not reported to DHS, Medicare in the reference period or a change of address after receiving the service was reported to DHS, Medicare in the reference period.</p> <p>Health assessment rebate claims that are not processed within 12 months of the reference period are excluded. This does not significantly affect the data.</p> <p>Clients are counted once only in the reference period.</p> <p>Data do not include:</p> <ul style="list-style-type: none">• health assessment activity for which practitioners do not claim the rebate• services that qualify under the DVA National Treatment Account and services provided in public hospitals <p>Data have not been adjusted to account for known under-identification of Indigenous status in MBS data.</p> <p>Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.</p>
Coherence	<p>The following changes to MBS items occurred on 1 May 2010, but are unlikely to impact time-series analysis. As of 1 May 2010:</p> <ul style="list-style-type: none">• MBS Items 704, 706, 708, 710 (age based Health Assessments for Aboriginal and Torres Strait Islander People) have been replaced with one MBS Item that covers Health Assessments for Aboriginal and Torres Strait Islander People of all ages (Item 715)• MBS Items 700 and 702 (Health assessments for older people) have been replaced with four new MBS items that cover Health assessments for all ages and are based on time and complexity of the visit — Items 701 (brief), 703 (standard), 705 (long) and 707 (prolonged).

For services provided from 1 May 2010, disaggregation by age is based on client date of birth in DHS, Medicare records at the date the service was received.

Health assessments for people who are refugees or humanitarian entrants can also be claimed from 1 May 2010 under MBS Items 701, 703, 705 and 707. This is likely to have little impact on the totals reported as the usage rates for these health assessments are low to extremely low.

Accessibility Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.

Interpretability General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps The Steering Committee notes the following issues:

/issues

- No adjustment was made to this indicator to account for under-identification of Indigenous people in DHS, Medicare data.

Proportion of children receiving a fourth year developmental health check

Data quality information for this indicator has been prepared based on the Steering Committee's 2012 report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the AIHW) with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Developmental health checks.
Measure/s (computation)	<p>Proportion of children who have received a 4 year old development health check.</p> <p>Numerator: The number of people aged 3, 4 or 5 years with an MBS claim for Items 709, 711, 701, 703, 705, 707 and 10 986 (Healthy Kids Check or Health Assessment) or 708 and 715 (Aboriginal and Torres Strait Islander Peoples Health Assessment) in the reference period.</p> <p>Denominator: The population aged 4 years, estimated using ERP data from the ABS. It was calculated by multiplying the 0-4 years ERP disaggregated by Indigenous status by the percentage of children aged 4 years in this age group nationally.</p> <p>Calculation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Data source/s	<p>Numerator: Australian Government Department of Human Services (DHS), Medicare Statistics data.</p> <p>Denominator: For total population: 2011 census based Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December derived by averaging the 30 June population at each end of the reference year.</p> <p>For data by Indigenous status: 2011 census based ABS Indigenous Experimental Estimates and Projections (Indigenous Population) Series B as at 31 December derived by averaging the 30 June population at each end of the reference year.</p>

Data Quality Framework Dimensions

Institutional environment	<p>DHS, Medicare processes claims made through the MBS under the <i>Human Services (Medicare) Act 1973</i>. These data are then regularly provided to Australian Government Department of Health.</p> <p>Data for 2009-10 and 2010-11 were calculated by Australian Government Department of Health, using a denominator supplied by the AIHW. Australian Government Department of Health drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies) and then further comments were added by the AIHW, in consultation with Australian Government Department of Health.</p> <p>Data from 2011-12 are calculated by the Secretariat using numerator data supplied by Australian Government Department of Health and denominator data sourced from the ABS.</p>
Relevance	<p>The measure relates to specific identified DHS, Medicare services for which DHS, Medicare has processed a claim.</p> <p>The MBS items included in this indicator do not cover all developmental health check activity such as that conducted through state and territory early childhood health assessments in preschools and community health centres.</p>
Timeliness	MBS claims data are available within 14 days of the end of a month. The indicator relates to all claims processed in the reference year.
Accuracy	<p>As with any administrative system a small degree of error may be present in the data captured.</p> <p>Analyses by state/territory are based on postcode of residence of the client as recorded by DHS, Medicare at the date the last service was received in the reference period. This</p>

postcode may not reflect the current postcode of the patient if an address change has not been notified to DHS, Medicare.

Data to 2010-11 are based on the date the claim was processed. From 2011-12, data are based on the date the service was rendered. From 2012 13, data include only services for which rebates were claimed in the reference year. This has minimal impact on the data.

Children who received more than one type of health check are counted once only in the calculations for this indicator. Where a child received both a healthy kids check and an Aboriginal and Torres Strait Islander people's health assessment during the reference period, the child was counted once against the Aboriginal and Torres Strait Islander health assessment.

From 2011-12, children are counted only if they have not received a fourth year developmental health check in a previous reference period at the age of 3, 4 or 5 years.

MBS data presented for Aboriginal and Torres Strait Islander Peoples Health Assessments have not been adjusted to account for known under identification of Indigenous status.

Cells have been suppressed where the numerator is less than 10 for confidentiality reasons and where rates are highly volatile (for example, the denominator is very small) or data are known to be of insufficient quality (for example, where Indigenous identification rates are low).

Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.

Coherence

As of 1 May 2010, the following changes to MBS items occurred:

The Healthy Kids Check Item 709 was replaced with four MBS health assessment items (based on time and complexity) that cover all ages — Items 701 (brief), 703 (standard), 705 (long) and 707 (prolonged). This renders it possible that health assessments for refugees and humanitarian entrants and for people with an intellectual disability (previously claimed under items 714, 718 or 719 and now claimed under the new MBS health assessment items) have been counted. This is likely to have little impact on the totals reported as the usage rates for these health assessments are low to extremely low for children aged 3–5 years.

A Healthy Kids Check provided by a practice nurse or a registered Aboriginal health worker on behalf of a medical practitioner (previously item 711) was replaced with MBS item number 10 986. The change to the MBS item number does not impact time series analysis.

The Aboriginal and Torres Strait Islander Child Health Check (previously item 708) was replaced by the Aboriginal and Torres Strait Islander People's Health Assessment (715) that has no designated time or complexity requirements and covers all ages. The change to the MBS item number does not impact time series analysis.

Accessibility

Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.

Interpretability

General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data do not include developmental health check activity conducted outside the MBS, for example, in preschools and community health centres. Accordingly, the indicator understates developmental health check activity.
- No adjustment was made to this indicator to account for under-identification of Indigenous children in DHS, Medicare data.

Effectiveness of access to GPs

Measure 1: Bulk billing rates

Data quality information has been developed for this measure by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Effectiveness of access to GPs
Measure/s (computation)	<p>Bulk billing rates</p> <p>Definition: The number of non-referred attendances to GPs that were bulk billed as a proportion of all non-referred attendances to GPs.</p> <p>Numerator: The number of non-referred attendances to GPs that were bulk billed.</p> <p>Denominator: The number of non-referred attendances to GPs.</p> <p>Computation: Expressed as a percentage.</p> <p>Disaggregations:</p> <ul style="list-style-type: none">• State/Territory by age• Region by age
Data source/s	<p>Numerator: Australian Government Department of Human Services (DHS), Medicare data.</p> <p>Denominator: Australian Government Department of Human Services (DHS), Medicare data.</p>

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> and regularly provides the data to DoHA.
Relevance	<p>These measures relate to DHS, Medicare services for which claims data are available.</p> <p>Data include non-referred attendances by general practice nurses.</p> <p>Disaggregation by region:</p> <p>From 2012-13, disaggregation by region is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification. For previous years, disaggregation by region is based on the Rural, Remote and Metropolitan Areas (RRMA) classification. The RRMA classification was developed in 1994 based on population figures and Statistical Local Area (SLA) boundaries as at the 1991 census. It has not been officially updated and does not reflect population growth or redistribution since 1991 — metropolitan, rural and remote areas are defined as they existed in 1991.</p> <p>RRMA categories are: Capital city — State and Territory capital city statistical divisions; Other metropolitan centre — one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; Large rural centre — statistical local areas (SLAs) where most of the population resides in urban centres with a population of 25 000 or more; Small rural centre — SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; Other rural area — all remaining SLAs in the rural zone; Remote centre — SLAs in the remote zone containing populations of 5000 or more; Other remote area — all remaining SLAs in the remote zone.</p>
Timeliness	MBS claims data are available within 14 days of the end of a month.
Accuracy	<p>As with any administrative system a small degree of error may be present in the data captured.</p> <p>Allocation to jurisdiction/region: DHS, Medicare claims data used for statistical purposes</p>

are based on enrolment postcode of the client at time of processing the final claim in the reference period. This postcode may not be current if the client changed address but did not notify DHS, Medicare.

Allocation to age group: Allocation to age group is based on client date of birth in DHS, Medicare records at the date the service was received. Where client age is unknown, attendances are included in totals.

Allocation to reference period: Data include all claims processed in the reference period. Data are based on the date on which the MBS claim was processed by DHS, Medicare, not the date on which the service was rendered. The use of data based on when the claim was processed rather than when the service was rendered produces little difference in the total number of services included in the numerator for the reference period.

Coherence Estimates are compiled the same way across jurisdictions.

Disaggregation by State/Territory:

Rates are derived using the ABS ERP as at 30 June preceding the reference year.

From 2012-13, the ERP is based on the ABS 2011 Census.

For data for 2007-08 to 2011-12, the ERP is based on the ABS 2006 Census.

For data to 2006-07, the ERP is based on the ABS 2001 Census.

Rates derived using ERPs based on different Censuses are not comparable.

Disaggregation by region:

The change in geographical location classification constitutes a break in time series. Data from 2012-13 are not comparable with data for previous years.

Accessibility Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.

Interpretability General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues The Steering Committee notes the following issues:

- The classification system used to allocate data to regions from the reference year 2012-13 is current, a major improvement over data for previous years which were based on a system developed in 1994
- Data are of acceptable accuracy.

Measure 2: People deferring visits to GPs due to financial barriers

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Effectiveness of access to GPs
Measure/s (computation)	People deferring access to GPs due to cost. Definition: Proportion of people that required GP treatment but deferred that treatment due to cost. Numerator: People reporting delaying/not seeing a GP in the last 12 months due to cost. Denominator: People aged 15 years or over who needed to see a GP in the last 12 months. Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the ABS.</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible.</p>
Relevance	<p>Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia).</p> <p>Data Completeness: All data are available for this measure from this source.</p> <p>Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.</p> <p>Numerator/Denominator Source: Same data source.</p> <p>Data for this indicator were collected for all people aged 15 years or over in Australia, excluding the following:</p> <ul style="list-style-type: none">• members of the Australian permanent defence forces• diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts• overseas residents in Australia• members of non-Australian defence forces (and their dependents)

- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

Data were self-reported for this indicator. The definition of 'urgent medical care' was left up to the respondent, although discretionary interviewer advice was to include health issues that arose suddenly and were serious (e.g. fever, headache, vomiting, unexplained rash), and that seeing a GP to get a medical certificate for work for a less serious illness would not be considered urgent.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The data used for this indicator became available 22 November 2013 for 2012-13 and 28 November 2014 for 2013-14.

Referenced Period: July 2013 to June 2014 (2013-14 data); July 2012 to June 2013 (2012-13 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: For this iteration of the Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.

The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEx included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.

Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEx sample only and estimates obtained using the combined MPHS PEx and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (The majority of MPHS PEx interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience Survey.

Response rate and sample size: The response rate in 2013-14 to the MPHS PEx was 77 per cent (27 327 fully responding persons) while the response rate to HSS was 83 per cent (8541 fully responding persons) resulting in a total sample size of 35 868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.

Note this is a substantial increase from the 2012-13 sample size of 30 749, which had a response rate 78.9 per cent. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Data for MPHS PEx and HSS were weighted separately and then combined to produce output.

Confidentiality — For the first time in 2013-14, the data has been perturbed. This has been footnoted in the tables. Perturbation is used to minimise the risk of identifying individuals in aggregate statistics. Perturbation involves small random adjustment of the statistics and is considered the most satisfactory technique for avoiding the release of identifiable statistics while maximising the range of information that can be released. These adjustments have a negligible impact on the underlying pattern of the statistics.

After perturbation, a given published cell value will be consistent across all tables. However, adding up cell values to derive a total will not necessarily give the same result as published totals.

As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95% confidence intervals. Estimates with a relative standard error between 25 per cent and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.

The standard errors for the key data items in this indicator are relatively low and provide reliable state and territory data as well as remoteness breakdowns. An exception to this would be data for the "other" remoteness category when cross classified by State, which can result in high RSEs. Caution should be used when interpreting these data.

Known Issues: Data were self-reported.

Explanatory footnotes are provided for each table.

Coherence

2009 was the first year data was collected for this indicator. Questions relating to this indicator were also asked in 2010-11, 2011-12, 2012-13 and 2013-14.

Consistency over time: Data for 2013-14 are comparable to data for 2012-13 but not to data for previous years, due to a change in question ordering in 2012-13 which had a noticeable context effect. As a result, ABS recommends that this data item is not comparable over time. This has been footnoted in the relevant tables.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the 2011-12 and 2012-13 surveys, and of very remote communities in the previous surveys, will affect the NT more than it affects other jurisdictions (people usually resident in very remote areas account for about 23 per cent of people in the NT).

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Due to differences in survey scope, collection methodology and question wording, these data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009* (Cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12, 2012-13 and 2013-14* (Cat. no. 4839.0).

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period which should minimise any seasonality effects in the data.

The 2013-14 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2013-14* (Cat. no. 4839.0). The publication includes explanatory and technical notes.

Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in the publication.

Data Gaps/Issues Analysis

**Key data gaps
/issues**

The Steering Committee notes the following issues:

- Data for 2013-14 are comparable to data for 2012-13 but not for previous years. Comparable time series data is a priority.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- The sample size increase from 30 749 in 2012-13 to 35 868 in 2013-14 strengthens reliability of the population level estimates.
- Data from the Patient Experience survey are not comparable with data from the 2012-13 NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.

Measure 3: GP Waiting times

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Effectiveness of access to GPs
Measure/s (computation)	GP Waiting Times Definition Length of time a patient needs to wait to see a GP for an urgent appointment. Numerator Number of people aged 15 years or over who reported seeing a GP for urgent medical care (for their own health) within specified waiting time categories (less than 4 hours, 4 to less than 24 hours, 24 hours or more). Denominator Number of people aged 15 years or over who saw a GP for urgent medical care (for their own health) in the last 12 months. Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	Patient Experience Survey, ABS.

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the ABS.</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re released with the correct data. Key users are also notified where possible.</p>
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Relevance

Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia).

Data Completeness: All data are available for this measure from this source.

Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.

Numerator/Denominator Source: Same data source.

Data for this indicator were collected for all people aged 15 years or over in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

Data were self-reported for this indicator. The definition of 'urgent medical care' was left up to the respondent, although discretionary interviewer advice was to include health issues that arose suddenly and were serious (e.g. fever, headache, vomiting, unexplained rash), and that seeing a GP to get a medical certificate for work for a less serious illness would not be considered urgent.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The data used for this indicator became available 22 November 2013 for 2012-13 and 28 November 2014 for 2013-14.

Referenced Period: July 2013 to June 2014 (2013-14 data); July 2012 to June 2013 (2012-13 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: For this iteration of the Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.

The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEx included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.

Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEx sample only and estimates obtained using the combined MPHS PEx and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (The majority of MPHS PEx interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience

Survey.

Response rate and sample size: The response rate in 2013-14 to the MPHS PEx was 77 per cent (27 327 fully responding persons) while the response rate to HSS was 83 per cent (8541 fully responding persons) resulting in a total sample size of 35 868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.

Note this is a substantial increase from the 2012-13 sample size of 30 749, which had a response rate 78.9 per cent. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Data for MPHS PEx and HSS were weighted separately and then combined to produce output.

Confidentiality:

For the first time in 2013-14, the data has been perturbed. This has been footnoted in the tables. Perturbation is used to minimise the risk of identifying individuals in aggregate statistics. Perturbation involves small random adjustment of the statistics and is considered the most satisfactory technique for avoiding the release of identifiable statistics while maximising the range of information that can be released. These adjustments have a negligible impact on the underlying pattern of the statistics.

After perturbation, a given published cell value will be consistent across all tables. However, adding up cell values to derive a total will not necessarily give the same result as published totals.

As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a relative standard error between 25 per cent and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.

This indicator generally has acceptable levels of sampling error and provides reliable data for most breakdowns. However, RSEs for the waiting time category "4 hours or more but within 24 hours" breakdowns are mostly greater than 25 per cent and should either be used with caution or are considered too unreliable for general use. Similarly, data for the "other" remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data.

Known Issues: Data was self-reported and interpretation of urgent medical care was left up the respondent.

The data is self-reported but not attitudinal, as respondents are reporting their experiences of using the health system (in this instance, the time they waited between making an appointment for urgent medical care and the time they got to see the GP).

Explanatory footnotes are provided for each table.

Coherence

Consistency over time: 2009 was the first year data was collected for this indicator. Questions relating to this indicator were also asked in 2010-11, 2011-12, 2012-13 and 2013-14.

Time series issues: 2013-14 is comparable to 2012-13 and 2011-12, but not before this (ie 2013-14 is not comparable to 2010-11 or 2009). This has been footnoted in the relevant tables. The reason for the comparability issues stem from a significant change in question wording and coding methodology in the 2011-12 Patient Experience Survey for the 'waiting times for GPs' questions, and this has had an impact on the data.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete indigenous communities in the sample will affect the NT more than it affects other jurisdictions.

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Due to differences in survey scope, collection methodology and question wording, these data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009* (Cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12, 2012-13 and 2013-14* (Cat. no. 4839.0).

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period which should minimise any seasonality effects in the data.

The 2013-14 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2013-14* (Cat. no. 4839.0). The publication includes explanatory and technical notes.

Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in the publication.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data for 2011-12, 2012-13 and 2013-14 are comparable.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- Data are based on waiting times for self-defined urgent medical care.
- Disaggregation of this measure by Indigenous status is a priority.
- The sample size increase from 30 749 in 2012-13 to 35 868 in 2013-14 strengthens reliability of the population level estimates.

Measure 4: Selected potentially avoidable GP-type presentations to emergency departments

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Attendances at public hospital emergency departments that could have potentially been avoided through the provision of appropriate non-hospital services in the community.
Measure/s (computation)	<p>The number of presentations to public hospital emergency departments in hospitals that were classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or peer group B (Large hospitals), where:</p> <ul style="list-style-type: none">• there was a type of visit of Emergency presentation (or, for SA for 2008-09 and 2009-10, Emergency presentation or Not reported)• a triage category of 4 or 5 was allocated• the patient did not arrive by ambulance or police or correctional vehicle; and• the patient was not admitted to the hospital, was not referred to another hospital, and did not die.
Data source/s	This indicator is calculated using data from the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), based on the national minimum data set (NMDS) for Non-admitted patient emergency department care (NAPEDC).

Data Quality Framework Dimensions

Institutional environment The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the *Australian Institute of Health and Welfare Act 1987* to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance to the *Privacy Act 1988 (Commonwealth)*, ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au

Data for the NNAPEDCD were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

- www.aihw.gov.au/nhissc/
- <http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

The purpose of the NNAPEDCD is to collect information on the characteristics of emergency department care (including waiting times for care) for non-admitted patients registered for care in emergency departments in selected public hospitals classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or B (Large hospitals). In 2012–13, hospitals in peer groups A and B provided about 86 per cent of all public hospital emergency presentations.

The data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Hospitals not included do not necessarily have emergency departments that are equivalent to those in hospitals in peer groups A and B.

The indicator includes only peer group A (Principal referral and Specialist women's and children's hospitals) and peer group B (Large hospitals).

The definition of potentially avoidable GP type presentations is an interim measure, based on data available in the NNAPEDCD. The AIHW is managing revision work for this indicator under the auspices of the Australian Health Ministers' Advisory Council.

Timeliness

The reference period for these data is 2012-13 and 2013-14.

Accuracy

For 2012–13, the coverage of the NNAPEDCD was 100 per cent in all jurisdictions for public hospitals in peer groups A and B. For 2013-14, the preliminary estimate of the proportion of emergency occasions of service reported to the NNAPEDCD was 100 per cent for public hospitals in peer groups A and B although final coverage cannot be calculated until the 2013-14 National Public Hospital Establishments Database (NPHEd) data are available.

In the baseline year (2007-08), the Tasmanian North West Regional Hospital comprised the combined activity of its Burnie Campus and its Mersey Campus. This hospital was a Peer Group B hospital. There was then a change in administrative arrangements for Mersey and it became the only hospital in the country owned and funded by the Australian Government and, by arrangement, operated by the Tasmanian Government. This administrative change necessitated reporting of these campuses as separate hospitals from 2008-09 onwards. On its own the North West Regional Hospital (Burnie Campus only) is a Peer Group B hospital, whilst, on its own the Mersey Community Hospital is a Peer Group C hospital. Burnie and Mersey did not substantially change their activity, rather, it is simply a case that activity is now spread across two hospitals. For National Healthcare Agreement purposes, although it is a Peer Group C hospital, the Mersey Community Hospital continues to be included in reporting for Peer Group B hospitals to ensure comparability over time for Tasmania.

From 2009-10, the data for the Albury Base Hospital (previously reported in New South Wales hospital statistics) were reported in Victorian hospital statistics. This change in reporting arrangements should be factored into any analysis of data for New South Wales and Victoria.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

Comparability across jurisdictions may be impacted by variation in the assignment of triage categories.

Coherence

The data reported for 2012-13 and 2013-14 are consistent with data reported for the NNAPEDCD for previous years for individual hospitals.

In addition, the data reported to the NNAPEDCD in previous years has been consistent with the numbers of emergency occasions of services reported to the NPHEd for each hospital for the same reference year.

Time series presentations may be affected by changes in the number of hospitals reported to the collection and changes in coverage.

The information presented for this indicator is calculated using the same methodology as data published in Australian hospital statistics: emergency department care (report series) and the National healthcare agreement: performance report 2012-13.

However, 2012-13 data reported previously in these publications are different from the equivalent data published here because the hospitals classified as peer groups A and B were based on 2011-12, rather than 2012-13 peer groups.

Caution should be used in comparing these data with earlier years, as the number of hospitals classified as peer group A or B, or the peer group of a hospital, may vary over time.

Accessibility The AIHW provides a variety of products that draw upon the NNAPEDCD. Published products The AIHW provides a variety of products that draw upon the NNAPEDCD. Published products available on the AIHW website are: Australian hospital statistics suite of products with associated Excel tables. These products may be accessed on the AIHW website at www.aihw.gov.au/hospitals/.

Interpretability Metadata information for the NAPEDC NMDS and the NAPEDC DSS are published in the AIHW's online metadata repository, METeOR, and the *National health data dictionary*.

The *National health data dictionary* can be accessed online at www.aihw.gov.au/publication-detail/?id=10737422826

The Data Quality Statement for the 2012-13 NNAPEDCD can be accessed on the AIHW website at <http://meteor.aihw.gov.au/content/index.phtml/itemId/546749>

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The scope of the data used to produce this indicator is non-admitted patients registered for care in emergency departments in public hospitals classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or peer group B (Large hospitals). Most of the hospitals in peer groups A and B are in major cities. Therefore, disaggregation by remoteness, socioeconomic status and Indigenous status should be interpreted with caution.
- For 2012-13, the coverage of the NNAPEDCD collection is complete for public hospitals in peer groups A and B. It is estimated that 2013-14 has similar coverage, although final coverage cannot be calculated until the 2013-14 NPHEd data are available.
- The definition of potentially avoidable GP type presentations is an interim measure, based on data available in the NNAPEDCD. The AIHW is managing revision work for this indicator under the auspices of the Australian Health Ministers' Advisory Council, to be completed by the end of 2013.
- Caution should be used in comparing these data with earlier years as the number of hospitals classified as peer group A or B, and the peer group classification for a hospital, may vary over time.

Financial barriers to PBS medicines

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	
Measure/s (computation)	People deferring purchase of prescribed medicines due to cost. Definition: Proportion of people that deferred purchase of prescribed medicines due to cost. Numerator: Number of people who reported delaying or not getting a prescription filled for medication in the last 12 months because of cost. Denominator: Total number of people aged 15 years or over who received a prescription for medication from a GP in the last 12 months. Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i> . These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au . Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i> . Data Compiler(s): Data are compiled by the Health section of the ABS. Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i> . The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re released with the correct data. Key users are also notified where possible.
Relevance	Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia). Data Completeness: All data are available for this measure from this source. Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable. Numerator/Denominator Source: Same data source.

**Relevance
(cont.)**

Data for this indicator were collected for all people aged 15 years or over in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

Data were self-reported for this indicator. The definition of 'urgent medical care' was left up to the respondent, although discretionary interviewer advice was to include health issues that arose suddenly and were serious (e.g. fever, headache, vomiting, unexplained rash), and that seeing a GP to get a medical certificate for work for a less serious illness would not be considered urgent.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The data used for this indicator became available 22 November 2013 for 2012-13 and 28 November 2014 for 2013-14.

Referenced Period: July 2013 to June 2014 (2013-14 data); July 2012 to June 2013 (2012-13 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: For this iteration of the Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.

The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEX included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.

Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEX sample only and estimates obtained using the combined MPHS PEX and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (The majority of MPHS PEX interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience Survey.

Response rate and sample size: The response rate in 2013-14 to the MPHS PEX was 77 per cent (27 327 fully responding persons) while the response rate to HSS was 83 per cent (8541 fully responding persons) resulting in a total sample size of 35 868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.

Note this is a substantial increase from the 2012-13 sample size of 30,749, which had a response rate 78.9 per cent. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Data for MPHS PEx and HSS were weighted separately and then combined to produce output.

Confidentiality:

For the first time in 2013-14, the data has been perturbed. This has been footnoted in the tables. Perturbation is used to minimise the risk of identifying individuals in aggregate statistics. Perturbation involves small random adjustment of the statistics and is considered the most satisfactory technique for avoiding the release of identifiable statistics while maximising the range of information that can be released. These adjustments have a negligible impact on the underlying pattern of the statistics.

After perturbation, a given published cell value will be consistent across all tables. However, adding up cell values to derive a total will not necessarily give the same result as published totals.

As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a relative standard error between 25 per cent and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.

This indicator generally has acceptable levels of sampling error and provides reliable data for most breakdowns. However, RSEs for the waiting time category "4 hours or more but within 24 hours" breakdowns are mostly greater than 25% and should either be used with caution or are considered too unreliable for general use. Similarly, data for the "other" remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data.

Known Issues: Data was self-reported and interpretation of urgent medical care was left up the respondent.

The data is self-reported but not attitudinal, as respondents are reporting their experiences of using the health system (in this instance, the time they waited between making an appointment for urgent medical care and the time they got to see the GP).

Explanatory footnotes are provided for each table.

Coherence

2009 was the first year data was collected for this indicator. Questions relating to this indicator were also asked in 2010-11, 2011-12, 2012-13 and 2013-14.

Consistency over time: Data for 2013-14 are comparable to data for 2012-13, 2011-12 and 2010-11, but not before this (ie not comparable to 2009). This is due to changes in question wording/sequencing in the patient experience survey. As a result, a time series can be started from 2010-11 onwards. This has been footnoted in the relevant tables.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the 2011-12 and 2012-13 surveys, and of very remote communities in the previous surveys, will affect the NT more than it affects other jurisdictions (people usually resident in very remote areas account for about 23 per cent of people in the NT).

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Due to differences in survey scope, collection methodology and question wording, these data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Accessibility Data are publicly available in *Health Services: Patient Experiences in Australia, 2009* (Cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12, 2012-13 and 2013-14* (Cat. no. 4839.0).

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period which should minimise any seasonality effects in the data.

The 2013-14 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2013-14* (Cat. no. 4839.0). The publication includes explanatory and technical notes.

Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in the publication.

Data Gaps/Issues Analysis

Key data gaps /issues The Steering Committee notes the following issues:

- Data from the Patient Experience survey are not comparable with data from the NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- The sample size increase from 30 749 in 2012-13 to 35 868 in 2013-14 strengthens reliability of the population level estimates.

Public dentistry waiting times

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Public dentistry waiting times.
Measure/s (computation)	<p>Definition Waiting time between being placed on a public dentistry waiting list and being seen by a dental professional.</p> <p>Numerator: Number of people aged 15 years or over on a public dental waiting list who reported seeing a dental professional at a government dental clinic or, from 2013-14, attending a private dental clinic for a public dental service (for their own health) within specified waiting time categories (less than 1 month, 1 month or more).</p> <p>Denominator: Number of people aged 15 years or over who were on a public dentistry waiting list (for their own health) in the last 12 months.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.</p>
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the ABS.</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re released with the correct data. Key users are also notified where possible.</p>
Relevance	<p>Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia).</p> <p>Data Completeness: All data are available for this measure from this source.</p> <p>Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on public dentistry waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.</p> <p>Numerator/Denominator Source: Same data source.</p> <p>Data for this indicator were collected for all people aged 15 years or over in Australia, excluding the following:</p> <ul style="list-style-type: none">• members of the Australian permanent defence forces• diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts• overseas residents in Australia

- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

Data were self-reported for this indicator.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The data used for this indicator became available 22 November 2013 for 2012-13 and 28 November 2014 for 2013-14.

Referenced Period: July 2013 to June 2014 (2013-14 data); July 2012 to June 2013 (2012-13 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: For this iteration of the Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.

The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEX included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.

Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEX sample only and estimates obtained using the combined MPHS PEX and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (The majority of MPHS PEX interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience Survey.

Response rate and sample size: The response rate in 2013-14 to the MPHS PEX was 77 per cent (27 327 fully responding persons) while the response rate to HSS was 83 per cent (8541 fully responding persons) resulting in a total sample size of 35 868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.

Note this is a substantial increase from the 2012-13 sample size of 30 749. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Data for MPHS PEX and HSS were weighted separately and then combined to produce output.

Confidentiality:

For the first time in 2013-14, the data has been perturbed. This has been footnoted in the tables. Perturbation is used to minimise the risk of identifying individuals in aggregate statistics. Perturbation involves small random adjustment of the statistics and is considered the most satisfactory technique for avoiding the release of identifiable statistics while maximising the range of information that can be released. These adjustments have a negligible impact on the underlying pattern of the statistics.

After perturbation, a given published cell value will be consistent across all tables. However, adding up cell values to derive a total will not necessarily give the same result as published totals.

As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a relative standard error between 25 per cent and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.

RSEs for this indicator are often greater than 25 per cent and should either be used with caution or are considered too unreliable for general use. Specifically, data for the "less than one month" waiting time category have high RSEs and should be used with caution.

Known Issues: This indicator may not cover those who saw a public dental professional but were not placed on a public dental waiting list.

Explanatory footnotes are provided for each table.

Coherence

Consistency over time: Data are not comparable over time, due to significant changes in question wording and sequencing in both the 2012-13 and 2013-14 surveys.

- In 2011-12, respondents were:
 - limited to those whose most recent dental visit was to a government clinic
 - instructed to exclude treatment for urgent dental care.
- From 2012-13:
 - treatment for urgent dental care was not excluded
 - respondents included all people who needed to see a dental professional
- In 2013-14, respondents:
 - were asked for the first time to include public dental services provided at a private dental clinic.

As a result, time series comparisons are not possible. This has been footnoted in the relevant tables.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the sample will affect the NT more than it affects other jurisdictions.

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Due to differences in survey scope, collection methodology and question wording, these data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Accessibility

Data publicly available. Tables showing waiting times for dental professionals are available in *Patient Experiences in Australia: Summary of Findings, 2011-12, 2012-13 and 2013-14* (Cat. no. 4839.0).

The dental data available in 4839.0 are shown by SEIFA, remoteness, country of birth, self-assessed health status and whether has a long term health condition. Jurisdictional data are not currently publically available but may be made available in the future.

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service on 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period and therefore should minimise any seasonality effects in the data.

Other Supporting information: The ABS Patient Experience data are published in Patient Experiences in Australia: Summary of Findings,

2011-12 and 2012-13 (Cat. no. 4839.0). This publication includes explanatory and technical notes. Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in that publication.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data for 2013-14 are not comparable with data for prior years due to changes in question wording and sequencing in the 2013-14 survey. Comparable time series data is a priority.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- Data from the Patient Experience survey are not comparable with data from the AATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- The sample size increase from 30 749 in 2012-13 to 35 868 in 2013-14 strengthens reliability of the population level estimates.

GPs with vocational registration

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Appropriateness
Indicator	GPs with vocational registration
Measure/s (computation)	<p>The proportion of general practitioners (GPs) with vocational registration.</p> <p>Definition: The number of Full-time Workload Equivalent (FWE) vocationally registered GPs divided by the number of FWE GPs and Other medical practitioners (OMP).</p> <p>Numerator: Number of FWE vocationally registered GPs.</p> <p>Denominator: Number of FWE vocationally registered GPs and OMPs.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.</p> <p>Disaggregations:</p> <ul style="list-style-type: none">• State/Territory• Region
Data source/s	Australian Government Department of Human Services (DHS), Medicare data.

Data Quality Framework Dimensions

Institutional environment	MBS data are an administrative by-product of the DHS, Medicare fee for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> (previously <i>Medicare Australia Act 1973</i>) and regularly provides the data to the Department of Health.
Relevance	<p>Data capture all vocationally registered GPs and OMPs.</p> <p>A vocationally registered GP is a medical practitioner who is vocationally registered under s.3F of the <i>Health Insurance Act 1973</i> (Cwth), holds Fellowship of the RACGP, ACCRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her DHS Medicare billing from non-referred attendances.</p> <p>An OMP is 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.</p> <p>Allocation of FWE GPs and OMPs to state or territory and region is based on the practice location at which services were rendered within the reference period.</p> <p>Disaggregation by region:</p> <p>From 2012-13, disaggregation by region is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification. For previous years, disaggregation by region is based on the Rural, Remote and Metropolitan Areas (RRMA) classification. The RRMA classification was developed in 1994 based on population figures and Statistical Local Area (SLA) boundaries as at the 1991 census. It has not been officially updated and does not reflect population growth or redistribution since 1991 — metropolitan, rural and remote areas are defined as they existed in 1991.</p> <p>RRMA categories are: Capital city — State and Territory capital city statistical divisions; Other metropolitan centre — one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; Large rural centre — statistical local areas (SLAs) where most of the population resides in urban centres with a population of 25 000 or more; Small rural centre — SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; Other rural area — all remaining SLAs in the rural zone; Remote centre — SLAs in the remote zone containing populations of 5000 or more; Other remote area — all remaining SLAs in the remote zone. FWE is a standardised measure adjusted for the partial contribution of casual and part-time doctors and is a reliable estimate of the GP workforce. FWE is calculated by dividing</p>

	each doctor's DHS, Medicare billing by the average billing of full time doctors for the reference period.
Timeliness	GP FWE figures are available 10 weeks after the close of the reference period.
Accuracy	As with any administrative system a small degree of error may be present in the data captured.
Coherence	Estimates are compiled the same way across jurisdictions. For data by region, there is a break in time series between 2011-12 and 2012-13 due to the change in geographical location classification. Data from 2012-13 are not comparable with data for previous years.
Accessibility	Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9 .
Interpretability	General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • The classification system used to allocate GPs to regions from the reference year 2012-13 is current, a major improvement over data for previous years which were based on a system developed in 1994.
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Management of upper respiratory tract infections

Data quality information has been developed by the Health Working Group for one of the measures for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Management of upper respiratory tract infections
Measure/s (computation)	<p>Definition: The number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat upper respiratory tract infection [URTI]) that are provided per 1000 people.</p> <p>Numerator: The number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) that are provided and dispensed.</p> <p>Denominator: ERP</p> <p>Computation: $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.</p>
Data source/s	<p>Numerator: Australian Government Department of Health Pharmaceutical Benefits Scheme (PBS) Statistics data.</p> <p>Denominator: ABS preliminary ERP based on the 2011 Census at 31 December in the reference year.</p>

Data Quality Framework Dimensions

Institutional environment	<p>PBS claims data is a record of all dispensed prescriptions subsidised by the Australian Government. The PBS is managed by Australian Government Department of Health and administered by the Department of Human Services (DHS), Medicare. Provisions governing the operation of the PBS are contained in the National Health Act 1953.</p> <p>The indicator was calculated by the Secretariat using the numerator data supplied by Australian Government Department of Health and ABS ERP.</p>
Relevance	<p>These measures relate to PBS subsidised oral antibiotics used most commonly in treating URTI: phenoxymethylpenicillin (penicillin V); amoxycillin; erythromycin; roxithromycin; cefaclor; amoxycillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names that were ordered by GPs and dispensed to patients were extracted for each reference period.</p> <p>These antibiotics are used to treat a range of conditions in addition to URTI. Data disaggregated by the condition being treated are not available. The proportion of these antibiotics prescribed for treatment of URTI is unknown.</p> <p>Allocation to state or territory is based on the state or territory of the pharmacy supplying the prescription.</p>
Timeliness	PBS claims data are available within three working days of the end of a month.
Accuracy	<p>PBS data from 2012-13 are complete. For previous years, PBS data for general patients was available only for items priced above the PBS general co payment (\$35.40 in 2012) and therefore, the majority of script data for these patients was missing.</p> <p>Data include only prescriptions provided by GPs and OMPs.</p>
Coherence	Data from 2012-13 are not comparable to data for previous years which were available only for concession card holders.
Accessibility	PBS Claims data is available from www.medicareaustralia.gov.au/provider/pbs/stats.jsp .
Interpretability	Information on PBS data is available from www.medicareaustralia.gov.au/provider/pbs/stats.jsp at the PBS item reports and PBS group reports links.

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none">• URTI is one of a range of conditions for which these antibiotics are prescribed. Data
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- are not able to be disaggregated by condition.
- The availability of complete data on the selected antibiotics dispensed in the general population significantly improves data quality from 2012-13.

Chronic disease management

Management of diabetes — HbA1c level

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — Appropriateness
Indicator	Chronic disease management
Measure/s (computation)	<p>Management of diabetes — HbA1c.</p> <p>Numerator: Number of people aged between 18 and 69 years with known diabetes, as determined by a fasting plasma glucose test, who have an HbA1c level of less than or equal to 7.0 per cent.</p> <p>Denominator: Number of persons aged between 18 and 69 years with known diabetes, as determined by a fasting plasma glucose test.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.</p>
Data source/s	<p>For the 2014 reporting cycle, the denominator and numerator for this indicator use data from the 2011–12 National Health Measures Survey (NHMS) component of the Australian Bureau Statistics (ABS) Australian Health Survey (AHS), which is weighted to benchmarks for the total AHS in-scope population derived from ERP.</p> <p>For information on scope and coverage, see the <i>Australian Health Survey: Users' Guide</i> (Cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The 2011–12 NHMS was collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.</p>
Relevance	<p>For this measure, the fasting plasma glucose test is used in the determination of people with known diabetes and the HbA1c test is used in the determination of effective management of diabetes.</p> <p>The 2011-12 NHMS uses a combination of blood test results for fasting plasma glucose and self-reported information on diabetes diagnosis and medication use to measure prevalence of known diabetes.</p> <p>A respondent to the survey is considered to have known diabetes if they had ever been told by a doctor or nurse that they have diabetes and:</p> <ul style="list-style-type: none">• they were taking diabetes medication (either insulin or tablets) <p>or</p> <ul style="list-style-type: none">• their blood test result for fasting plasma glucose was greater than or equal to 7.0 mmol/L. <p>Persons with known diabetes who have an HbA1c result of less than or equal to 7.0 per cent are considered to be managing their diabetes effectively.</p> <p>The estimates exclude persons who did not fast for 8 hours or more prior to their blood test. Excludes women with gestational diabetes.</p>

Timeliness The NHMS was conducted for the first time in 2011–13. Results from the 2011-12 NHMS were released in August 2013.

Accuracy The AHS was conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the Northern Territory, where such persons make up approximately 23 per cent of the population. The final response rate for the 'core' component of the AHS was 82 per cent.

All selected persons aged 5 years and over were invited to participate in the voluntary NHMS. Of all of those who took part in the AHS, 38 per cent went on to complete the biomedical component.

Analysis of the sample showed that the characteristics of persons who participated in the NHMS were similar with those for the AHS overall. The only significant difference was for smoking, where the NHMS sample had a lower rate of current smokers than the AHS sample (12.0 per cent compared with 17.6 per cent). For more information, see the Explanatory Notes in *Australian Health Survey: Biomedical Results for Chronic Disease* (cat. no. 4364.0.55.005).

In order to get an accurate reading for the fasting plasma glucose test, participants were asked to fast for 8 hours before their test. The results presented for this indicator refer only to those people who did fast (approximately 79 per cent of adults who participated in the NHMS). Analysis of the characteristics of people who fasted compared with those who did not fast showed no difference between fasters and non-fasters.

As they are drawn from a sample survey, data for the indicator are subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use.

This indicator produces high levels of sampling error for some States and Territories when split by sex. Estimates for males and females in Victoria have RSEs greater than 50 per cent and should be considered unreliable for general use. Likewise, estimates for males in the Northern Territory and females in the Australian Capital Territory also have RSEs greater than 50 per cent.

Data for several State and Territories also have RSEs greater than 25 per cent, including the total for Victoria, SA, the ACT and the NT, and these estimates should be used with caution.

Coherence The AHS collected a range of other health-related information that can be analysed in conjunction with diabetes management.

The 2009-10 Victorian Health Monitor (VHM) reported estimates of diabetes management based on the proportion of people with known diabetes meeting the HbA1c management target of less than or equal to 7.0 nmol/L. The VHM age-standardised rate (39 per cent) was similar to the NHMS rate for Victoria (36 per cent).

Accessibility See *Australian Health Survey: Biomedical Results for Chronic Disease* (Cat. no. 4364.0.55.005). Other information from this survey is also available on request.

Interpretability Information to aid interpretation of the data is available from the Australian Health Survey: Users' Guide on the ABS website.

Many health-related issues, including diabetes, are closely associated with age. However, numbers across age ranges were too few to do any meaningful age standardisation at the State/Territory level for this measure. Therefore the data presented are based on crude rates.

Data Gaps/Issues Analysis

Key data gaps /issues The Steering Committee notes the following issues:

- Data by Indigenous status are not available for this measure.

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- The 2011-12 National Health Measures Survey (NHMS) was conducted for the first time as part of the 2011–13 Australian Health Survey (AHS), with participation voluntary in the NHMS. Of those who took part in the AHS, 38 per cent took part in the NHMS. The NHMS sample was found to be representative of the AHS population.
 - The NHMS does not include people living in very remote areas, which affects the comparability of the NT results.

Measure 2: Management of asthma

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — Appropriateness
Indicator	Chronic disease management
Measure/s (computation)	Management of asthma Definition <ul style="list-style-type: none">• Proportion of people with asthma who have a written asthma action plan. Numerator: <ul style="list-style-type: none">• Estimated number of people with asthma with a written asthma action plan. Denominator: Estimated number of people with asthma. Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	Data reported for 2011–13 are from the ABS 2011–13 Australian Health Survey (AHS) (2011-12 National Health Survey (NHS) component) and the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (NATSIHS component). Data reported for 2007-08 are from the ABS 2007-08 NHS. Data reported for 2004-05 are from the ABS 2004-05 NHS and the ABS 2004-05 NATSIHS. NHS data are weighted to benchmarks for the total NHS in-scope population, derived from the ERP. For information on NHS scope and coverage, see <i>ABS Australian Health Survey: Users' Guide</i> (Cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au . NATSIHS data are benchmarked to the estimated population of Aboriginal and Torres Strait Islander Australians (adjusted for the scope of the survey).

Data Quality Framework Dimensions

Institutional environment	The NHS and NATSIHS are collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.
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Relevance

The NHS 2011-12 and 2007-08 asked all respondents whether they had ever been told by a doctor or nurse that they have asthma, whether symptoms were present or they had taken treatment in the 12 months prior to interview, and whether they still had asthma. Those who answered yes to these questions were asked whether they had “a written asthma action plan, that is, written instructions of what to do if your asthma is worse or out of control”. A very small number of respondents who were sequenced around these questions may have reported current long-term asthma in response to later general questions about medical conditions. These people are included in and contribute to estimates of the prevalence of asthma, but information about written action plans was not collected from them.

In the 2012-13 NATSIHS, non-remote respondents who reported they have been told by a doctor that they have asthma, and who still get asthma or have had symptoms of asthma in the last 12 months were asked about written asthma action plans. In the 2004-05 NATSIHS, non-remote respondents who answered questions about having asthma ‘yes’ were asked about written asthma action plans.

In both the 2004-05 NHS and NATSIHS, respondents were asked if they had “a written asthma action plan”. If they queried the interviewer about what to include, they were told to include management plans developed in consultation with a doctor, cards associated with peak flow meters and medication cards distributed through chemists. In 2007, if they queried the interviewer, respondents were asked to include plans that were worked out in consultation with a doctor, but not cards associated with peak flow meters or medications cards handed out by chemists.

Ideally this indicator would relate to the proportion of people with moderate to severe asthma, as people with only very mild asthma are unlikely to require planned care. Consequently, there is no clear direction of improvement in this indicator: a lower proportion of people with asthma with an asthma care plan may simply mean that those people with asthma have less severe asthma (which would actually be a positive outcome).

Timeliness

The NHS is conducted every three years over a 12 month period. Results from the 2011-12 NHS component of the AHS were released in October 2012.

The NATSIHS is conducted every six years. Results from the 2012-13 survey were released in November 2013.

Accuracy

The NHS is conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of people usually resident in very remote areas has a small impact on estimates, except for the Northern Territory, where such people make up approximately 23 per cent of the population. Results are weighted to account for non-response.

The response rate for the 2011-12 NHS was 85 per cent and for the 2007-08 NHS was 91 per cent.

The NATSIHS is conducted in all States and Territories and includes remote and non-remote areas. The 2012-13 sample was 9317 people/5371 households, with a response rate of 80 per cent. The 2004-05 sample was 10 000 people/5200 households, with a response rate of 81 per cent of households. Results are weighted to account for non-response.

As it is drawn from a sample survey, the indicator is subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use.

Coherence

Questions used in the 2011-12 and 2007-08 NHS to collect data for this indicator are consistent with the questions recommended for use by the Australian Centre for Asthma Monitoring (ACAM). Data for 2011-12 and 2007-08 are comparable over time (except for the Northern Territory) but are not comparable to data from the 2004-05 survey due to better alignment of questions and concepts with the ACAM recommendations since 2004-05.

Data for the NT in 2011-12 are not comparable to previous years due to the increase in sample size in 2011-12.

The NHS and NATSIHS collect a range of other health-related information (for example, information on smoking) that can be analysed in conjunction with data on asthma and asthma plans.

Accessibility See *Australian Health Survey: First Results* (Cat. no. 4364.0.55.001) and *Australian Health Survey: Health Service Usage and Health Related Actions* (Cat. no. 4364.0.55.002) for an overview of results from the NHS component of the AHS. Other information from this survey is also available on request.

See *Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13* (Cat. no. 4727.0.55.001) for an overview of results from the 2012-13 NATSIHS. Other information from the survey is available on request.

Interpretability Information to aid interpretation of the data is available from the *Australian Health Survey: Users' Guide* and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide* on the ABS website.

Many health-related issues are closely associated with age, therefore data for this indicator have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories and the Indigenous and non-Indigenous population. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The data provide relevant information on the proportion of asthmatics who have an asthma management plan. However, there is no information about the severity of the condition and people with mild asthma are unlikely to require a written plan.
- NATSIHS data are only collected every six years. An assessment of the relative speed of change in outcomes is required to determine whether more regular data collection is necessary.
- The NHS does not include people living in very remote areas which affects the comparability of the NT results.

Use of pathology tests and diagnostic imaging

Data quality information has been developed for this measure by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — Appropriateness
Indicator	Use of pathology tests and diagnostic imaging
Measure 1	<p>MBS items rebated through Department of Human Services (DHS), Medicare for pathology tests requested by general practitioners (GP), and Other Medical Practitioners (OMP), per person (age-standardised)</p> <p>Definition: The number of MBS items rebated through DHS, Medicare for pathology tests requested by specialist GPs and OMPs, per person (age standardised)</p> <p>Numerator: The number of MBS items rebated through DHS, Medicare for pathology tests requested by GPs and OMPs</p> <p>Denominator: Estimated Resident Population (ERP)</p> <p>Computation: Numerator ÷ Denominator, age-standardised</p>
Measure 2	<p>Diagnostic imaging services provided on referral from specialist GPs and OMPs and rebated through DHS, Medicare, per person (age standardised)</p> <p>Definition: The number of MBS items rebated through DHS, Medicare for diagnostic imaging services referred by GPs and OMPs, per person (age standardised)</p> <p>Numerator: The number of MBS items rebated through DHS, Medicare for diagnostic imaging services referred by GPs and OMPs</p> <p>Denominator: Estimated Resident Population (ERP)</p> <p>Computation: Numerator ÷ Denominator, age-standardised</p>
Measure 3	<p>DHS, Medicare benefits paid per person for pathology tests requested by GPs and OMPs (age-standardised).</p> <p>Data are deflated using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) to provide real expenditure, comparable over time.</p>
Measure 4	<p>DHS, Medicare benefits paid per person for diagnostic imaging referred by GPs and OMPs (age-standardised).</p> <p>Data are deflated using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) to provide real expenditure, comparable over time.</p>
Data source/s	<p>Numerator:</p> <ul style="list-style-type: none">• For MBS data: DHS, Medicare data.• For DVA data: Australian Government Department of Veterans' Affairs (DVA) Statistical Services and Nominal Rolls using the Departmental Management Information System (DMIS). These data are known as Treatment Account System (TAS) data. <p>Denominator: ABS ERP. For reference periods prior to and including 2009-10, ERP as at 30 June, based on the 2006 Census. From the 2010-11 reference year ABS ERP as at 31 December, based on the 2011 Census.</p>

Data Quality Framework Dimensions

Institutional environment	<p>DHS, Medicare processes and collects MBS data for:</p> <ul style="list-style-type: none">• claims made through the MBS under the <i>Health Insurance Act 1973</i>. These data are regularly provided to Australian Government Department of Health.• claims for DVA Treatment Card holders, also made through the MBS, under the <i>Veterans' Entitlements Act 1986</i>; <i>Military Rehabilitation and Compensation Act 2004</i>
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	<p>and <i>Human Services (Medicare) Act 1973</i>. All claims data are regularly provided to DVA as per the Memorandum of Understanding between DHS, Medicare and DVA.</p> <p>MBS claims data are an administrative by-product of DHS, Medicare's fee for-service payment systems.</p> <p>For reference periods to 2009-10, Australian Government Department of Health provided raw data and rates inclusive of DVA data.</p> <p>From 2010-11, DHS, Medicare and DVA data are provided separately to the Secretariat. The Secretariat collates the data and computes rates.</p>
Relevance	<p>The measure relates to specific identified MBS services for which DHS, Medicare has processed a claim:</p> <ul style="list-style-type: none"> • Pathology tests — all items in Broad Type of Service (BTOS) 'N' or 'F'. • Diagnostic imaging services — all items in BTOS 'G'. <p>Claims are allocated to state/territory based on location at which the service was rendered.</p> <p>Expenditure data reflect only the benefits paid by the Australian Government. Contributions made by insurance companies and/or individuals are excluded.</p>
Timeliness	<p>Data include all claims processed in the reference period.</p>
Accuracy	<p>Data are limited to claims for services requested/referred by GPs and, for MBS data, OMPs (DVA data include only services requested/referred by specialist GPs). Data do not include claims for services requested/referred by other medical specialists.</p> <p>Data include all claims processed in the reference period.</p> <p><u>Pathology tests</u></p> <p>The pathology episode cone applies to services requested by general practitioners for non-hospitalised patients:</p> <p>when more than three MBS pathology items are requested by a GP in a patient episode, the benefits payable will be equivalent to the sum of the benefits for three items — those with the highest schedule fees (there are some items exempted from the episode cone). Where additional tests performed in a patient episode are not rebated through DHS, Medicare, they are not included in the data. This results in some underreporting of the number of pathology tests conducted on request by GPs and OMPs.</p> <p>Data include Patient Episode Initiated Items.</p> <p><u>Diagnostic imaging</u></p> <p>Diagnostic imaging services provided and rebated through DHS, Medicare can differ from the services requested by GPs and OMPs.</p> <p>In certain circumstances, as defined by legislation, a radiologist can identify the need for, and perform, more or different diagnostic imaging services than are requested by a GP/OMP. The data reflect the services provided and rebated through DHS, Medicare, rather than the services requested by GPs/OMPs.</p>
Coherence	<p>Rates from 2012-13 are age-standardised to the 2001 Australian Standard Population. These data are not comparable to crude rates reported for previous years.</p> <p>Data were computed by Australian Government Department of Health for this indicator for reference years prior to and including 2009-10, using the 2006 Census based ERP as at 30 June preceding the reference year.</p> <p>From 2010-11, data are computed by the Secretariat from numerator data obtained separately from Australian Government Department of Health and the DVA, using the ERP as at 31 December based on the 2011 Census. Rates derived using ERPs based on different Censuses are not comparable.</p>
Accessibility	<p>Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.</p> <p>DVA data are not publically accessible.</p>
Interpretability	<p>General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1</p>

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Age-standardisation of rates from 2012-13 is a significant improvement. However, rates are not comparable with crude rates reported for previous years.
- This is a proxy measure — data are limited to those services rebated through DHS, Medicare that were provided in response to request/referral by GPs/OMPs.
- Provides information about relative requests/referrals for pathology tests and diagnostic imaging across jurisdictions and over time, but not the appropriateness thereof.

Patient satisfaction

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Quality — responsiveness
Indicator	Patient satisfaction/experience around key aspects of care they received.
Measure/s (computation)	<p>Measure a: people who saw a GP in the last 12 months reporting the GP always or often: listened carefully, showed respect, and spent enough time with them</p> <p>Definition: Proportion of people satisfied with selected aspects of GP/dentist care.</p> <p>Numerator: People who saw a GP/dentist in the last 12 months reporting the GP/dentist always or often: listened carefully; showed respect; spent enough time with them.</p> <p>Denominator: People who saw a GP/dentist for their own health in the last 12 months, excluding people who were interviewed by proxy.</p>
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the ABS.</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re released with the correct data. Key users are also notified where possible.</p>
Relevance	<p>Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia).</p> <p>Data Completeness: All data are available for this measure from this source.</p> <p>Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.</p> <p>Numerator/Denominator Source: Same data source.</p>

**Relevance
(cont.)**

Data for this indicator were collected for all people aged 15 years or over in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

Data were self-reported for this indicator.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The data used for this indicator became available 22 November 2013 for 2012-13 and 28 November 2014 for 2013-14.

Referenced Period: July 2013 to June 2014 (2013-14 data); July 2012 to June 2013 (2012-13 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: For this iteration of the Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.

The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEx included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.

Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEx sample only and estimates obtained using the combined MPHS PEx and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (the majority of MPHS PEx interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience Survey.

Response rate and sample size: The response rate in 2013-14 to the MPHS PEx was 77 per cent (27 327 fully responding persons) while the response rate to HSS was 83 per cent (8541 fully responding persons) resulting in a total sample size of 35 868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.

Note this is a substantial increase from the 2012-13 sample size of 30 749. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Data for MPHS PEx and HSS were weighted separately and then combined to produce output.

Confidentiality — For the first time in 2013-14, the data has been perturbed. This has been footnoted in the tables. Perturbation is used to minimise the risk of identifying

individuals in aggregate statistics. Perturbation involves small random adjustment of the statistics and is considered the most satisfactory technique for avoiding the release of identifiable statistics while maximising the range of information that can be released. These adjustments have a negligible impact on the underlying pattern of the statistics.

After perturbation, a given published cell value will be consistent across all tables. However, adding up cell values to derive a total will not necessarily give the same result as published totals.

As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a relative standard error between 25 per cent and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.

This indicator generally has acceptable levels of sampling error and provides reliable data for most breakdowns. However, RSEs for remote/very remote breakdowns are mostly greater than 25 per cent and should either be used with caution or are considered too unreliable for general use. Similarly, data for the "other" remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data.

The data for this indicator is attitudinal, as it collects whether people felt they waited too long to get an appointment with a GP, and whether the person felt the health professional in question spent enough time with them, listened carefully and showed them respect (the 'patient satisfaction' questions).

Data is used from personal interviews only (i.e. excluding proxy interviews).

Explanatory footnotes are provided for each table.

Coherence

2009 was the first year data was collected for this indicator. Questions relating to this indicator were also asked in 2010-11, 2011-12, 2012-13 and 2013-14.

Consistency over time: Data are comparable over time.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the 2011-12 and 2012-13 surveys, and of very remote communities in the previous surveys, will affect the NT more than it affects other jurisdictions (people usually resident in very remote areas account for about 23 per cent of people in the NT).

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Due to differences in survey scope, collection methodology and question wording, these data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009* (Cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12, 2012-13 and 2013-14* (Cat. no. 4839.0).

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period which should minimise any seasonality effects in the data.

The 2013-14 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2013-14* (Cat. no. 4839.0). The publication includes explanatory and technical notes.

Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in the publication.

Data Gaps/Issues Analysis**Key data gaps
/issues**

The Steering Committee notes the following issues:

- Data from the Patient Experience survey are not comparable with data from the 2012-13 NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- The sample size increase from 30 749 in 2012-13 to 35 868 in 2013-14 strengthens reliability of the population level estimates.

Health assessments for older people

Data quality information has been developed for this indicator by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Quality — Continuity
Indicator	Health assessments for older people
Measure/s (computation)	<p>Definition: The proportion of older people who received a health assessment.</p> <p>Numerator: The number of people aged 75 years or over with an MBS claim for Items 700, 701, 702, 703, 705 or 707 (Health assessment) and the number of Indigenous people aged 55 years or over with an MBS claim for Items 704, 706 (Health assessment for older Aboriginal and Torres Strait Islander People) or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period.</p> <p>Denominator: The population of Indigenous people aged 55 years or over and the estimated population of non-Indigenous people aged 75 years or over (computed by subtracting the projected population of Indigenous people aged 75 or over from the ERP aged 75 years or over) in the reference period.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Data source/s	<p>Numerator: Australian Government Department of Human Services (DHS), Medicare data.</p> <p>Denominator – computed by the Secretariat using Australian Bureau of Statistics (ABS) 2011 Census based ERP:</p> <ul style="list-style-type: none">• ABS various years, <i>Australian demographic statistics</i>, Cat. no. 3101.0.• ABS 2014, <i>Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026</i>, Cat. No. 3238.0 (B Series).

Data Quality Framework Dimensions

Institutional environment	<p>MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> and regularly provides the data to Australian Government Department of Health.</p> <p>The indicator was calculated by the Secretariat using the numerator data supplied by Australian Government Department of Health and denominator data sourced from the ABS.</p>
Relevance	<p>These measures relate to specific DHS, Medicare services for which claims data are available.</p> <p>Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to affect overall proportions significantly because the life expectancy of Indigenous people is, on average, relatively low.</p> <p>Allocation of clients to state or territory is based on client postcode of residence as recorded by DHS, Medicare at time of processing the final claim in the reference period. This might differ from the client's residential postcode at the time the service was received.</p> <p>For services provided from 1 May 2010, age is based on client date of birth in DHS, Medicare records at the date the service was received. Prior to 1 May 2010 unique MBS item numbers applied to health assessments for older people and health assessments for older Indigenous people.</p> <p>Eligible populations exclude people who are hospital in-patients or living in a residential aged care facility.</p> <p>In the NT, MBS statistics do not necessarily fully reflect services supplied to Indigenous people as the claim rate is low due to a smaller number of GPs in remote areas.</p>

Timeliness	MBS claims data are available within 14 days of the end of a month.
Accuracy	<p>Data include only the services for which claims were processed in the reference year. This is not expected to significantly affect the data.</p> <p>Allocation to state and territory does not necessarily reflect the client residence at the time of receiving the service if a change of address prior to receiving the service was not reported to DHS, Medicare in the reference period or a change of address after receiving the service was reported to DHS, Medicare in the reference period.</p> <p>Health assessment rebate claims that are not processed within 12 months of the reference period are excluded. This does not significantly affect the data.</p> <p>Clients are counted once only in the reference period.</p> <p>Data do not include:</p> <ul style="list-style-type: none"> • health assessment activity where practitioners do not claim the rebate • services that qualify under the DVA National Treatment Account and services provided in public hospitals • people living in residential aged care facilities. <p>Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.</p>
Coherence	<p>The following changes to MBS items occurred on 1 May 2010, but are unlikely to impact time-series analysis.</p> <p>As of 1 May 2010:</p> <ul style="list-style-type: none"> • MBS Items 704 and 706 (Health Assessments for older Aboriginal and Torres Strait Islander People) have been replaced with one MBS Item that covers Health Assessments for Aboriginal and Torres Strait Islander People of all ages (Item 715) • MBS Items 700 and 702 (Health assessments for older people) have been replaced with four new MBS items that cover Health assessments for all ages and are based on time and complexity of the visit — Items 701 (brief), 703 (standard), 705 (long) and 707 (prolonged). <p>For services provided from 1 May 2010, disaggregation by age is based on client date of birth in DHS, Medicare records at the date the service was received.</p> <p>Health assessments for people who are refugees or humanitarian entrants can also be claimed from 1 May 2010 under MBS Items 701, 703, 705 and 707. This is likely to have little impact on the totals reported as the usage rates for these health assessments are low to extremely low.</p>
Accessibility	Information is available for MBS Claims data at www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9 .
Interpretability	DHS, Medicare claims statistics are available at ww.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1
<u>Data Gaps/Issues Analysis</u>	
Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • Data are of acceptable accuracy.

Cost to government of general practice per person

Data quality information has been developed for this indicator by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Cost to government of general practice per person
Measure/s (computation)	<p>Government Expenditure on GPs per person</p> <p>Definition: Cost to government of general practice per person in the population</p> <p>Numerator: Nominal expenditure on services rendered by GPs and OMPs.</p> <p>Denominator: Estimated Resident Population (ERP).</p> <p>Computation: Numerator ÷ Denominator, directly age-standardised from 2012-13; crude rates for previous years.</p> <p>Data are deflated using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) to provide real expenditure, comparable over time.</p>
Data source/s	<p>Numerator:</p> <ul style="list-style-type: none">• For MBS data: Department of Human Services (DHS), Medicare data sourced by the Australian Government Department of Health• For DVA data: Australian Government Department of Veterans' Affairs (DVA) Statistical Services and Nominal Rolls using the Departmental Management Information System (DMIS). These data are known as Treatment Account System (TAS) data. <p>Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December.</p>

Data Quality Framework Dimensions

Institutional environment	<p>DHS, Medicare processes and collects MBS data for:</p> <ul style="list-style-type: none">• claims made through the MBS under the <i>Health Insurance Act 1973</i>. These data are regularly provided to Australian Government Department of Health.• claims for DVA Treatment Card holders, also made through the MBS, under the <i>Veterans' Entitlements Act 1986</i>; <i>Military Rehabilitation and Compensation Act 2004</i> and <i>Human Services (Medicare) Act 1973</i>. All claims data are regularly provided to DVA as per the Memorandum of Understanding between DHS, Medicare and DVA. <p>MBS claims data are an administrative by-product of the DHS, Medicare fee for-service payment systems.</p>
Relevance	<p>The measure relates to:</p> <ul style="list-style-type: none">• services provided by GPs and, for MBS data, OMPs (DVA data include only services provided by specialist GPs) for which DHS, Medicare has processed a claim. <p>Claims allocated to state/territory based on location at which service rendered.</p> <p>Data exclude costs for primary healthcare services provided by salaried GPs in community health settings, particularly in rural and remote areas, through emergency departments, and Indigenous-specific primary healthcare services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, where a salaried GP services delivery model is used.</p> <p>From 2012-13, data exclude expenditure on services provided under the Practice incentive program (PIP), Medicare Locals and the General Practice Immunisation Incentive Scheme (GPPI) as these data cannot be subjected to age-standardisation.</p>
Timeliness	Data include all claims processed in the reference period.
Accuracy	From 2012-13, DHS, Medicare data include claimed services by GPs and OMPs as well as by practice nurses or registered Aboriginal health workers for and on behalf of the

	<p>GMP/OMP. For previous years, DHS, Medicare data also include services rendered under PIP, DGPP and GPII. DVA data are limited to claims for services provided by specialist GPs.</p> <p>Data include all claims processed in the reference period.</p>
Coherence	<p>Age-standardised rates reported from 2012-13 are not comparable with crude rates reported for previous years due to the effect of age standardisation and the exclusion of services rendered under PIP, DGPP and GPII from age standardised rates.</p> <p>Nominal State and Territory total expenditure data were computed by Australian Government Department of Health for the reference periods 2006-07 to 2009-10. From the 2010-11 reference period, DHS, Medicare and DVA nominal expenditure data are provided separately to and compiled by the Secretariat. These changes are expected to have negligible impact on the data.</p> <p>Expenditure per person data computed by the Secretariat using the 2011 Census-based ERP as at 31 December for all reference periods.</p>
Accessibility	<p>Information is available for MBS Claims data at www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.</p> <p>DVA data are not publically accessible.</p>
Interpretability	<p>DHS, Medicare claims statistics are available at www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1</p>

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • Data exclude costs for primary healthcare services provided by salaried GPs in community health settings, particularly in rural and remote areas, through emergency departments, and Indigenous specific primary healthcare services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, where a salaried GP services delivery model is used.
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Child immunisation coverage

Data quality information has been developed for this indicator by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Child immunisation coverage.
Measure/s (computation)	<p>Proportion of children who are fully vaccinated at the age of:</p> <ul style="list-style-type: none">• 12 months to less than 15 months• 24 months to less than 27 months• 60 months to less than 63 months. <p>Definition: Proportion of children who are fully vaccinated at the specified ages.</p> <p>Numerator: children who turned 1, 2 and 5 years of age in the reference year who were recorded as fully vaccinated on the Australian Childhood Immunisation Register (ACIR) in the reference year.</p> <p>Denominator: number of children who turned 1, 2 and 5 years in the reference year registered on ACIR.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate per 100 children aged 1, 2 and 5 years.</p>
Data source/s	The Australian Childhood Immunisation Register (ACIR).

Data Quality Framework Dimensions

Institutional environment	<p>The ACIR is administered and operated by Australian Government Department of Human Services (DHS), Medicare. DHS, Medicare provides Australian Government Department of Health with quarterly coverage reports at the national and state level.</p> <p>Immunisations are notified to DHS, Medicare by a range of immunisation providers including General Practitioners, Councils, Aboriginal Medical Services, State and Territory Health departments.</p> <p>For information on the institutional environment of the ACIR, including the legislative obligations of the ACIR, financing and governance arrangements, and mechanisms for scrutiny of ACIR operations, please see www.humanservices.gov.au/customer/services/medicare/australian-childhood-immunisation-register.</p> <p>The tables for this indicator were prepared by DHS, Medicare and quality assessed by Australian Government Department of Health. Australian Government Department of Health drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies).</p>
Relevance	<p>The ACIR records details of vaccinations given to children under seven years of age who live in Australia.</p> <p>Children assessed as fully immunised at one year of age are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b and, from the quarter ending 31 December 2013, pneumococcal.</p> <p>Children assessed as fully immunised at two years of age are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b and measles, mumps and rubella.</p> <p>A child is assessed as fully immunised at five years of age if they have received immunisations against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella.</p> <p>There are possible gaps in coverage due to unknown vaccination status of children less than 5 years migrating to Australia. The extent of this is not currently quantifiable.</p> <p>The analyses by state/territory are based on postcode of residence of the child as recorded on ACIR.</p>

Timeliness	ACIR data are reported quarterly. Data are processed on 30 June in the reference year as a minimum 3-month lag period is allowed for late notification of immunisations to ACIR.
Accuracy	<p>Vaccination coverage rates calculated using ACIR data are believed to underestimate actual vaccination rates because of under-reporting by immunisation providers. However, the extent of any under-reporting has not been estimated.</p> <p>Provider notification payments and links to family assistance payments for parents have helped minimise under-reporting by providing a financial incentive for parents to vaccinate their children and for providers to notify the ACIR.</p> <p>The data contains minimal if any duplication of immunisations, as children are identified via their DHS, Medicare number. Approximately 99 per cent of children are registered with DHS, Medicare by 12 months of age.</p> <p>The ACIR covers virtually all children, particularly because participation in the ACIR is via an 'opt-out' arrangement.</p>
Coherence	The definitions of numerators and denominators have been consistent since the inception of the ACIR in 1996.
Accessibility	<p>Information contained in the indicator for disaggregation by Indigenous status and remoteness are not publicly accessible. Current total percentage and total numbers can be viewed on the DHS, Medicare web site.</p> <p>DHS, Medicare publishes current immunisation coverage from the ACIR on its website, www.medicareaustralia.gov.au/provider/patients/acir/statistics.jsp. Authorised immunisation providers can access detailed reports via a secured area of the DHS, Medicare web site.</p> <p>Immunisation coverage data derived from the ACIR have been reported in Communicable Disease Intelligence since early 1998. Data for 3 key milestone ages (12 months, 24 months and 5 years [6 years prior to 2008]), nationally and by jurisdiction are published quarterly.</p>
Interpretability	<p>Further information on the ACIR can be found at www.humanservices.gov.au/customer/services/medicare/australian-childhood-immunisation-register.</p> <p>Information on the National Immunisation Program and vaccinations can be found at www.immunise.health.gov.au.</p>

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • The data used to calculate this indicator are from an administrative data collection — the Australian Childhood Immunisation Register (ACIR) —for which there is an incentive payment for notification, and there are further incentives for parents to have their child's vaccination status up to date. The Register is linked to the DHS, Medicare enrolment register, and approximately 99 per cent of children are registered with DHS, Medicare by 12 months of age. • Data have been reported using the program definition of fully immunised for children aged 12 to 15 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b and, from 2013-14, pneumococcal disease. • Data have been reported using the program definition of fully immunised for children aged 24 to 27 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b, and measles, mumps, and rubella. • Data have been reported using the program definition of fully immunised for children aged 60 to 63 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella. • From 31 December 2014, reporting of vaccination coverage will be amended to include meningococcal C and varicella in the 24 to < 27 month cohort. • From 31 December 2017, reporting of vaccination coverage will be amended to remove the assessment of MMR in the 60 to < 63 month cohort. • Given these changes, trends in vaccination coverage rates over time need to be interpreted carefully.
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Notifications of selected childhood diseases

Data quality information has been developed for this indicator by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Notifications of selected childhood diseases.
Measure/s (computation)	<p>Measures:</p> <ul style="list-style-type: none">• Notifications of measles for children aged 0–14 years• Notifications of whooping cough (pertussis) for children aged 0–14 years• Notifications of invasive Haemophilus influenzae type b (Hib) for children aged 0–14 years <p>Definition: Number of notifications reported to the National Notifiable Diseases Surveillance System (NNDSS) by State and Territory health authorities for children aged 0–14 years by date of diagnosis, per 100 000 children aged 0–14 years for:</p> <ul style="list-style-type: none">• measles• whooping cough (pertussis)• invasive Haemophilus influenzae type b (Hib). <p>Numerator: number of notifications reported to the NNDSS for children aged 0–14 years in the reference period.</p> <p>Denominator: estimated resident population of children aged 0–14 years at 31 December in the reference period.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate per 100 000 children aged 0–14 years.</p>
Data source/s	<p>Numerator: The National Notifiable Diseases Surveillance System (NNDSS)</p> <p>Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) at 31 December in the reference period (ABS Australian Demographic Statistics (various years), Cat. no. 3101.0).</p>

Data Quality Framework Dimensions

Institutional environment	<p>The NNDSS is administered and operated by the Department of Health.</p> <p>Notifiable diseases are notified to the relevant State/Territory government health departments by clinicians and laboratories under jurisdictional public health legislation. The Department of Health receives data for these notifiable diseases under the National Health Security Act 2007.</p> <p>For information on the institutional environment of the NNDSS, including the legislative obligations of the NNDSS, financing and governance arrangements, and mechanisms for scrutiny of NNDSS operations, please see www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi2903q.htm.</p>
Relevance	<p>Nationally notifiable diseases require notification of the relevant State/Territory health authority upon diagnosis. Cases are defined on the basis of the Communicable Diseases Network Australia (CDNA) NNDSS case definitions. State/Territory health authorities notify the NNDSS of notified cases.</p> <p>Allocation to State/Territory is by postcode of residence of the case as provided by the notifying doctor or laboratory.</p>
Timeliness	<p>State/Territory health authorities notify data to the NNDSS on a daily basis. Data include all notifications for the selected diseases for each reference period (financial year).</p>
Accuracy	<p>Measles and invasive Hib</p> <p>The 'notified fraction' represents the proportion of total cases for which notification is made. This is expected to be high for measles and invasive Hib as it is uncommon for either disease to go undiagnosed, due to the often severe presentations of the disease.</p>

Comprehensive follow up of the contacts of all cases also enables identification of cases.

Pertussis (whooping cough)

The notified fraction for whooping cough is likely to be only a proportion of the total number of cases that occur, as identification of pertussis is limited by patient and physician awareness, testing practices and in some cases, the limited sensitivity of diagnostics tests. Pertussis is generally believed to be significantly under-diagnosed.

ERPs to 31 December 2010 are the ABS' final 2011 Census rebased ERPs. ERPs from 31 December 2011 are ABS first preliminary estimates based on the 2011 Census.

Data for the number of notifications are suppressed for confidentiality reasons where the number of notifications was less than 3.

Data for notification rates are suppressed where there were less than 5 notifications.

Coherence

Data are reported for each financial year in the period 2006-07 to 2012-13.

Changes in surveillance and testing methods over time and by jurisdiction may make comparisons both over time and across jurisdictions difficult. Changes in the national case definition criteria for establishing a case may affect the coherence of the data over time. The current NNDSS case definition, including historical edits, can be found at www.health.gov.au/casedefinitions.

Accessibility

The Department of Health publishes aggregated levels of data from the NNDSS on its website www9.health.gov.au/cda/source/cda-index.cfm. Data are updated on a daily basis.

Interpretability

The current NNDSS case definitions, including edits, can be found at www.health.gov.au/internet/main/publishing.nsf/Content/cdna-casedefinitions.htm.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Whooping cough notifications may undercount the actual number of cases that occur as diagnosis cannot always be confirmed using currently available diagnostic tools.

Participation rates for women in cervical screening

Data quality information for this indicator has been drafted by the AIHW, with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Participation rates for women in cervical screening.
Measure/s (computation)	<p>Definition:</p> <p>This indicator presents the number of women within the national target age group (20–69 years) screened in a 2 year period as a proportion of the eligible female population and age standardised to the Australian standard population at 30 June 2001.</p> <p>The eligible female population is the average of the Australian Bureau of Statistics (ABS) estimated resident female population for the 2 year reporting period. This population is adjusted for the estimated proportion of women who have had a hysterectomy using national hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database.</p> <p>Numerator: Total number of women aged 20–69 years who were screened in the 2 year period.</p> <p>Denominator: Average number of women aged 20–69 years in the same 2 year period, adjusted using national hysterectomy fractions to exclude the estimated number of women who have had a hysterectomy.</p> <p>Computation/s: $100 \times (\text{Numerator} \div \text{Denominator})$ and age-standardised to the Australian population at 30 June 2001.</p>
Data source/s	<p>Numerator: State and territory cervical cytology registers.</p> <p>Denominator: ABS estimated resident population 2011 Census based (ERP) for females aged 20–69 years adjusted using national hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The National Cervical Screening Program (NCSP) is a joint program of the Australian Government and State and Territory governments. The target age group is women aged 20–69 years.</p> <p>Cervical cytology registries in each state and territory are maintained by jurisdictional Program managers. Data are supplied to the registries from pathology laboratories. Data from cervical cytology registers are provided to the Australian Institute of Health and Welfare (AIHW) annually in an aggregated format.</p> <p>The NCSP is monitored annually. Results are compiled and reported at the national level by the AIHW in an annual Cervical screening in Australia report.</p> <p>The Institute is an independent statutory authority within the Health and Ageing portfolio. It is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website (www.aihw.gov.au).</p>
Relevance	<p>The data used to calculate this indicator are accurate and of high quality. The cervical cytology registers collect information on all Pap tests undertaken in Australia except where women advise the clinician they do not wish to have their data collected. The use of ERP based on Census data for denominators provide the most comprehensive data coverage possible. The data are entirely appropriate for this indicator.</p> <p>For participation by state and territory, the numerator is the number of women aged 20–69 years screened in each state and territory in the reference period, except for Victoria and the ACT where data are for residents (and some immediate border residents) of the jurisdiction only. Data are supplied as aggregated data by each state and territory. The denominator is the average of the ABS ERP for women aged 20–69 years in each State</p>

and Territory, adjusted to exclude the estimated number of women who have had a hysterectomy, using national hysterectomy fractions.

Caution is required when examining differences across states and territories of Australia due to the substantial differences in population, area, geographic structure, policies and other factors.

Timeliness The most recent data available for the 2015 RoGS report are based on the two-year calendar period 1 January 2012 to 31 December 2013. Data are presented as a rate for the two-year period to reflect the recommended screening interval.

Accuracy This indicator is calculated on data that have been supplied to the AIHW by individual state and territory registers. Prior to publication, the results of analyses are referred back to states and territories for checking and clearance. Any errors found by states and territories are corrected once confirmed. Thus participation by state and territory, based on the state or territory in which the woman was screened, is both robust and readily verified.

Women who opt off the cervical cytology register are not included in the participation data, but this is thought to only exclude around 1 per cent of all women screened.

Coherence Some of these data are published annually in Program monitoring reports prepared by the AIHW and are consistent across reports published at similar times.

Rates may differ from those presented in reports published in 2011 or previous years which are derived from ABS 2006 Census based ERPs.

Accessibility The NCSP annual reports are available via the AIHW website where they can be downloaded free of charge.

Interpretability While numbers of women screened are easy to interpret, calculation of age standardised rates with allowance for the proportion of the population who have had a hysterectomy is more complex and the concept may be confusing to some users. Information on how and why age-standardised rates have been calculated and how to interpret them as well as the hysterectomy fraction is available in all AIHW NCSP monitoring reports, example, Cervical screening in Australia 2011–2012.

Data Gaps/Issues Analysis

Key data gaps The Steering Committee notes the following issues:

/issues

- Hysterectomy fractions are derived from the AIHW National Hospitals Morbidity Database.
- Indigenous status is not collected by cervical cytology registers.

Selected potentially preventable hospitalisations

Measure 1: Selected potentially preventable hospitalisations for vaccine preventable, acute and chronic conditions

Data quality information for this measure has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome — Australians receive appropriate high quality and affordable hospital and hospital related care.
Indicator	Selected potentially preventable hospitalisations — Admissions to hospital that could have potentially been prevented through the provision of appropriate non-hospital services.
Measure/s (computation)	<p>Selected potentially preventable hospitalisations for vaccine-preventable, acute and chronic conditions.</p> <p>The numerator is the number of separations for selected potentially preventable hospitalisations, for each of the following three groups and their sub-categories:</p> <ul style="list-style-type: none">• Vaccine-preventable conditions<ul style="list-style-type: none">- Pneumonia and influenza (vaccine-preventable)- Other vaccine preventable conditions (for example, tetanus, measles, mumps, rubella)- Total.• Acute conditions<ul style="list-style-type: none">- Cellulitis- Convulsions and epilepsy- Dental conditions- Ear, nose and throat infections- Eclampsia- Gangrene- Pelvic inflammatory disease- Perforated/bleeding ulcer- Pneumonia (not vaccine-preventable)- Urinary tract infections, including pyelonephritis- Total acute conditions• Chronic conditions<ul style="list-style-type: none">- Angina- Asthma- Bronchiectasis- Chronic obstructive pulmonary disease- Congestive heart failure- Diabetes complications (principal diagnosis only)- Hypertension- Iron deficiency anaemia- Nutritional deficiencies- Rheumatic heart disease- Total• Total selected potentially preventable hospitalisations.

The denominator is the Estimated Resident Population (ERP).

A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay

beginning or ending in a change of type of care (for example, from acute care to rehabilitation).

Potentially preventable hospitalisations are defined by International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) diagnosis codes and/or Australian Classification of Health Interventions (ACHI) procedure codes in scope for each category of potentially preventable hospitalisations (see METeOR id 559032).

Calculation is $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a number per 1000 and age standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 combined. Indigenous population data are not available for all states and territories for 5-year age groups beyond 64 years, so the Indigenous disaggregation was standardised to 64 years, with ages over 64 combined.

Data source/s Numerator: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care.

Denominators:

- For total population: ABS ERP as at 30 June 2012.
- For data by Indigenous status: ABS *Aboriginal and Torres Strait Islander Experimental Estimates and Projections Series B* as at 30 June 2012.
- For data by remoteness: ABS ERP as at 30 June 2011, by remoteness areas, as specified in the Australian Statistical Geography Standard 2011 (ASGS).
- For data by socioeconomic status: calculated by AIHW using the ABS Socio-Economic Indexes For Areas (SEIFA) Index of Relative Socio-economic Disadvantage (IRSD) 2011 and ERP by Statistical Area 2 (SA2) as at 30 June 2012. Each SA2 in Australia is ranked and divided into quintiles and deciles in a population-based manner, such that each quintile has approximately 20 per cent of the population and each decile has approximately 10 per cent of the population.

Computation: $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.

The AIHW is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance to the *Privacy Act 1988 (Commonwealth)*, ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au

Data for the NHMD were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

- <http://www.aihw.gov.au/nhissc/>
- <http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

The analyses by state and territory, remoteness and socioeconomic status are based on the Statistical Area 2 (SA2) of usual residence of the patient, not the location of the hospital. Hence rates represent the number separations for patients living in each state/territory, remoteness area or Socio-Economic Indexes for Areas (SEIFA) population group (regardless of the jurisdiction of the hospital they were admitted to) divided by the total number of people living in that remoteness area or SEIFA group in the state/territory.

The SEIFA categories for socioeconomic status represent approximately the same proportion of the national population, but do not necessarily represent that proportion of the population in each state or territory (each SEIFA decile or quintile represents 10 per cent and 20 per cent respectively of the national population). The SEIFA scores for each SA2 are derived from 2011 Census data and represent the attributes of the population in that SLA in 2011.

Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated.

Timeliness

The reference period for this data set is 2012-13.

Accuracy

For 2012-13, almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the ACT.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

The AIHW report *Indigenous identification in hospital separations data: quality report* (AIHW 2013) found that nationally, about 88 per cent of Indigenous Australians were identified correctly in hospital admissions data in the 2011-12 study period, and the 'true' number of separations for Indigenous Australians was about 9 per cent higher than reported. The report recommended that the data for all jurisdictions are used in analysis of Indigenous hospitalisation rates, for hospitalisations in total in national analyses of Indigenous admitted patient care. However, these data should be interpreted with caution as there is variation among jurisdictions in the quality of the Indigenous status data.

Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

Cells have been suppressed to protect confidentiality where the presentation could identify a patient or a service provider or where rates are likely to be highly volatile, for example where the denominator is very small. The following rule was applied:

Rates were suppressed where the numerator was less than 5 and/or the denominator was less than 1000.

Coherence

The specification for this performance indicator was revised for the 2015 reporting period. The AIHW recalculated this indicator for the period 2007-08 to 2012-13 using the new specification. Therefore, the data are not comparable to data calculated in previous reporting periods.

For ICM-10-AM coding details, please refer to the specification for National Healthcare Agreement Performance Indicator 18 - Selected potentially preventable hospitalisations, 2015 (<http://meteor.aihw.gov.au/content/index.phtml/itemId/559032>)

The information presented for this indicator is calculated using the same methodology as data published in the *National healthcare agreement: performance report 2012–13*.

However, caution should be used when comparing data across reporting periods as changes between the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 5th edition (used in 2007-08), ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11, 2011-12 and 2012-13) and the associated Australian Coding Standards that resulted in fluctuations in the reporting of diagnoses for diabetes.

In addition, Tasmanian data are not comparable over time as 2008-09 data for Tasmania does not include two private hospitals that were included in 2007-08 and 2009-10 data reported in the National Healthcare Agreement performance reports.

Interpretation of the related performance benchmark over time is also problematic because the benchmark is specified as a proportion of separations rather than a population rate, and admission practices vary across jurisdictions and over time. Changes in a jurisdiction's denominator (separations) can artificially increase or decrease the results of the benchmark. Therefore the data provided in 2012-13 (and interim years) may not be directly comparable to the baseline data from which the target is based.

Methodological variations also exist in the application of SEIFA to various data sets and performance indicators. Any comparisons of the SEIFA analysis for this indicator with other related SEIFA analysis should be undertaken with careful consideration of the methods used, in particular the SEIFA Census year, the SEIFA index used and the approach taken to derive quintiles and deciles.

National level data disaggregated by Indigenous status for 2007-08 to 2009-10 include data from NSW, Vic, Qld, WA, SA and NT. National level data disaggregated by Indigenous status for 2010-11 and subsequent years includes data from all eight states and territories. Therefore, data disaggregated by Indigenous status from 2007-08, 2008-09 and 2009-10 are not comparable to data for 2010-11 and subsequent years.

In 2011, the ABS updated the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006. Data for 2007-08 through to 2010-11 reported for SEIFA quintiles and deciles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011-12 are reported using SEIFA 2011 at the SLA level. Data for 2012-13 are reported using SEIFA 2011 at the SA2 level. The AIHW considers the change from SEIFA 2006 to SEIFA 2011, and the change from SLA to SA2 to be series breaks when applied to data supplied for this indicator. Therefore, SEIFA data for 2010-11 and previous years are not directly comparable with SEIFA data for 2011-12, and SEIFA data for 2011-12 and previous years are not directly comparable with SEIFA data for 2012-13 and subsequent years.

Accessibility

The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:

- *Australian hospital statistics* with associated Excel tables.
- Interactive data cubes for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).

These products may be accessed on the AIHW website at: www.aihw.gov.au/hospitals/.

Interpretability

Supporting information on the quality and use of the NHMD are published annually in *Australian hospital statistics* (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to note caveat information to ensure appropriate

interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and variation in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care is published in the AIHW's online metadata repository, METeOR, and the *National health data dictionary*.

The *National health data dictionary* can be accessed online at www.aihw.gov.au/publication-detail/?id=10737422826

The Data Quality Statement for the NHMD can be accessed on the AIHW website at <http://meteor.aihw.gov.au/content/index.phtml/itemId/568730>.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The National Hospital Morbidity Database (NHMD) is a comprehensive data set that has records for all separations of admitted patients from essentially all public and private hospitals in Australia
- The specification for this performance indicator was revised for the 2015 reporting period. The AIHW recalculated this indicator for the period 2007-08 to 2012-13 using the new specification. Therefore, the data are not comparable to data calculated in previous reporting periods.
- Caution should be used in comparing data across reporting periods as changes between the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 5th edition (used in 2007-08), ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11, 2011-12 and 2012-13) and the associated Australian Coding Standards resulted in fluctuations in the reporting of diagnoses for diabetes (chronic category affected). These changes should also be taken into consideration in interpretation of these data against the National Healthcare Agreement performance benchmark for potentially preventable hospitalisations.
- In addition, interpretation of the related performance benchmark over time is problematic because the benchmark is specified as a proportion of separations rather than a population rate, and admission practices vary across jurisdictions and over time.
- The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.
- Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.
- Remoteness data for 2011-12 and previous years are not directly comparable to remoteness data for 2012-13 and subsequent years.
- SEIFA data for 2010-11 and previous years are not directly comparable with SEIFA data for 2011-12, and SEIFA data for 2011-12 and previous years are not directly comparable with SEIFA data for 2012-13 and subsequent years.

Measure 2: Selected potentially preventable hospitalisations for diabetes

Data quality information for this measure has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Selected potentially preventable hospitalisations.
Measure/s (computation)	<p>Selected potentially preventable hospitalisations for diabetes.</p> <p>The numerator is the number of hospitalisations for type 2 diabetes mellitus (as principal or additional diagnosis), divided into seven groups:</p> <ul style="list-style-type: none">• Circulatory complications (E11.5x)• Renal complications (E11.2x)• Ophthalmic complications (E11.3x)• Other specified complications (E11.0x, E11.1x, E11.4x, E11.6x)• Multiple complications (E11.7x)• No complications (E11.9x)• Total. <p>The denominator is the Estimated Resident Population.</p> <p>A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).</p> <p>Potentially preventable hospitalisations for diabetes are defined by ICD-10-AM diagnosis codes.</p> <p>Calculation is $100\,000 \times (\text{Numerator} \div \text{Denominator})$, presented as a number per 100 000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 years combined.</p>
Data source/s	<p>Numerator: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care.</p> <p>Denominator: For total population: ABS Estimated Resident Population (ERP) as at 30 June 2011.</p> <p>Computation: $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.</p> <p>The Institute is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.</p> <p>The data were supplied to the Institute by state and territory health authorities. The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p> <p>States and territories supplied these data under the terms of the National Health Information Agreement, available online at: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442472807&libID=6442472788</p>
Relevance	<p>The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals.</p> <p>The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental</p>

	<p>hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.</p> <p>The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.</p>
Timeliness	The reference period for this data set is 2012-13.
Accuracy	<p>Reporting of diabetes increased by on average 29.6 per cent for diabetes as a principal diagnosis and 247 per cent for diabetes as an additional diagnosis, between 2011-12 and 2012-13 — in large part due to changes in Australian Coding Standards. Accordingly, data for 2012-13 are not comparable with data for previous years.</p> <p>For 2012-13 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the ACT.</p> <p>States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked with data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.</p> <p>Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions. Variations in both admission and administration practices and policies mean that dialysis treatments may be counted as separations with diabetes complications by some hospitals and not others, reducing the comparability of the data at state and territory level. This is particularly significant for Indigenous people because of the high prevalence of diabetes in that population.</p> <p>Cells have been suppressed to protect confidentiality (where the presentation could identify a patient or a single service provider) or where rates are likely to be highly volatile (for example, the denominator is very small).</p>
Coherence	<p>The information presented for this indicator is calculated using the same methodology as other potentially preventable hospitalisations data published in Australian hospital statistics 2012-13 and the National healthcare agreement: performance report 2011-12.</p> <p>Reporting of diabetes increased by on average 29.6 per cent for diabetes as a principal diagnosis and 247 per cent for diabetes as an additional diagnosis, between 2011-12 and 2012-13 — in large part due to changes in Australian Coding Standards. Accordingly, data for 2012-13 are not comparable with data for previous years.</p> <p>Changes between the ICD-10-AM 5th edition (used in 2007-08), ICD 10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) and the associated Australian Coding Standards apparently resulted in decreased reporting of additional diagnoses for diabetes.</p>
Accessibility	<p>The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:</p> <ul style="list-style-type: none"> • Australian hospital statistics with associated Excel tables. • Interactive data cube for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups). <p>Some data are also included on the MyHospitals website.</p>
Interpretability	Supporting information on the quality and use of the NHMD are published annually in Australian hospital statistics (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Further work is required to improve the comparability of data due to changes across editions of the ICD-10-AM.
- The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.
- Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.
- Changes to Australian Coding Standards mean that data for 2012-13 are not comparable to data for previous years.

Measure 3: Potentially preventable hospitalisations of older people for falls

Data quality information for this measure has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Selected potentially preventable hospitalisations.
Measure/s (computation)	<p>Potentially preventable hospitalisations of older people for falls.</p> <p>The number of hospitalisations for people aged 65 years or over with a reported external cause of falls, per 1000 people.</p> <p>The numerator is the number of hospitalisations for people aged 65 years or over with a reported external cause of falls.</p> <p>The denominator is the Estimated Resident Population.</p> <p>A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).</p> <p>Potentially preventable hospitalisations for falls are defined by ICD-10-AM external cause codes (W00–W19).</p> <p>Calculation is $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a number per 1000 and age standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 combined.</p>
Data source/s	<p>Numerator: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care.</p> <p>Denominator: ABS Estimated Resident Population (ERP) as at 30 June in the year preceding the reference period.</p> <p>Computation: $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.</p> <p>The Institute is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.</p> <p>The data were supplied to the Institute by state and territory health authorities. The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p> <p>States and territories supplied these data under the terms of the National Health Information Agreement, available online at: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442472807&libID=6442472788</p>
Relevance	<p>The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.</p> <p>The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.</p>

Timeliness	The reference periods for this data set are 2005-06, 2006-07, 2007-08, 2008-09, 2009-10, 2010-11, 2011-12, 2012-13.
Accuracy	<p>For 2006-07 almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private day hospital facilities in the ACT, the single private free standing day hospital facility in the NT, and a small private hospital in Victoria.</p> <p>For 2007-08 almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private day hospital facilities in the ACT, the single private free-standing day hospital facility in the NT, and a small private hospital in Victoria.</p> <p>For 2008-09 , almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private day hospital facilities in the ACT, the single private free-standing day hospital facility in the NT, and two private hospitals in Tasmania.</p> <p>For 2009-10 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT and about 2400 separations for one public hospital in Western Australia. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the Australian Capital Territory and the Northern Territory. In addition, Western Australia was not able to provide about 10 600 separations for one private hospital.</p> <p>For 2010-11 and 2011-12, almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the Australian Capital Territory and the Northern Territory. However, 2010-11 data were not available for the NT.</p> <p>For 2012-13, almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the ACT.</p> <p>States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked with data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.</p> <p>Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.</p> <p>Cells have been suppressed to protect confidentiality (where the presentation could identify a patient or a single service provider) or where rates are likely to be highly volatile (for example, the denominator is very small).</p>
Coherence	NT data are not available for 2010-11, and are excluded from the Australian total for that year. With this exception, data for this indicator are comparable over time.
Accessibility	<p>The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:</p> <ul style="list-style-type: none"> • Australian hospital statistics with associated Excel tables. • Interactive data cube for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups). <p>Some data are also included on the MyHospitals website.</p>
Interpretability	Supporting information on the quality and use of the NHMD are published annually in Australian hospital statistics (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and changes in

service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

**Key data gaps
/issues**

The Steering Committee notes the following issues:

- NT data were not available for 2010-11.
- The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

11 Public hospitals

CONTENTS

11.1	Profile of public hospitals	11.2
11.2	Framework of performance indicators for public hospitals	11.14
11.3	Key performance indicator results for public hospitals	11.16
11.4	Profile of maternity services	11.64
11.5	Framework of performance indicators for maternity services	11.66
11.6	Key performance indicator results for maternity services	11.68
11.7	Future directions in performance reporting	11.86
11.8	Definitions of key terms	11.88
11.9	List of attachment tables	11.92
11.10	References	11.97

Attachment tables

Attachment tables are identified in references throughout this chapter by a '11A' prefix (for example, table 11A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

Public hospitals are important providers of government funded health services in Australia. This chapter reports on the performance of State and Territory public hospitals, focusing on acute care services. It also reports separately on a significant component of the services provided by public hospitals — maternity services.

Improvements to the reporting of public hospitals in this edition include:

- a new measure 'Proportion of emergency department presentations with length of stay of 4 hours or less' is reported under the 'Emergency department waiting times' indicator

-
- ‘Elective surgery waiting times by clinical urgency category’ data are reported on a more timely basis. Data for 2013-14 are reported in line with the other waiting time measures (previously data had been lagged a year)
 - the measure ‘Falls resulting in patient harm in hospitals’ is reported under the ‘Adverse events in public hospitals’ indicator for the first time since the 2012 Report
 - a change in the definition for maternal sentinel events to improve comparability across jurisdictions
 - the age group used for the ‘Caesareans and inductions for selected primiparae’ indicators has been changed from 25–29 years to 20–34 years to align with national data definitions
 - the name of the indicator ‘Vaginal delivery following previous caesarean’ has been changed to ‘Vaginal birth after caesarean section’
 - data quality information (DQI) is available for the first time for the measures ‘Presentations to emergency departments with a length of stay of 4 hours or less ending in admission’, ‘Proportion of emergency department presentations with length of stay of 4 hours or less’, ‘Adverse events’ and ‘Falls resulting in patient harm in hospitals’, and the indicator ‘Mother’s average length of stay’.

11.1 Profile of public hospitals

A key objective of Australian governments is to provide public hospital services to ensure the population has access to cost-effective health services, based on clinical need and within clinically appropriate times, irrespective of geographic location. Public hospitals provide a range of services, including:

- acute care services to admitted patients
- subacute and non-acute services to admitted patients (for example, rehabilitation, palliative care and long stay maintenance care)
- emergency, outpatient and other services to non-admitted patients
- mental health services, including services provided to admitted patients by designated psychiatric/psychogeriatric units
- public health services
- teaching and research activities.

This chapter focuses on services provided to admitted patients and emergency services provided to non-admitted patients in public hospitals. These services comprise the bulk of public hospital activity and, in the case of services to admitted patients, have the most reliable data relative to other hospitals data. Data in the chapter include subacute and non-acute care services.

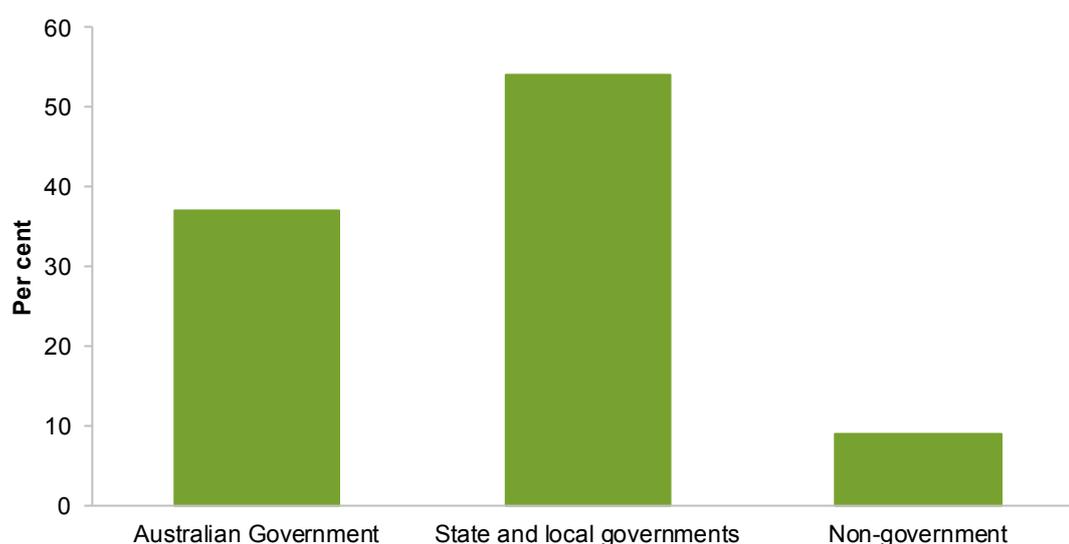
In some instances, data for stand-alone psychiatric hospitals are included in this chapter. However, under the National Mental Health Strategy, the provision of psychiatric treatment is shifting away from specialised psychiatric hospitals to mainstream public hospitals and the community sector. The performance of psychiatric hospitals and psychiatric units of public hospitals is examined more closely in the ‘Mental health management’ chapter of this Report (chapter 12).

Funding

Total recurrent expenditure on public hospitals (excluding depreciation) was \$41.7 billion in 2012-13 (table 11A.1). The majority of public hospital recurrent expenditure is spent on admitted patients. Non-admitted patients account for a much smaller share. For selected public hospitals, in 2012-13, the proportion of total public hospital recurrent expenditure that related to the care of admitted patients (based on the admitted patient cost proportion) was around 70 per cent across Australia (AIHW 2014a).

Funding for public hospitals comes from a number of sources. The Australian, State and Territory governments contributed 91.0 per cent of funding for public hospital services in 2012-13 (figure 11.1). Public hospital services accounted for 41.8 per cent of government recurrent expenditure on health services in 2012-13 (AIHW 2014b).

Figure 11.1 **Recurrent expenditure, public hospital services, by source of funds, 2012-13**

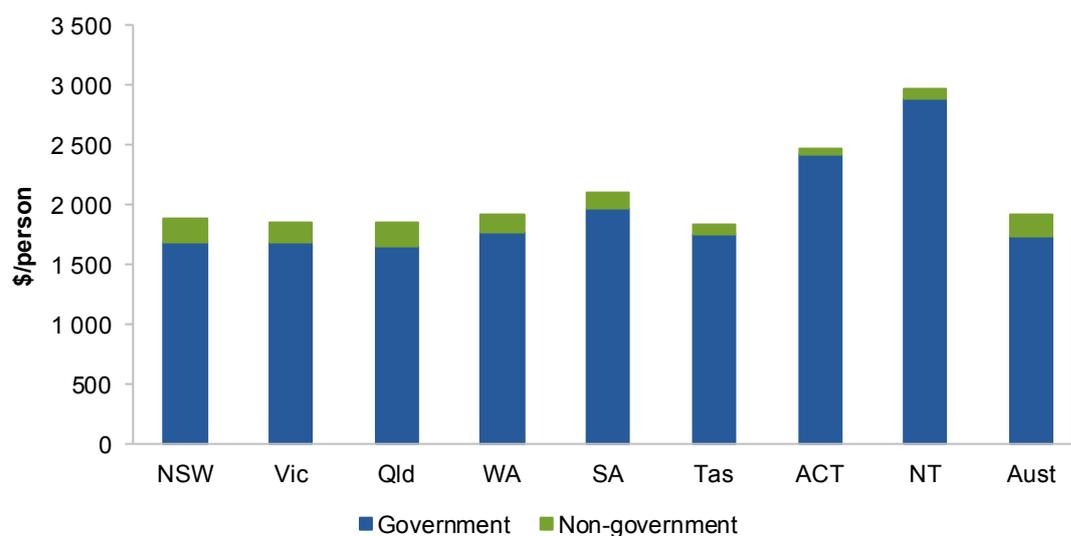


Source: AIHW (2014), *Health expenditure Australia 2012-13*, Health and Welfare Expenditure Series No. 52, Cat. no. HWE 61. Canberra.

Non-government sources contributed 9.0 per cent of all recurrent expenditure on public hospital services in 2012-13 (including depreciation) (figure 11.2 and table 11A.2).

Non-government expenditure comprised revenue from health insurance funds, individuals, workers' compensation and compulsory third-party motor vehicle insurers, and other sources. The proportion of hospitals' revenue per person funded from non-government sources varied across jurisdictions in 2012-13 (figure 11.2).

Figure 11.2 **Source of public hospital recurrent expenditure, 2012-13^{a, b, c}**



^a Depreciation is included in recurrent expenditure. ^b Non-government expenditure includes expenditure by health insurance funds, individuals, workers' compensation, compulsory third-party motor vehicle insurers and other sources. ^c The expenditure numbers for the ACT include substantial expenditures for NSW residents, and so the ACT expenditure is overstated.

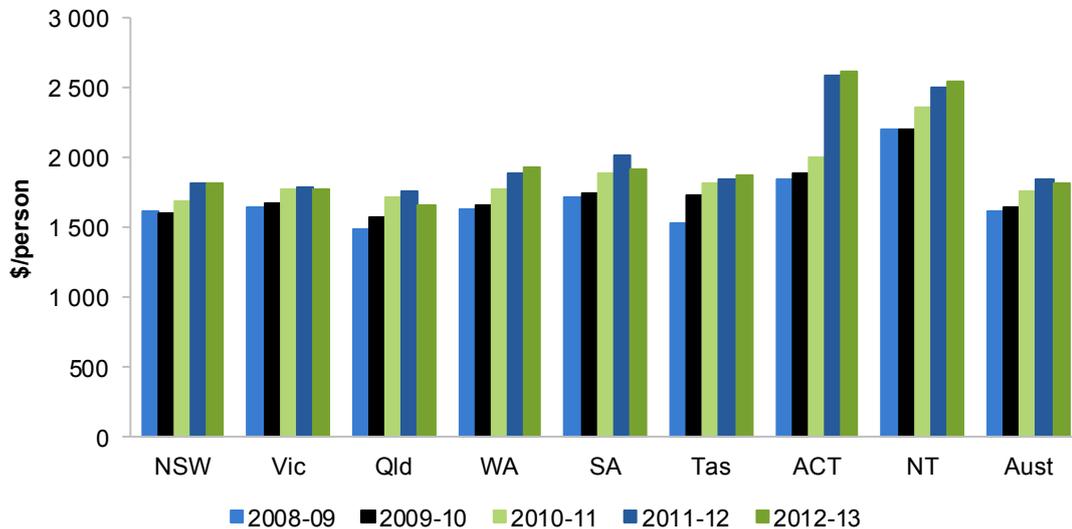
Source: AIHW (2014), *Health expenditure Australia 2012-13*, Health and Welfare Expenditure Series No. 52, Cat. no. HWE 61. Canberra; table 11A.2.

Expenditure data in figures 11.1 and 11.2 are sourced from unpublished data from the AIHW Health Expenditure Australia database, and are not directly comparable with other expenditure data used in this chapter, which are drawn from *Australian Hospital Statistics 2012-13* (AIHW 2014a). The AIHW publication *Health Expenditure Australia 2012-13* provides information about the differences in the expenditure data between the two sources (AIHW 2014b).

In 2012-13, government real recurrent expenditure on public hospitals was \$1819 per person nationally, up from \$1616 in 2008-09 (in 2012-13 dollars) (figure 11.3). It is difficult to make comparisons across jurisdictions based on these recurrent expenditure data, due to differences in the data coverage. The main differences are:

- the inclusion, by some jurisdictions, of expenditure on community health services as well as public hospital services
- the exclusion, by some jurisdictions, of expenditure on privately owned or privately operated hospitals that have been contracted to provide public hospital services.

Figure 11.3 **Real recurrent expenditure per person, public hospitals (including psychiatric) (2012-13 dollars)^{a, b, c, d, e, f}**



^a Expenditure data exclude depreciation and interest payments. ^b Recurrent expenditure on purchase of public hospital services at the State, or area health service level, from privately owned and/or operated hospitals is excluded. ^c Expenditure data are deflated using the hospital/nursing home care price index from the AIHW (2014b). ^d Queensland pathology services were purchased from a Statewide pathology service rather than being provided by hospital employees. ^e In SA in 2011-12 there were significant once-off revaluations of other employee related expenses. This has caused an artificial reduction in expenditure, including for salaries and wages expenditure components, for 2012-13 results. ^f The expenditure numbers for the ACT include substantial expenditures for NSW residents, and so the ACT expenditure is overstated.

Source: AIHW (various years), *Australian hospital statistics*, Health Services Series, Cat. nos HSE 84, 107, 117, 134 and 145; AIHW (2014), *Health expenditure Australia 2012–13*, Health and Welfare Expenditure Series No. 52, Cat. no. HWE 61. Canberra, AIHW; table 11A.3.

Size and scope of sector

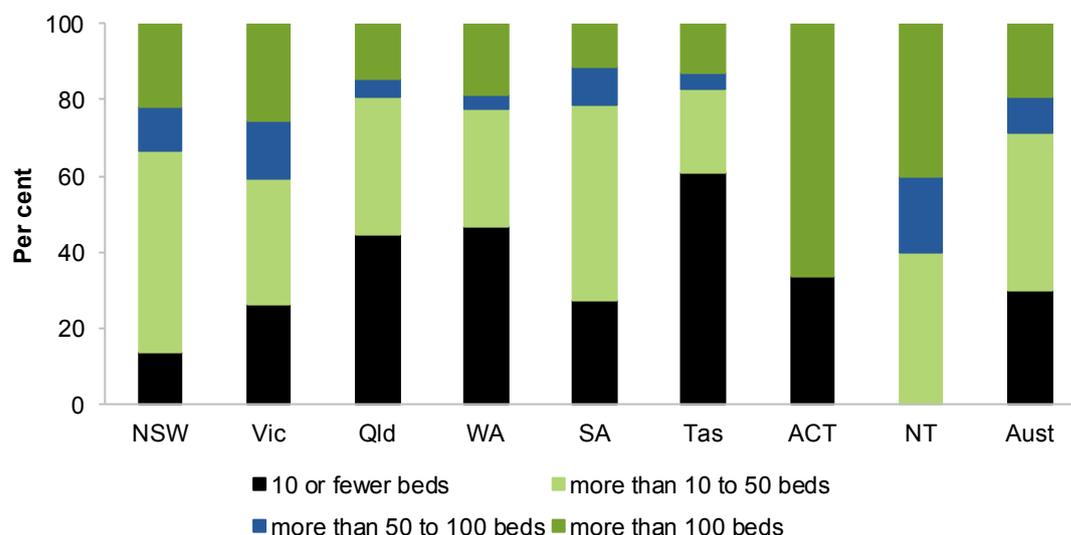
There are several ways to measure the size and scope of Australia's public hospital sector. This chapter reports on: the number and size of hospitals; the number and location of public hospital beds; the number and type of public hospital separations; the number of separations by age group of the patient; the number of separations and incidence of treatment, by the Indigenous status of the patient; the number of hospital staff; and types of public hospital activity.

Hospitals

In 2012-13, Australia had 746 public hospitals (including 17 psychiatric hospitals) (table 11A.4 and AIHW 2014a). Although 71 per cent of hospitals had 50 or fewer beds,

these smaller hospitals represented only 15 per cent of total available beds (figure 11.4 and table 11A.4).

Figure 11.4 Public hospitals, by size, 2012-13^{a, b, c, d, e}



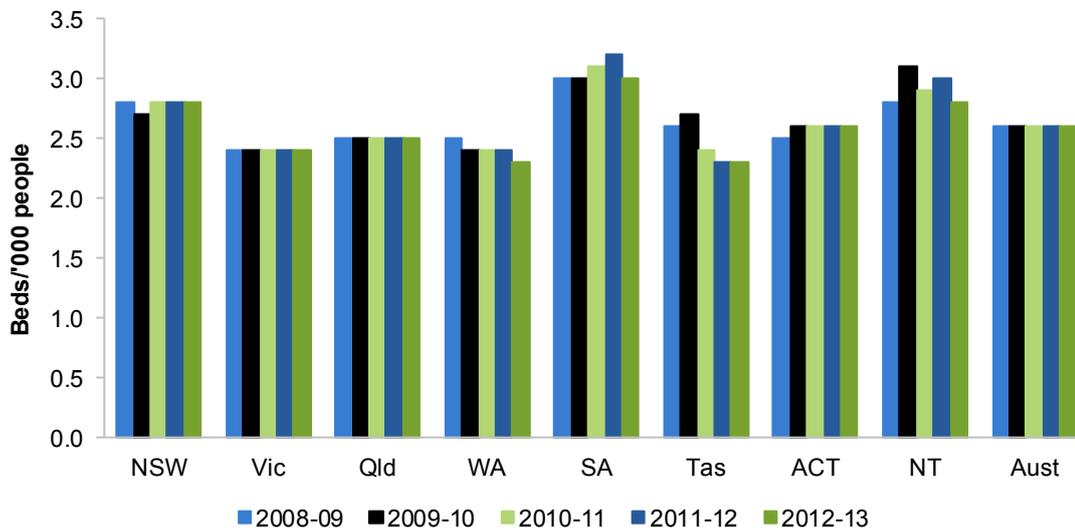
^a The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of hospital buildings or campuses. ^b Size is based on the average number of available beds. ^c The comparability of bed numbers can be affected by the casemix of hospitals, including the extent to which hospitals provide same day admitted services and other specialised services. ^d The count of hospitals in Victoria is a count of the campuses that report data separately to the National Hospital Morbidity Database. ^e The ACT did not have hospitals with more than 10 to 50 beds or more than 50 to 100 beds. The NT did not have hospitals with 10 or fewer beds.

Source: AIHW (2014), *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no HSE 145; table 11A.4.

Hospital beds

There were 58 311 available beds for admitted patients in public hospitals in 2012-13, equivalent to 2.6 beds per 1000 people (figure 11.5 and table 11A.4). The concept of an available bed is becoming less important in the overall context of hospital activity, particularly given the increasing significance of same day hospitalisations and hospital-in-the-home care (AIHW 2011). Nationally, about 87 per cent of beds in public acute hospitals were available for overnight-stay patients in 2012-13 (AIHW 2014a).

Figure 11.5 Available beds, public hospitals^{a, b}



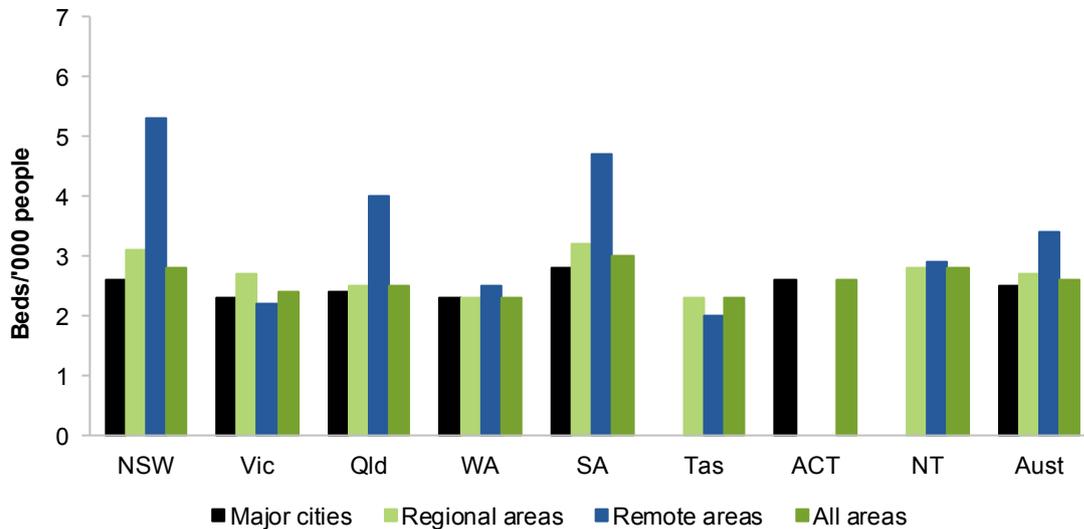
^a Available beds includes both average available beds for overnight and same day accommodation. Average available overnight beds is the number of beds available to provide overnight accommodation for patients (other than neonatal cots (nonspecial-care) and beds occupied by hospital-in-the-home patients), averaged over the counting period. Average available same day beds is the number of beds, chairs or trolleys available to provide accommodation for same-day patients, averaged over the counting period (HDSC 2012). ^b In 2012-13 a large number of SA state-funded aged care beds in country hospitals converted into Commonwealth multi-purpose service places. This has resulted in an apparent decrease in the numbers of available beds between 2011-12 and 2012-13.

Source: AIHW (various years), *Australian hospital statistics*, Health Services Series, Cat. nos HSE 84, 107, 117, 134 and 145; table 11A.5.

The comparability of bed numbers can be affected by the casemix of hospitals, including the extent to which hospitals provide same day admitted services and other specialised services. There are also differences in admission practices and how available beds are counted, both across jurisdictions and over time.

Nationally, more beds were available per 1000 people in remote areas (figure 11.6). The patterns of bed availability can reflect a number of factors, including patterns of availability of other healthcare services, patterns of disease and injury and the relatively poor health of Aboriginal and Torres Strait Islander Australians, who have higher population concentrations in remote areas. These data also need to be viewed in the context of the age and sex structure (reported in chapter 2) and the morbidity and mortality (reported in the 'Health sector overview') of the population in each State and Territory.

Figure 11.6 Available beds, public hospitals, by location, 2012-13^{a, b, c}



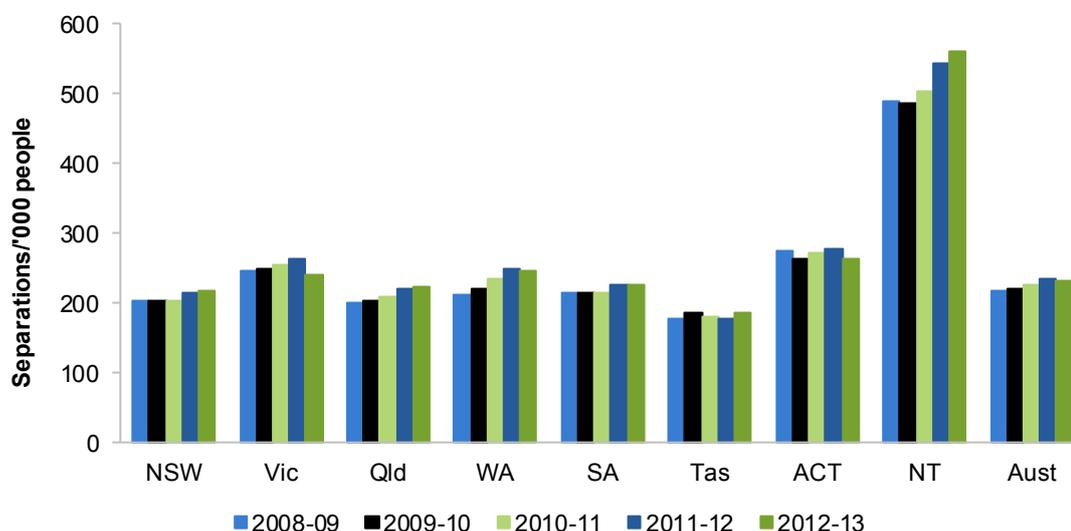
^a Available beds includes both average available beds for overnight and same day accommodation. Average available overnight beds is the number of beds available to provide overnight accommodation for patients (other than neonatal cots (nonspecial-care) and beds occupied by hospital-in-the-home patients), averaged over the counting period. Average available same day beds is the number of beds, chairs or trolleys available to provide accommodation for same-day patients, averaged over the counting period (HDSC 2012). ^b Analysis by remoteness area is of less relevance to geographically smaller jurisdictions and those jurisdictions with small populations residing in remote areas (such as Victoria) (AIHW 2014a). ^c Tasmania and the NT do not have major cities and the ACT does not have regional and remote areas.

Source: AIHW (2014), *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145; table 11A.5.

Admitted patient care

There were approximately 5.5 million separations from public (non-psychiatric) hospitals in 2012-13 (table 11A.6). Nationally, this translates into 231.6 separations per 1000 people (figure 11.7). Acute separations accounted for 95.1 per cent of separations from public hospitals, newborns who required acute care accounted for 1.4 per cent and rehabilitation care accounted for 1.9 per cent (table 11A.13). Palliative care, geriatric evaluation and management, and maintenance care constitute the remainder. Of the total number of separations in public (non-psychiatric) hospitals, 50.4 per cent were for same day patients. Public psychiatric hospitals accounted for around 0.2 per cent of total separations in public hospitals in 2012-13 (table 11A.6).

Figure 11.7 Separation rates in public (non-psychiatric) hospitals^{a, b, c, d}



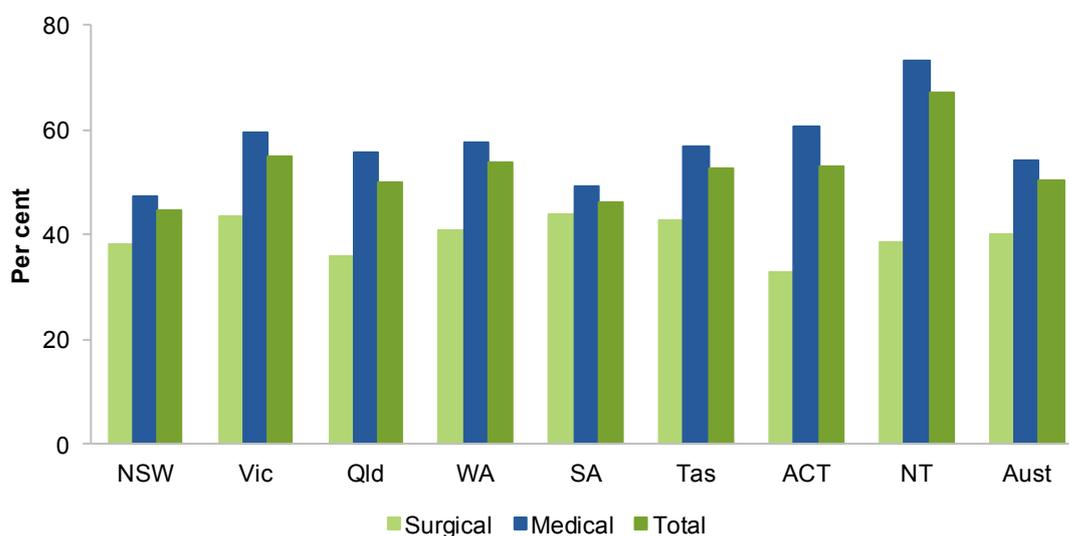
^a Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders (hospital boarder is defined in section 11.8) and posthumous organ procurement. ^b Rates are directly age standardised to the Australian population at 30 June 2001. ^c There was a change in Victorian admission policy from 1 July 2012 that has impacted the separation time series. ^d Aboriginal and Torres Strait Islander people make up a high proportion of the population in the NT which contributes to the high level of separations in the NT. Aboriginal and Torres Strait Islander people are more likely than other Australians to experience poor health (see Health sector overview).

Source: AIHW (various years), *Australian Hospital Statistics*, Health Services Series, Cat. nos HSE 84, 107, 117, 134 and 145; table 11A.7.

Differences across jurisdictions in separation rates reflect variations in the health profiles of the people living in each State and Territory, the decisions made by medical staff about the type of care required and people's access to services other than public hospitals (for example, primary care and private hospitals).

Variations in admission rates can reflect different practices in classifying patients as either admitted same day patients or outpatients. For example, in SA, chemotherapy and scope procedures are treated as outpatient rather than same day services. The extent of differences in classification practices can be inferred from the variation in the proportion of same day separations across jurisdictions for certain conditions or treatments. This is particularly true of medical separations. Significant variation across jurisdictions in the proportion of same day medical separations was evident in 2012-13 (figure 11.8). Lower jurisdictional variation is likely in admission practices for surgical procedures, as reflected by the lower variability in the proportion of same day surgical separations.

Figure 11.8 Proportion of medical, surgical and total separations that were same day, public (non-psychiatric) hospitals, 2012-13^a



^a 'Total' includes medical, surgical, chemotherapy, radiotherapy, renal dialysis and 'other' separations based on AR-DRG version 6.0x categories.

Source: AIHW (unpublished), National Hospital Morbidity Database; table 11A.8.

People aged 55 years and over accounted for half of the separations in public hospitals (52.6 per cent) in 2012-13, even though they accounted for only 25.6 per cent of the estimated resident population at 30 June 2012 (table 11A.9 and AIHW 2014a).

In 2012-13, the most common principal diagnoses for overnight acute separations in public hospitals were for single spontaneous delivery (4.6 per cent), followed by single delivery by caesarean section (2.3 per cent) and pain in throat and chest (2.3 per cent) (table 11A.15). The most common principal diagnoses for same day acute separations in public hospitals were for care involving dialysis (37.7 per cent), other medical care, including radiotherapy, chemotherapy, some blood transfusions and palliative care (5.1 per cent) and pain in throat and chest (2.1 per cent) (table 11A.14).

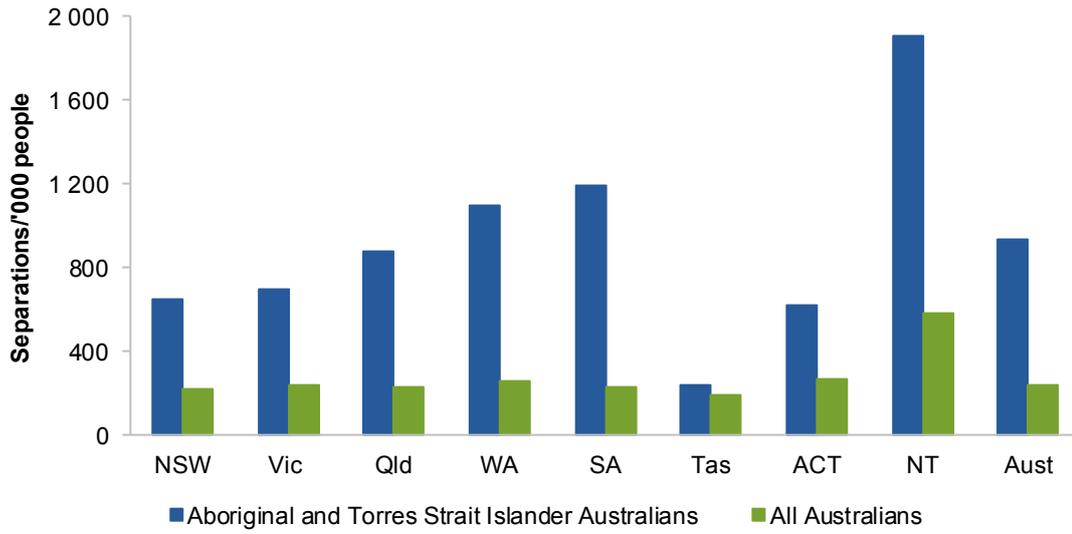
Most patient days in public hospitals in 2012-13 were for acute care (79.2 per cent) and rehabilitation care (8.9 per cent). The remainder was mainly accounted for by palliative care, geriatric evaluation and management, psychogeriatric care and maintenance care (table 11A.16). Patient days by care type for private hospitals are reported in table 11A.16.

Admitted patient care for Aboriginal and Torres Strait Islander Australians

The completeness of identification of Aboriginal and Torres Strait Islander people in hospital admitted patient data varies across states and territories. Efforts to improve identification are ongoing. In 2012-13, on an age standardised basis, 938.6 public hospital

separations (including same day separations) for Aboriginal and Torres Strait Islander Australians were reported per 1000 Aboriginal and Torres Strait Islander Australians. This rate was markedly higher than the corresponding rate of 237.0 per 1000 for all Australians (figure 11.9).

Figure 11.9 Public hospital separations, 2012-13^{a, b}



^a The rates are directly age standardised to the Australian population at 30 June 2001. ^b Identification of Aboriginal and Torres Strait Islander Australians is incomplete and completeness varies across jurisdictions.

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

Hospital episodes of care involving dialysis accounted for a large portion of same day separations, particularly for Aboriginal and Torres Strait Islander Australians. The hospitalisation rate for Aboriginal and Torres Strait Islander Australians for dialysis was 12 times as high as the rate for other Australians. When dialysis is excluded, the same day hospitalisation rate for Aboriginal and Torres Strait Islander Australians in 2012-13 (152.8 per 1000 of the population) was less than that for other Australians (168.7 per 1000 of the population) (AIHW 2014a).

In 2012-13, separations for Aboriginal and Torres Strait Islander Australians accounted for around 4.1 per cent of total separations and 6.4 per cent of separations in public hospitals (table 11A.10). Aboriginal and Torres Strait Islander Australians made up only around 3 per cent of the population nationally, although this rate varied significantly from 0.9 per cent in Victoria to 29.8 per cent in the NT (tables 2A.1 and 2A.14). Most separations involving Aboriginal and Torres Strait Islander Australians (91.7 per cent) in these jurisdictions occurred in public hospitals (table 11A.10).

Non-admitted patient services

A total of 54.1 million individual occasions of service were provided to non-admitted patients in public acute hospitals in 2012-13 (table 11.1). In addition, public hospitals delivered 516 129 group sessions during this time (a group session is defined as a service provided to two or more patients, excluding services provided to two or more family members) (table 11A.17). In public acute hospitals in 2012-13, accident and emergency services comprised 14.6 per cent of all individual occasions of service to non-admitted patients. 'Other medical, surgical and obstetric services' (24.4 per cent), 'pathology services' (17.8 per cent) and 'pharmacy' (9.3 per cent) were other common types of non-admitted patient care (table 11.1).

Table 11.1 Non-admitted patient occasions of service, by type of non-admitted patient care, public acute hospitals, 2012-13^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT ^b	Aust
Occasions of service for the most common types of non-admitted patient care as a proportion of all occasions of service for non-admitted patients (%)									
Accident and emergency	10.6	20.9	16.1	16.6	25.2	33.1	6.4	24.3	14.6
Pathology	13.3	11.1	35.4	14.4	..	..	36.5	22.0	17.8
Radiology and organ imaging	2.6	8.1	9.1	7.5	8.9	..	2.2	15.3	5.6
Pharmacy ^c	15.4	5.3	5.0	4.0	..	..	2.3	5.9	9.3
Other medical/surgical/obstetric	23.4	25.8	24.1	18.4	44.3	50.2	20.7	28.5	24.4
Mental health	4.2	..	0.3	1.7	0.6	0.9	14.1	..	2.6
Dental	1.8	5.7	..	0.2	0.4	..	..	..	1.7
Allied health	3.1	12.7	6.2	15.3	7.9	13.0	8.5	2.9	6.9
Other non-admitted									
Community health	10.4	5.4	2.1	18.2	..	2.8	9.1	..	8.2
District nursing ^d	6.7	2.0	..	2.0	..	..	..	..	3.5
Most common occasions of service (%)	91.5	97.2	98.3	98.2	87.4	100.0	99.8	98.9	94.7
Total occasions of service ('000)	24 412	7 925	10 835	5 823	2 168	482	1 870	600	54 115

^a Individual non-admitted patient care services. Excludes group sessions. Reporting arrangements vary significantly across jurisdictions. ^b Radiology data for the NT are underestimated and pathology data relate to only three of the five hospitals. ^c Justice Health in NSW reported a large number of occasions of service that may not be typical of pharmacy. ^d Justice Health in NSW reported a large number of occasions of service that may not be typical of district nursing. .. Not applicable.

Source: AIHW (2014), *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145; table 11A.17.

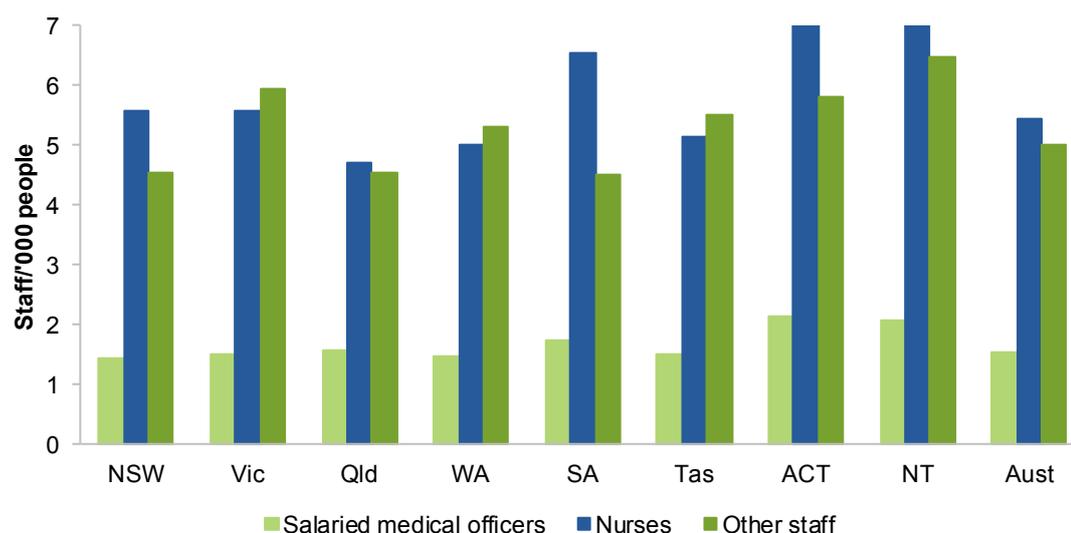
There is considerable variation among states and territories and across reporting years in collection of non-admitted patient occasions of service. Differing admission practices

across states and territories also lead to variation among jurisdictions in the services reported (AIHW 2014a).

Staff

In 2012-13, nurses comprised the single largest group of full time equivalent (FTE) staff employed in public hospitals (5.4 per 1000 people) (figure 11.10). Comparing data on FTE staff across jurisdictions should be undertaken with care, because these data are affected by differences across jurisdictions in the recording and classification of staff. The outsourcing of services with a large labour related component (for example, food services and domestic services) can have a large impact on hospital staffing figures and can explain some of the differences in FTE staff in some staffing categories across jurisdictions (AIHW 2011).

Figure 11.10 **Average FTE staff per 1000 people, public hospitals, 2012-13^{a, b, c, d, e}**



^a 'Other staff' include diagnostic and allied health professionals, other personal care staff, administrative and clerical staff, and domestic and other staff. ^b Staff per 1000 people are calculated from ABS population data at 31 December 2012 (table 2A.2). Population data used to derive rates are revised to the final 2011 Census rebased estimates and projections. Population data for All Australians for all years are estimates. See chapter 2 (table 2A.2) for details. ^c Queensland pathology services staff employed by the State pathology service are not included. ^d Data for two small Tasmanian hospitals are not included. ^e Caution should be used in comparing data for the ACT with other jurisdictions as the ACT workforce serves many residents of southern NSW in addition to ACT residents, while only ACT residents are captured in the denominator.

Source: AIHW (2014), *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145; ABS (unpublished), Australian Demographic Statistics, December Quarter 2012, Cat. no. 3101.0; tables 11A.12 and 2A.2.

11.2 Framework of performance indicators for public hospitals

Performance is reported against objectives that are common to public hospitals in all jurisdictions (box 11.1). The Health sector overview explains the performance indicator framework for health services as a whole, including the subdimensions of quality and sustainability that have been added to the standard Review framework.

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations).

The National Healthcare Agreement (NHA) covers the area of health and aged care, and health indicators in the National Indigenous Reform Agreement (NIRA) establish specific outcomes for reducing the level of disadvantage experienced by Aboriginal and Torres Strait Islander Australians. Both agreements include sets of performance indicators. The Steering Committee collates NIRA performance information for analysis by the Department of Prime Minister and Cabinet. Performance indicators reported in this chapter are aligned with health performance indicators in the most recent version of the NHA, where relevant.

Box 11.1 Objectives for public hospitals

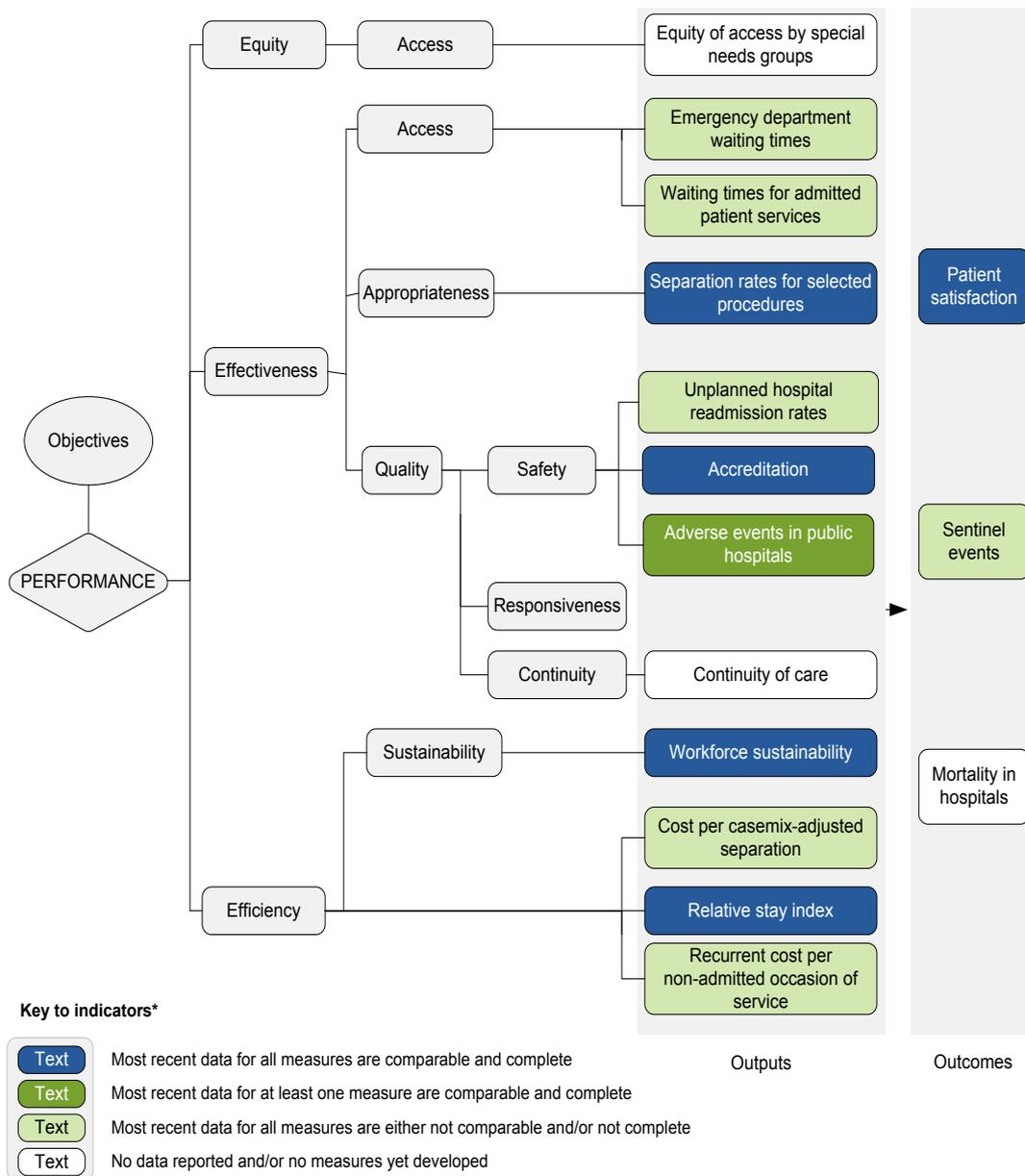
The common government objectives for public hospitals are to provide acute and specialist services that are:

- safe and of high quality
- appropriate and responsive to individual needs
- affordable, timely and accessible
- equitably and efficiently delivered.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of public hospital services (figure 11.11). 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 (section 1.6).

The Report's statistical context chapter contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous- and ethnic-status) (chapter 2).

Figure 11.11 Public hospitals performance indicator framework



* A description of the comparability and completeness of each measure is provided in indicator interpretation boxes within the chapter

Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators, in addition to material in the chapter or sector overview and attachment tables. DQI in this Report cover the seven dimensions in the ABS' data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and

key data gaps and issues identified by the Steering Committee. All DQI for the 2015 Report can be found at www.pc.gov.au/rogs/2015.

11.3 Key performance indicator results for public hospitals

Different delivery contexts, locations and types of client can affect the equity, effectiveness and efficiency of health services.

As discussed in section 11.1, public hospitals provide a range of services to admitted patients, including some sub-acute and non-acute services such as rehabilitation and palliative care. The extent to which these sub-acute and non-acute treatments can be identified and excluded from the data differs across jurisdictions. Similarly, psychiatric treatments are provided in public (non-psychiatric) hospitals at different rates across jurisdictions.

Outputs

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

Equity — access

Equity indicators measure how well a service is meeting the needs of certain groups in society (see chapter 1). Public hospitals have a significant influence on the equity of the overall healthcare system. While access to public hospital services is important to the community in general, it is particularly important for people of low socioeconomic status (and others) who can have difficulty in accessing alternative services, such as those provided by private hospitals.

Equity of access by special needs groups

‘Equity of access by special needs groups’ is an indicator of governments’ objective to provide accessible services (box 11.2).

Box 11.2 **Equity of access by special needs groups**

'Equity of access by special needs groups' measures the performance of agencies providing services for identified special needs groups including: Aboriginal and Torres Strait Islander Australians; people living in communities outside the capital cities (that is, people living in other metropolitan areas, or rural and remote communities); and people from culturally and linguistically diverse backgrounds. Chapter 1 outlines special needs groups in more detail.

Equity of access by special needs groups has been identified as a key area for development in future Reports. Data for the emergency department waiting times and waiting times for admitted patient services indicators are reported by Indigenous status and remoteness.

Effectiveness — access

Emergency department waiting times

'Emergency department waiting times' is an indicator of governments' objective to provide accessible services (box 11.3).

Box 11.3 **Emergency department waiting times**

'Emergency department waiting times' is defined by the following two measures:

- Emergency department waiting times by triage category
- Proportion of emergency department presentations with length of stay of 4 hours or less.

Emergency department waiting times by triage category

Emergency department waiting times by triage category is calculated by subtracting the time at which the patient presents at the emergency department (that is, the time at which the patient is clerically registered or triaged, whichever occurs earlier) from the time of commencement of service by a treating medical officer or nurse. Patients who do not wait for care after being triaged or clerically registered are excluded from the data.

'Emergency department waiting times by triage category' is defined as the proportion of patients seen within the benchmarks set by the Australasian Triage Scale. The Australasian Triage Scale is a scale for rating clinical urgency, designed for use in hospital-based emergency services in Australia and New Zealand.

(Continued on next page)

Box 11.3 (continued)

The benchmarks, set according to triage category, are as follows:

- triage category 1: need for resuscitation — patients seen immediately
- triage category 2: emergency — patients seen within 10 minutes
- triage category 3: urgent — patients seen within 30 minutes
- triage category 4: semi-urgent — patients seen within 60 minutes
- triage category 5: non-urgent — patients seen within 120 minutes (HDSC 2008).

A high or increasing proportion of patients seen within the benchmarks set for each triage category is desirable.

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across 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 measure is at www.pc.gov.au/rogs/2015.

Proportion of emergency department presentations with length of stay of 4 hours or less

'Proportion of Emergency department presentations with length of stay of 4 hours or less' is defined as the percentage of presentations to public hospital emergency departments where the time from presentation to physical departure is less than or equal to four hours. It is a measure of the duration of the emergency department service rather than a waiting time for emergency department care.

A high or increasing proportion of patients with a length of stay of four hours or less is desirable.

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across 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 measure is at www.pc.gov.au/rogs/2015.

Emergency department waiting times by triage category

The comparability of emergency department waiting times data across jurisdictions can be influenced by differences in data coverage (table 11.2) and clinical practices — in particular, the allocation of cases to urgency categories. The proportion of patients in each triage category who were subsequently admitted can indicate the comparability of triage categorisations across jurisdictions and thus the comparability of the waiting times data (table 11A.18).

Nationally, in 2013-14, 100 per cent of patients in triage category 1 were seen within the clinically appropriate timeframe, and 82 per cent of patients in triage category 2 were seen within the clinically appropriate timeframe. For all triage categories combined, 75 per cent of patients were seen within triage category timeframes (table 11.2). Emergency department waiting times for peer group A and B hospitals are reported in table 11A.19.

Table 11.2 Emergency department patients seen within triage category timeframes, public hospitals (per cent)^a

<i>Triage category</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2012-13									
1 — Resuscitation ^b	100	100	100	100	100	100	100	100	100
2 — Emergency	83	84	84	81	75	83	74	66	82
3 — Urgent	73	72	68	52	66	65	43	52	68
4 — Semi-urgent	77	68	74	67	78	70	46	52	72
5 — Non-urgent	92	87	92	93	92	90	79	89	91
Total	78	73	74	66	75	71	51	57	73
Data coverage ^c	88	92	74	78	83	92	100	100	85
2013-14									
1 — Resuscitation ^b	100	100	100	100	100	100	100	100	100
2 — Emergency	83	84	80	86	74	85	83	61	82
3 — Urgent	76	73	67	58	65	66	50	51	70
4 — Semi-urgent	80	71	75	71	77	71	57	53	75
5 — Non-urgent	94	88	92	94	92	90	86	89	92
Total	81	75	73	70	73	72	61	57	75
Data coverage ^c	99	92	74	78	83	92	100	100	88

^a Percentages are derived from all hospitals that reported to the Non-admitted Patient Emergency Department Care Database, including all principal referral and specialist women's and children's hospitals, large hospitals and public hospitals that were classified to other peer groups. ^b Resuscitation patients whose waiting time for treatment was less than or equal to two minutes are considered to have been seen on time. ^c Data coverage is estimated as the number of occasions of service with waiting times data divided by the number of emergency department occasions of service. This can underestimate coverage because some occasions of service are for other than emergency presentations. For some jurisdictions, the number of emergency department occasions of service reported to the Non-admitted Patient Emergency Department Care Database exceeded the number of accident and emergency occasions of service reported to the National Public Hospital Establishments Database. For these jurisdictions the coverage has been estimated as 100 per cent.

Source: AIHW (2014), *Australian hospital statistics 2013–14: emergency department care*, Health services series no. 58 Cat. no. HSE 153. Canberra; AIHW (2013), *Australian hospital statistics 2012–13: emergency department care*, Health services series no. 52. Cat. no. HSE 142. Canberra; table 11A.18.

Emergency department waiting times by Indigenous status, remoteness and socioeconomic status for peer group A and B hospitals are reported in the attachment (tables 11A.20–22). Nationally, there was little difference between Aboriginal and Torres Strait Islander and other Australians in the percentages of patients treated within national benchmarks across the triage categories, although there were variations across states and territories for some triage categories (table 11A.20). At the national level, there was variation in waiting times

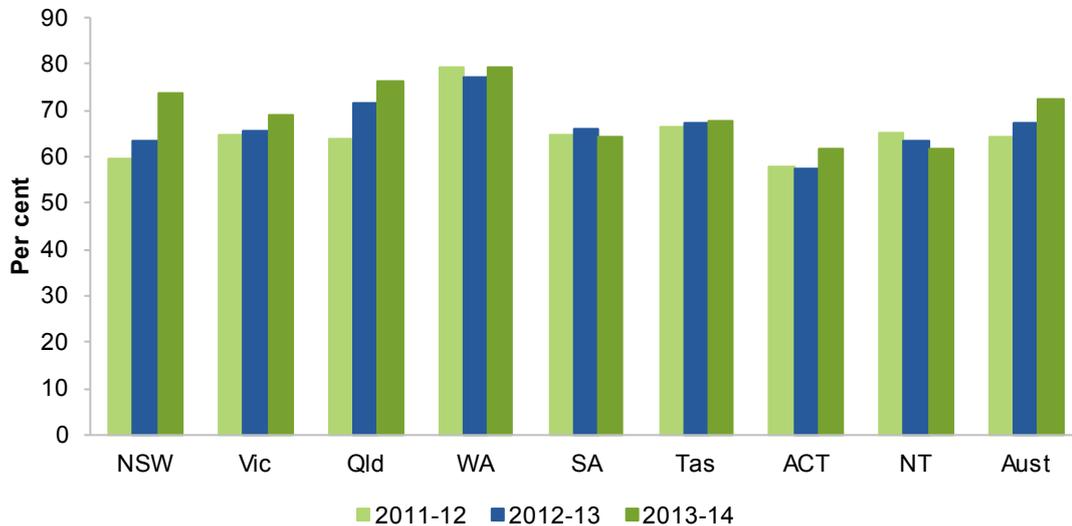
across triage categories by remoteness, although there was less variation for the most serious category, resuscitation (table 11A.21). There was little difference in waiting times across triage categories by socioeconomic status on a national basis (table 11A.22).

Proportion of emergency department presentations with length of stay of 4 hours or less

The proportion of emergency department presentations with length of stay of 4 hours or less is reported for the first time in this Report edition. Data for this measure are sourced from the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD). The purpose of the NNAPEDCD is to collect information on the characteristics of emergency department care for non-admitted patients registered for care in emergency departments in selected public hospitals classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or B (Large hospitals). However, data were also provided by some states and territories for hospitals in peer groups other than A and B. For 2013–14, coverage of the NNAPEDCD collection was estimated to be about 88 per cent of emergency occasions of service in Australian public hospitals (AIHW 2014d). The data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Hospitals not included do not necessarily have emergency departments that are equivalent to those in hospitals in peer groups A and B.

The proportion of emergency department presentations with length of stay of 4 hours or less has increased from 64.3 per cent in 2011-12 to 72.7 per cent in 2013-14 (figure 11.12).

Figure 11.12 Proportion of emergency department presentations with length of stay of 4 hours or less^{a, b}



^a Excludes records for which the emergency department length of stay could not be calculated due to missing date or time data. ^b The emergency department length of stay is the amount of time between the patient presenting to the emergency department (arrival) and the physical departure of the patient.

Source: AIHW (2014), *Australian hospital statistics 2013–14: emergency department care*, Health services series no. 58. Cat. no. HSE 153. Canberra: AIHW, Canberra; AIHW (2013), *Australian hospital statistics 2012–13: emergency department care*, Health services series no. 52. Cat. no. HSE 142. Canberra: AIHW, Canberra; AIHW (2012), *Australian hospital statistics 2011–12: emergency department care*, Health services series no. 45. Cat. no. HSE 126. Canberra; table 11A.23.

Waiting times for admitted patient services

‘Waiting times for admitted patient services’ is an indicator of governments’ objective to provide accessible services (box 11.4). Elective surgery patients who wait longer are likely to suffer discomfort and inconvenience, and more urgent patients can experience poor health outcomes as a result of extended waits.

Box 11.4 **Waiting times for admitted patient services**

'Waiting times for admitted patient services' is defined by the following three measures:

- Overall elective surgery waiting times
- Elective surgery waiting times by clinical urgency category
- Presentations to emergency departments with a length of stay of 4 hours or less ending in admission.

Overall elective surgery waiting times

'Overall elective surgery waiting times' are calculated by comparing the date on which patients are added to a waiting list with the date on which they are admitted. Days on which the patient was not ready for care are excluded. 'Overall waiting times' are presented as the number of days within which 50 per cent of patients are admitted and the number of days within which 90 per cent of patients are admitted. The proportion of patients who waited more than 12 months is also shown.

For overall elective surgery waiting times, a low or decreasing number of days waited at the 50th and 90th percentiles, and a low or decreasing proportion of people waiting more than 365 days are desirable.

Data reported for this measure are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across 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 measure is at www.pc.gov.au/rogs/2015.

Elective surgery waiting times by clinical urgency category

'Elective surgery waiting times by clinical urgency category' reports the proportion of patients who were admitted from waiting lists after an extended wait. The three generally accepted clinical urgency categories for elective surgery are:

- category 1 — admission is desirable within 30 days for a condition that has the potential to deteriorate quickly to the point that it may become an emergency
- category 2 - admission is desirable within 90 days for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency
- category 3 — admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency. The desirable timeframe for this category is admission within 365 days.

(Continued on next page)

Box 11.4 (continued)

The term 'extended wait' is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting more than the agreed desirable waiting times of 30 days and 90 days respectively.

For elective surgery waiting times by clinical urgency category, a low or decreasing proportion of patients who have experienced extended waits at admission is desirable. However, variation in the way patients are classified to urgency categories should be taken into account. Rather than comparing jurisdictions, the results for individual jurisdictions should be viewed in the context of the proportions of patients assigned to each of the three urgency categories (table 11.3).

Data reported for this measure are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across 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 measure is at www.pc.gov.au/rogs/2015.

Presentations to emergency departments with a length of stay of 4 hours or less ending in admission

'Presentations to emergency departments with a length of stay of 4 hours or less ending in admission' is defined as the percentage of presentations to public hospital emergency departments where the time from presentation to admission to hospital is less than or equal to four hours.

A high or increasing proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission is desirable.

Data reported for this measure are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across 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 measure is at www.pc.gov.au/rogs/2015.

Overall elective surgery waiting times

Elective surgery waiting times data are provided for waiting lists managed by public acute hospitals. The data collection covers most public hospitals that undertake elective surgery, and in 2013-14 covered 93 per cent of separations for elective surgery in public acute hospitals (table 11A.24).

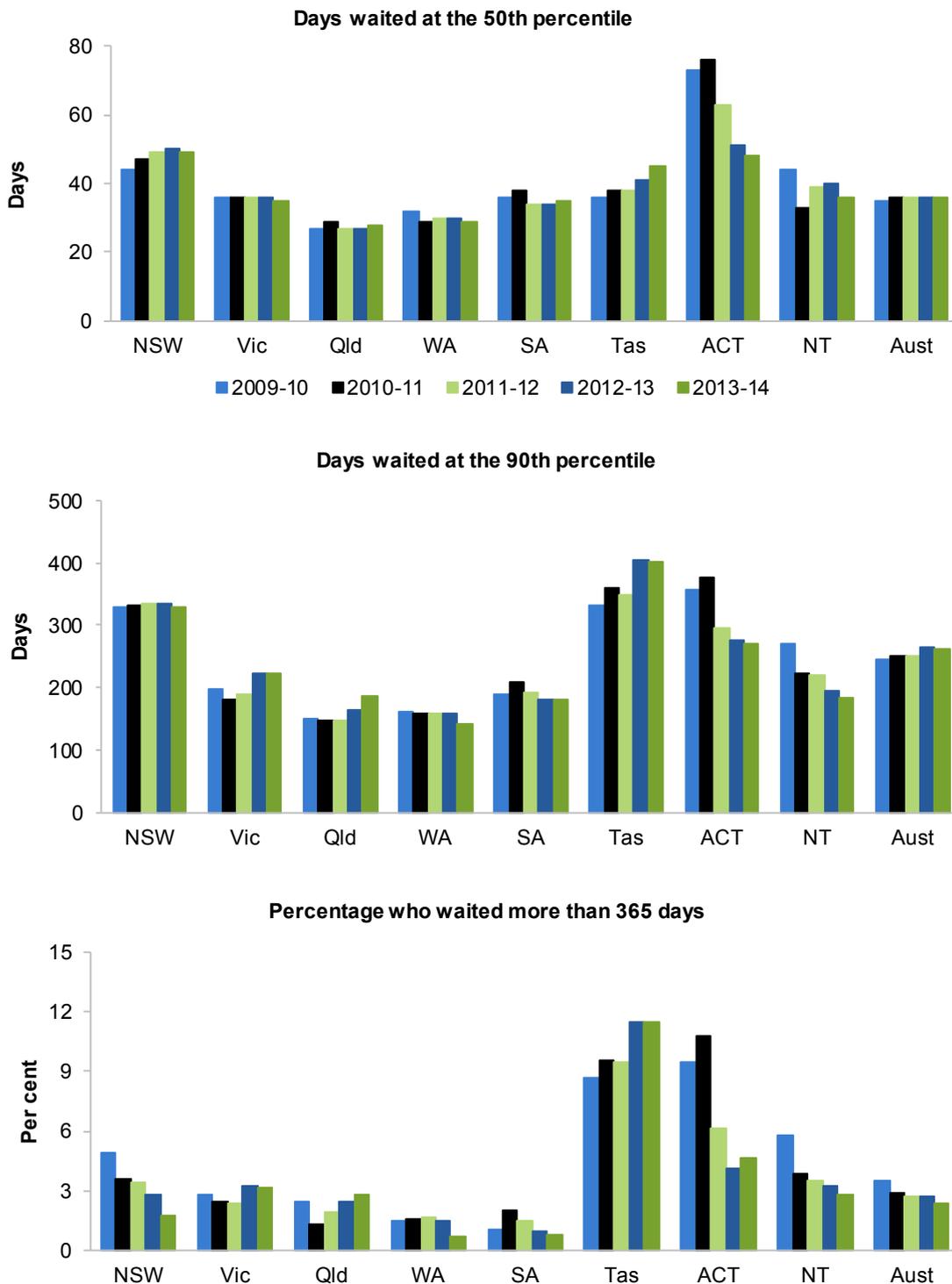
Patients on waiting lists who were not subsequently admitted to hospital are excluded. Patients can be removed from waiting lists because they no longer need the surgery, die, are treated at another location, decline to have the surgery, or cannot be contacted by the

hospital (AIHW 2014c). In 2013-14, 14.1 per cent of patients who were removed from waiting lists were removed for reasons other than elective or emergency admission (AIHW 2014c).

Comparisons across jurisdictions should be made with caution, due to differences in clinical practices and classification of patients across Australia. The measures are also affected by variations across jurisdictions in the method used to calculate waiting times for patients who transferred from a waiting list managed by one hospital to a waiting list managed by another hospital. For patients who were transferred from a waiting list managed by one hospital to that managed by another, the time waited on the first list is included in the waiting time reported in NSW, SA and the NT. This approach can have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions (AIHW 2014c).

Nationally in 2013-14, 50 per cent of patients were admitted within 36 days and 90 per cent of patients were admitted within 262 days. The proportion of patients who waited more than a year was 2.4 per cent. Nationally, waiting times at the 50th percentile increased by one day between 2009-10 and 2013-14, from 35 to 36 days. However, there were different trends for different jurisdictions and for different sized hospitals over that period (figure 11.13 and table 11A.24).

Figure 11.13 Waiting times for elective surgery, public hospitals



Source: AIHW (various years), *Australian Hospital Statistics*, Health Services Series, Cat nos. HSE 107 and 117; AIHW (various years), *Australian hospital statistics: elective surgery waiting times*, Cat. nos. HSE 127, 140 and 151; table 11A.24.

Attachment 11A includes data on elective surgery waiting times by hospital peer group, specialty of surgeon and indicator procedure. It also includes waiting times by Indigenous status, remoteness and socioeconomic status (tables 11A.24–29). Nationally, Aboriginal and Torres Strait Islander Australians had longer waiting times for elective surgery than other Australians at the 50th percentile and 90th percentile (table 11A.26). Those living in regional areas had longer waiting times than those in major cities at the 50th and 90th percentiles at the national level (table 11A.27). Elective surgery waiting times tended to increase with social disadvantage at the 50th and 90th percentiles on a national basis (table 11A.28).

Elective surgery waiting times by clinical urgency category

Elective surgery waiting times by urgency category not only provide an indication of the extent to which patients are seen within a clinically desirable time, but also draw attention to the variation in the way in which patients are classified across jurisdictions. Jurisdictional differences in the classification of patients by urgency category in 2013-14 are shown in table 11.3. The states and territories with lower proportions of patients in category 1 tended to have smaller proportions of patients in this category who were ‘not seen on time’. NSW, Victoria and the ACT, for example, had low proportions of patients in category 1 and also had low proportions of patients in category 1 who had extended waits (tables 11.3, 11A.31, 11A.33 and 11A.43).

The system of urgency categorisation for elective surgery in public hospitals is important to ensure that priority is given to patients according to their needs. While elective surgery waiting times by urgency category are not comparable across jurisdictions, this measure has the advantage of providing an indication of the extent to which patients are seen within a clinically desirable time according to the urgency category to which they have been assigned.

The AIHW, with the Royal Australasian College of Surgeons, submitted a proposal to Health Ministers in December 2012 for nationally agreed elective surgery urgency category definitions, including consistent treatment of patients ‘not ready for care’. This was endorsed by Health Ministers, and NSW is now leading work on nation-wide implementation of the recommendations outlined in the proposal.

Table 11.3 Classification of elective surgery patients, by clinical urgency category, 2013-14 (per cent)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
Patients on waiting lists								
Category 1	2.5	4.1	7.6	5.1	4.2	5.7	4.4	5.3
Category 2	16.0	50.1	34.9	27.7	22.4	50.9	35.9	41.0
Category 3	81.5	45.8	57.5	67.1	73.4	43.4	59.7	53.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Patients admitted from waiting lists								
Category 1	23.5	28.9	39.0	24.9	25.5	38.2	29.3	29.8
Category 2	33.2	47.7	41.8	37.1	36.0	42.0	44.5	48.5
Category 3	43.3	23.3	19.1	38.0	38.5	19.8	26.3	21.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: AIHW (unpublished) National Elective Surgery Waiting Times Data Collection; table 11A.30.

Reporting of elective surgery waiting times by clinical urgency category includes the proportions of patients with extended waits at admission. The proportions of patients on waiting lists who already had an extended wait are reported in tables 11A.31, 11A.33, 11A.35, 11A.37, 11A.39, 11A.41, 11A.43 and 11A.45. The proportion of patients on waiting lists who already had an extended wait at the date of assessment does not represent the completed waiting times of patients. This is represented by the proportion of patients with extended waits at admission.

Elective surgery waiting times by clinical urgency category data are sourced from the AIHW for the years 2013-14 and 2012-13. This is the first year that these data have been sourced from the AIHW. In previous Report editions, all data were sourced directly from states and territories. In this Report edition, data for all years prior to 2012-13 were sourced directly from states and territories. Due to the difference in data sources, comparisons over time should be made with care.

Elective surgery waiting times by clinical urgency category data are reported on a more timely basis in this Report edition. Data for 2013-14 are reported in line with the other waiting time measures, previously the elective surgery waiting times by clinical urgency category data had been lagged a year.

Of patients admitted from waiting lists in NSW in 2013-14:

- 23.5 per cent were classified to category 1, of whom 0.3 per cent had an extended wait
- 33.2 per cent were classified to category 2, of whom 3.1 per cent had an extended wait
- 43.3 per cent were classified to category 3, of whom 4.1 per cent had an extended wait.

Overall in NSW, 2.9 per cent of all patients experienced extended waits (table 11.3 and table 11A.31).

Of patients admitted from waiting lists in Victoria in 2013-14:

- 28.9 per cent were classified to category 1, of whom zero per cent had an extended wait
- 47.7 per cent were classified to category 2, of whom 31.4 per cent had an extended wait
- 23.3 per cent were classified to category 3, of whom 9.9 per cent had an extended wait.

Overall in Victoria, 17.3 per cent of all patients experienced extended waits (table 11.3 and table 11A.33).

Of patients admitted from waiting lists in Queensland in 2013-14:

- 39.0 per cent were classified to category 1, of whom 5.0 per cent had an extended wait
- 41.8 per cent were classified to category 2, of whom 19.5 per cent had an extended wait
- 19.1 per cent were classified to category 3, of whom 11.4 per cent had an extended wait.

Overall in Queensland, 12.3 per cent of all patients experienced extended waits (table 11.3 and table 11A.35).

Of patients admitted from waiting lists in WA in 2013-14:

- 24.9 per cent were classified to category 1, of whom 2.2 per cent had an extended wait
- 37.1 per cent were classified to category 2, of whom 8.2 per cent had an extended wait
- 38.0 per cent were classified to category 3, of whom 1.7 per cent had an extended wait.

Overall in WA, 4.2 per cent of all patients experienced extended waits (table 11.3 and table 11A.37).

Of patients admitted from waiting lists in SA in 2013-14:

- 25.5 per cent were classified to category 1, of whom 6.7 per cent had an extended wait
- 36.0 per cent were classified to category 2, of whom 7.7 per cent had an extended wait
- 38.5 per cent were classified to category 3, of whom 2.1 per cent had an extended wait.

Overall in SA, 5.3 per cent of all patients experienced extended waits (table 11.3 and table 11A.39).

Of patients admitted from waiting lists in Tasmania in 2013-14:

- 38.2 per cent were classified to category 1, of whom 24.8 per cent had an extended wait
- 42.0 per cent were classified to category 2, of whom 50.3 per cent had an extended wait
- 19.8 per cent were classified to category 3, of whom 24.7 per cent had an extended wait.

Overall in Tasmania, 35.5 per cent of all patients experienced extended waits (table 11.3 and table 11A.41).

Of patients admitted from waiting lists in the ACT in 2013-14:

- 29.3 per cent were classified to category 1, of whom 1.5 per cent had an extended wait
- 44.5 per cent were classified to category 2, of whom 26.2 per cent had an extended wait
- 26.3 per cent were classified to category 3, of whom 12.8 per cent had an extended wait.

Overall in the ACT, 15.4 per cent of all patients experienced extended waits (table 11.3 and table 11A.43).

Of patients admitted from waiting lists in NT in 2013-14:

- 29.8 per cent were classified to category 1, of whom 9.8 per cent had an extended wait
- 48.5 per cent were classified to category 2, of whom 24.7 per cent had an extended wait
- 21.7 per cent were classified to category 3, of whom 12.5 per cent had an extended wait.

Overall in the NT, 17.6 per cent of all patients experienced extended waits (table 11.3 and table 11A.45).

Waiting times data by urgency category and surgical speciality were also provided (tables 11A.32, 11A.34, 11A.36, 11A.38, 11A.40, 11A.42, 11A.44 and 11A.46).

Presentations to emergency departments with a length of stay of 4 hours or less ending in admission

Nationally in 2013-14, 45 per cent of those who presented to an emergency department waited 4 hours or less to be admitted to hospital. Nationally, the percentage waiting 4 hours or less to be admitted was 56 per cent of patients requiring resuscitation, 47 per cent of emergency patients and 43 per cent of urgent patients. Waiting times improved for all triage categories for all hospitals from 2012-13 to 2013-14 on a national basis (table 11.4).

Table 11.4 Proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission, public hospitals^{a, b, c, d}

<i>Triage category</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2012-13									
1 — Resuscitation	44	56	54	59	55	56	62	48	52
2 — Emergency	32	44	40	52	41	32	40	23	39
3 — Urgent	27	36	39	43	38	22	24	23	34
4 — Semi-urgent	30	36	45	45	43	24	28	24	35
5 — Non-urgent	53	53	62	55	61	47	40	50	54
Total^d	30	38	41	46	41	25	29	24	36
2013-14									
1 — Resuscitation	51	57	59	66	54	58	63	46	56
2 — Emergency	43	49	53	58	37	33	45	21	47
3 — Urgent	40	44	51	51	35	25	29	21	43
4 — Semi-urgent	44	45	57	52	42	28	33	22	46
5 — Non-urgent	65	60	68	60	59	44	45	50	62
Total^d	42	46	53	53	38	28	34	22	45

^a Includes presentations for all types of visit. ^b Length of stay is calculated as the length of time between presentation to the emergency department and physical departure. ^c Data includes Principal referral and specialist women's and children's hospitals, Large hospitals and hospitals in other peer groups that reported to the National Non-Admitted Patient Emergency Department Care Database. ^d Total includes presentations for which the triage category was not reported.

Source(s): AIHW (2014), *Australian hospital statistics 2013–14: emergency department care*, Health services series no. 58. Cat. no. HSE 153. Canberra; AIHW (2013), *Australian hospital statistics 2012–13: emergency department care*, Health services series no. 52. Cat. no. HSE 142. Canberra; table 11A.47.

Data on emergency department presentations for non-admitted patients may be affected by variations in reporting practices across states and territories and over time. The comparability of emergency department waiting times data across jurisdictions can be influenced by differences in data coverage (table 11.2) and clinical practices — in particular, the allocation of cases to urgency categories.

Data in table 11.4 are for all hospitals. Data for peer group A ('Principal referral and specialist women's and children's' hospitals) and B ('Large hospitals') are presented in table 11A.47. Nationally in 2013-14, a lower proportion of patients were admitted within 4 hours or less in large hospitals than in principal referral and specialist women's and children's hospitals for all triage categories (table 11A.47).

Effectiveness — appropriateness

Separation rates for selected procedures

‘Separation rates for selected procedures’ is an indicator of the appropriateness of hospital services (box 11.5).

Box 11.5 Separation rates for selected procedures

‘Separation rates for selected procedures’ is defined as separations per 1000 people for certain procedures in public hospitals. The procedures are selected for their frequency, for sometimes being elective and discretionary, and because alternative treatments are sometimes available.

Higher/lower or increasing/decreasing rates are not necessarily associated with inappropriate care. However, large jurisdictional variations in rates for particular procedures can require investigation to determine whether service levels are appropriate.

Care needs to be taken when interpreting differences in the separation rates for the selected procedures. Variations in rates can be attributable to variations in the prevalence of the conditions being treated, or to differences in clinical practice across states and territories. Higher rates can be acceptable for certain conditions and not for others. Higher rates of angioplasties, for example, can represent appropriate levels of care, whereas higher rates of hysterectomies or tonsillectomies can represent an over-reliance on procedures. Some of the selected procedures, such as angioplasty and coronary artery bypass graft, are alternative treatment options for people diagnosed with similar conditions.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

The separation rates for selected procedures reported here reflect the activities of the public health system. For all procedures, separation rates varied across jurisdictions (table 11.5).

Table 11.5 Separations for selected procedures per 1000 people, public hospitals, 2012-13^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Procedure</i>									
Cataract extraction	2.7	3.0	1.6	4.7	3.4	2.0	4.1	6.7	2.8
Cholecystectomy	1.4	1.5	1.2	1.2	1.5	1.4	1.4	1.2	1.4
Coronary angioplasty	0.9	0.8	0.8	0.8	0.9	1.0	2.0	..	0.9
Coronary artery bypass graft	0.3	0.3	0.3	0.2	0.3	0.3	0.5	..	0.3
Cystoscopy	1.6	2.9	2.0	3.3	2.7	1.6	3.0	2.0	2.3
Haemorrhoidectomy	1.0	0.8	0.3	0.5	0.5	0.6	0.3	0.9	0.7
Hip replacement	0.6	0.7	0.5	0.8	0.7	0.7	1.0	0.6	0.6
Hysterectomy, females aged 15–69 years	1.0	1.1	1.0	1.0	1.2	1.2	0.9	0.8	1.0
Inguinal herniorrhaphy	1.0	1.0	0.8	1.0	1.0	1.0	1.0	1.0	1.0
Knee replacement	0.7	0.5	0.5	0.7	0.6	0.4	0.7	0.5	0.6
Myringotomy (with insertion of tube)	0.5	0.7	0.6	0.8	1.4	0.5	0.5	0.6	0.7
Prostatectomy	0.9	1.0	0.7	0.9	1.0	0.8	1.1	0.5	0.9
Septoplasty	0.3	0.4	0.2	0.2	0.5	0.1	0.3	0.2	0.3
Tonsillectomy	0.9	1.3	0.8	0.9	1.5	0.7	0.8	1.0	1.0
Varicose veins, stripping and ligation	0.2	0.3	0.1	0.1	0.3	<0.1	0.5	0.2	0.2

^a Rates are standardised to the Australian population as at 30 June 2001 and are calculated for the total population for all procedures except prostatectomy (rates calculated for the male population only) and hysterectomy (rates calculated for females aged 15–69 years). .. Not applicable.

Source: AIHW (2014), *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145; table 11A.48.

Data for private hospitals are reported in table 11A.48. Table 11A.48 also reports selected separations for all hospitals by Indigenous status, remoteness and socioeconomic status. Table 11A.49 reports additional information for the selected separations for all hospitals such as numbers of separations and the standardised separation rate ratio.

Effectiveness — quality

There is no single definition of quality in healthcare, but the Australian Commission on Safety and Quality in Health Care (ACSQHC) has defined quality as ‘the extent to which the properties of a service or product produce a desired outcome’ (Runciman 2006). No single indicator can measure quality across all providers. An alternative approach is to identify and report on aspects of quality of care. The aspects of quality highlighted in the performance indicator framework are safety, responsiveness and continuity. This Report includes indicators of safety, but no indicators have yet been developed for responsiveness or continuity.

Various governments publicly report performance indicators for service quality of public hospitals. Some have adopted the same indicators reported in this chapter. For example:

- The Australian Government's MyHospitals website, which is managed by the National Health Performance Authority, reports *staphylococcus aureus* bacteraemia (SAB) infections as counts and rates per 10 000 patient days under surveillance for most public hospitals and a number of private hospitals.
- In NSW, reporting of surgical site infection rates for hip and knee surgery is mandatory for public hospitals.
- Victorian hospitals are required to publish annual quality of care reports that include safety and quality indicators for infection control, medication errors, falls monitoring and prevention, pressure wound monitoring and prevention, patient satisfaction and consumer participation in health care decision making.
- Queensland Health publishes regular online public hospitals performance, which among other measures, includes patient experience results.
- Both the WA and Tasmanian health departments' annual reports include information on unplanned readmission rates and WA also includes a section on patient evaluation of health services.
- SA Health publishes an annual patient safety report, which provides a summary of the types of incidents that occurred in public hospitals and a comprehensive overview of the major patient safety programs being conducted by SA Health. It links the programs to the safety issues identified by analysis of data from the incident management system (Safety Learning System), Coronial recommendations and other sources, to help explain what actions are being taken to address these safety issues. A Measuring Consumer Experience SA Public Hospital Inpatient Annual Report, which details the key findings from the SA Consumer Experience Surveillance System, is also published.
- ACT Health publishes quarterly reports that include data on unplanned readmissions, unplanned returns to operating theatre and hospital acquired infection rates. Information about quality and safety activities and consumer feedback management is also included in an annual report.
- The NT Health Department Annual Report has a chapter on clinical governance including information on complaints, hand hygiene, *staphylococcus aureus* bacteraemia and unplanned readmission rates. Other sections report unplanned readmission rates after discharge for acute mental health episodes.

Safety

Improving patient safety is an important issue for all hospitals. Studies on medical errors have indicated that adverse healthcare related events occur in public hospitals in Australia and internationally, and that their incidence is potentially high (for example Eshani et al. 2006). These adverse events can result in serious consequences for individual

patients, and the associated costs to individuals and the health care system can be considerable (Van den Bos et al. 2011).

Safety — unplanned hospital readmission rates

‘Unplanned hospital readmission rates’ is an indicator of governments’ objective to provide public hospital services that are safe and of high quality (box 11.6). Patients might be re-admitted unexpectedly if the initial care or treatment was ineffective or unsatisfactory, if post-discharge planning was inadequate, or for reasons outside the control of the hospital (for example poor post-discharge care).

Box 11.6 Unplanned hospital readmission rates

‘Unplanned hospital readmission rates’ is defined as the rate at which patients unexpectedly return to hospital within 28 days for further treatment of the same condition. It is calculated as the number of separations that were unplanned or unexpected readmissions to the same hospital following a separation in which a selected surgical procedure was performed and which occurred within 28 days of the previous date of separation, expressed per 1000 separations in which one of the selected surgical procedures was performed. Selected surgical procedures are knee replacement, hip replacement, tonsillectomy and adenoidectomy, hysterectomy, prostatectomy, cataract surgery and appendectomy. Unplanned readmissions are those having a principal diagnosis of a post-operative adverse event for which a specified ICD-10-AM diagnosis code has been assigned.

Low or decreasing rates for this indicator are desirable. Conversely, high rates for this indicator suggest the quality of care provided by hospitals, or post-discharge care or planning, should be examined, because there may be scope for improvement.

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Unplanned readmission rates are not adjusted for casemix or patient risk factors, which can vary across hospitals and across jurisdictions. Unplanned hospital readmission rates in public hospitals in 2012-13 are reported in table 11.6. Unplanned hospital readmission rates are reported by hospital peer group, Indigenous status, remoteness and socioeconomic status in table 11A.51.

Table 11.6 Unplanned hospital readmission rates, per 1000 separations, 2012-13

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total^a</i>
Surgical procedure prior to separation									
Knee replacement	21.6	15.1	35.1	22.3	18.6	37.0	–	np	22.4
Hip replacement	18.0	16.1	16.1	15.9	19.3	29.6	12.9	np	17.5
Tonsillectomy and adenoidectomy	30.3	29.1	35.7	42.4	37.5	51.9	44.7	83.0	33.1
Hysterectomy	31.6	25.9	31.8	43.6	28.7	52.0	23.1	np	30.6
Prostatectomy	27.3	26.5	40.7	33.9	28.9	57.8	np	np	31.1
Cataract surgery	3.4	3.0	4.6	2.6	2.9	4.4	0.9	6.0	3.4
Appendicectomy	22.4	22.8	22.0	29.0	27.0	26.5	20.4	43.5	23.1

^a Total rates for Australia do not include WA. **np** Not published. – Nil or rounded to zero.

Source: AIHW (unpublished) National Hospital Morbidity Database; WA Health (unpublished); table 11A.50.

There are some difficulties in identifying readmissions that were unplanned. The indicator is likely to be an under-estimate because:

- it identifies only those patients readmitted to the same hospital, so does not include patients who go to another hospital
- episodes of non-admitted patient care provided in outpatient clinics or emergency departments which may have been related to a previous admission are not included
- the unplanned and/or unexpected readmissions are limited to those having a principal diagnosis of a post-operative adverse event. This does not include all possible unplanned/unexpected readmissions.

Safety — hospital accreditation

‘Accreditation’ is an indicator of governments’ objective to provide public hospital services that are of high quality (box 11.7). Data for this indicator are shown in figure 11.14.

Box 11.7 **Accreditation**

'Accreditation' is defined as the number of beds in accredited hospitals as a percentage of total beds. 'Accreditation' signifies professional and national recognition awarded to hospitals and other healthcare facilities that meet defined industry standards.

Australian Health Ministers have mandated accreditation in all public and private hospitals and day procedure services in Australia from 1 January 2013. From this date health services are to be assessed to the National Safety and Quality Health Service (NSQHS) Standards by accrediting agencies approved by the ACSQHC. There are currently 10 accrediting agencies with approval listed on the ACSQHC website. By 2016 it is anticipated all Australian hospitals will have been accredited to all 10 NSQHS Standards. Until 1 January 2013 public hospital accreditation was voluntary in all jurisdictions except Victoria and Queensland, where it was mandatory for all public hospitals (excluding those in Victoria that provide only dental or mothercraft services and those in Queensland that do not routinely admit patients). Public hospitals could seek accreditation through a number of agencies. These agencies were accredited through the Joint Accreditation System of Australia and New Zealand or the International Society for Quality in Healthcare. Caution should therefore be used when comparing 2012-13 data with prior years.

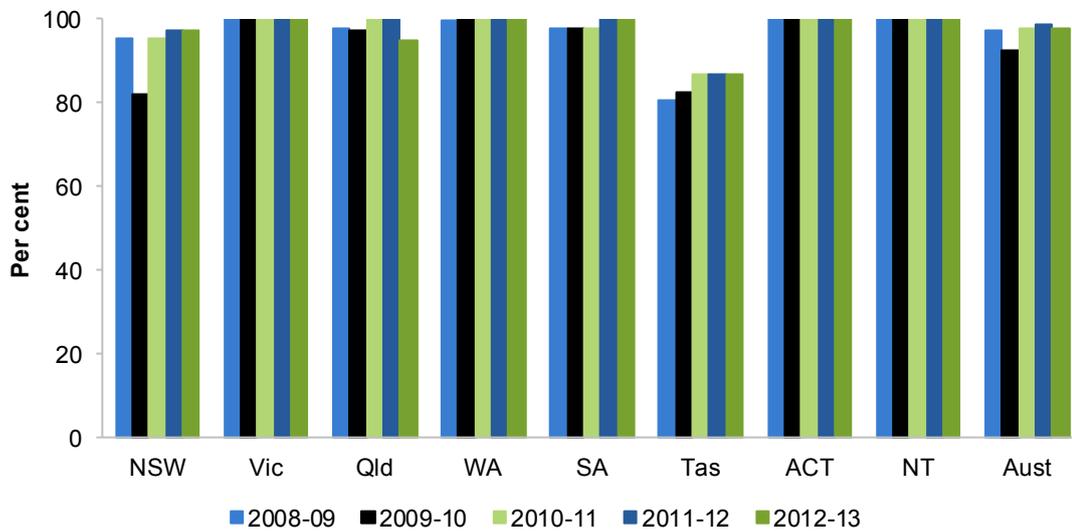
A high or increasing rate of accreditation is desirable. However, it is not possible to draw conclusions about the quality of care in those hospitals that do not have accreditation.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but not over time. Data for 2012-13 are not comparable with prior years.
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Figure 11.14 Proportion of accredited beds, public hospitals^{a, b, c, d}



^a Where average available beds for the year were not available, bed numbers at 30 June were used. ^b Includes psychiatric hospitals. ^c Australian Health Ministers have mandated accreditation in all public and private hospitals and day procedure services in Australia from 1 January 2013. From this date health services are to be assessed to the NSQHS Standards by accrediting agencies approved by the ACSQHC. Caution should therefore be used when comparing 2012-13 data with prior years. ^d Accreditation status for three Queensland hospitals was not provided.

Source: AIHW (various years), *Australian Hospital Statistics*, Health Services Series, Cat nos. HSE 84, 107, 117, 134 and 145; table 11A.52.

Safety — adverse events in public hospitals

‘Adverse events in public hospitals’ is an indicator of governments’ objective to provide public hospital services that are safe and of high quality (box 11.8). Adverse events in public hospitals can result in serious consequences for individual patients, place a significant burden on the health system and are influenced by the safety of hospital practices and procedures. Sentinel events, which are a subset of adverse events that result in death or very serious harm to the patient, are reported separately in this chapter as an outcome indicator.

Box 11.8 Adverse events in public hospitals

'Adverse events in public hospitals' is defined by the following three measures:

- healthcare-associated infections
- adverse events treated in hospitals
- falls resulting in patient harm in hospitals.

Healthcare-associated infections

'Healthcare-associated infections' is the number of *Staphylococcus aureus* (including Methicillin-resistant *Staphylococcus aureus* [MRSA]) bacteraemia (SAB) patient episodes associated with public hospitals, expressed as a rate per 10 000 patient days for public hospitals reporting for the SAB indicator.

A patient episode of SAB is defined as a positive blood culture for SAB. Only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded.

SAB is considered to be healthcare-associated if the first positive blood culture is collected more than 48 hours after hospital admission or less than 48 hours after discharge, or if the first positive blood culture is collected 48 hours or less after admission and one or more of the following key clinical criteria was met for the patient episode of SAB:

- SAB is a complication of the presence of an indwelling medical device
- SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site
- an invasive instrumentation or incision related to the SAB was performed within 48 hours
- SAB is associated with neutropenia ($<1 \times 10^9/L$) contributed to by cytotoxic therapy.

Cases where a known previous blood culture has been obtained within the last 14 days are excluded. Patient days for unqualified newborns are included. Patient days for hospital boarders and posthumous organ procurement are excluded.

A low or decreasing healthcare-associated infections rate is desirable.

Data reported for this measure are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across 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 measure is at www.pc.gov.au/rogs/2015.

(Continued on next page)

Box 11.8 (continued)

Adverse events treated in hospitals

'Adverse events treated in hospitals' are incidents in which harm resulted to a person during hospitalisation. They are measured by separations that had an adverse event, including infections, falls resulting in injuries and problems with medication and medical devices that occurred during a hospitalisation. Hospitalisation is identified by diagnoses, places of occurrence and external causes of injury and poisoning that can indicate that an adverse event was treated and/or occurred during the hospitalisation.

Low or decreasing adverse events treated in hospitals is desirable.

Data reported for this measure are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this measure is at www.pc.gov.au/rogs/2015.

Falls resulting in patient harm in hospitals

'Falls resulting in patient harm in hospitals' is defined as the number of separations with an external cause code for fall and a place of occurrence of health service area, expressed as a rate per 1000 hospital separations.

It is not possible to determine if the place of occurrence was a public setting, only that it was a health service area.

A low or decreasing rate of falls resulting in patient harm in hospitals is desirable.

Data reported for this measure are:

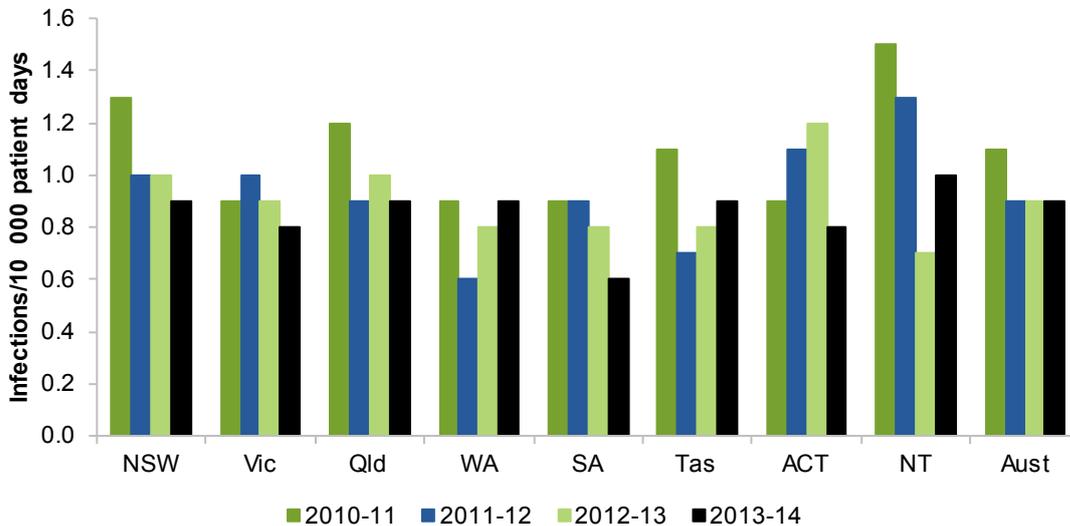
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this measure is at www.pc.gov.au/rogs/2015.

Safety — healthcare-associated infections

Healthcare-associated infections in public hospitals per 10 000 patient days is reported in figure 11.15.

Figure 11.15 Healthcare-associated infections, public hospitals^{a, b}



^a Comprises both Methicillin resistant *Staphylococcus aureus* and Methicillin sensitive *Staphylococcus aureus*. ^b The SAB patient episodes were associated with both admitted patient care and with non-admitted patient care (including emergency departments and outpatient clinics). The comparability of the SAB rates across jurisdictions and over time is limited, because of coverage differences and because the count of patient days reflects the amount of admitted patient activity, but does not necessarily reflect the amount of non-admitted patient activity.

Source: AIHW (2014), *Staphylococcus aureus bacteraemia in Australian public hospitals 2013–14: Australian hospital statistics*. Health services series no. 59. Cat. no. HSE 155. Canberra: AIHW.; table 11A.53.

Safety — adverse events treated in hospitals

In 2012-13, 6.5 per cent of separations in public hospitals reported an ICD-10-AM code indicating an adverse event (table 11.7). Around 54 per cent of separations with an adverse event reported procedures causing abnormal reactions/complications, and 38 per cent reported adverse effects of drugs, medicaments and biological substances (table 11A.54).

Table 11.7 Separations with an adverse event, per 100 separations, public hospitals, 2012-13^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
External cause of injury and poisoning									
Adverse effects of drugs, medicaments and biological substances	2.5	2.3	2.4	2.5	2.8	2.7	2.5	0.9	2.4
Misadventures to patients during surgical and medical care	0.2	0.4	0.3	0.3	0.3	0.4	0.3	0.1	0.3
Procedures causing abnormal reactions/complications	3.1	3.8	3.3	3.3	3.6	4.8	4.3	2.2	3.4
Other external causes of adverse events	0.1	0.2	0.1	0.1	0.3	0.2	0.2	0.1	0.2
Place of occurrence of injury and poisoning									
Place of occurrence: Health service area	6.2	6.6	6.1	6.2	6.8	8.1	7.2	3.3	6.3
Diagnoses									
Selected post-procedural disorders	0.9	0.7	0.8	0.8	1.1	1.3	1.3	0.4	0.8
Haemorrhage and haematoma complicating a procedure	0.5	0.5	0.4	0.5	0.4	0.5	0.6	0.3	0.5
Infection following a procedure	0.5	0.4	0.4	0.4	0.4	0.5	0.4	0.4	0.4
Complications of internal prosthetic devices	1.2	1.6	1.3	1.2	1.2	1.4	1.8	0.9	1.3
Other diagnoses of complications of medical and surgical care	0.7	1.3	0.9	0.8	0.9	1.1	1.0	0.6	0.9
Total (any of the above) ^c	6.3	6.8	6.3	6.4	7.2	8.2	7.4	3.4	6.5

^a Separations that included ICD-10-AM diagnosis and/or external cause codes that indicated an adverse event was treated and/or occurred during the hospitalisation. ^b Age standardised rate. ^c Categories do not sum to the totals because multiple diagnoses and external causes can be recorded for each separation, and external cause codes and diagnosis codes can be used together to describe an adverse event.

Source: AIHW (unpublished), National Hospital Morbidity Database; table 11A.54.

A separation may be recorded against more than one category in table 11.7, as some adverse events are reported as diagnoses and others as external causes or places of occurrence (of the injury or poisoning).

These data can be interpreted as representing selected adverse events in health care that have resulted in, or have affected, hospital admissions, rather than all adverse events that occurred in hospitals. Some of the adverse events included in these tables may represent events that occurred before admission.

Some adverse events are not identifiable using the codes for an adverse event or a place of occurrence of hospital. Some other diagnosis codes may suggest that an adverse event has occurred when it has not.

Safety — falls resulting in patient harm in hospitals

Data for falls resulting in patient harm in hospitals are available this year for the first time since the 2012 Report. Falls resulting in patient harm recorded in public hospital separations where the place of occurrence was a health service area varied across states and territories in 2012-13, with a national rate of 4.0 falls per 1000 separations (figure 11.16). Data are reported by Indigenous status and remoteness in table 11A.55.

Figure 11.16 Separations for falls resulting in patient harm in public hospitals, 2012-13^{a, b}



^a Falls resulting in patient harm occurring in hospitals could be underestimated, as the place of occurrence was not reported (or unspecified) for about 26 per cent of separations with an external cause of injury of falls. ^b It is not possible to identify falls specifically occurring in hospitals. The data identify falls occurring in any health service setting, including day surgery centres or hospices. To minimise the inclusion of falls that occurred before admission, separations with an injury or poisoning principal diagnosis are excluded.

Source: AIHW (2014), *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145; table 11A.55.

Falls resulting in patient harm occurring in hospitals could be underestimated as the place of occurrence was not reported (or unspecified) for about 26 per cent of separations with an external cause of injury of falls (AIHW 2014a).

Falls could also be overestimated, as it is not currently possible to identify falls specifically occurring in hospitals. Currently, the data identify falls occurring in any health service setting, including day surgery centres or hospices. However, to minimise the inclusion of

falls that occurred before admission, separations with an injury or poisoning principal diagnosis are excluded.

Responsiveness

The Steering Committee has identified the responsiveness of public hospitals as an area for development in future Reports.

Continuity — continuity of care

‘Continuity of care’ is an indicator of governments’ objective to provide public hospital services that are of high quality (box 11.9).

Box 11.9 Continuity of care

‘Continuity of care’ measures the provision of uninterrupted, timely, coordinated healthcare, interventions and actions across programs, practitioners and organisations.

Continuity of care has been identified as a key area for development in future Reports.

Sustainability

Workforce sustainability

‘Workforce sustainability’ is an indicator of governments’ objective to provide sustainable public hospital services (box 11.10). Labour, particularly nurses and medical practitioners, is the most significant and costly resource used in providing public hospital services (figure 11.23), and the sustainability of the workforce helps determine whether problems might arise in the future delivery of public hospital services.

Box 11.10 Workforce sustainability

‘Workforce sustainability’ reports age profiles for nurse and medical practitioner workforces. It shows the proportions of registered nurses and medical practitioners in ten year age brackets, by jurisdiction and by region.

High or increasing proportions of the workforce that are new entrants and/or low or decreasing proportions of the workforce that are close to retirement is desirable.

All nurses (including midwives) and medical practitioners in the workforce are included in these measures, as crude indicators of the potential respective workforces for public hospitals.

(Continued on next page)

Box 11.10 (continued)

These measures are not a substitute for a full workforce analysis that allows for migration, trends in full-time work and expected demand increases. They can, however, indicate that further attention should be given to workforce sustainability for public hospitals.

Data reported for this indicator are:

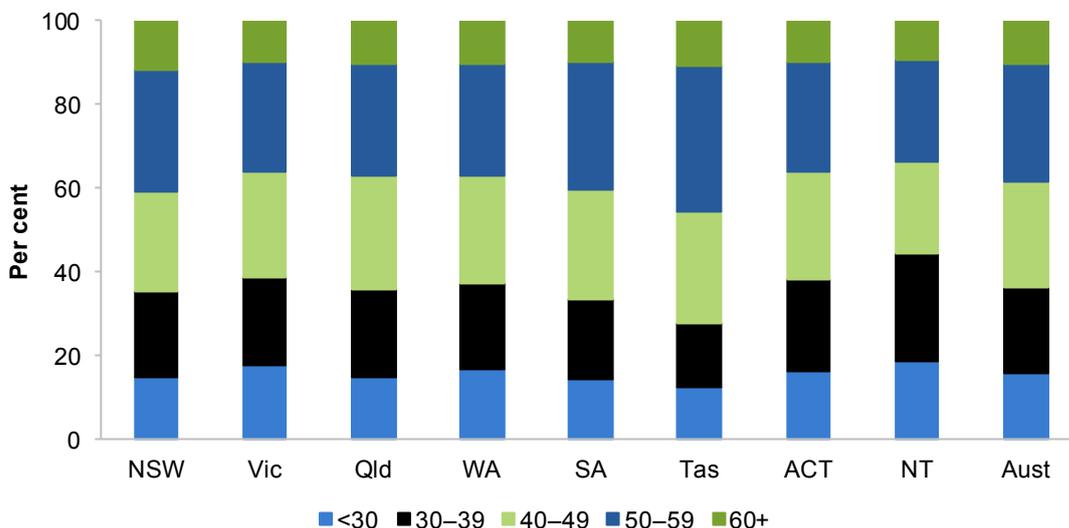
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2013 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

The sustainability of the public hospital workforce is affected by a number of factors; in particular, whether the number of new entrants are sufficient to maintain the existing workforce, and the proportion of the workforce that is close to retirement.

The age profile of the nursing workforce (which includes midwives) for 2013 for each jurisdiction is shown in figure 11.17. Nationally, 15.9 per cent of the nursing workforce was aged under 30 years and 10.6 per cent were aged 60 years and over.

Figure 11.17 Nursing workforce, by age group, 2013^{a, b}

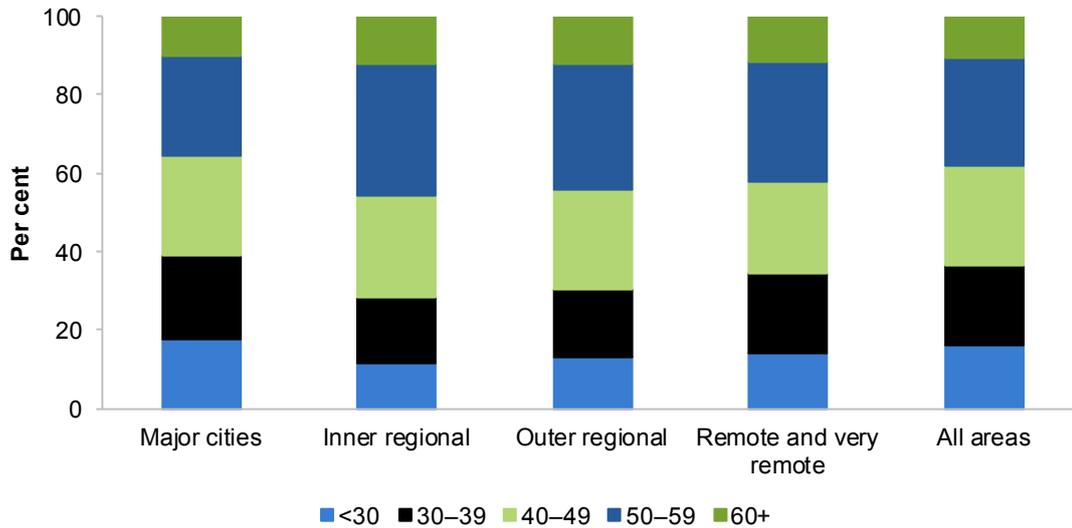


^a Includes registered and enrolled nurses (including midwives) who are employed in nursing, nurses who are registered but on extended leave and nurses who are registered and looking for work in nursing. ^b State and Territory is derived from State and Territory of main job where available; otherwise State and Territory of principal practice is used as a proxy. If principal practice details are unavailable, State and Territory of residence is used. Records with no information on all three locations are coded to 'Not stated'.

Source: AIHW (unpublished) National Health Workforce Data Set; table 11A.57.

Almost three quarters of the workforce was aged between 30 and 59 years. Nursing workforce data by remoteness area for 2013 are shown in figure 11.18.

Figure 11.18 **Nursing workforce, by age group and remoteness area, 2013^a**

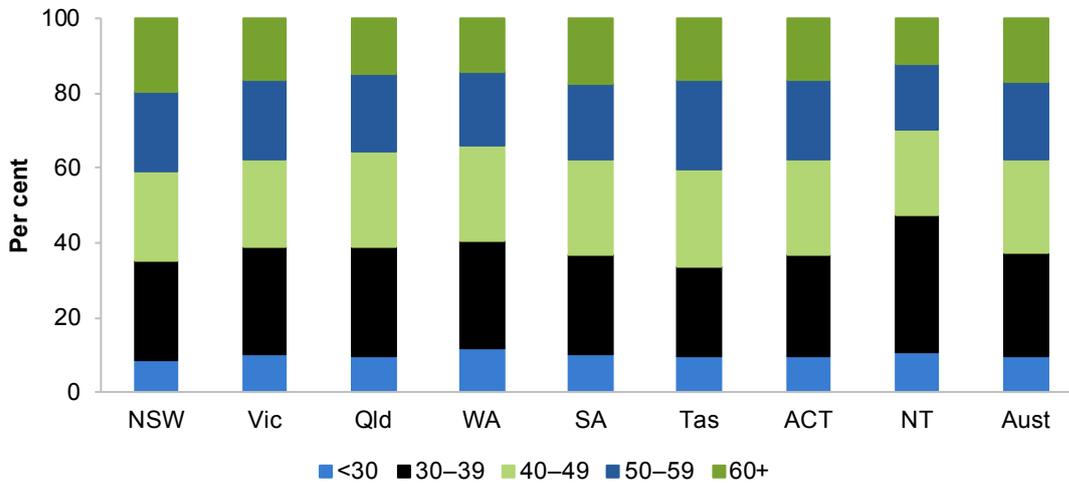


^a Includes registered and enrolled nurses (including midwives) who are employed in nursing, nurses who are registered but on extended leave and nurses who are registered and looking for work in nursing.

Source: AIHW (unpublished) National Health Workforce Data Set; table 11A.56.

The age profile of the medical practitioner workforce in 2013 for each jurisdiction is shown in figure 11.19. Nationally, 10.0 per cent of the medical practitioner workforce was aged under 30 years and 17.0 per cent were aged 60 years and over. Almost three quarters of the workforce was aged between 30 and 59 years. Medical practitioner workforce data for 2013 by remoteness area are shown in figure 11.20.

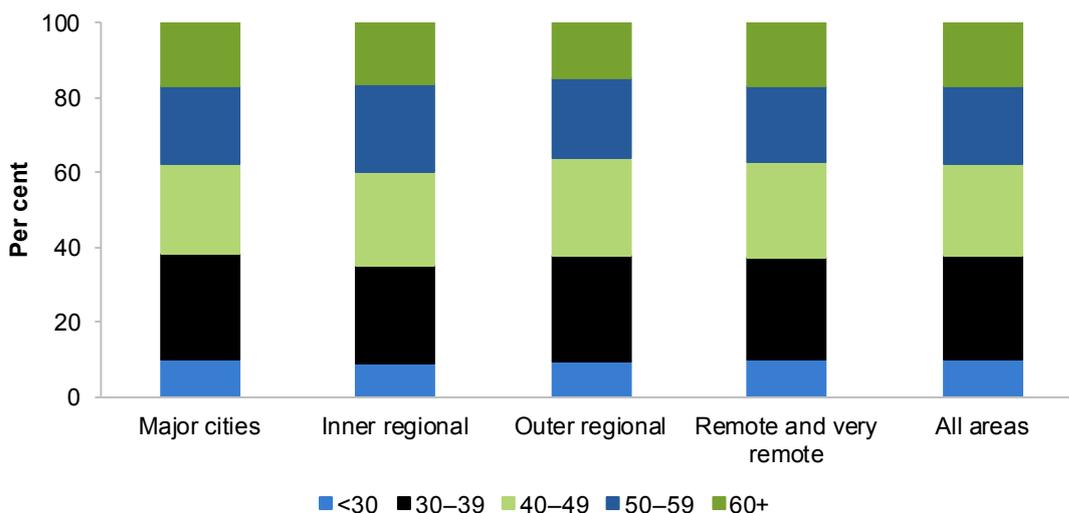
Figure 11.19 Medical practitioner workforce, by age group, 2013^{a, b}



^a Includes employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine. ^b State and Territory is derived from State and Territory of main job where available; otherwise State and Territory of principal practice is used as a proxy. If principal practice details are unavailable, State and Territory of residence is used. Records with no information on all three locations are coded to 'Not stated'.

Source: AIHW (unpublished) National Health Workforce Data Set; table 11A.59.

Figure 11.20 Medical practitioner workforce, by age group and remoteness area, 2013^a



^a Includes employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine.

Source: AIHW (unpublished) National Health Workforce Data Set; table 11A.58.

Efficiency

Two approaches to measuring the efficiency of public hospital services are included in this Report: the 'cost per casemix-adjusted unit of output' (the unit cost) and the 'casemix-adjusted relative length of stay index'. Length of stay is correlated with costs at aggregate levels of reporting.

The Steering Committee's approach is to report the full costs of a service where they are available. Where the full costs of a service cannot be accurately measured, the Steering Committee seeks to report estimated costs that are comparable. Where differences in comparability remain, the differences are documented. The Steering Committee has identified financial reporting issues that have affected the accuracy and comparability of unit costs for acute care services. These include the treatment of payroll tax, superannuation, depreciation and the user cost of capital associated with buildings and equipment. A number of issues remain to improve further the quality of these estimates.

Costs associated with non-current physical assets (such as depreciation and the user cost of capital) are potentially important components of the total costs of many services delivered by government agencies. Differences in the techniques for measuring non-current physical assets (such as valuation methods) can reduce the comparability of cost estimates across jurisdictions. In response to concerns regarding data comparability, the Steering Committee initiated a study, reported in *Asset Measurement in the Costing of Government Services (SCRCSSP 2001)*. The study examined the extent to which differences in asset measurement techniques applied by participating agencies can affect the comparability of reported unit costs.

The results reported in the study for public hospitals indicate that different methods of asset measurement could lead to quite large variations in reported capital costs. However, considered in the context of total unit costs, the differences created by these asset measurement effects were relatively small, because capital costs represent a small proportion of total cost (although the differences can affect cost rankings across jurisdictions). A key message from the study was that the adoption of nationally uniform accounting standards across all service areas would be a desirable outcome.

Care needs to be taken, therefore, in comparing unit costs across jurisdictions. Differences in counting rules, the treatment of various expenditure items (for example, superannuation) and the allocation of overhead costs have the potential to affect such comparisons. In addition, differences in the use of salary packaging can allow hospitals to lower their wage bills (and thus State or Territory government expenditure) while maintaining the after-tax income of their staff. No data were available for reporting on the effect of salary packaging and any variation in its use across jurisdictions.

Cost per casemix-adjusted separation

‘Cost per casemix-adjusted separation’ is an indicator of governments’ objective to deliver services in a cost effective manner (box 11.11).

Box 11.11 **Cost per casemix-adjusted separation**

‘Cost per casemix-adjusted separation’ is defined by the following two measures:

- Recurrent cost per casemix-adjusted separation
- Total cost per casemix-adjusted separation.

Recurrent cost per casemix-adjusted separation

‘Recurrent cost per casemix-adjusted separation’ is the average cost of providing care for an admitted patient (overnight stay or same day) adjusted with AR-DRG cost weights for the relative complexity of the patient’s clinical condition and of the hospital services provided (AIHW 2000).

A low or decreasing recurrent cost per casemix-adjusted separation can reflect more efficient service delivery in public hospitals. However, this indicator needs to be viewed in the context of the set of performance indicators as a whole, as decreasing cost could also be associated with decreasing quality and effectiveness.

This measure includes overnight stays, same day separations, private patient separations in public hospitals and private patient recurrent costs. It excludes non-acute hospitals, mothercraft hospitals, multipurpose hospitals, multipurpose services, hospices, rehabilitation hospitals, psychiatric hospitals and hospitals in the ‘unpeered and other’ peer group. The data exclude expenditure on non-admitted patient care, the user cost of capital and depreciation, and research costs.

All admitted patient separations and their costs are included, and most separations are for acute care. Cost weights are not available for admitted patients who received non-acute care (4.7 per cent of total separations in 2011-12 (table 11A.13)), so the acute care cost weights are applied to non-acute separations. The admitted patient cost proportion is an estimate only.

Some jurisdictions have developed experimental cost estimates for acute, non-psychiatric patients, which are reported here. Separations for non-acute patients and psychiatric acute care patients are excluded from these estimates because AR-DRG cost weights are a poor predictor of the cost of these separations.

Data reported for this measure are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete (subject to caveats) for the current reporting period. All required 2011-12 data are available for all jurisdictions.

Data quality information for this measure is at www.pc.gov.au/rogs/2015.

(Continued on next page)

Box 11.11 (continued)

Total cost per casemix-adjusted separation

'Total cost per casemix adjusted separation' is the recurrent cost per casemix-adjusted separation plus the capital costs per casemix-adjusted separation. Recurrent costs include labour and material costs, and capital costs include depreciation and the user cost of capital for buildings and equipment. This measure allows the full cost of hospital services to be considered. The hospitals included in this measure are the same as for recurrent cost per casemix-adjusted separation.

Depreciation is defined as the cost of consuming an asset's services. It is measured by the reduction in value of an asset over the financial year. The user cost of capital is the opportunity cost of the capital invested in an asset, and is equivalent to the return foregone from not using the funds to deliver other services or to retire debt. Interest payments represent a user cost of capital, so are deducted from capital costs to avoid double counting.

A low or decreasing cost per casemix-adjusted separation can reflect more efficient service delivery in public hospitals. However, this indicator needs to be viewed in the context of the set of performance indicators as a whole, as decreasing cost could also be associated with decreasing quality and effectiveness.

Data reported for this measure are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete (subject to caveats) for the current reporting period. All required 2011-12 data are available for all jurisdictions.

Data quality information for this measure is at www.pc.gov.au/rogs/2015.

Data for 2012-13 were not available for the recurrent and total cost per casemix-adjusted separation measures for this Report edition. Data for these measures are sourced from the AIHW. The AIHW are currently changing the methodology for this indicator. Data for the new methodology were not available in time for inclusion in this Report edition.

Recurrent cost per casemix-adjusted separation

'Recurrent cost per casemix-adjusted separation' data are presented in figure 11.21.

Figure 11.21 Recurrent cost per casemix-adjusted separation, 2011-12^{a, b, c, d}



^a Excludes depreciation and the user cost of capital, spending on non-admitted patient care and research costs. ^b Casemix-adjusted separations are the product of total separations and average cost weight. Average cost weights are from the National Hospital Cost Data Collection, based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2008-09 AR-DRG v 5.2 cost weights. ^c Excludes separations for which the care type was reported as 'newborn with no qualified days', and records for hospital boarders and posthumous organ procurement. ^d Psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute hospitals and multi purpose services are excluded from these data. The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included.

Source: AIHW (2013), *Australian Hospital Statistics 2011-12*, Health Services Series No. 50, Cat no. HSE 134; table 11A.60.

Experimental estimates of 'recurrent cost per casemix-adjusted separation' for acute non-psychiatric patients are reported for NSW, Victoria and WA (figure 11.22). (These estimates relate to a subset of the selected public hospitals reported in figure 11.21 and are not available for other jurisdictions.) The experimental estimates aim to overcome the need to apply cost weights for acute care to non-acute care separations (box 11.11). The effect of restricting the analysis to acute, non-psychiatric admitted patients was to decrease the estimated recurrent cost per casemix adjusted separation for the subset of hospitals by 5.6 per cent for NSW, 14.0 per cent for Victoria and 4.1 per cent for WA (AIHW 2013).

Figure 11.22 **Recurrent cost per acute non-psychiatric casemix-adjusted separation, subset of hospitals, 2011-12^{a, b, c, d}**



^a Excludes psychiatric hospitals, subacute, non-acute and unpeered hospitals. This subset excludes hospitals where the inpatient fraction was equal to the acute inpatient fraction and more than 1000 non-acute patient days were recorded. Also excludes hospitals where the apparent cost of non-acute patients exceeded \$1000 per day and more than \$1 million of apparent expenditure on non-acute patients days was reported. ^b Separations are those where the care type is acute, newborn with qualified days, or not reported. Psychiatric separations are those with psychiatric care days. ^c Average cost weight from the National Hospital Cost Data Collection, based on acute, newborn with at least one qualified day, or not reported, using the 2008-09 AR-DRG version 5.2 cost weights. ^d These estimates are not available for Queensland, SA, Tasmania, the ACT or the NT.

Source: AIHW (2013), *Australian Hospital Statistics 2011-12*, Health Services Series No. 50, Cat no. HSE 134; table 11A.60.

Recurrent cost per casemix-adjusted separation is affected by differences in the mix of admitted patient services produced by hospitals in each jurisdiction. Hospitals have been categorised by 'peer groups' to enable those with similar activities to be compared. The public hospital peer groups include 'Principal referral and Specialist women's and children's hospitals', 'Large hospitals', 'Medium hospitals' and 'Small acute hospitals'.

The dominant peer classification is the 'Principal referral and Specialist women's and children's' category. The 90 hospitals in this group had an average of 45 440 separations each at an average cost of \$5222 per separation (table 11A.61 and table 11.8). Data for each of the hospital peer groups are presented in table 11.8. Detailed data for all peer groups are presented in table 11A.61.

Table 11.8 Recurrent cost per casemix-adjusted separation, by hospital peer group, 2011-12^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Hospital peer group									
Principal referral and Specialist women's and children's	5 337	4 670	5 355	5 738	5 287	5 777	6 384	5 967	5 222
Large	5 003	4 593	3 973	5 149	5 051	7 390	..	..	4 912
Medium	4 964	4 945	4 645	5 399	5 208	6 406	..	..	5 025
Small acute	5 931	5 947	5 065	8 259	4 884	7 514	..	6 424	6 171
All hospitals^d	5 280	4 693	5 246	5 733	5 251	6 033	6 384	6 017	5 204

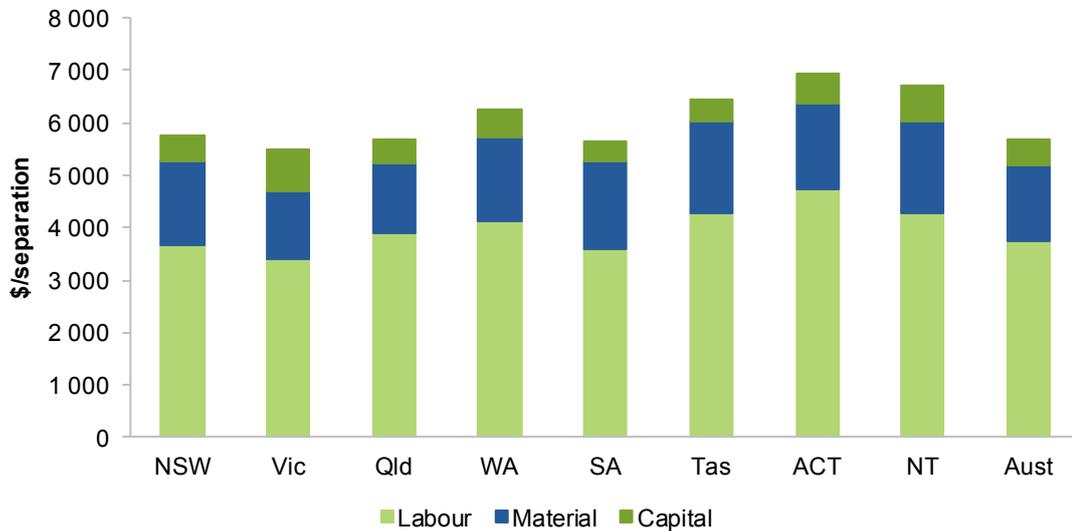
^a Data exclude depreciation and the user cost of capital, spending on non-admitted patient care and research costs. ^b The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included. ^c Separations for which the care type was reported as newborn with no qualified days, and records for hospital boarders and posthumous organ procurement have been excluded. ^d Includes all hospitals in this cost per casemix adjusted analysis. .. Not applicable.

Source: AIHW (2013), *Australian Hospital Statistics 2011-12*, Health Services Series No. 50, Cat no. HSE 134; table 11A.61.

Total cost per casemix-adjusted separation

Total cost includes both the recurrent costs (as discussed above) and the capital costs associated with hospital services. Results for this measure in 2011-12 are reported in figure 11.23. Labour costs accounted for the majority of costs in all jurisdictions. The user cost of capital for land is not included in figure 11.23 but is reported in table 11A.62.

Figure 11.23 Total cost per casemix-adjusted separation, public hospitals, 2011-12^{a, b, c}



^a Labour includes medical and non-medical labour costs. Material includes other non-labour recurrent costs, such as repairs and maintenance (table 11A.60). ^b Capital cost includes depreciation and the user cost of capital for buildings and equipment that is associated with the delivery of admitted patient services in the public hospitals as described in the data for recurrent cost per casemix-adjusted separation. Capital cost excludes the user cost of capital associated with land (reported in table 11A.62). ^c Variation across jurisdictions in the collection of capital related data suggests the data are only indicative. The capital cost per casemix adjusted separation is equal to the capital cost adjusted by the inpatient fraction, divided by the number of casemix-adjusted separations.

Data source: AIHW (2013), *Australian Hospital Statistics 2011-12*, Health Services Series No. 50, Cat no. HSE 134; State and Territory governments (unpublished); tables 11A.60 and 11A.62.

Relative stay index

‘Relative stay index’ is an indicator of governments’ objective to deliver services efficiently (box 11.12). Data for this indicator are reported in figure 11.24. The relative stay index is reported by funding source and by medical, surgical and other AR-DRGs in tables 11A.63–64.

Box 11.12 **Relative stay index**

'Relative stay index' is defined as the actual number of acute care patient days divided by the expected number of acute care patient days, adjusted for casemix. Casemix adjustment allows comparisons to take account of variation in types of service provided but not other influences on length of stay, such as the Indigenous status of the patient. Acute care separations only are included. Section 11.8 contains a more detailed definition outlining exclusions from the index.

The relative stay index for Australia for all hospitals (public and private) is one. A relative stay index greater than one indicates that average length of patient stay is higher than expected given the jurisdiction's casemix distribution. A relative stay index of less than one indicates that the number of bed days used was less than expected. A low or decreasing relative stay index is desirable if it is not associated with poorer health outcomes or significant extra costs outside the hospital systems (for example, in home care).

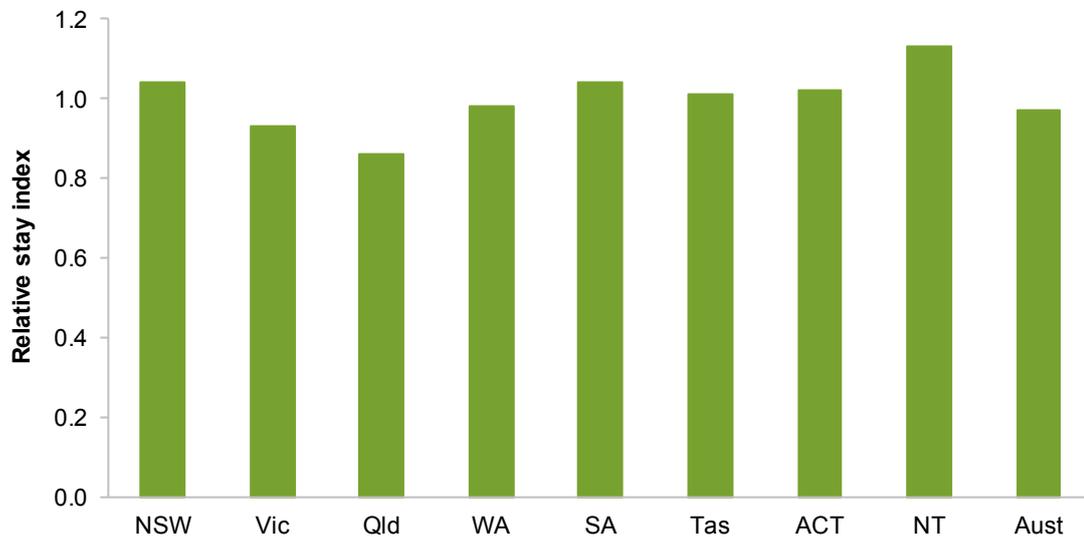
States and territories vary in their thresholds for classifying patients as either same day admitted patients or outpatients. These variations affect the relative stay index.

Data reported for this measure are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Figure 11.24 **Relative stay index, public hospitals, 2012-13^{a, b}**



^a Separations exclude newborns with unqualified days, organ procurement posthumous and hospital boarders. ^b The relative stay index is based on all hospitals and is estimated using the indirect standardisation method and AR-DRG version 6.0x. The indirectly standardised relative stay index is not strictly comparable across jurisdictions but is a comparison of the jurisdiction with the national average based on the casemix of the jurisdiction.

Source: AIHW (2014), *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145; table 11A.63.

Recurrent cost per non-admitted occasion of service

‘Recurrent cost per non-admitted occasion of service’ is an indicator of governments’ objective to deliver services in a cost effective manner (box 11.13).

Box 11.13 Recurrent cost per non-admitted occasion of service

'Recurrent cost per non-admitted occasion of service' is defined as the proportion of recurrent expenditure allocated to patients who were not admitted, divided by the total number of non-admitted patient occasions of service in public hospitals. Occasions of service include examinations, consultations, treatments or other services provided to patients in each functional unit of a hospital. Non-admitted occasions of service (including emergency department presentations and outpatient services) account for a significant proportion of hospital expenditure.

A low or decreasing recurrent cost per non-admitted occasion of service can reflect more efficient service delivery in public hospitals. However, this indicator should be viewed in the context of the set of performance indicators as a whole, as decreasing cost could also be associated with decreasing quality and effectiveness. This indicator does not adjust for the complexity of service — for example, a simple urine glucose test is treated equally with a complete biochemical analysis of all body fluids (AIHW 2000).

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- incomplete for the current reporting period. All required data were not available for Victoria, Queensland and the NT.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

These data are not comparable across jurisdictions. Reporting categories vary across jurisdictions, and further inconsistencies arise as a result of differences in outsourcing practices. In some cases, for example, outsourced occasions of service can be included in expenditure on non-admitted services, but not in the count of occasions of service. Jurisdictions able to supply 2012-13 data for this indicator reported the following results for non-admitted patient services:

- In NSW, the emergency department cost per occasion of service was \$260 for 2.5 million occasions, the outpatient cost per occasion of service was \$117 for 16.6 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was \$127 for 23.1 million occasions (table 11A.65).
- In WA, the emergency department cost per occasion of service was \$568 for 991 000 occasions, the outpatient cost per occasion of service was \$289 for 1.8 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was \$389 for 2.8 million occasions (table 11A.66).
- In SA, the emergency department cost per occasion of service was \$549 for 553 000 occasions, the outpatient cost per occasion of service was \$356 for 1.5 million occasions and the overall cost per occasion of service (emergency plus outpatient) was \$408 for 2.1 million occasions (table 11A.67).
- In Tasmania, the emergency department cost per occasion of service was \$363 for 129 000 occasions. The outpatient cost per occasion of service was \$272 for

473 000 occasions. An overall cost per occasion of service was not available (table 11A.68).

- In the ACT, the emergency department cost per occasion of service was \$832 for 119 000 occasions, the outpatient cost per occasion of service was \$358 for 319 000 occasions and the overall cost per occasion of service (emergency plus outpatient) was \$357 for 827 000 occasions (table 11A.69).

Given the lack of a nationally consistent non-admitted patient classification system, this Report includes national data from the Independent Hospital Pricing Authority's National Hospital Cost Data Collection (NHCDC). The NHCDC collects data across a sample of hospitals that is expanding over time. The sample for each jurisdiction is not necessarily representative, because hospitals contribute data on a voluntary basis. The NHCDC data are affected by differences in costing and admission practices across jurisdictions and hospitals. Therefore, an estimation process has been carried out to create representative national activity figures from the sample data. In addition, the purpose of the NHCDC is to calculate between-DRG cost weights, not to compare the efficiency of hospitals.

The emergency department cost per presentation in 2011-12 was \$585 nationally (table 11A.70). Wages and salaries accounted for around two thirds of this average cost nationally (table 11A.70). Emergency department costs per presentation by urgency related grouping are reported in table 11A.71 for the period 2009-10 to 2011-12 on a national basis. Non-admitted service events had an average cost of \$318 in 2011-12 nationally (table 11A.72).

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the services delivered) (see chapter 1, section 1.5).

Patient satisfaction

'Patient satisfaction' provides a proxy measure of governments' objective to deliver services that are high quality and responsive to individual patient needs (box 11.14). Patient satisfaction surveys are different from other sources of hospital quality data, because they provide information on hospital quality from the patient's perspective. Surveys can be useful for obtaining information on patient views of both clinical and non-clinical hospital care (such as whether patients feel they were treated with respect and provided with appropriate information regarding their treatment).

Box 11.14 Patient satisfaction

'Patient satisfaction' is defined by the following six measures for the purposes of this report:

- Proportion of people who went to an emergency department in the last 12 months reporting that the emergency department doctors, specialists or nurses 'always' or 'often' listened carefully to them
- Proportion of people who went to an emergency department in the last 12 months reporting that the emergency department doctors, specialists or nurses 'always' or 'often' showed respect to them
- Proportion of people who went to an emergency department in the last 12 months reporting that the emergency department doctors, specialists or nurses 'always' or 'often' spent enough time with them
- Proportion of people who were admitted to hospital in the last 12 months reporting that the hospital doctors, specialists or nurses 'always' or 'often' listened carefully to them
- Proportion of people who were admitted to hospital in the last 12 months reporting that the hospital doctors, specialists or nurses 'always' or 'often' showed respect to them
- Proportion of people who were admitted to hospital in the last 12 months reporting that the hospital doctors, specialists or nurses 'always' or 'often' spent enough time with them.

A high or increasing proportion of patients who were satisfied is desirable, because it suggests the hospital care received was of high quality and better met the expectations and needs of patients.

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.

Descriptive information on patient surveys undertaken by states and territories is also reported. The descriptive information includes the survey time period, method, sample size, response rate and a selection of results where available. Information on how jurisdictions have used patient satisfaction surveys to improve public hospital quality in recent years is also reported. If public hospitals respond to patient views and modify services, service quality can be improved to better meet patients' needs. As State and Territory based surveys differ in content, timing and scope across jurisdictions, it is not possible to compare their results nationally.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Patient satisfaction data for emergency department and admitted hospital patients are reported in table 11.9. Relative standard errors and confidence intervals are reported in attachment tables 11A.73–80. These tables also report patient satisfaction by remoteness.

Table 11.9 Patient satisfaction, hospitals, 2013-14

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Emergency department patients									
Proportion of people who went to an emergency department in the last 12 months reporting the emergency department doctors, specialists or nurses always or often listened carefully to them									
Doctors or specialists	86.6	84.9	84.4	86.7	86.8	76.9	75.2	90.6	85.4
Nurses	90.2	89.7	90.4	87.0	90.3	85.3	81.7	90.6	89.1
Proportion of people who went to an emergency department in the last 12 months reporting the emergency department doctors, specialists or nurses always or often showed respect to them									
Doctors or specialists	87.2	86.2	86.1	87.4	86.3	85.5	77.3	87.2	86.5
Nurses	90.7	90.1	91.7	88.7	90.4	87.6	85.1	92.0	90.2
Proportion of people who went to an emergency department in the last 12 months reporting the emergency department doctors, specialists or nurses always or often spent enough time with them									
Doctors or specialists	81.5	80.4	81.3	81.3	81.7	77.9	75.3	85.0	81.0
Nurses	85.9	86.0	86.7	85.5	84.9	79.7	82.5	94.2	85.8
Admitted hospital patients									
Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often listened carefully to them									
Doctors or specialists	91.3	90.5	88.4	90.0	93.6	88.5	83.9	91.0	90.6
Nurses	92.3	92.5	90.1	91.3	91.4	88.5	83.9	91.3	91.5
Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often showed respect to them									
Doctors or specialists	92.7	93.0	90.3	91.2	96.0	89.5	84.8	91.8	92.4
Nurses	94.0	93.3	91.4	91.5	92.9	90.9	83.9	94.2	92.6
Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often spent enough time with them									
Doctors or specialists	87.7	88.4	86.1	86.9	92.3	84.7	79.1	92.3	87.7
Nurses	88.6	91.2	87.2	88.4	88.9	86.2	81.9	94.2	89.0

Source: ABS (unpublished) *Patient Experience Survey 2013-14*, tables 11A.73–80.

State and Territory based survey data

State and Territory survey approaches differed markedly across jurisdictions, so it is not possible to compare results:

- All jurisdictions provided details of surveys conducted in 2013 and/or 2014, with the exception of Tasmania and the NT, which did not update survey details for this Report.
- The length of time that surveys were conducted varied from a 12 month period to a two month period.
- Queensland, WA and SA used Computer Assisted Telephone Interviewing, while other jurisdictions used a combination of mail and internet surveys.
- Most jurisdictions surveyed admitted and non-admitted patients. One jurisdiction surveyed emergency department patients only.
- Sample sizes varied from around 500 to around 73 000 patients.

More information on the survey methods and results are in tables 11A.81–88.

All jurisdictions reported that they use survey results in some way to improve services. All jurisdictions provide survey results or feedback to hospitals. Most jurisdictions have a formalised approach to prioritising the areas in need of improvement identified by the surveys and then implementing quality improvements. More information on how survey results are used to improve services are in tables 11A.81–88.

Sentinel events

‘Sentinel events’ is an indicator of governments’ objective to deliver public hospital services that are safe and of high quality (box 11.15). Sentinel events can indicate hospital system and process deficiencies that compromise quality and safety. Sentinel events are a subset of adverse events that result in death or very serious harm to the patient. Adverse events are reported elsewhere in this chapter as an output indicator.

Box 11.15 **Sentinel events**

‘Sentinel events’ is defined as the number of reported adverse events that occur because of hospital system and process deficiencies, and which result in the death of, or serious harm to, a patient. Sentinel events occur relatively infrequently and are independent of a patient’s condition. Sentinel events have the potential to seriously undermine public confidence in the healthcare system.

Australian health ministers have agreed on a national core set of sentinel events for which all public hospitals are required to provide data. The eight nationally agreed core sentinel events are:

1. Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.
2. Suicide of a patient in an inpatient unit.
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure.
4. Intravascular gas embolism resulting in death or neurological damage.
5. Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.
6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.
7. Maternal death associated with pregnancy, birth or the puerperium.
8. Infant discharged to the wrong family.

A low or decreasing number of sentinel events is desirable.

(Continued next page)

Box 11.15 (continued)

Over time, an increase in the number of sentinel events reported might reflect improvements in incident reporting mechanisms and organisational cultural change, rather than an increase in the frequency of such events. However, trends need to be monitored to establish whether this is the underlying reason.

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is under development.

Sentinel event programs have been implemented by all State and Territory governments. The purpose of these programs is to facilitate a safe environment for patients by reducing the frequency of these events. The programs are not punitive, and are designed to facilitate self reporting of errors so that the underlying causes of the events can be examined, and action taken to reduce the risk of these events re-occurring.

In 2007, the AIHW, in conjunction with the ACSQHC, published a report that included national sentinel events data for 2004-05 (AIHW and ACSQHC 2007). The report identified that reporting practices differ across jurisdictions and, as a result, the data are not comparable across jurisdictions.

In this Report edition the sentinel event classification ‘maternal death or serious morbidity associated with labour or delivery’ used in previous years has been changed to ‘maternal deaths associated with pregnancy, birth or the puerperium’ to improve data comparability across states and territories. WA, Victoria and the ACT reported data using the previous definition for the period 2008-09 to 2012-13.

Numbers of sentinel events for 2012-13 are reported below. Data for 2008-09 to 2012-13 are reported in tables 11A.89–96. Australian totals are reported in table 11A.97. As larger states and territories will tend to have more sentinel events than smaller jurisdictions, the numbers of separations and individual occasions of service are also presented to provide context.

In NSW public hospitals in 2012-13, there was a total of 38 sentinel events (table 11A.89) compared to around 1.7 million separations (table 11A.6) and around 24.0 million individual occasions of service (table 11A.17). The sentinel events comprised:

- 15 suicides of a patient in an inpatient unit
- 13 retained instruments or other material after surgery requiring re-operation or further surgical procedure
- 2 intravascular gas embolisms resulting in death or neurological damage

-
- 1 haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility
 - 2 medication errors leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
 - 5 maternal deaths associated with pregnancy, birth or the puerperium. This figure is for calendar year 2012 rather than financial year 2012-13 (table 11A.89).

In Victorian public hospitals in 2012-13, there was a total of 17 sentinel events (table 11A.90) compared to around 1.4 million separations (table 11A.6) and around 7.9 million individual occasions of service (table 11A.17). The sentinel events comprised:

- 9 suicides of a patient in an inpatient unit
- 6 retained instruments or other material after surgery requiring re-operation or further surgical procedure
- 1 medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
- 1 maternal death or serious morbidity associated with labour or delivery (table 11A.90).¹

In Queensland public hospitals in 2012-13, there was a total of 7 sentinel events (table 11A.91) compared to around 1.0 million separations (table 11A.6) and around 10.8 million individual occasions of service (table 11A.17). The sentinel events comprised:

- 2 suicides of a patient in an inpatient unit
- 4 retained instruments or other material after surgery requiring re-operation or further surgical procedure
- 1 maternal death associated with pregnancy, birth or the puerperium (table 11A.91).

In WA public hospitals in 2012-13, there was a total of 15 sentinel events (table 11A.92) compared to around 607 000 separations (table 11A.6) and around 5.8 million individual occasions of service (table 11A.17). The sentinel events comprised:

- 1 procedure involving the wrong patient or body part resulting in death or major permanent loss of function
- 7 suicides of a patient in an inpatient unit
- 3 retained instruments or other material after surgery requiring re-operation or further surgical procedure
- 3 medication errors leading to the death of a patient reasonably believed to be due to incorrect administration of drugs

¹ Victoria has supplied data using the sentinel event definition applicable to the data collection period. Most other jurisdictions have retrospectively applied the amended definition to 2012-13 data.

-
- 1 maternal death or serious morbidity associated with labour or delivery (table 11A.92).²

In SA public hospitals in 2012-13, there was a total of 9 sentinel events (table 11A.93) compared to around 414 000 separations (table 11A.6) and around 2.2 million individual occasions of service (table 11A.17). The sentinel events comprised:

- 1 suicide of a patient in an inpatient unit
- 5 retained instruments or other material after surgery requiring re-operation or further surgical procedure
- 1 haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility
- 2 maternal deaths associated with pregnancy, birth or the puerperium (table 11A.93).

In Tasmanian public hospitals in 2012-13, there were no reported sentinel events (table 11A.94) compared to around 106 000 separations (table 11A.6) and around 482 000 individual occasions of service (table 11A.17).

In ACT public hospitals in 2012-13, there was a total of 3 sentinel events (table 11A.95) compared to around 95 000 separations (table 11A.6) and around 1.9 million individual occasions of service (table 11A.17). ACT sentinel events were not reported by category due to confidentiality concerns.

In the NT public hospitals in 2012-13, there was one sentinel event (table 11A.96) compared to around 118 000 separations (table 11A.6) and around 600 000 individual occasions of service. The sentinel event was a suicide of a patient in an inpatient unit (table 11A.17).

Mortality in hospitals

‘Mortality in hospitals’ is an indicator of governments’ objective to deliver public hospital services that are safe and of high quality (box 11.16).

² WA has supplied data using the sentinel event definition applicable to the data collection period. Most other jurisdictions have retrospectively applied the amended definition to 2012-13 data.

Box 11.16 Mortality in hospitals

'Mortality in hospitals' is defined by the following three measures:

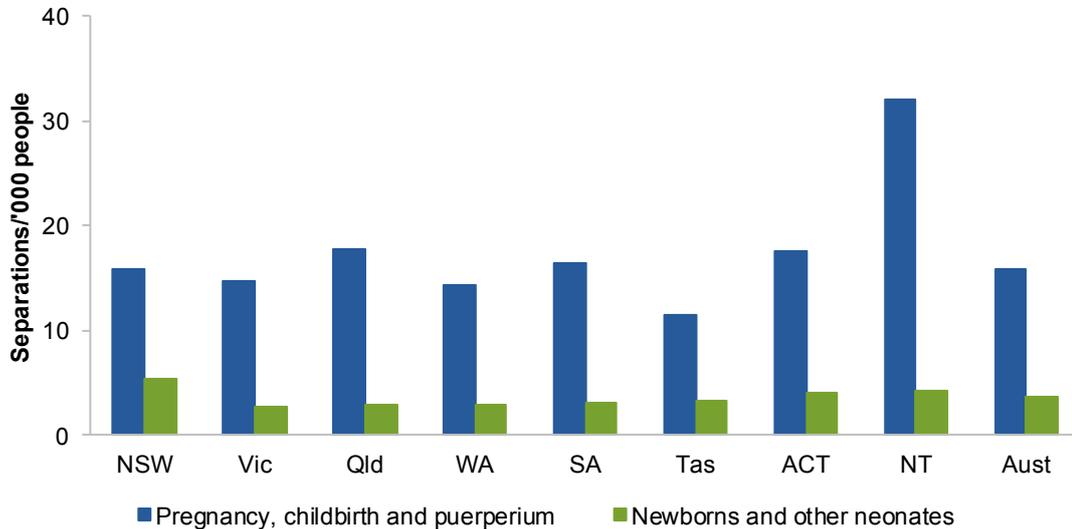
- Hospital standardised mortality ratio
- Death in low-mortality diagnostic related groups
- In-hospital mortality rates.

Mortality in hospitals has been identified as a key area for development in future Reports.

11.4 Profile of maternity services

Maternity services (defined as AR-DRGs relating to pregnancy, childbirth and the puerperium, and newborns and other neonates) accounted for 8.5 per cent of total acute separations in public hospitals (table 11A.99) and around 10.6 per cent of the total cost of all acute separations in public hospitals in 2012-13 (table 11A.98). Figure 11.25 shows the rate of acute separations per 1000 people for maternity services across jurisdictions in 2012-13.

Figure 11.25 **Separation rates for maternity services, public hospitals, 2012-13^{a, b, c, d}**



^a The puerperium refers to the period of confinement immediately after labour (around six weeks). ^b Newborns and other neonates include babies aged less than 28 days or babies aged less than one year with admission weight of less than 2500 grams. ^c Includes separations for which the type of episode of care was reported as 'acute', or 'newborn with qualified patient days'. ^d Population data used to derive rates are revised to the ABS' final 2011 Census rebased estimates and projections. See chapter 2 (table 2A.2) for details.

Source: AIHW (2014), *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145; ABS (unpublished), *Australian Demographic Statistics*, December Quarter 2012, Cat. no. 3101.0; tables 2A.2 and 11A.99.

In Australian public hospitals in 2012-13, 41.9 per cent of the separations for pregnancy, childbirth and the puerperium had a DRG of vaginal delivery (tables 11A.99 and 11A.100). In the context of all AR-DRGs in public hospitals, vaginal deliveries comprised the largest number of overnight acute separations (4.6 per cent of all separations) (table 11A.15). The cost of vaginal deliveries was \$775.6 million in 2012-13 (table 11A.100).

The complexity of maternity services is partly related to the mother's age at the time of giving birth. The mean age of mothers giving birth varied across jurisdictions (table 11.10).

Table 11.10 Mean age of mothers at time of giving birth, public hospitals

	NSW	Vic ^a	Qld	WA ^a	SA ^a	Tas	ACT ^{a, b}	NT
2009								
First birth	27.9	28.2	25.6	26.2	27.0	27.9	28.0	24.2
Second birth	30.4	30.6	28.3	28.6	29.6	30.4	30.5	26.8
Third birth	31.6	32.0	29.8	30.1	31.1	31.6	31.4	28.6
All births	29.9	30.1	28.0	28.3	29.1	29.9	29.8	26.9
2010								
First birth	28.2	28.4	25.6	26.3	27.1	28.2	28.0	24.6
Second birth	30.3	30.8	28.2	28.8	29.6	30.3	30.4	27.1
Third birth	31.6	32.1	29.8	30.3	31.3	31.6	31.9	28.9
All births	29.9	30.2	28.0	28.4	29.2	29.9	29.9	27.0
2011								
First birth	28.2	28.4	25.9	26.5	27.3	28.2	28.4	24.7
Second birth	30.4	30.7	28.2	28.8	29.8	30.4	30.6	27.2
Third birth	31.6	32.2	30.1	30.4	31.3	31.6	32.2	28.7
All births	29.9	30.2	28.1	28.5	29.3	29.9	30.0	27.1
2012								
First birth	28.3	28.6	26.0	26.6	27.3	27.8	28.3	24.8
Second birth	30.4	30.9	28.4	28.9	29.8	30.3	30.7	27.4
Third birth	31.8	32.2	29.9	30.3	31.3	31.5	31.8	28.8
All births	30.0	30.3	28.2	28.5	29.3	29.5	29.9	27.2
2013								
First birth	28.6	28.8	26.1	26.9	27.6	na	28.7	25.2
Second birth	30.5	30.9	28.4	29.1	30.0	na	30.8	27.9
Third birth	31.7	32.2	29.9	30.4	31.2	na	32.4	29.7
All births	30.1	30.4	28.2	28.5	29.4	na	30.3	27.6

^a Data for Victoria, WA, SA and the ACT for 2013 are preliminary. ^b Between 12 and 15 per cent of births each year in the ACT are to non-residents of the ACT. **na** Not available.

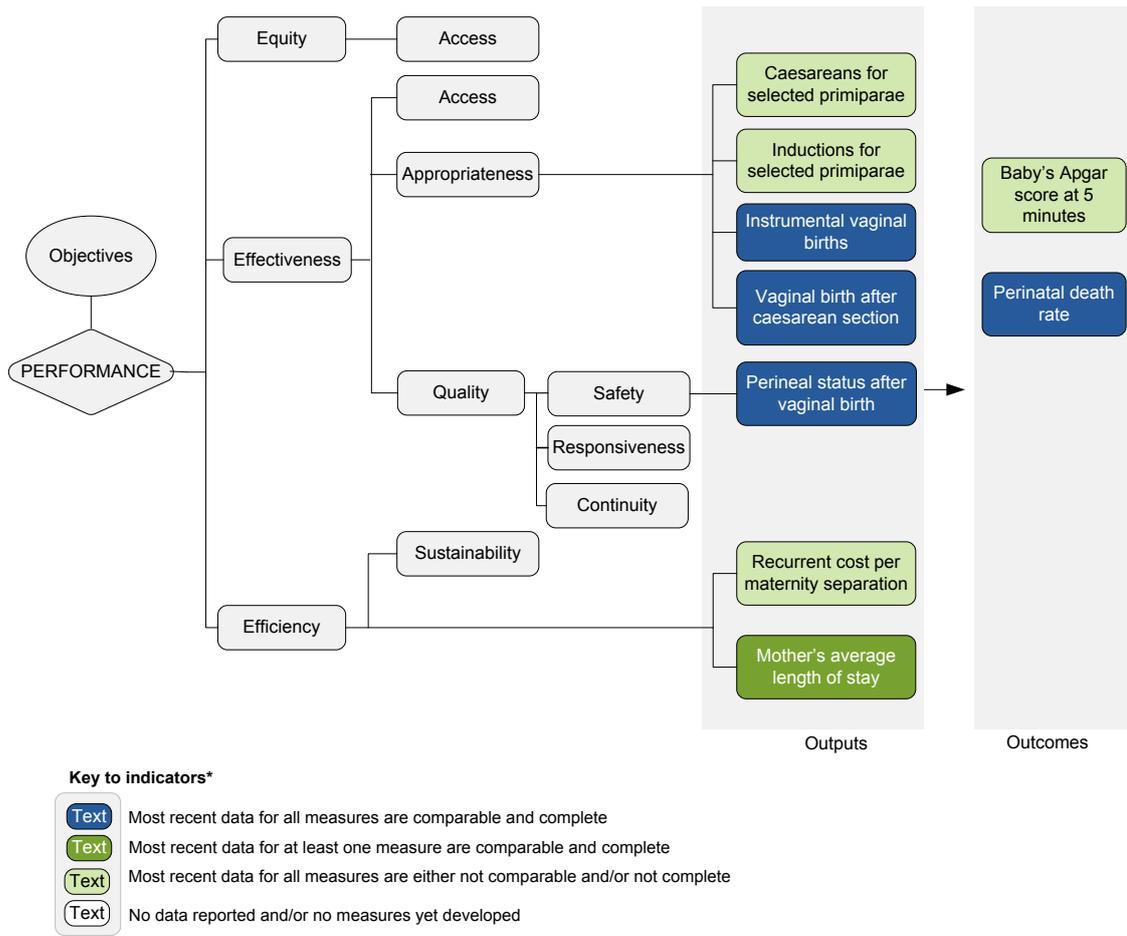
Source: State and Territory governments (unpublished); table 11A.101.

11.5 Framework of performance indicators for maternity services

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of maternity services (figure 11.26). 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 (section 1.6). The Health sector overview explains the performance indicator framework for health services as a whole, including the subdimensions of quality and sustainability that have been added to the standard Review framework.

The Report’s statistical context chapter contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous- and ethnic-status) (chapter 2).

Figure 11.26 **Maternity services performance indicator framework**



Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators, in addition to material in the chapter or sector overview and attachment tables. DQI in this Report cover the seven dimensions in the ABS’ data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and key data gaps and issues identified by the Steering Committee. All DQI for the 2015 Report can be found at www.pc.gov.au/rogs/2015.

11.6 Key performance indicator results for maternity services

Outputs

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

Equity — access

The Steering Committee has identified equity of access as an area for development in future Reports. Equity of access indicators will measure access to maternity services by special needs groups such as Aboriginal and Torres Strait Islander Australians or people in rural and remote areas.

Effectiveness — access

The Steering Committee has identified the effectiveness of access to maternity services as an area for development in future Reports. Effectiveness of access indicators will measure access to appropriate services for the population as a whole, particularly in terms of affordability and/or timeliness.

Effectiveness — appropriateness

Caesareans and inductions for selected primiparae

‘Caesareans for selected primiparae’ and ‘Inductions for selected primiparae’ are indicators of the appropriateness of maternity services in public hospitals (box 11.17).

Box 11.17 **Caesareans and inductions for selected primiparae^a**

'Caesareans and inductions for selected primiparae' are defined as the number of inductions or caesareans for the selected primiparae^a divided respectively by the number of the selected primiparae who gave birth.

The indicator is calculated for women aged between 20 and 34 years who have had no previous deliveries, with a singleton baby with a vertex presentation (that is, the crown of the baby's head is at the lower segment of the mother's uterus) and a gestation length of 37 to 41 weeks. This group is considered to be low risk parturients,^b so caesarean or induction rates should be low in their population.

High intervention rates can indicate a need for investigation, although labour inductions and birth by caesarean section are interventions that are appropriate in some circumstances, depending on the health and wellbeing of mothers and babies.

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions and over time but are not comparable across jurisdictions and are not comparable with data in previous report editions
- incomplete for the current reporting period. All required data were not available for Tasmania.

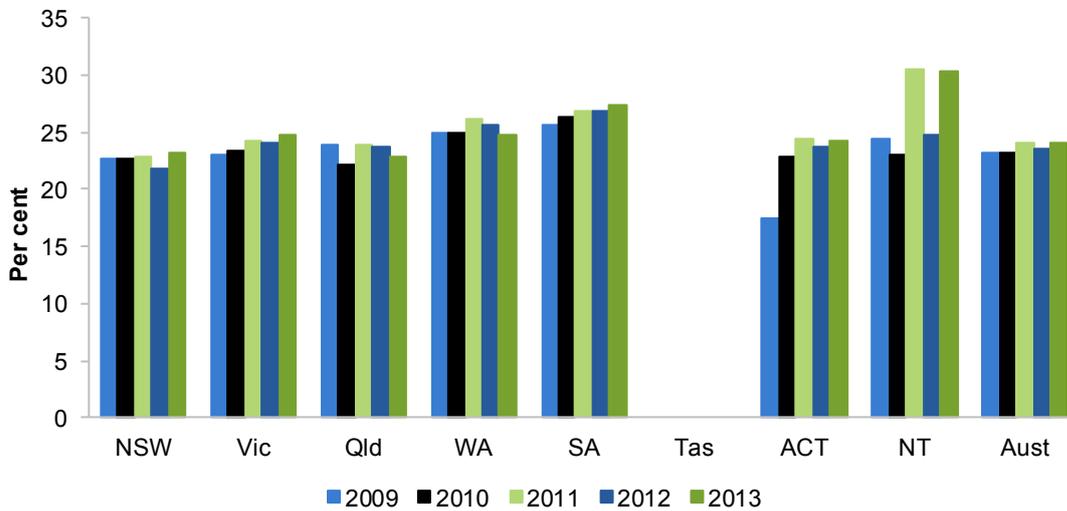
Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

^a Primiparae refers to a woman who has given birth to a liveborn or stillborn infant for the first time. ^b Parturient means 'about to give birth'.

This year the age group of women used for this indicator has been changed from 25–29 years to 20–34, years to align with national data definitions. All time series data in attachment tables 11A.103–110 for this Report edition have been backcast using the 20–34 year age group. Therefore, data for this indicator are not comparable with data in previous report editions.

Caesarean rates for selected primiparae in public hospitals are reported in figure 11.27. Induction rates for selected primiparae in public hospitals are reported in figure 11.28. Caesarean and induction rates for private hospitals are shown in table 11A.102 for comparison. They are higher than the rate for public hospitals in almost all jurisdictions for which data are available. Data for all jurisdictions for earlier years are included in tables 11A.103–110.

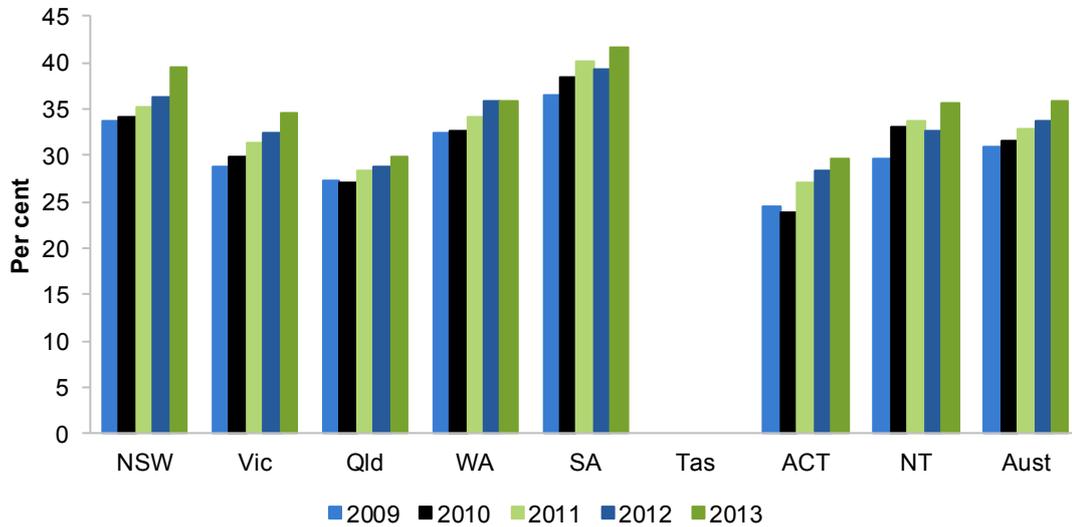
Figure 11.27 Caesareans for selected primiparae, public hospitals^{a, b, c, d, e, f}



a Data for 2013 for Victoria, WA, SA and the ACT are preliminary. **b** Data for Tasmania are not available. **c** Between 12 and 15 per cent of births each year in the ACT are to non-residents of the ACT. **d** Total includes only jurisdictions for which data are available. **e** The indicator is calculated for women aged between 20 and 34 years who have had no previous deliveries, with a singleton baby with a vertex presentation (that is, the crown of the baby’s head is at the lower segment of the mother’s uterus) and a gestation length of 37 to 41 weeks. **f** The age group of women used for this indicator has been changed from 25–29 years to 20–34 years in this Report edition to align with national data definitions. Therefore, data for this indicator are not comparable with data in previous report editions.

Source: State and Territory governments (unpublished); tables 11A.103–110.

Figure 11.28 Inductions for selected primiparae, public hospitals^{a, b, c, d, e, f}



^a Data for 2013 for Victoria, WA, SA and the ACT are preliminary. ^b Data for Tasmania are not available. ^c Between 12 and 15 per cent of births each year in the ACT are to non-residents of the ACT. ^d Total includes only jurisdictions for which data are available. ^e The indicator is calculated for women aged between 20 and 34 years who have had no previous deliveries, with a singleton baby with a vertex presentation (that is, the crown of the baby's head is at the lower segment of the mother's uterus) and a gestation length of 37 to 41 weeks. ^f The age group of women used for this indicator has been changed from 25–29 years to 20–34 years in this Report edition to align with national data definitions. Therefore, data for this indicator are not comparable with data in previous report editions.

Source: State and Territory governments (unpublished); tables 11A.103–110.

Instrumental vaginal births

'Instrumental vaginal births' is an indicator of the appropriateness of maternity services (box 11.18).

Box 11.18 Instrumental vaginal births

'Instrumental vaginal births' is defined as the number of selected primiparas^a who had an instrumental vaginal birth as a percentage of all selected primiparas that gave birth. Instrumental vaginal births includes the use of forceps and vacuum extraction.

The indicator is calculated for women aged between 20 and 34 years who have had no previous deliveries, with a singleton baby with a vertex presentation (that is, the crown of the baby's head is at the lower segment of the mother's uterus) and a gestation length of 37 to 41 weeks.

While low or decreasing instrumental vaginal births can be desirable, a high rate does not necessarily indicate inappropriate care. Reasons for instrumental vaginal births often include:

- the first baby/birth of the mother
- the baby was becoming distressed during birth
- the baby was not moving down through the birth canal
- there was a medical reason why the mother should or could not push.

In these cases, the use of instruments is often necessary and appropriate and can often have a better outcome for mother and baby than a caesarean section. A low or decreasing rate of instrumental vaginal births could be undesirable in situations such as this if there is a corresponding increase in the rate of caesarean sections.

Data reported for this indicator are:

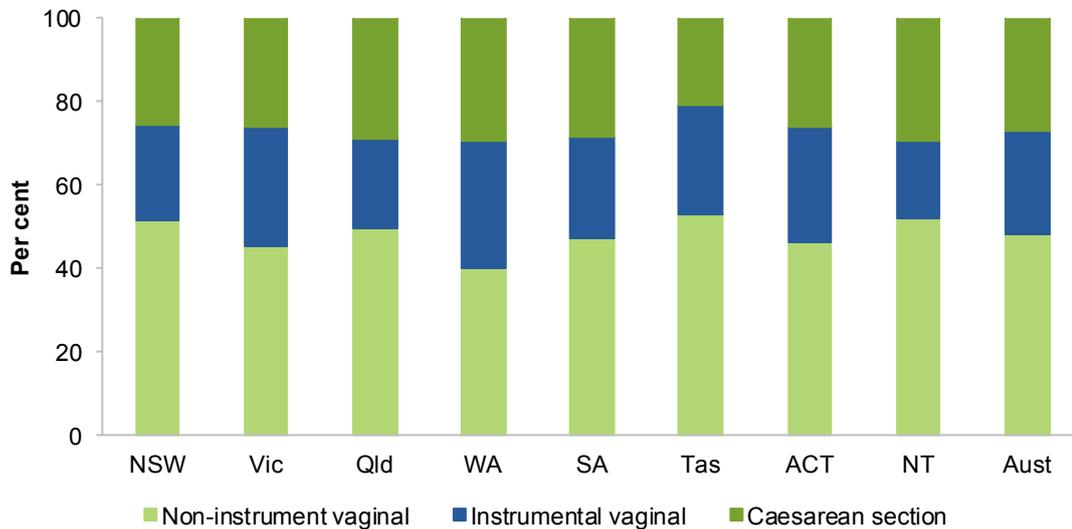
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

^a Primiparas refers to women who have given birth to a liveborn or stillborn infant for the first time.

In 2012 across Australia, 48.0 per cent of women giving birth for the first time gave birth without the assistance of instruments, while 24.9 per cent gave birth with the use of instruments and 27.0 per cent had a caesarean section. There was significant variation across states and territories (figure 11.29).

Figure 11.29 **Method of birth for selected women giving birth for the first time, 2012^{a, b}**



^a Selection criteria: women aged 20 to 34 years, with a singleton baby positioned with head towards the cervix at the onset of labour born between 37 and 41 weeks gestation. ^b Data for Victoria are preliminary.
 Source: AIHW (unpublished) National Perinatal Data Collection; table 11A.111.

Vaginal birth after caesarean section

‘Vaginal birth after caesarean section’ is an indicator of the appropriateness of maternity services (box 11.19). This indicator was named ‘vaginal delivery following previous caesarean’ in previous report editions.

Box 11.19 **Vaginal birth after caesarean section**

‘Vaginal birth after caesarean section’ is defined as the percentage of multiparous^a mothers who have had a previous caesarean, whose current method of birth was either an instrumental or non-instrumental vaginal birth.

Interpretation of this indicator is ambiguous. There is ongoing debate about the relative risks of a repeat caesarean section or vaginal birth following a caesarean section. The decision should always be based on clinical assessment. Low rates of vaginal birth following a caesarean may warrant investigation, or on the other hand, they can indicate appropriate clinical caution. When interpreting this indicator, emphasis needs to be given to the potential for improvement.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time

(Continued on next page)

Box 11.19 (continued)

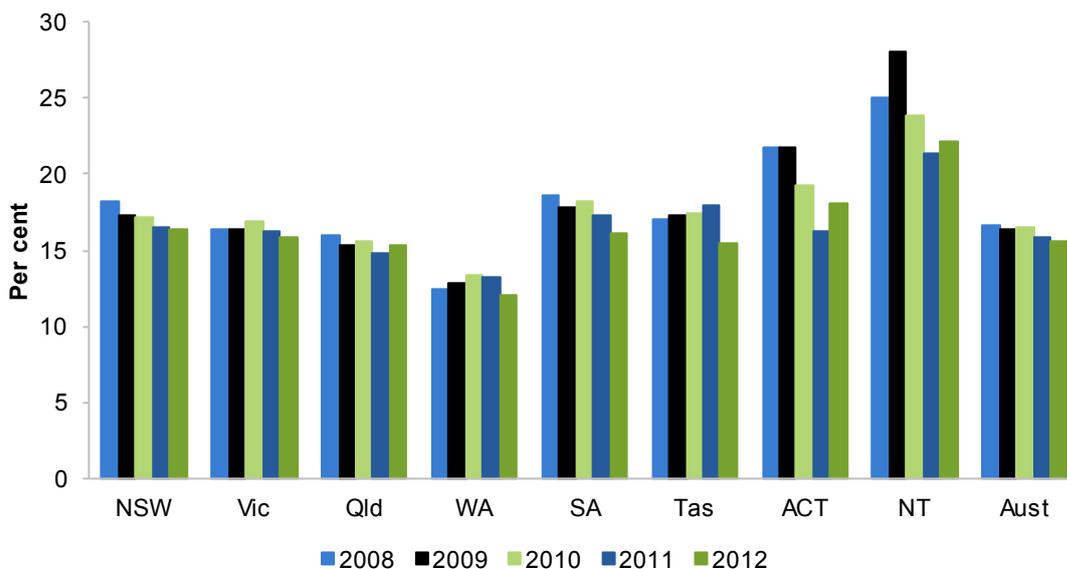
- complete (subject to caveats) for the current reporting period. All required 2012 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

^a Multiparous means a woman who has given birth from at least two pregnancies that each resulted in a live birth or stillbirth.

Nationally in 2012, 15.6 per cent of women had either an instrumental or non-instrumental vaginal delivery after a caesarean section, while 84.4 per cent had another caesarean section (figure 11.30 and table 11A.112).

Figure 11.30 **Women who had a vaginal birth after a caesarean section^{a, b, c, d, e}**



^a Vaginal birth comprises both instrumental and non-instrumental vaginal births. ^b For multiple births, the method of birth of the first born baby was used. ^c For NSW, Victoria, WA and the NT, non-instrumental vaginal birth includes all women who had a vaginal breech birth, whether or not instruments were used. For the remaining jurisdictions, vaginal breech births are only included where instruments were not used. ^d Instrumental vaginal birth includes forceps and vacuum extraction. ^e Between 12 and 15 per cent of births each year in the ACT are to non-residents of the ACT.

Source: Li, Z., McNally, L., Hilder, L. and Sullivan, EA. (various years), Australia's mothers and babies, Perinatal statistics series Cat nos. PER 50, 52 and 56; table 11A.112.

Effectiveness — quality

The performance indicator framework for maternity services identifies three subdimensions of quality for health services: safety; responsiveness and continuity. For

maternity services in this Report, data are reported against the subdimension of safety only. Other subdimensions of quality have been identified by the Steering Committee for future development.

Safety — perineal status after vaginal birth

‘Perineal status after vaginal birth’ is an indicator of governments’ objective to provide safe and high quality services (box 11.20). Perineal lacerations caused by childbirth are painful, take time to heal and can result in ongoing discomfort and debilitating conditions such as faecal incontinence.

Box 11.20 Perineal status after vaginal birth

‘Perineal status after vaginal birth’ is defined as the state of the perineum following a vaginal birth (HDSC 2008). A third or fourth degree laceration is a perineal laceration or rupture (or tear following episiotomy) extending to, or beyond, the anal sphincter (see section 11.8 for definitions) (NCCH 2008). It is measured by the proportion of women giving birth with third or fourth degree lacerations to their perineum following vaginal birth.

A low or decreasing rate of women giving birth with third or fourth degree lacerations after vaginal birth is desirable. Maternity services staff aim to minimise lacerations, particularly more severe lacerations (third and fourth degree), through labour management practices. Severe lacerations (third and fourth degree laceration) of the perineum are not avoidable in all cases and so safe labour management is associated with a low (rather than zero) proportion of third or fourth degree lacerations.

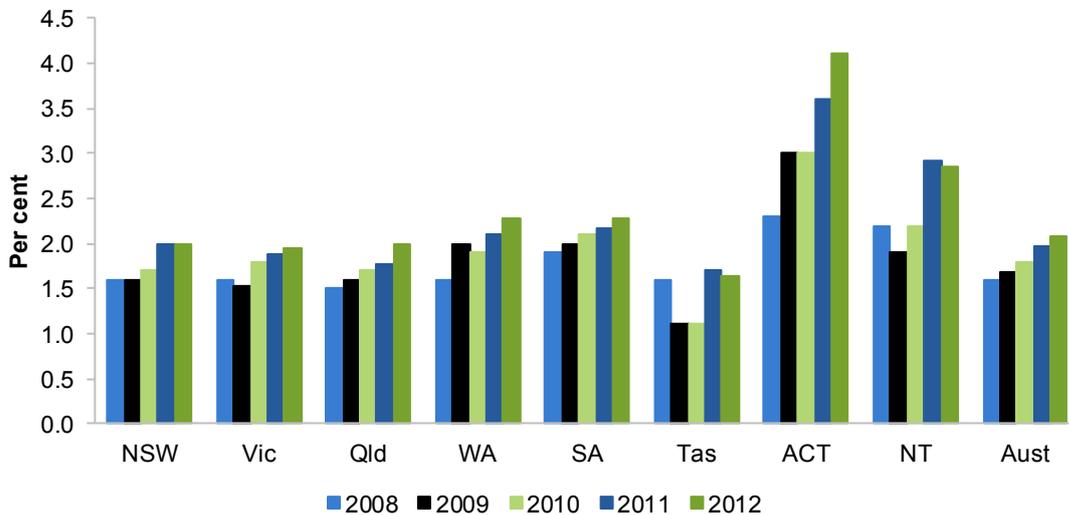
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

The proportion of mothers with third or fourth degree lacerations to their perineum following vaginal births is shown in figure 11.31. More information on perineal status after vaginal birth (including the proportion of mothers with intact perineum following vaginal births) is contained in table 11A.113.

Figure 11.31 **Perineal status — mothers with third or fourth degree lacerations after vaginal births^{a, b, c}**



^a For multiple births, the perineal status recorded against the birth of the first child was used. ^b Data include all women who gave birth vaginally, including births in public hospitals, private hospitals and outside of hospital, such as homebirths. ^c Between 12 and 15 per cent of births each year in the ACT are to non-residents of the ACT.

Source: Li, Z., McNally, L., Hilder, L. and Sullivan, EA. (various years), *Australia's mothers and babies*, Perinatal statistics series Cat nos. PER 22, 48, 50, 52 and 56; table 11A.113.

Responsiveness, continuity

The Steering Committee has identified the responsiveness and continuity of care of maternity services as an area for development in future Reports.

Efficiency — sustainability

The Steering Committee has identified the sustainability of maternity services as an area for development in future Reports.

Efficiency

Recurrent cost per maternity separation

'Recurrent cost per maternity separation' is an indicator of governments' objective to deliver cost effective services (box 11.21).

Box 11.21 Recurrent cost per maternity separation

'Recurrent cost per maternity separation' is presented for the two AR-DRGs that account for the largest number of maternity patient days: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery without catastrophic or severe complications and comorbidities.

Low or decreasing recurrent costs per maternity separation can reflect high or increasing efficiency in providing maternity services to admitted patients. However, this is only likely to be the case where the low cost maternity services are provided at equal or superior effectiveness.

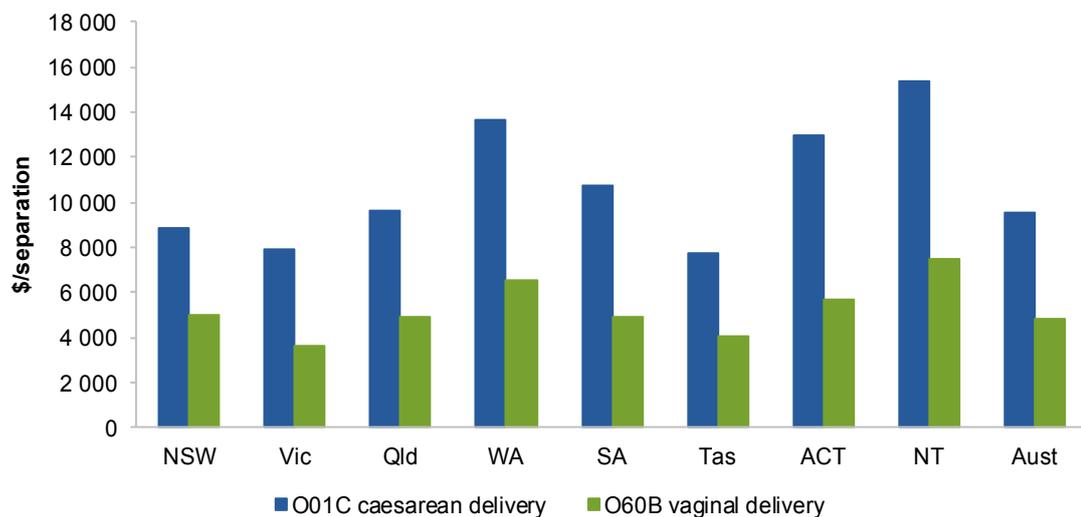
Data reported for this indicator are:

- comparable (subject to caveats) within some jurisdictions over time but are not comparable across jurisdictions or over time for other jurisdictions (see caveats in attachment tables for specific jurisdictions)
- complete (subject to caveats) for the current reporting period. All required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is under development.

Data are reported for the two most common maternity AR-DRGs: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery without catastrophic or severe complications and comorbidities (figure 11.32).

Figure 11.32 Estimated average cost per separation for selected maternity related AR-DRGs, public hospitals, 2011-12^{a, b}



^a Includes AR-DRG O01C caesarean delivery without catastrophic or severe complications and comorbidities and AR-DRG O60B vaginal delivery without catastrophic or severe complications and comorbidities. ^b Average cost is affected by a number of factors including admission practices, sample size, remoteness and the types of hospital contributing to the collection. Caution must be used in making direct comparisons across jurisdictions, because of differences in hospital costing systems.

Source: IHPA (unpublished), National Hospital Cost Data Collection; table 11A.114.

Data for a number of other maternity related AR-DRGs are shown in table 11A.114. Data are sourced from the NHCDC. The NHCDC is a voluntary annual collection, the purpose of which is to calculate DRG cost weights. The samples are not necessarily representative of the set of hospitals in each jurisdiction. An estimation process has been carried out to create representative national activity figures from the sample data.

Mother's average length of stay

'Mother's average length of stay' is an indicator of governments' objective to deliver services efficiently (box 11.22).

Box 11.22 Mother's average length of stay

'Mother's average length of stay' is defined as the total number of patient days for the selected maternity AR-DRG, divided by the number of separations for that AR-DRG.

Shorter stays for mothers reduce hospital costs but whether they represent genuine efficiency improvements depends on a number of factors. Shorter stays can, for example, have an adverse effect on the health of some mothers and result in additional costs for in-home care and potential readmissions. The indicator is not adjusted for multiple births born vaginally and without complications but requiring a longer stay to manage breastfeeding.

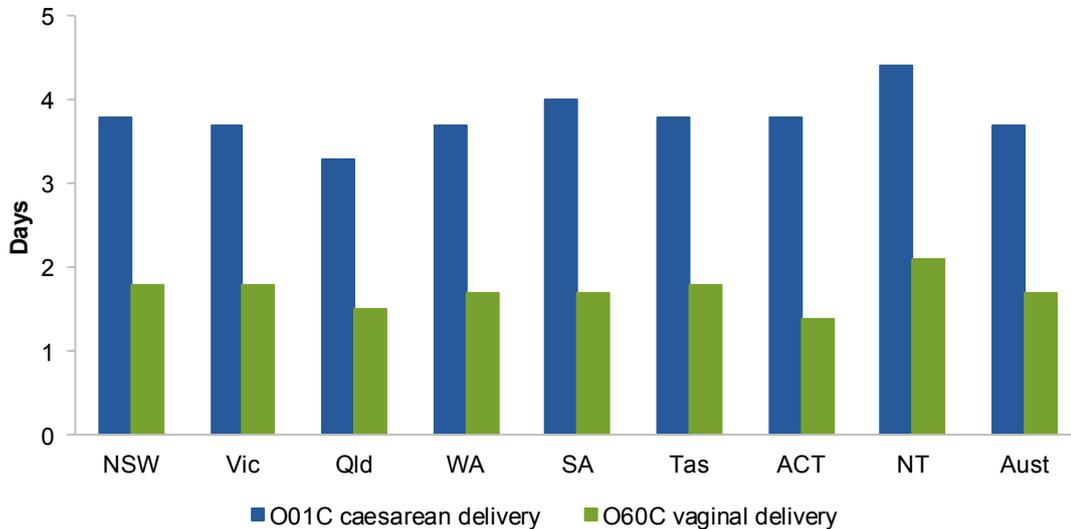
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Data are reported for two selected maternity AR-DRGs: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery single uncomplicated (figure 11.33).

Figure 11.33 **Average length of stay for selected maternity-related AR-DRGs, public hospitals, 2012-13^a**



^a Includes AR-DRG O01C caesarean delivery without catastrophic or severe complications and comorbidities and AR-DRG O60C vaginal delivery single uncomplicated.

Data source: AIHW (2014), *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145; table 11A.115.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the services delivered) (see chapter 1, section 1.5).

Baby's Apgar score

'Baby's Apgar score at five minutes' is an indicator of governments' objective to deliver maternity services that are safe and of high quality (box 11.23). The future health of babies with lower Apgar scores is often poorer than those with higher scores.

Box 11.23 **Baby's Apgar score at five minutes**

Baby's Apgar score at five minutes is defined as the number of live births with an Apgar score of less than 4, at 5 minutes post-delivery, as a proportion of the total number of live births by specified birthweight categories. The Apgar score is a numerical score that indicates a baby's condition shortly after birth. Apgar scores are based on an assessment of the baby's heart rate, breathing, colour, muscle tone and reflex irritability. Between 0 and 2 points are given for each of these five characteristics and the total score is between 0 and 10. The Apgar score is routinely assessed at 1 and 5 minutes after birth, and subsequently at 5 minute intervals if it is still low at 5 minutes (Day et al. 1999).

A high or increasing Apgar score is desirable.

Low Apgar scores (defined as less than 4) are strongly associated with low birthweights. The management of labour in hospitals does not usually affect birthweights, but can affect the prevalence of low Apgar scores for babies with similar birthweights. Apgar scores can therefore indicate relative performance within birthweight categories, although factors other than hospital maternity services can influence Apgar scores within birthweight categories — for example, antenatal care, multiple births and socioeconomic factors.

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- incomplete for the current reporting period. All required data were not available for Tasmania.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

'Low' (less than 4) Apgar scores for babies by birthweight category are reported in table 11.11. The full range of Apgar scores for 2004 to 2013 are reported in table 11A.116.

Table 11.11 Live births with an Apgar score of less than 4, 5 minutes post delivery, public hospitals, 2013

<i>Birthweight (grams)</i>	<i>Unit</i>	<i>NSW</i>	<i>Vic^a</i>	<i>Qld</i>	<i>WA^a</i>	<i>SA^a</i>	<i>Tas</i>	<i>ACT^{a, b}</i>	<i>NT</i>
Less than 1500	no.	846	726	544	294	225	na	80	50
Low Apgar	%	15.1	18.7	18.6	5.4	8.0	na	13.8	26.0
1500-1999	no.	965	757	648	374	297	na	70	64
Low Apgar	%	1.7	1.3	1.5	1.1	0.6	na	1.4	np
2000-2499	no.	3 021	2 407	1 815	904	708	na	210	172
Low Apgar	%	0.8	0.3	0.6	0.6	0.6	na	1.0	np
2500 and over	no.	67 065	53 069	41 458	18 485	14 046	na	4 444	2 960
Low Apgar	%	0.3	0.2	0.2	0.2	0.1	na	0.3	0.4

^a Data for Victoria, WA, SA and the ACT are preliminary. ^b ACT data include both ACT and non-ACT residents where the birth occurred in the ACT. **na** Not available. **np** Not published.

Source: State and Territory governments (unpublished); table 11A.116.

Perinatal death rate

‘Perinatal death rate’ is an indicator of governments’ objective to deliver maternity services that are safe and of high quality (box 11.24).

Box 11.24 Perinatal death rate

‘Perinatal death rate’ is defined by the following three measures:

- Fetal death (stillbirth) is the birth of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Fetal deaths by definition include only infants weighing at least 400 grams or of a gestational age of at least 20 weeks. The fetal death rate is calculated as the number of fetal deaths divided by the total number of births (live births and fetal deaths combined). The rate of fetal deaths is expressed per 1000 total births, by State or Territory of usual residence of the mother.
- Neonatal death is the death of a live born infant within 28 days of birth (see section 11.8 for a definition of a live birth). The neonatal death rate is calculated as the number of neonatal deaths divided by the number of live births registered. The rate of neonatal deaths is expressed per 1000 live births, by State or Territory of usual residence of the mother.
- A perinatal death is a fetal or neonatal death. The perinatal death rate is calculated as the number of perinatal deaths divided by the total number of births (live births and fetal deaths combined). It is expressed per 1000 total births, by State or Territory of usual residence of the mother.

Low or decreasing death rates are desirable and can indicate high quality maternity services. The neonatal death rate tends to be higher among premature babies, so a lower neonatal death rate can also indicate a lower percentage of pre-term births.

Differences in the fetal death rate across jurisdictions are likely to be due to factors outside the control of admitted patient maternity services (such as the health of mothers and the progress of pregnancy before hospital admission). To the extent that the health system influences fetal death rates, the health services that can have an influence include outpatient services, general practice services and maternity services. In jurisdictions where the number of fetal deaths is low, small annual fluctuations in the number affect the annual rate of fetal deaths.

As for fetal deaths, a range of factors contribute to neonatal deaths. However, the influence of maternity services for admitted patients is greater for neonatal deaths than for fetal deaths, through the management of labour and the care of sick and premature babies.

Data reported for this indicator are:

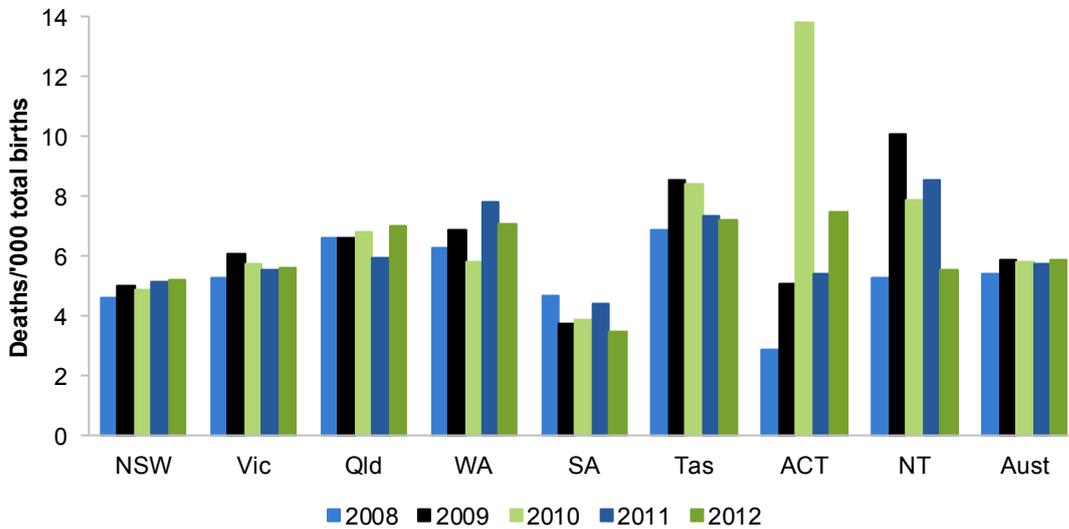
- comparable (subject to caveats) across jurisdictions and over time
- incomplete for the current reporting period. All required data for Aboriginal and Torres Strait Islander people were not available for Victoria, Tasmania and the ACT.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Fetal death rate

Fetal death rates are reported in figure 11.34. National time series for fetal death rates for the period 2003 to 2012 are included in table 11A.119.

Figure 11.34 Fetal death rate^{a, b, c}



^a Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of fetal deaths and small populations. ^b Some fetal deaths occurring in WA could be the result of termination of pregnancy at 20 weeks gestation or more. ^c Some ACT stillbirth data were not received or processed by the ABS in time for finalisation of the 2008 reference year. According to scope rules these 2008 data were included in the 2010 reference year. The data for the ACT and the Australian total therefore show a decline in 2008 and an increase in 2010 which is not related to any actual significant change in fetal death rates.

Source: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 11A.117.

Fetal deaths data by the Indigenous status of the mother are available for NSW, Queensland, WA, SA and the NT only. These five states and territories are considered to have adequate levels of identification of Aboriginal and Torres Strait Islander people in mortality data (ABS 2004). There was significant variation in the fetal death rates for Aboriginal and Torres Strait Islander Australians for the five jurisdictions for which data are available (figure 11.35).

Figure 11.35 Fetal death rate by Indigenous status of mother 2008–2012^a



^a Data are reported individually by jurisdiction of residence of mother for NSW, Queensland, WA, SA and the NT only. These jurisdictions have evidence of sufficient levels of identification and sufficient numbers of deaths. Data are not available for other jurisdictions. The total relates to those jurisdictions for which data are published.

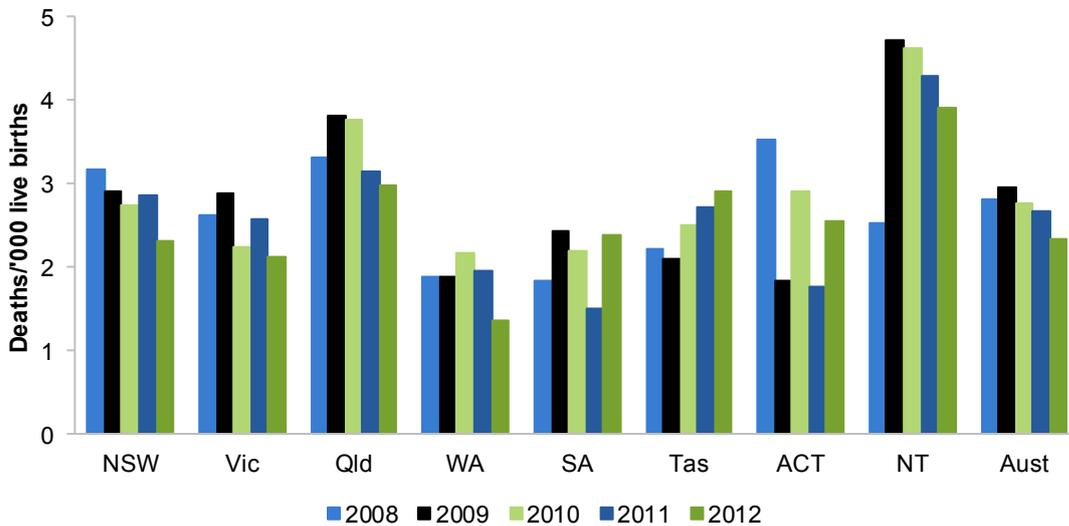
Source: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 11A.121.

Neonatal death rate

Neonatal death rates are reported in figure 11.36. Nationally, neonatal death rates have declined over the period 2008–2012. National time series for neonatal death rates for the period 2003 to 2012 are included in table 11A.119.

Neonatal deaths data by the Indigenous status of the mother are available for NSW, Queensland, WA, SA and the NT only. These five states and territories are considered to have adequate levels of identification of Aboriginal and Torres Strait Islander people in mortality data (ABS 2004). In four of the jurisdictions for which data are available, the neonatal death rates for Aboriginal and Torres Strait Islander Australians are higher than those for other Australians (figure 11.37).

Figure 11.36 Neonatal death rate^a



^a Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of neonatal deaths and small populations.

Source: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 11A.118.

Figure 11.37 Neonatal death rate by Indigenous status of mother 2008–2012^a



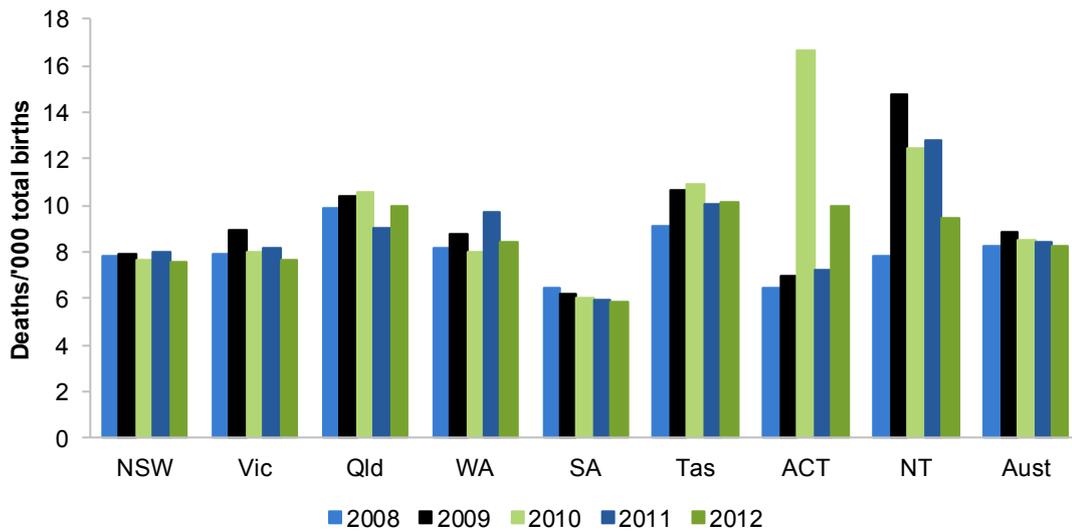
^a Data are reported individually by jurisdiction of residence of mother for NSW, Queensland, WA, SA and the NT only. These jurisdictions have evidence of sufficient levels of identification and sufficient numbers of deaths. Data are not available for other jurisdictions. The total relates to those jurisdictions for which data are published.

Source: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 11A.121.

Perinatal death rate

Perinatal death rates are shown in figure 11.38. Nationally, perinatal death rates have been steady over the period 2008–2012. National time series for perinatal death rates for the period 2003 to 2012 are included in table 11A.119.

Figure 11.38 Perinatal death rate^{a, b}

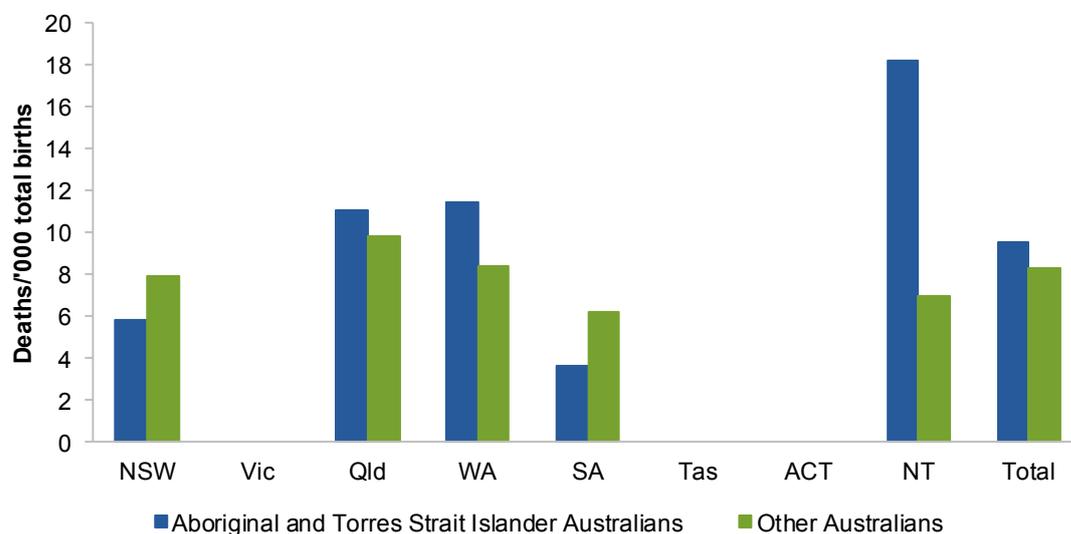


^a Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of perinatal deaths. ^b Some ACT stillbirth data were not received or processed by the ABS in time for finalisation of the 2008 reference year. According to scope rules these 2008 data were included in the 2010 reference year. The data for the ACT and the Australian total therefore show a decline in 2008 and an increase in 2010 which is not related to any actual significant change in fetal death rates.

Source: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 11A.120.

Perinatal deaths data by the Indigenous status of the mother are available for NSW, Queensland, WA, SA and the NT only. These five states and territories are considered to have adequate levels of identification of Aboriginal and Torres Strait Islander people in mortality data (ABS 2004). In three of the jurisdictions for which data are available, perinatal death rates for Aboriginal and Torres Strait Islander Australians are higher than those for other Australians (figure 11.39).

Figure 11.39 **Perinatal death rate by Indigenous status of mother 2008–2012^a**



^a Data are reported individually by jurisdiction of residence of mother for NSW, Queensland, WA, SA and the NT only. These jurisdictions have evidence of sufficient levels of identification and sufficient numbers of deaths. Data are not available for other jurisdictions. The total relates to those jurisdictions for which data are published.

Source: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 11A.121.

11.7 Future directions in performance reporting

Priorities for future reporting on public hospitals and maternity services include the following:

- Improving the comprehensiveness of reporting by filling in gaps in the performance indicator frameworks. Important gaps in reporting for public hospitals include indicators of equity of access to services for special needs groups, and indicators of continuity of care. Gaps in the maternity services framework include equity of access, effectiveness of access, two aspects of quality — responsiveness and continuity — and the efficiency subdimension of sustainability.
- Improving currently reported indicators for public hospitals and maternity services where data are not complete or not directly comparable. There is scope to improve reporting of the quality and access dimensions of the public hospitals framework, and the output indicators for maternity services.
- Improving the reporting of elective surgery waiting times by urgency category to achieve greater comparability across jurisdictions and improving timeliness of the data.
- Improving the reporting of quality and safety indicators in both the public hospitals' and maternity services' frameworks.

-
- Improving the quality of data on Aboriginal and Torres Strait Islander Australians. Work on improving the identification of Aboriginal and Torres Strait Islander people in hospital admitted patient data across states and territories is ongoing.

11.8 Definitions of key terms

Accreditation	Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals can seek accreditation through the ACHS Evaluation and Quality Improvement Program, the Australian Quality Council (now known as Business Excellence Australia), the Quality Improvement Council, the International Organisation for Standardization 9000 Quality Management System or other equivalent programs.
Acute care	Clinical services provided to admitted or non-admitted patients, including managing labour, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures. Most episodes involve a relatively short hospital stay.
Admitted patient	A patient who has undergone a formal admission process in a public hospital to begin an episode of care. Admitted patients can receive acute, subacute or non-acute care services.
Admitted patient cost proportion	The ratio of admitted patient costs to total hospital costs, also known as the inpatient fraction.
Allied health (non-admitted)	Occasions of service to non-admitted patients at units/clinics providing treatment/counselling to patients. These include units providing physiotherapy, speech therapy, family planning, dietary advice, optometry and occupational therapy.
Apgar score	Numerical score used to evaluate a baby's condition after birth. The definition of the reported indicator is the number of babies born with an Apgar score of 3 or lower at 5 minutes post delivery, as a proportion of the total number of babies born. Excludes fetal deaths in utero before commencement of labour.
AR-DRG	Australian Refined Diagnosis Related Group - a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 6.0x is based on the ICD-10-AM classification.
Australian Classification of Health Interventions (ACHI)	ACHI is the Australian classification of health interventions.
Average length of stay	The mean length of stay for all patient episodes, calculated by dividing total occupied bed days by total episodes of care.
Caesarean section	Operative birth through an incision into abdomen and uterus.
Casemix adjusted	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted by AR-DRG into categories of patients with similar clinical conditions and requiring similar hospital services. Casemix adjustment is an important step to achieving comparable measures of efficiency across hospitals and jurisdictions.
Casemix adjusted separations	The number of separations adjusted to account for differences across hospitals in the complexity of episodes of care.
Catastrophic	An acute or prolonged illness usually considered to be life threatening or with the threat of serious residual disability. Treatment can be radical and is frequently costly.
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 of capital	The return foregone on the next best investment, estimated at a rate of 8 per cent of the depreciated replacement value of buildings, equipment and land. Also called the 'opportunity cost' of capital.
Cost per casemix adjusted separation	Recurrent expenditure multiplied by the inpatient fraction and divided by the total number of casemix-adjusted separations plus estimated private patient medical costs.
Cost per non-admitted occasion of service	Recurrent expenditure divided by the inpatient fraction and divided by the total number of non-admitted occasions of service.
Elective surgery waiting times	Elective surgery waiting times are calculated by comparing the date on which patients are added to a waiting list with the date on which they are admitted for the awaited procedure. Days on which the patient was not ready for care are excluded.
Emergency department waiting time to commencement of clinical care	The time elapsed for each patient from presentation to the emergency department (that is, the time at which the patient is clerically registered or triaged, whichever occurs earlier) to the commencement of service by a treating medical officer or nurse.
Emergency department waiting times to admission	The time elapsed for each patient from presentation to the emergency department to admission to hospital.
Episiotomy	A surgical incision into the perineum and vagina that attempts to control trauma while widening the vaginal opening to expedite birth of the infant or provide better access for application of forceps or vacuum cup to the fetus.
Fetal death	Delivery of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Excludes infants that weigh less than 400 grams or that are of a gestational age of less than 20 weeks.
Fetal death rate	The number of fetal deaths divided by the total number of births (that is, by live births registered and fetal deaths combined).
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 can include services for specific populations, such as women's health or Aboriginal and Torres Strait Islander people's health.
ICD-10-AM	The Australian modification of the International Standard Classification of Diseases and Related Health Conditions. This is the current classification of diagnoses in Australia.
Hospital boarder	A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.
Inpatient fraction	The ratio of admitted patient costs to total hospital costs, also known as the admitted patient cost proportion.
Labour cost per casemix-adjusted separation	Salary and wages plus visiting medical officer payments, multiplied by the inpatient fraction, divided by the number of casemix-adjusted separations.
Length of stay	The period from admission to separation less any days spent away from the hospital (leave days).
Live birth	Birth of a child who, after delivery, breathes or shows any other evidence of life, such as a heartbeat. Includes all registered live births regardless of birthweight.
Medicare	Australian Government funding of private medical and optometrical services (under the Medicare Benefits Schedule). Sometimes defined to include other forms of Australian Government funding such as subsidisation of selected

	pharmaceuticals (under the Pharmaceutical Benefits Scheme) and public hospital funding (under the Australian Health Care Agreements), which provides public hospital services free of charge to public patients.
Mortality rate	The number of deaths per 100 000 people.
Neonatal death	Death of a live born infant within 28 days of birth. Defined in Australia as the death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Neonatal death rate	Neonatal deaths divided by the number of live births registered.
Newborn qualification status	<p>A newborn qualification status is assigned to each patient day within a newborn episode of care.</p> <p>A newborn patient day is qualified if the infant meets at least one of the following criteria:</p> <ul style="list-style-type: none"> • is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient, • is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care, • is admitted to, or remains in hospital without its mother. <p>A newborn patient day is unqualified if the infant does not meet any of the above criteria.</p> <p>The day on which a change in qualification status occurs is counted as a day of the new qualification status.</p> <p>If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day.</p>
Nursing workforce	Registered and enrolled nurses who are employed in nursing, on extended leave or looking for work in nursing.
Medical practitioner workforce	Registered medical practitioners who are employed as medical practitioners, on extended leave or looking for work as a medical practitioner.
Multiparous	A woman who has given birth from at least two pregnancies that each resulted in a live birth or stillbirth.
Non-acute care	Includes maintenance care and newborn care (where the newborn does not require acute care).
Non-admitted occasions of service	Occasion of examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service establishment. Services can include emergency department visits, outpatient services (such as pathology, radiology and imaging, and allied health services, including speech therapy and family planning) and other services to non-admitted patients. Hospital non-admitted occasions of service are not yet recorded consistently across states and territories, and relative differences in the complexity of services provided are not yet documented.
Non-admitted patient	A patient who has not undergone a formal admission process, but who may receive care through an emergency department, outpatient or other non-admitted service.
Perinatal death	Fetal death or neonatal death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Perinatal death rate	Perinatal deaths divided by the total number of births (that is, live births registered and fetal deaths combined).
Perineal laceration (third or fourth degree)	A 'third degree' laceration or rupture during birth (or a tear following episiotomy) involves the anal sphincter, rectovaginal septum and sphincter NOS. A 'fourth degree' laceration, rupture or tear also involves the anal mucosa and rectal mucosa (NCCH 2008).
Perineal status	The state of the perineum following a birth.
Primary care	Essential healthcare based on practical, scientifically sound and socially acceptable methods made universally accessible to individuals and families

	in the community.
Primipara	A woman who has given birth to a liveborn or stillborn infant for the first time.
Public hospital	A hospital that provides free treatment and accommodation to eligible admitted persons who elect to be treated as public patients. It also provides free services to eligible non-admitted patients and can provide (and charge for) treatment and accommodation services to private patients. Charges to non-admitted patients and admitted patients on discharge can be levied in accordance with the Australian Health Care Agreements (for example, aids and appliances).
Puerperium	The time in the woman's perinatal period between the birth and up to 42 days after the birth.
Real expenditure	Actual expenditure adjusted for changes in prices.
Relative stay index	The actual number of patient days for acute care separations in selected AR-DRGs divided by the expected number of patient days adjusted for casemix. Includes acute care separations only. Excludes: patients who died or were transferred within 2 days of admission, or separations with length of stay greater than 120 days, AR-DRGs which are for 'rehabilitation', AR-DRGs which are predominantly same day (such as R63Z chemotherapy and L61Z admit for renal dialysis), AR-DRGs which have a length of stay component in the definition, and error AR-DRGs.
Same day patients	A patient whose admission date is the same as the separation date.
Sentinel events	Adverse events that cause serious harm to patients and that have the potential to undermine public confidence in the healthcare system.
Separation	A total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change in the type of care for an admitted patient (for example, from acute to rehabilitation). Includes admitted patients who receive same day procedures (for example, renal dialysis).
Separation rate	Hospital separations per 1000 people or 100 000 people.
Selected primiparae	Primiparae with no previous deliveries, aged 20–34 years, singleton, vertex presentation and gestation of 37–41 weeks (inclusive).
Subacute care	Specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction. Subacute care comprises the defined care types of rehabilitation, palliative care, geriatric evaluation and management and psychogeriatric care.
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).
Urgency category for elective surgery	Category 1 patients — admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it can become an emergency. Category 2 patients — admission within 90 days is desirable for a condition that is causing some pain, dysfunction or disability, but that is not likely to deteriorate quickly or become an emergency. Category 3 patients — admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, that is unlikely to deteriorate quickly and that does not have the potential to become an emergency.

11.9 List of attachment tables

Attachment tables are identified in references throughout this chapter by a '11A' prefix (for example, table 11A.1). Attachment tables are available from the Review website (www.pc.gov.au/gsp).

Table 11A.1	Recurrent expenditure, public hospitals (including psychiatric hospitals), (2012-13 dollars, million)
Table 11A.2	Recurrent expenditure, public hospital services, by source of funding, (2012-13 dollars)
Table 11A.3	Recurrent expenditure per person, public hospitals (including psychiatric) (2012-13 dollars)
Table 11A.4	Public hospitals (including psychiatric hospitals) by hospital size
Table 11A.5	Available beds per 1000 people, by region, public hospitals (including psychiatric) (number)
Table 11A.6	Summary of separations, public hospitals
Table 11A.7	Separations, public (non-psychiatric) hospitals
Table 11A.8	Same-day and overnight separations by broad category of service, public hospitals
Table 11A.9	Separations in public hospitals, by age group
Table 11A.10	Separations by hospital sector and Indigenous status of patient
Table 11A.11	Separations per 1000 people, by Indigenous status of patient (number)
Table 11A.12	Average full time equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals)
Table 11A.13	Separations, by type of episode of care, public hospitals (including psychiatric), 2012-13
Table 11A.14	Same-day acute separations for the 50 most common principal diagnoses, public hospitals, states and territories, 2012-13
Table 11A.15	Overnight acute separations, for the 50 most common principal diagnoses, public hospitals, states and territories, 2012-13
Table 11A.16	Patient days, by care type, public and private hospitals, 2012-13
Table 11A.17	Non-admitted patient occasions of service, by type of non-admitted patient care, public hospitals, 2012-13
Table 11A.18	Emergency department waiting times, by triage category, public hospitals
Table 11A.19	Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory
Table 11A.20	Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory
Table 11A.21	Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory
Table 11A.22	Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles

Table 11A.23	Percentage of presentations where the time from presentation to physical departure (Emergency Department (ED) Stay length) is within four hours, by State and Territory
Table 11A.24	Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals
Table 11A.25	Elective surgery waiting times, by specialty of surgeon
Table 11A.26	Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days)
Table 11A.27	Waiting times for elective surgery in public hospitals, by State and Territory, by remoteness area (days)
Table 11A.28	Waiting times for elective surgery in public hospitals, by State and Territory, by SEIFA IRSD quintiles (days)
Table 11A.29	Elective surgery waiting times, by indicator procedure
Table 11A.30	Classification of elective surgery patients, by clinical urgency category (per cent)
Table 11A.31	NSW elective surgery waiting times by clinical urgency category, public hospitals (per cent)
Table 11A.32	NSW elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.33	Victorian elective surgery waiting times by clinical urgency category, public hospitals (per cent)
Table 11A.34	Victorian elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.35	Queensland elective surgery waiting times, by clinical urgency category, public hospitals (per cent)
Table 11A.36	Queensland elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.37	WA elective surgery waiting times, by clinical urgency category, public hospitals (per cent)
Table 11A.38	WA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.39	SA elective surgery waiting times, by clinical urgency category, public hospitals
Table 11A.40	SA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.41	Tasmanian elective surgery waiting times, by clinical urgency category, public hospitals
Table 11A.42	Tasmania elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.43	ACT elective surgery waiting times, by clinical urgency category, public hospitals
Table 11A.44	ACT elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.45	NT elective surgery waiting times, by clinical urgency category, public hospitals

Table 11A.46	NT elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.47	Proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission, public hospitals,
Table 11A.48	Separation statistics for selected hospital procedures per 1000 people, all hospitals 2012-13
Table 11A.49	Separation statistics for selected hospital procedures, all hospitals, 2012-13
Table 11A.50	Unplanned hospital readmissions rates
Table 11A.51	Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2012-13
Table 11A.52	Proportion of accredited beds in public hospitals (per cent)
Table 11A.53	Episodes of <i>Staphylococcus aureus</i> (including MRSA) bacteraemia (SAB) in acute care hospitals, by MRSA and MSSA
Table 11A.54	Separations with an adverse event, public hospitals
Table 11A.55	Separations for falls resulting in patient harm in hospitals, per 1000 separations, 2012-13
Table 11A.56	Nursing workforce (includes midwives), by age group and remoteness area
Table 11A.57	Nursing workforce (includes midwives), by age group
Table 11A.58	Medical practitioner workforce, by age group and remoteness area
Table 11A.59	Medical practitioner workforce, by age group
Table 11A.60	Recurrent cost per casemix-adjusted separation, selected public acute hospitals 2011-12
Table 11A.61	Costs and utilisation by hospital peer group, public hospitals, 2011-12
Table 11A.62	Capital cost per casemix-adjusted separation — indicative estimates for inpatient services at major public acute hospitals, 2011-12
Table 11A.63	Relative stay index for patients in public hospitals, by funding source, 2012-13
Table 11A.64	Relative stay index, indirectly standardised, patients in public hospitals, by medical, surgical and other type of diagnosis related group 2012-13
Table 11A.65	NSW recurrent cost per non-admitted patient occasion of service, public hospitals
Table 11A.66	WA recurrent cost per non-admitted patient occasion of service, public hospitals
Table 11A.67	SA recurrent cost per non-admitted patient occasion of service, public hospitals
Table 11A.68	Tasmania recurrent cost per non-admitted patient occasion of service, public hospitals
Table 11A.69	ACT recurrent cost per non-admitted patient occasion of service, public hospitals
Table 11A.70	Emergency department admitted and non-admitted cost per presentation, 2011-12
Table 11A.71	Emergency department presentations by Urgency Related Groupings (URG) codes - presentations and average cost per presentation
Table 11A.72	Non-admitted service events and average cost per service event

Table 11A.73	Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2013-14
Table 11A.74	Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2013-14
Table 11A.75	Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2013-14
Table 11A.76	Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2013-14
Table 11A.77	Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2013-14
Table 11A.78	Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2013-14
Table 11A.79	Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2013-14
Table 11A.80	Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2013-14
Table 11A.81	NSW patient evaluation of hospital services
Table 11A.82	Victorian patient evaluation of hospital services
Table 11A.83	Queensland patient evaluation of hospital services
Table 11A.84	WA patient evaluation of hospital services
Table 11A.85	SA patient evaluation of hospital services
Table 11A.86	Tasmanian patient evaluation of hospital services
Table 11A.87	ACT patient evaluation of hospital services
Table 11A.88	NT patient evaluation of hospital services
Table 11A.89	NSW selected sentinel events (number)
Table 11A.90	Victoria selected sentinel events (number)
Table 11A.91	Queensland selected sentinel events (number)
Table 11A.92	WA selected sentinel events (number)
Table 11A.93	SA selected sentinel events (number)
Table 11A.94	Tasmania selected sentinel events (number)
Table 11A.95	ACT selected sentinel events (number)
Table 11A.96	NT selected sentinel events (number)

Table 11A.97	Australia selected sentinel events (number)
Table 11A.98	Separations, same day separations, patient days, average length of stay and costs for MDC 14 and MDC 15, public hospitals, Australia, 2012-13
Table 11A.99	Separations by major diagnostic category (AR-DRGs) version 6.0x, public hospitals, 2012-13
Table 11A.100	10 Diagnosis related groups with highest cost, by volume, public hospitals, Australia, 2012-13
Table 11A.101	Mean age of mothers at time of giving birth, public hospitals
Table 11A.102	Intervention rates for selected primiparae, 2013
Table 11A.103	Intervention rates for selected primiparae, NSW
Table 11A.104	Intervention rates for selected primiparae, Victoria
Table 11A.105	Intervention rates for selected primiparae, Queensland
Table 11A.106	Intervention rates for selected primiparae, WA
Table 11A.107	Intervention rates for selected primiparae, SA
Table 11A.108	Intervention rates for selected primiparae, Tasmania
Table 11A.109	Intervention rates for selected primiparae, ACT
Table 11A.110	Intervention rates for selected primiparae, NT
Table 11A.111	Method of birth for selected women giving birth for the first time, 2012
Table 11A.112	Multiparous mothers who have had a previous caesarean section by current method of birth
Table 11A.113	Perineal status after vaginal births
Table 11A.114	Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals
Table 11A.115	Average length of stay for selected maternity AR-DRG (version 6.0x) 2012-13
Table 11A.116	Baby's Apgar scores at five minutes, by birthweight, public hospitals
Table 11A.117	Fetal deaths
Table 11A.118	Neonatal deaths
Table 11A.119	Neonatal, fetal and perinatal death rates, Australia
Table 11A.120	Perinatal deaths
Table 11A.121	Perinatal, neonatal and fetal deaths

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11A Public hospitals — attachment

Definitions for the indicators and descriptors in this attachment are in section 11.8 of the chapter. Unsourced information was obtained from the Australian, State and Territory governments.

Data in this Report are examined by the Health Working Group, but have not been formally audited by the Secretariat.

Data reported in the attachment tables are the most accurate available at the time of data collection. Historical data may have been updated since the last edition of RoGS.

This file is available in Adobe PDF format on the Review web page (www.pc.gov.au/gsp).

Attachment contents

Table 11A.1	Recurrent expenditure, public hospitals (including psychiatric hospitals), (2012-13 dollars, million)
Table 11A.2	Recurrent expenditure, public hospital services, by source of funding, (2012-13 dollars)
Table 11A.3	Recurrent expenditure per person, public hospitals (including psychiatric) (2012-13 dollars)
Table 11A.4	Public hospitals (including psychiatric hospitals) by hospital size
Table 11A.5	Available beds per 1000 people, by region, public hospitals (including psychiatric) (number)
Table 11A.6	Summary of separations, public hospitals
Table 11A.7	Separations, public (non-psychiatric) hospitals
Table 11A.8	Same-day and overnight separations by broad category of service, public hospitals
Table 11A.9	Separations in public hospitals, by age group
Table 11A.10	Separations by hospital sector and Indigenous status of patient
Table 11A.11	Separations per 1000 people, by Indigenous status of patient (number)
Table 11A.12	Average full time equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals)
Table 11A.13	Separations, by type of episode of care, public hospitals (including psychiatric), 2012-13
Table 11A.14	Same-day acute separations for the 50 most common principal diagnoses, public hospitals, states and territories, 2012-13
Table 11A.15	Overnight acute separations, for the 50 most common principal diagnoses, public hospitals, states and territories, 2012-13
Table 11A.16	Patient days, by care type, public and private hospitals, 2012-13
Table 11A.17	Non-admitted patient occasions of service, by type of non-admitted patient care, public hospitals, 2012-13
Table 11A.18	Emergency department waiting times, by triage category, public hospitals
Table 11A.19	Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory
Table 11A.20	Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory
Table 11A.21	Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory
Table 11A.22	Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles
Table 11A.23	Percentage of presentations where the time from presentation to physical departure (Emergency Department (ED) Stay length) is within four hours, by State and Territory
Table 11A.24	Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals
Table 11A.25	Elective surgery waiting times, by speciality of surgeon

Attachment contents

Table 11A.26	Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days)
Table 11A.27	Waiting times for elective surgery in public hospitals, by State and Territory, by remoteness area (days)
Table 11A.28	Waiting times for elective surgery in public hospitals, by State and Territory, by SEIFA IRSD quintiles (days)
Table 11A.29	Elective surgery waiting times, by indicator procedure
Table 11A.30	Classification of elective surgery patients, by clinical urgency category (per cent)
Table 11A.31	NSW elective surgery waiting times by clinical urgency category, public hospitals (per cent)
Table 11A.32	NSW elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.33	Victorian elective surgery waiting times by clinical urgency category, public hospitals (per cent)
Table 11A.34	Victorian elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.35	Queensland elective surgery waiting times, by clinical urgency category, public hospitals (per cent)
Table 11A.36	Queensland elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.37	WA elective surgery waiting times, by clinical urgency category, public hospitals (per cent)
Table 11A.38	WA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.39	SA elective surgery waiting times, by clinical urgency category, public hospitals
Table 11A.40	SA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.41	Tasmanian elective surgery waiting times, by clinical urgency category, public hospitals
Table 11A.42	Tasmania elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.43	ACT elective surgery waiting times, by clinical urgency category, public hospitals
Table 11A.44	ACT elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.45	NT elective surgery waiting times, by clinical urgency category, public hospitals
Table 11A.46	NT elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14
Table 11A.47	Proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission, public hospitals,
Table 11A.48	Separation statistics for selected hospital procedures per 1000 people, all hospitals 2012-13
Table 11A.49	Separation statistics for selected hospital procedures, all hospitals, 2012-13
Table 11A.50	Unplanned hospital readmissions rates

Attachment contents

Table 11A.51	Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2012-13
Table 11A.52	Proportion of accredited beds in public hospitals (per cent)
Table 11A.53	Episodes of Staphylococcus aureus (including MRSA) bacteraemia (SAB) in acute care hospitals, by MRSA and MSSA
Table 11A.54	Separations with an adverse event, public hospitals
Table 11A.55	Separations for falls resulting in patient harm in hospitals, per 1000 separations, 2012-13
Table 11A.56	Nursing workforce (includes midwives), by age group and remoteness area
Table 11A.57	Nursing workforce (includes midwives), by age group
Table 11A.58	Medical practitioner workforce, by age group and remoteness area
Table 11A.59	Medical practitioner workforce, by age group
Table 11A.60	Recurrent cost per casemix-adjusted separation, selected public acute hospitals 2011-12
Table 11A.61	Costs and utilisation by hospital peer group, public hospitals, 2011-12
Table 11A.62	Capital cost per casemix-adjusted separation — indicative estimates for inpatient services at major public acute hospitals, 2011-12
Table 11A.63	Relative stay index for patients in public hospitals, by funding source, 2012-13
Table 11A.64	Relative stay index, indirectly standardised, patients in public hospitals, by medical, surgical and other type of diagnosis related group 2012-13
Table 11A.65	NSW recurrent cost per non-admitted patient occasion of service, public hospitals
Table 11A.66	WA recurrent cost per non-admitted patient occasion of service, public hospitals
Table 11A.67	SA recurrent cost per non-admitted patient occasion of service, public hospitals
Table 11A.68	Tasmania recurrent cost per non-admitted patient occasion of service, public hospitals
Table 11A.69	ACT recurrent cost per non-admitted patient occasion of service, public hospitals
Table 11A.70	Emergency department admitted and non-admitted cost per presentation, 2011-12
Table 11A.71	Emergency department presentations by Urgency Related Groupings (URG) codes - presentations and average cost per presentation
Table 11A.72	Non-admitted service events and average cost per service event
Table 11A.73	Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2013-14
Table 11A.74	Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2013-14
Table 11A.75	Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2013-14

Attachment contents

Table 11A.76	Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2013-14
Table 11A.77	Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2013-14
Table 11A.78	Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2013-14
Table 11A.79	Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2013-14
Table 11A.80	Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2013-14
Table 11A.81	NSW patient evaluation of hospital services
Table 11A.82	Victorian patient evaluation of hospital services
Table 11A.83	Queensland patient evaluation of hospital services
Table 11A.84	WA patient evaluation of hospital services
Table 11A.85	SA patient evaluation of hospital services
Table 11A.86	Tasmanian patient evaluation of hospital services
Table 11A.87	ACT patient evaluation of hospital services
Table 11A.88	NT patient evaluation of hospital services
Table 11A.89	NSW selected sentinel events (number)
Table 11A.90	Victoria selected sentinel events (number)
Table 11A.91	Queensland selected sentinel events (number)
Table 11A.92	WA selected sentinel events (number)
Table 11A.93	SA selected sentinel events (number)
Table 11A.94	Tasmania selected sentinel events (number)
Table 11A.95	ACT selected sentinel events (number)
Table 11A.96	NT selected sentinel events (number)
Table 11A.97	Australia selected sentinel events (number)
Table 11A.98	Separations, same day separations, patient days, average length of stay and costs for MDC 14 and MDC 15, public hospitals, Australia, 2012-13
Table 11A.99	Separations by major diagnostic category (AR-DRGs) version 6.0x, public hospitals, 2012-13
Table 11A.100	10 Diagnosis related groups with highest cost, by volume, public hospitals, Australia, 2012-13
Table 11A.101	Mean age of mothers at time of giving birth, public hospitals
Table 11A.102	Intervention rates for selected primiparae, 2013

Attachment contents

Table 11A.103	Intervention rates for selected primiparae, NSW
Table 11A.104	Intervention rates for selected primiparae, Victoria
Table 11A.105	Intervention rates for selected primiparae, Queensland
Table 11A.106	Intervention rates for selected primiparae, WA
Table 11A.107	Intervention rates for selected primiparae, SA
Table 11A.108	Intervention rates for selected primiparae, Tasmania
Table 11A.109	Intervention rates for selected primiparae, ACT
Table 11A.110	Intervention rates for selected primiparae, NT
Table 11A.111	Method of birth for selected women giving birth for the first time, 2012
Table 11A.112	Multiparous mothers who have had a previous caesarean section by current method of birth
Table 11A.113	Perineal status after vaginal births
Table 11A.114	Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals
Table 11A.115	Average length of stay for selected maternity AR-DRG (version 6.0x) 2012-13
Table 11A.116	Baby's Apgar scores at five minutes, by birthweight, public hospitals
Table 11A.117	Fetal deaths
Table 11A.118	Neonatal deaths
Table 11A.119	Neonatal, fetal and perinatal death rates, Australia
Table 11A.120	Perinatal deaths
Table 11A.121	Perinatal, neonatal and fetal deaths

Table 11A.1 Recurrent expenditure, public hospitals (including psychiatric hospitals), (2012-13 dollars, million) (a), (b)

	NSW (c)	Vic	Qld (d)	WA (e)	SA (f)	Tas (g)	ACT	NT (h)	Aust
2003-04									
Salary and wages	5 807	4 450	2 472	1 541	1 211	299	252	198	16 229
Non-salary	3 731	2 616	1 470	889	836	229	210	122	10 104
Total	9 538	7 066	3 942	2 430	2 047	528	462	319	26 333
2004-05									
Salary and wages	6 125	4 689	2 557	1 665	1 308	348	293	232	17 216
Non-salary	3 940	2 714	1 640	936	872	241	206	130	10 679
Total	10 064	7 402	4 197	2 601	2 180	589	499	362	27 895
2005-06									
Salary and wages	6 488	4 760	2 915	1 728	1 389	388	312	265	18 245
Non-salary	4 024	2 868	1 775	958	896	289	207	139	11 156
Total	10 512	7 628	4 690	2 687	2 285	677	519	404	29 401
2006-07									
Salary and wages	6 607	4 993	3 339	1 950	1 452	412	319	280	19 352
Non-salary	4 163	2 927	1 895	1 098	887	303	228	149	11 650
Total	10 770	7 920	5 235	3 048	2 339	715	547	429	31 002
2007-08									
Salary and wages	6 655	5 304	3 795	2 150	1 575	398	356	287	20 521
Non-salary	4 420	3 071	2 091	1 172	1 087	319	241	155	12 555
Total	11 075	8 375	5 886	3 322	2 662	717	597	442	33 076
2008-09									
Salary and wages	6 933	5 558	4 142	2 366	1 671	452	393	320	21 835
Non-salary	4 385	3 214	2 237	1 246	1 064	317	256	171	12 891
Total	11 318	8 772	6 380	3 612	2 735	768	650	491	34 726
2009-10									
Salary and wages	6 822	5 778	4 516	2 395	1 741	544	401	345	22 542
Non-salary	4 550	3 325	2 383	1 368	1 077	334	273	159	13 469
Total	11 372	9 103	6 899	3 764	2 818	878	674	503	36 011
2010-11									
Salary and wages	7 131	6 178	5 097	2 581	1 825	573	436	371	24 193
Non-salary	5 044	3 542	2 555	1 547	1 267	354	298	172	14 779
Total	12 175	9 720	7 652	4 128	3 093	927	734	543	38 972
2011-12									
Salary and wages	7 749	6 436	5 276	2 855	1 979	585	588	403	25 870
Non-salary	5 529	3 591	2 652	1 652	1 344	357	372	181	15 677
Total	13 277	10 027	7 928	4 507	3 323	942	960	584	41 548
2012-13									
Salary and wages	7 794	6 438	4 922	3 057	1 889	585	647	419	25 751
Non-salary	5 661	3 655	2 735	1 733	1 304	372	341	189	15 989
Total	13 454	10 093	7 656	4 790	3 194	957	988	608	41 741

(a) Expenditure data exclude depreciation.

(b) Recurrent expenditure on the purchase of public hospitals services at the State, or area health service-level, from privately owned and/or operated hospitals is excluded.

(c) NSW hospital expenditure recorded against special purposes and trust funds is excluded.

(d) Queensland pathology services were purchased from a statewide pathology service rather than being provided by hospital employees.

(e) In WA, expenditure on public patients at Joondalup and Peel Health Campuses is included from 2006-07 figures but not in those for previous years.

(f) In SA in 2011-12 there were significant once-off revaluations of other employee related expenses. This reflects as an artificial reduction in expenditure, including for salaries and wages expenditure components, for 2012-13 results.

(g) For 2005-06 data for one hospital are not included.

(h) Interest payments for the NT were not reported

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra; AIHW (2014), *Health expenditure Australia 2012-13*, Health and Welfare Expenditure Series No. 52, Cat. no. HWE 61. Canberra, AIHW.

TABLE 11A.2

Table 11A.2 Recurrent expenditure, public hospital services, by source of funding, (2012-13 dollars) (a), (b)

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA (c)</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT</i>	<i>Aust (e)</i>
2003-04									
Total expenditure									
Government \$'000	7 581 579	6 155 263	3 713 158	2 151 316	1 723 684	431 579	414 474	306 579	22 477 632
Non-government \$'000	793 421	526 316	148 684	123 684	73 684	63 158	35 526	13 158	1 777 632
Expenditure per person									
Government \$ per person	1 142.7	1 256.2	980.0	1 094.3	1 130.3	897.3	1 263.6	1 517.7	1 133.8
Non-government \$ per person	119.6	107.4	39.2	62.9	48.3	131.3	108.3	65.1	89.7
2004-05									
Total expenditure									
Government \$'000	9 028 205	6 657 692	3 801 282	2 437 179	2 133 333	514 103	479 487	383 333	25 434 253
Non-government \$'000	974 359	700 000	92 308	243 590	71 795	33 333	39 744	6 410	2 161 538
Expenditure per person									
Government \$ per person	1 353.8	1 343.1	981.7	1 222.3	1 391.6	1 060.0	1 457.4	1 879.1	1 268.9
Non-government \$ per person	146.1	141.2	23.8	122.2	46.8	68.7	120.8	31.4	107.8
2005-06									
Total expenditure									
Government \$'000	9 894 608	6 579 657	4 767 157	2 578 431	2 231 618	557 598	482 843	401 961	27 547 794
Non-government \$'000	1 012 255	683 824	172 794	171 569	80 882	42 892	73 529	6 127	2 254 902
Expenditure per person									
Government \$ per person	1 472.9	1 309.9	1 202.6	1 270.2	1 444.4	1 142.6	1 445.6	1 941.8	1 356.4
Non-government \$ per person	150.7	136.1	43.6	84.5	52.4	87.9	220.1	29.6	111.0
2006-07									
Total expenditure									
Government \$'000	10 438 679	6 655 660	5 514 151	2 836 085	2 413 915	660 377	576 651	500 000	29 595 519
Non-government \$'000	869 104	739 387	205 189	168 632	94 340	45 991	70 755	9 434	2 201 651
Expenditure per person									

TABLE 11A.2

Table 11A.2 Recurrent expenditure, public hospital services, by source of funding, (2012-13 dollars) (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA (c)</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT</i>	<i>Aust (e)</i>
Government	\$ per person	1 538.3	1 304.0	1 359.5	1 365.5	1 546.4	1 342.2	1 706.1	2 369.7	1 434.9
Non-government	\$ per person	128.1	144.9	50.6	81.2	60.4	93.5	209.3	44.7	106.7
2007-08										
Total expenditure										
Government	\$'000	10 924 485	7 495 423	6 370 709	3 200 229	2 749 428	763 158	678 490	540 046	32 721 968
Non-government	\$'000	1 018 307	724 256	312 357	186 499	155 606	52 632	73 227	16 018	2 538 902
Expenditure per person										
Government	\$ per person	1 586.9	1 441.4	1 531.4	1 498.9	1 742.3	1 538.6	1 972.4	2 488.7	1 557.2
Non-government	\$ per person	147.9	139.3	75.1	87.4	98.6	106.1	212.9	73.8	120.8
2008-09										
Total expenditure										
Government	\$'000	11 265 953	7 713 620	6 786 447	3 469 404	2 825 552	786 644	752 030	519 373	34 119 023
Non-government	\$'000	1 144 479	903 867	391 781	250 649	144 497	66 812	17 465	15 051	2 934 601
Expenditure per person										
Government	\$ per person	1 609.0	1 451.8	1 587.1	1 570.6	1 768.2	1 567.0	2 142.5	2 329.0	1 588.9
Non-government	\$ per person	163.5	170.1	91.6	113.5	90.4	133.1	49.8	67.5	136.7
2009-10										
Total expenditure										
Government	\$'000	11 653 846	8 360 043	7 147 436	3 454 060	2 938 034	819 444	792 735	518 162	35 683 761
Non-government	\$'000	1 211 538	898 504	474 359	227 564	164 530	25 641	17 094	13 889	3 032 051
Expenditure per person										
Government	\$ per person	1 640.9	1 542.7	1 636.7	1 525.6	1 814.7	1 619.5	2 214.3	2 272.6	1 632.2
Non-government	\$ per person	170.6	165.8	108.6	100.5	101.6	50.7	47.7	60.9	138.7
2010-11										
Total expenditure										
Government	\$'000	12 022 129	9 253 952	7 136 986	3 739 726	3 054 795	905 163	856 691	606 955	37 576 396

TABLE 11A.2

Table 11A.2 Recurrent expenditure, public hospital services, by source of funding, (2012-13 dollars) (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA (c)</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT</i>	<i>Aust (e)</i>
Non-government	\$'000	1 286 617	1 014 752	618 546	297 155	168 599	34 773	20 021	12 645	3 453 109
Expenditure per person										
Government	\$ per person	1 674.4	1 683.8	1 608.5	1 612.6	1 871.8	1 774.8	2 347.1	2 638.9	1 695.0
Non-government	\$ per person	179.2	184.6	139.4	128.1	103.3	68.2	54.9	55.0	155.8
2011-12										
Total expenditure										
Government	\$'000	12 514 403	9 359 053	7 505 144	4 295 267	3 427 984	898 148	916 667	673 868	39 590 535
Non-government	\$'000	1 362 140	1 109 053	809 671	113 169	185 185	42 181	23 663	9 259	3 654 321
Expenditure per person										
Government	\$ per person	1 723.3	1 676.3	1 660.8	1 795.7	2 081.4	1 754.2	2 470.8	2 892.1	1 758.3
Non-government	\$ per person	187.6	198.6	179.2	47.3	112.4	82.4	63.8	39.7	162.3
2012-13										
Total expenditure										
Government	\$'000	12 453 000	9 633 000	7 646 000	4 379 000	3 282 000	900 000	913 000	691 000	39 897 000
Non-government	\$'000	1 443 000	939 000	908 000	369 000	219 000	43 000	23 000	19 000	3 963 000
Expenditure per person										
Government	\$ per person	1 693.1	1 695.1	1 658.2	1 765.7	1 974.7	1 757.8	2 415.3	2 891.2	1 740.7
Non-government	\$ per person	196.2	165.2	196.9	148.8	131.8	84.0	60.8	79.5	172.9

(a) Depreciation is included in recurrent expenditure.

(b) Non-government expenditure includes expenditure by health insurance funds, individuals, workers' compensation and compulsory third-party motor vehicle insurers as well as other sources.

(c) In SA in 2011-12 there were significant once-off revaluations of other employee related expenses. This reflects as an artificial reduction in expenditure, including for salaries and wages expenditure components, for 2012-13 results.

(d) The expenditure numbers for the ACT include substantial expenditures for NSW residents, and so the ACT expenditure is overstated.

(e) Components may not add to totals due to rounding.

na Not available.

Table 11A.2 **Recurrent expenditure, public hospital services, by source of funding, (2012-13 dollars) (a), (b)**

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA (c)</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT</i>	<i>Aust (e)</i>
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Source: AIHW various years, Health Expenditure Australia, Health and Welfare Expenditure Series, AIHW, Canberra.

Table 11A.3 Recurrent expenditure per person, public hospitals (including psychiatric) (2012-13 dollars) (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld (c)</i>	<i>WA (d)</i>	<i>SA (e)</i>	<i>Tas (f)</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
2003-04	1 436.9	1 442.0	1 040.5	1 227.4	1 340.9	1 098.5	1 407.0	1 580.0	1 327.1
2004-05	1 508.5	1 493.3	1 083.9	1 296.5	1 421.0	1 214.0	1 516.5	1 774.7	1 390.6
2005-06	1 563.7	1 518.6	1 183.2	1 316.5	1 477.6	1 386.9	1 552.3	1 950.1	1 446.5
2006-07	1 585.9	1 551.7	1 290.6	1 462.2	1 497.0	1 452.5	1 618.8	2 031.3	1 502.1
2007-08	1 594.4	1 610.5	1 414.9	1 551.8	1 686.8	1 446.4	1 736.0	2 037.9	1 568.8
2008-09	1 615.1	1 651.0	1 492.0	1 630.0	1 711.5	1 530.8	1 850.9	2 201.3	1 616.2
2009-10	1 600.0	1 679.8	1 579.8	1 660.0	1 740.8	1 735.6	1 882.6	2 207.9	1 646.5
2010-11	1 694.8	1 768.6	1 724.6	1 778.5	1 892.0	1 817.3	2 010.5	2 359.3	1 757.3
2011-12	1 822.4	1 796.0	1 754.4	1 882.9	2 014.5	1 839.8	2 586.7	2 505.9	1 842.9
2012-13	1 822.8	1 776.0	1 660.5	1 930.6	1 920.5	1 869.2	2 613.5	2 544.2	1 818.9

(a) Expenditure data exclude depreciation and interest payments.

(b) Recurrent expenditure on the purchase of public hospitals services at the State, or area health service-level, from privately owned and/or operated hospitals is not included.

(c) Queensland pathology services were purchased from a statewide pathology service rather than being provided by hospital employees.

(d) In WA, recurrent expenditure per person from 2006-07 includes expenditure on public patients at Joondalup and Peel Health Campuses. Expenditure for these patients is not included in previous years.

(e) In SA in 2011-12 there were significant once-off revaluations of other employee related expenses. This reflects as an artificial reduction in expenditure, including for salaries and wages expenditure components, for 2012-13 results.

(f) In Tasmania, for 2005-06, data for one hospital are not included.

(g) The expenditure numbers for the ACT include substantial expenditures for NSW residents, and so the ACT expenditure is overstated

TABLE 11A.4

Table 11A.4 **Public hospitals (including psychiatric hospitals) by hospital size (a), (b), (c), (d)**

	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (f)</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09									
No. of hospitals									
10 or fewer beds	27	41	72	42	7	18	1	–	208
more than 10 to 50 beds	122	46	64	31	58	7	–	2	330
more than 50 to 100 beds	28	24	10	5	6	–	–	1	74
more than 100 to 200 beds	23	19	10	9	2	1	–	1	65
more than 200 to 500 beds	19	15	9	5	5	1	1	1	56
more than 500 beds	8	4	5	2	2	1	1	–	23
Total	227	149	170	94	80	28	3	5	756
Proportion of total hospitals (%)									
10 or fewer beds	11.9	27.5	42.4	44.7	8.8	64.3	33.3	0.0	27.5
more than 10 to 50 beds	53.7	30.9	37.6	33.0	72.5	25.0	0.0	40.0	43.7
more than 50 to 100 beds	12.3	16.1	5.9	5.3	7.5	0.0	0.0	20.0	9.8
more than 100 beds	22.0	25.5	14.1	17.0	11.3	10.7	66.7	40.0	19.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of available beds									
10 or fewer beds	99	197	270	235	41	99	10	..	951
more than 10 to 50 beds	3 186	1 071	1 466	738	1 468	150	..	40	8 119
more than 50 to 100 beds	2 023	1 724	690	330	460	..	..	60	5 288
more than 100 to 200 beds	3 464	2 795	1 634	1 345	316	130	..	171	9 855
more than 200 to 500 beds	5 752	4 727	2 688	1 435	1 387	330	223	335	16 876
more than 500 beds	5 281	2 354	4 057	1 286	1 201	566	642	..	15 388
Total	19 805	12 869	10 805	5 369	4 874	1 275	875	606	56 478
Proportion of total beds (%)									
10 or fewer beds	0.5	1.5	2.5	4.4	0.8	7.8	1.1	..	1.7
more than 10 to 50 beds	16.1	8.3	13.6	13.7	30.1	11.8	..	6.6	14.4
more than 50 to 100 beds	10.2	13.4	6.4	6.1	9.4	..	..	9.9	9.4
more than 100 beds	73.2	76.7	77.5	75.7	59.6	80.5	98.9	83.5	74.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2009-10									
No. of hospitals									
10 or fewer beds	31	41	74	44	10	14	1	–	215
more than 10 to 50 beds	119	48	62	31	55	5	–	2	322
more than 50 to 100 beds	27	22	10	4	6	2	–	1	72
more than 100 to 200 beds	23	18	10	9	2	1	–	1	64
more than 200 to 500 beds	18	17	9	5	5	1	1	1	57
more than 500 beds	8	4	5	2	2	1	1	–	23
Total	226	150	170	95	80	24	3	5	753
Proportion of total hospitals (%)									
10 or fewer beds	13.7	27.3	43.5	46.3	12.5	58.3	33.3	0.0	28.6

TABLE 11A.4

Table 11A.4 **Public hospitals (including psychiatric hospitals) by hospital size (a), (b), (c), (d)**

	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (f)</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
more than 10 to 50 beds	52.7	32.0	36.5	32.6	68.8	20.8	0.0	40.0	42.8
more than 50 to 100 beds	11.9	14.7	5.9	4.2	7.5	8.3	0.0	20.0	9.6
more than 100 beds	21.7	26.0	14.1	16.8	11.3	12.5	66.7	40.0	19.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of available beds									
10 or fewer beds	130	225	241	245	74	76	10	..	1 001
more than 10 to 50 beds	3 128	1 204	1 415	751	1 378	81	..	52	8 009
more than 50 to 100 beds	1 976	1 613	709	307	462	166	..	60	5 293
more than 100 to 200 beds	3 475	2 562	1 659	1 342	309	130	..	189	9 667
more than 200 to 500 beds	5 612	5 206	2 779	1 432	1 422	330	227	393	17 400
more than 500 beds	5 287	2 376	4 108	1 299	1 214	576	670	..	15 530
Total	19 608	13 186	10 911	5 376	4 859	1 359	907	694	56 900
Proportion of total beds (%)									
10 or fewer beds	0.7	1.7	2.2	4.6	1.5	5.6	1.1	..	1.8
more than 10 to 50 beds	16.0	9.1	13.0	14.0	28.4	6.0	..	7.5	14.1
more than 50 to 100 beds	10.1	12.2	6.5	5.7	9.5	12.2	..	8.6	9.3
more than 100 beds	73.3	76.9	78.3	75.8	60.6	76.2	98.9	83.9	74.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2010-11									
No. of hospitals									
10 or fewer beds	29	40	74	43	11	14	1	–	212
more than 10 to 50 beds	118	50	62	31	54	5	–	2	322
more than 50 to 100 beds	30	22	10	3	6	1	–	1	73
more than 100 to 200 beds	22	19	9	10	3	1	–	1	65
more than 200 to 500 beds	18	16	10	5	4	1	1	1	56
more than 500 beds	9	4	5	2	2	1	1	–	24
Total	226	151	170	94	80	23	3	5	752
Proportion of total hospitals (%)									
10 or fewer beds	12.8	26.5	43.5	45.7	13.8	60.9	33.3	0.0	28.2
more than 10 to 50 beds	52.2	33.1	36.5	33.0	67.5	21.7	0.0	40.0	42.8
more than 50 to 100 beds	13.3	14.6	5.9	3.2	7.5	4.3	0.0	20.0	9.7
more than 100 beds	21.7	25.8	14.1	18.1	11.3	13.0	66.7	40.0	19.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of available beds									
10 or fewer beds	122	209	224	239	51	76	10	–	930
more than 10 to 50 beds	3 026	1 220	1 394	761	1 328	81	–	52	7 862
more than 50 to 100 beds	2 146	1 596	697	226	452	87	–	60	5 263
more than 100 to 200 beds	3 278	2 839	1 505	1 496	519	116	–	183	9 936
more than 200 to 500 beds	5 473	5 065	3 111	1 469	1 262	333	223	367	17 303
more than 500 beds	5 887	2 480	4 186	1 302	1 428	503	693	–	16 478

TABLE 11A.4

Table 11A.4 **Public hospitals (including psychiatric hospitals) by hospital size (a), (b), (c), (d)**

	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (f)</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total	19 931	13 408	11 117	5 492	5 040	1 196	926	662	57 772
Proportion of total beds (%)									
10 or fewer beds	0.6	1.6	2.0	4.4	1.0	6.4	1.1	0.0	1.6
more than 10 to 50 beds	15.2	9.1	12.5	13.9	26.3	6.8	0.0	7.9	13.6
more than 50 to 100 beds	10.8	11.9	6.3	4.1	9.0	7.3	0.0	9.1	9.1
more than 100 beds	73.4	77.4	79.2	77.7	63.7	79.6	98.9	83.1	75.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2011-12									
No. of hospitals									
10 or fewer beds	32	40	74	44	12	14	1	–	217
more than 10 to 50 beds	116	50	62	32	51	5	–	2	318
more than 50 to 100 beds	27	21	10	3	8	1	–	1	71
more than 100 to 200 beds	22	20	8	10	3	1	–	1	65
more than 200 to 500 beds	19	16	10	5	4	1	1	1	57
more than 500 beds	9	4	6	2	2	1	1	–	25
Total	225	151	170	96	80	23	3	5	753
Proportion of total hospitals (%)									
10 or fewer beds	14.2	26.5	43.5	45.8	15.0	60.9	33.3	–	28.8
more than 10 to 50 beds	51.6	33.1	36.5	33.3	63.8	21.7	–	40.0	42.2
more than 50 to 100 beds	12.0	13.9	5.9	3.1	10.0	4.3	–	20.0	9.4
more than 100 beds	22.2	26.5	14.1	17.7	11.3	13.0	66.7	40.0	19.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of available beds									
10 or fewer beds	125	192	223	243	89	76	10	–	958
more than 10 to 50 beds	2 970	1 192	1 415	785	1 279	81	–	54	7 776
more than 50 to 100 beds	1 915	1 480	720	227	639	89	–	60	5 130
more than 100 to 200 beds	3 198	2 840	1 300	1 579	482	115	–	195	9 709
more than 200 to 500 beds	5 868	5 126	2 853	1 521	1 280	324	225	387	17 584
more than 500 beds	5 996	2 540	4 734	1 321	1 464	503	704	–	17 261
Total	20 073	13 370	11 245	5 677	5 232	1 188	939	696	58 420
Proportion of total beds (%)									
10 or fewer beds	0.6	1.4	2.0	4.3	1.7	6.4	1.1	0.0	1.6
more than 10 to 50 beds	14.8	8.9	12.6	13.8	24.4	6.8	0.0	7.8	13.3
more than 50 to 100 beds	9.5	11.1	6.4	4.0	12.2	7.5	0.0	8.6	8.8
more than 100 beds	75.0	78.6	79.0	77.9	61.7	79.3	98.9	83.6	76.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2012-13									
No. of hospitals									
10 or fewer beds	31	39	76	42	22	14	1	–	225
more than 10 to 50 beds	119	50	61	28	41	5	–	2	306

TABLE 11A.4

Table 11A.4 **Public hospitals (including psychiatric hospitals) by hospital size (a), (b), (c), (d)**

	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (f)</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
more than 50 to 100 beds	26	23	8	3	8	1	–	1	70
more than 100 to 200 beds	21	18	8	10	3	1	–	1	62
more than 200 to 500 beds	19	15	12	5	4	2	1	1	59
more than 500 beds	9	5	5	2	2	–	1	–	24
Total	225	150	170	90	80	23	3	5	746
Proportion of total hospitals (%)									
10 or fewer beds	13.8	26.0	44.7	46.7	27.5	60.9	33.3	–	30.2
more than 10 to 50 beds	52.9	33.3	35.9	31.1	51.3	21.7	–	40.0	41.0
more than 50 to 100 beds	11.6	15.3	4.7	3.3	10.0	4.3	–	20.0	9.4
more than 100 beds	21.8	25.3	14.7	18.9	11.3	13.0	66.7	40.0	19.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of available beds									
10 or fewer beds	103	226	244	233	137	76	10	–	1 029
more than 10 to 50 beds	3 045	1 199	1 448	723	1 018	82	–	54	7 569
more than 50 to 100 beds	1 944	1 699	621	226	580	89	–	60	5 218
more than 100 to 200 beds	3 123	2 589	1 294	1 547	444	115	–	183	9 295
more than 200 to 500 beds	5 964	4 663	3 880	1 590	1 280	826	235	367	18 804
more than 500 beds	6 003	3 073	3 786	1 330	1 464	–	741	–	16 396
Total	20 181	13 449	11 273	5 648	4 922	1 188	986	664	58 311
Proportion of total beds (%)									
10 or fewer beds	0.5	1.7	2.2	4.1	2.8	6.4	1.0	–	1.8
more than 10 to 50 beds	15.1	8.9	12.8	12.8	20.7	6.9	–	8.1	13.0
more than 50 to 100 beds	9.6	12.6	5.5	4.0	11.8	7.5	–	9.0	8.9
more than 100 beds	74.8	76.8	79.5	79.1	64.8	79.2	99.0	82.8	76.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospital buildings or campuses.

(b) Size is based on the average number of available beds.

(c) The comparability of bed numbers can be affected by the casemix of hospitals including the extent to which hospitals provide same day admitted services and other specialised services.

(d) A change in definition of average available beds may affect comparison over time.

(e) The count of hospitals in Victoria is a count of the campuses that report data separately to the National Hospital Morbidity Database.

(f) In 2012-13 a large number of SA state-funded aged care beds in country hospitals converted into Commonwealth multi-purpose service places. This has resulted in an apparent decrease in the numbers of available beds between 2011-12 and 2012-13. This has also resulted in hospitals shifting categories, there are more hospitals with 10 or fewer beds in 2012-13.

.. Not applicable. – Nil or rounded to zero.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra.

TABLE 11A.5

Table 11A.5 Available beds per 1000 people, by region, public hospitals (including psychiatric) (number) (a), (b), (c)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA (d)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2003-04									
Metropolitan	2.7	2.3	2.4	2.4	2.7	..	2.1	..	2.5
Rural	3.4	2.7	2.5	2.5	3.7	2.4	..	2.7	2.9
Remote	6.7	2.4	6.3	4.5	7.8	2.6	..	3.0	5.3
Total	2.9	2.4	2.6	2.5	3.2	2.4	2.1	2.9	2.7
2004-05									
Major cities	2.9	2.3	2.4	2.5	2.9	..	2.1	..	2.6
Regional	3.6	2.7	2.5	2.5	3.7	2.7	–	2.7	3.0
Remote	7.3	2.4	6.3	4.5	7.7	2.6	..	3.0	5.3
Total	3.1	2.4	2.6	2.6	3.3	2.7	2.1	2.9	2.8
2005-06									
Major cities	2.7	2.4	2.4	2.4	2.8	..	2.2	..	2.5
Regional	3.3	2.6	2.5	2.4	3.6	2.7	–	2.7	2.8
Remote	6.5	2.4	5.7	3.9	7.6	2.5	..	2.9	4.9
Total	2.9	2.4	2.5	2.5	3.2	2.7	2.2	2.8	2.7
2006-07									
Major cities	2.7	2.3	2.1	2.5	2.7	..	2.4	..	2.5
Regional	3.4	2.7	2.9	2.9	3.6	2.8	–	2.8	3.0
Remote	7.5	2.1	5.6	3.8	7.8	3.0	..	2.9	4.9
Total	2.9	2.4	2.5	2.7	3.1	2.8	2.3	2.8	2.7
2007-08									
Major cities	2.7	2.4	2.3	2.6	2.8	..	2.6	..	2.5
Regional	3.4	2.7	2.9	2.5	3.7	2.6	–	2.9	3.0
Remote	7.7	2.9	4.9	3.2	7.7	3.0	..	2.9	4.5
Total	2.9	2.5	2.6	2.6	3.2	2.6	2.5	2.9	2.7
2008-09									
Metropolitan	2.6	2.3	2.2	2.5	2.7	..	2.5	..	2.5
Rural	3.3	2.7	2.8	2.3	3.4	2.6	..	2.8	2.9
Remote	6.9	3.0	4.9	2.9	7.3	2.1	..	2.8	4.3
Total	2.8	2.4	2.5	2.5	3.0	2.6	2.5	2.8	2.6
2009-10									
Major cities	2.6	2.3	2.3	2.4	2.7	..	2.6	..	2.5
Regional	3.1	2.7	2.6	2.2	3.3	2.7	..	3.1	2.8
Remote	5.7	3.0	4.4	2.9	7.0	2.1	..	3.0	4.0
Total	2.7	2.4	2.5	2.4	3.0	2.7	2.6	3.1	2.6
2010-11									
Major cities	2.6	2.3	2.3	2.4	2.8	..	2.6	..	2.5
Regional	3.1	2.7	2.6	2.2	3.3	2.4	..	2.9	2.8
Remote	5.6	3.0	4.2	2.8	6.7	2.1	..	2.9	3.9
Total	2.8	2.4	2.5	2.4	3.1	2.4	2.6	2.9	2.6

Table 11A.5 **Available beds per 1000 people, by region, public hospitals (including psychiatric) (number) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA (d)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2011-12									
Major cities	2.7	2.3	2.3	2.5	2.9	..	2.6	..	2.5
Regional	3.1	2.7	2.8	2.2	3.6	2.3	..	3.0	2.8
Remote	5.3	2.5	4.1	2.6	6.6	2.2	..	3.1	3.7
Total	2.8	2.4	2.5	2.4	3.2	2.3	2.6	3.0	2.6
2012-13									
Major cities	2.6	2.3	2.4	2.3	2.8	..	2.6	..	2.5
Regional	3.1	2.7	2.5	2.3	3.2	2.3	–	2.8	2.7
Remote	5.3	2.2	4.0	2.5	4.7	2.0	..	2.9	3.4
Total	2.8	2.4	2.5	2.3	3.0	2.3	2.6	2.8	2.6

(a) Population calculated based on a crude rate. Data need to be viewed in the context of the age and sex structure and morbidity and mortality of the population in each jurisdiction. The age and sex structure of the population in each jurisdiction is provided in the 'Statistical appendix' and mortality rates in the 'Health sector summary'.

(b) An 'available bed' is one that is immediately available for exclusive or predominate use by admitted patients. A bed is immediately available for use if it is located in a suitable place for care, with nursing and auxiliary staff available within a reasonable period. Both occupied and unoccupied beds are included. Surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers/beds not normally authorised or funded, and beds designated for same day non-admitted patient care are excluded. Beds in wards that were closed for any reason (except weekend closures for beds/wards staffed and available on weekends only) are also excluded (National Health Data Dictionary, Version 14).

(c) The comparability of bed numbers can be affected by the casemix of hospitals including the extent to which hospitals provide same day admitted services and other specialised services.

(d) In WA, beds available for public patients at Joondalup and Peel Health Campuses are included from 2006-07 figures but not in those for previous years.

.. Not applicable. – Nil or rounded to zero.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra.

TABLE 11A.6

Table 11A.6 Summary of separations, public hospitals (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (c)</i>	<i>NT</i>	<i>Aust</i>
2008-09										
Separations										
Public hospitals	no.	1 505 969	1 379 624	883 340	467 433	374 540	94 892	89 869	95 356	4 891 023
Public acute hospitals	no.	1 500 020	1 379 132	882 933	465 971	372 401	94 226	89 869	95 356	4 879 908
Public psychiatric hospitals	no.	5 949	492	407	1 462	2 139	666	..	..	11 115
Overnight separations										
Public hospitals	no.	844 105	590 087	440 246	227 217	206 420	45 360	41 176	35 533	2 430 144
Public acute hospitals	no.	838 343	589 596	439 839	225 833	204 644	44 700	41 176	35 533	2 419 664
Public psychiatric hospitals	no.	5 762	491	407	1 384	1 776	660	..	..	10 480
Same day separations										
Public hospitals	no.	661 864	789 537	443 094	240 216	168 120	49 532	48 693	59 823	2 460 879
Public acute hospitals	no.	661 677	789 536	443 094	240 138	167 757	49 526	48 693	59 823	2 460 244
Public psychiatric hospitals	no.	187	1	–	78	363	6	..	..	635
Same day separations (per cent of total)										
Public hospitals	%	43.9	57.2	50.2	51.4	44.9	52.2	54.2	62.7	50.3
Public acute hospitals	%	44.1	57.2	50.2	51.5	45.0	52.6	54.2	62.7	50.4
Public psychiatric hospitals	%	3.1	0.2	0.0	5.3	17.0	0.9	..	..	5.7
Separations per 1000 population (d)										
Public hospitals	no.	204.2	247.3	202.1	212.6	216.3	179.0	275.4	487.9	219.3
Public acute hospitals	no.	203.4	247.2	202.0	212.0	215.1	177.7	275.4	487.9	218.8
Public psychiatric hospitals	no.	0.9	0.1	0.1	0.7	1.3	1.3	..	..	0.5
2009-10										
Separations										
Public hospitals	no.	1 542 968	1 424 663	922 970	505 909	383 055	101 673	88 356	99 694	5 069 288
Public acute hospitals	no.	1 536 690	1 424 134	922 581	504 381	381 202	101 038	88 356	99 694	5 058 076
Public psychiatric hospitals	no.	6 278	529	389	1 528	1 853	635	..	..	11 212

TABLE 11A.6

Table 11A.6 Summary of separations, public hospitals (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (c)</i>	<i>NT</i>	<i>Aust</i>
Overnight separations										
Public hospitals	no.	852 671	615 183	453 538	236 231	209 695	50 445	40 729	36 737	2 495 229
Public acute hospitals	no.	846 630	614 655	453 155	234 792	208 195	49 826	40 729	36 737	2 484 719
Public psychiatric hospitals	no.	6 041	528	383	1 439	1 500	619	..	..	10 510
Same day separations										
Public hospitals	no.	690 297	809 480	469 432	269 678	173 360	51 228	47 627	62 957	2 574 059
Public acute hospitals	no.	690 060	809 479	469 426	269 589	173 007	51 212	47 627	62 957	2 573 357
Public psychiatric hospitals	no.	237	1	6	89	353	16	..	..	702
Same day separations (per cent of total)										
Public hospitals	%	44.7	56.8	50.9	53.3	45.3	50.4	53.9	63.2	50.8
Public acute hospitals	%	44.9	56.8	50.9	53.4	45.4	50.7	53.9	63.2	50.9
Public psychiatric hospitals	%	3.8	0.2	1.5	5.8	19.1	2.5	..	..	6.3
Separations per 1000 population (d)										
Public hospitals	no.	204.3	248.8	204.8	222.8	217.3	188.0	263.6	486.8	221.4
Public acute hospitals	no.	203.4	248.7	204.7	222.1	216.2	186.7	263.6	486.8	220.9
Public psychiatric hospitals	no.	0.9	0.1	0.1	0.7	1.1	1.2	..	..	0.5
2010-11										
Separations										
Public hospitals	no.	1 582 804	1 496 041	964 349	548 272	390 154	99 333	93 745	104 434	5 279 132
Public acute hospitals	no.	1 576 866	1 495 555	964 025	546 785	388 483	99 118	93 745	104 434	5 269 011
Public psychiatric hospitals	no.	5 938	486	324	1 487	1 671	215	..	..	10 121
Overnight separations										
Public hospitals	no.	875 005	645 995	472 812	255 849	212 421	49 703	43 849	38 350	2 593 984
Public acute hospitals	no.	869 273	645 515	472 492	254 433	211 101	49 496	43 849	38 350	2 584 509
Public psychiatric hospitals	no.	5 732	480	320	1 416	1 320	207	..	..	9 475
Same day separations										

TABLE 11A.6

Table 11A.6 Summary of separations, public hospitals (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (c)</i>	<i>NT</i>	<i>Aust</i>
Public hospitals	no.	707 799	850 046	491 537	292 423	177 733	49 630	49 896	66 084	2 685 148
Public acute hospitals	no.	707 593	850 040	491 533	292 352	177 382	49 622	49 896	66 084	2 684 502
Public psychiatric hospitals	no.	206	6	4	71	351	8	..	..	646
Same day separations (per cent of total)										
Public hospitals	%	44.7	56.8	51.0	53.3	45.6	50.0	53.2	63.3	50.9
Public acute hospitals	%	44.9	56.8	51.0	53.5	45.7	50.1	53.2	63.3	50.9
Public psychiatric hospitals	%	3.5	1.2	1.2	4.8	21.0	3.7	..	..	6.4
Separations per 1000 population (d)										
Public hospitals	no.	205.7	255.7	209.4	235.2	217.2	181.4	272.3	504.5	225.9
Public acute hospitals	no.	204.8	255.6	209.3	234.6	216.2	180.9	272.3	504.5	225.5
Public psychiatric hospitals	no.	0.8	0.1	0.1	0.6	1.0	0.5	0.0	0.0	0.5
2011-12										
Separations										
Public hospitals	no.	1 660 602	1 543 773	1 001 215	588 143	407 315	99 632	97 455	113 357	5 511 492
Public acute hospitals	no.	1 655 276	1 543 310	1 000 832	586 745	405 462	99 276	97 455	113 357	5 501 713
Public psychiatric hospitals	no.	5 326	463	383	1 398	1 853	356	..	..	9 779
Overnight separations										
Public hospitals	no.	924 308	660 844	496 615	270 866	218 944	49 120	45 138	38 864	2 704 699
Public acute hospitals	no.	919 191	660 387	496 235	269 498	217 482	48 772	45 138	38 864	2 695 567
Public psychiatric hospitals	no.	5 117	457	380	1 368	1 462	348	–	–	9 132
Same day separations										
Public hospitals	no.	736 294	882 929	504 600	317 277	188 371	50 512	52 317	74 493	2 806 793
Public acute hospitals	no.	736 085	882 923	504 597	317 247	187 980	50 504	52 317	74 493	2 806 146
Public psychiatric hospitals	no.	209	6	3	30	391	8	..	..	647
Same day separations (per cent of total)										
Public hospitals	%	44.3	57.2	50.4	53.9	46.2	50.7	53.7	65.7	50.9

TABLE 11A.6

Table 11A.6 Summary of separations, public hospitals (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (c)</i>	<i>NT</i>	<i>Aust</i>
Public acute hospitals	%	44.5	57.2	50.4	54.1	46.4	50.9	53.7	65.7	51.0
Public psychiatric hospitals	%	3.9	1.3	0.8	2.1	21.1	2.2	..	..	6.6
Separations per 1000 population (d)										
Public hospitals	no.	216.1	264.9	220.3	248.8	227.6	179.9	278.8	544.7	236.4
Public acute hospitals	no.	215.3	264.8	220.2	248.2	226.5	179.2	278.8	544.7	236.0
Public psychiatric hospitals	no.	0.8	0.1	0.1	0.6	1.1	0.7	0.0	0.0	0.4
2012-13										
Separations										
Public hospitals	no.	1 716 789	1 429 453	1 044 011	606 809	413 756	106 358	94 712	118 307	5 530 195
Public acute hospitals	no.	1 711 419	1 429 009	1 043 492	605 499	412 239	105 263	94 712	118 307	5 519 940
Public psychiatric hospitals	no.	5 370	444	519	1 310	1 517	1 095	..	..	10 255
Overnight separations										
Public hospitals	no.	947 449	641 888	520 905	279 791	222 508	50 532	44 624	38 818	2 746 515
Public acute hospitals	no.	942 265	641 446	520 432	278 502	221 256	49 453	44 624	38 818	2 736 796
Public psychiatric hospitals	no.	5 184	442	473	1 289	1 252	1 079	..	..	9 719
Same day separations										
Public hospitals	no.	769 340	787 565	523 106	327 018	191 248	55 826	50 088	79 489	2 783 680
Public acute hospitals	no.	769 154	787 563	523 060	326 997	190 983	55 810	50 088	79 489	2 783 144
Public psychiatric hospitals	no.	186	2	46	21	265	16	..	..	536
Same day separations (per cent of total)										
Public hospitals	%	44.8	55.1	50.1	53.9	46.2	52.5	52.9	67.2	50.3
Public acute hospitals	%	44.9	55.1	50.1	54.0	46.3	53.0	52.9	67.2	50.4
Public psychiatric hospitals	%	3.5	0.5	8.9	1.6	17.5	1.5	..	..	5.2
Separations per 1000 population (d)										
Public hospitals	no.	219.6	239.5	224.3	247.9	228.0	189.5	263.7	561.6	232.1
Public acute hospitals	no.	218.9	239.5	224.2	247.3	227.1	187.4	263.7	561.6	231.6

Table 11A.6 **Summary of separations, public hospitals (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (c)</i>	<i>NT</i>	<i>Aust</i>
Public psychiatric hospitals	no.	0.8	0.1	0.1	0.5	0.9	2.1	..	..	0.5

- (a) Separations for which the care type was reported as newborn with no qualified days, and records for hospital boarders and posthumous organ procurement have been excluded.
- (b) There was a change in Victorian admission policy from 1 July 2012 that has impacted the separation time series.
- (c) Data on state of hospitalisation should be interpreted with caution because of cross-border flows of patients. This is particularly the case for the ACT. In 2009–10, about 23 per cent of separations for ACT hospitals were for patients who resided in NSW.
- (d) Figures are directly age-standardised to the June 2001 Australian population.
.. Not applicable.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra.

TABLE 11A.7

Table 11A.7 **Separations, public (non-psychiatric) hospitals (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA (c)</i>	<i>SA (d)</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total separations (no.)										
2003-04	'000	1 314	1 187	721	366	377	81	69	70	4 183
2004-05	'000	1 333	1 223	733	382	363	86	64	76	4 261
2005-06	'000	1 409	1 272	750	393	376	94	72	83	4 451
2006-07	'000	1 451	1 314	784	449	389	97	76	86	4 646
2007-08	'000	1 457	1 351	832	457	366	96	81	90	4 729
2008-09	'000	1 500	1 379	883	466	372	94	90	95	4 880
2009-10	'000	1 537	1 424	923	504	381	101	88	100	5 058
2010-11	'000	1 577	1 496	964	547	388	99	94	104	5 269
2011-12	'000	1 655	1 543	1 001	587	405	99	97	113	5 502
2012-13	'000	1 711	1 429	1 043	605	412	105	95	118	5 520
Overnight separations (no.)										
2003-04	'000	751	535	370	184	189	40	30	29	2 129
2004-05	'000	756	545	377	188	191	45	30	31	2 164
2005-06	'000	792	561	383	194	192	48	33	34	2 237
2006-07	'000	814	577	398	213	197	48	35	34	2 315
2007-08	'000	819	584	424	221	203	45	37	34	2 368
2008-09	'000	838	590	440	226	205	45	41	36	2 420
2009-10	'000	847	615	453	235	208	50	41	37	2 485
2010-11	'000	869	646	472	254	211	49	44	38	2 585
2011-12	'000	919	660	496	269	217	49	45	39	2 696
2012-13	'000	942	641	520	279	221	49	45	39	2 737
Same day separations (no.)										
2003-04	'000	562	652	351	181	187	40	39	41	2 054
2004-05	'000	577	678	356	193	172	42	34	45	2 097
2005-06	'000	617	711	367	200	184	46	39	50	2 214
2006-07	'000	637	737	386	236	192	49	41	52	2 331
2007-08	'000	638	767	408	235	163	51	44	56	2 362
2008-09	'000	662	790	443	240	168	50	49	60	2 460
2009-10	'000	690	809	469	270	173	51	48	63	2 573
2010-11	'000	708	850	492	292	177	50	50	66	2 685
2011-12	'000	736	883	505	317	188	51	52	74	2 806
2012-13	'000	769	788	523	327	191	56	50	79	2 783
Same day separations as a percentage of total separations (%)										
2003-04	%	42.8	55.0	48.7	49.6	49.8	49.9	56.5	58.2	49.1
2004-05	%	43.3	55.4	48.6	50.6	47.4	48.3	53.1	59.2	49.2
2005-06	%	43.8	55.9	48.9	50.8	48.9	49.0	54.7	59.6	49.7
2006-07	%	43.9	56.1	49.2	52.6	49.4	50.5	54.4	60.6	50.2
2007-08	%	43.8	56.8	49.0	51.5	44.6	52.8	54.0	62.0	49.9
2008-09	%	44.1	57.2	50.2	51.5	45.0	52.6	54.2	62.7	50.4
2009-10	%	44.9	56.8	50.9	53.4	45.4	50.7	53.9	63.2	50.9

TABLE 11A.7

Table 11A.7 **Separations, public (non-psychiatric) hospitals (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA (c)</i>	<i>SA (d)</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2010-11	%	44.9	56.8	51.0	53.5	45.7	50.1	53.2	63.3	50.9
2011-12	%	44.5	57.2	50.4	54.1	46.4	50.9	53.7	65.7	51.0
2012-13	%	44.9	55.1	50.1	54.0	46.3	53.0	52.9	67.2	50.4
Total separations (rate per 1000) (e)										
2003-04	no.	191.1	235.0	189.2	190.2	234.2	162.4	235.6	428.9	206.8
2004-05	no.	191.6	238.2	187.9	194.4	224.0	172.2	214.4	456.2	207.3
2005-06	no.	199.8	243.7	187.9	195.7	228.4	185.8	238.4	483.0	212.8
2006-07	no.	204.4	246.6	190.1	217.7	231.5	187.5	244.8	480.1	218.0
2007-08	no.	201.4	247.7	195.6	214.3	215.1	182.7	256.1	486.4	216.9
2008-09	no.	203.4	247.2	202.0	212.0	215.1	177.7	275.4	487.9	218.8
2009-10	no.	203.4	248.7	204.7	222.1	216.2	186.7	263.6	486.8	220.9
2010-11	no.	204.8	255.6	209.3	234.6	216.2	180.9	272.3	504.5	225.5
2011-12	no.	215.3	264.8	220.2	248.2	226.5	179.2	278.8	544.7	236.0
2012-13	no.	218.9	239.5	224.2	247.3	227.1	187.4	263.7	561.6	231.6

(a) Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement.

(b) There was a change in Victorian admission policy from 1 July 2012 that has impacted the separation time series.

(c) In WA, separations for public patients at Joondalup and Peel Health Campuses are included from 2006-07 figures but not in those for previous years.

(d) In SA as of 1 July 2007, all sameday chemotherapy and scopes patients were treated on an outpatient basis. This resulted in a drop in sameday inpatient activity from 2007-08 onwards. In addition to this flexible bronchoscopy patients were treated as outpatients from 1 July 2009.

(e) Rates per 1000 people are directly age standardised to the Australian population at June 2001.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra.

TABLE 11A.8

Table 11A.8 Same-day and overnight separations by broad category of service, public hospitals (a)

	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2009-10									
Same-day separations									
Childbirth	2 334	1 021	1 794	666	468	155	309	192	6 939
Specialist mental health	4 390	434	4 718	582	776	16	166	71	11 153
Emergency									
Surgical	7 525	5 687	2 414	1 997	1 238	204	691	123	19 879
Medical	128 936	145 428	109 633	40 892	31 604	2 231	8 343	7 638	474 705
Other	1 867	939	555	553	186	184	106	22	4 412
Non-emergency									
Surgical	96 644	109 687	52 775	35 500	34 771	8 143	4 314	3 797	345 631
Medical	385 232	464 083	263 294	152 675	96 096	33 425	30 648	49 879	1 475 332
Other	63 369	82 201	34 249	36 813	8 221	6 870	3 050	1 235	236 008
Total same-day separations	690 297	809 480	469 432	269 678	173 360	51 228	47 627	62 957	2 574 059
Overnight separations									
Childbirth	69 348	50 358	40 566	19 561	13 928	3 838	3 740	2 821	204 160
Specialist mental health	30 667	19 306	17 123	9 031	6 943	619	1 191	795	85 675
Emergency									
Surgical	70 281	52 069	34 513	24 027	17 436	2 287	5 085	3 801	209 499
Medical	436 052	282 606	223 399	119 018	110 609	10 319	16 405	20 753	1 219 161
Other	19 051	12 540	7 327	5 109	4 802	501	936	830	51 096
Non-emergency									
Surgical	97 915	92 884	61 491	30 427	28 656	9 862	5 496	2 638	329 369
Medical	122 923	99 073	64 351	27 680	25 212	21 904	7 696	4 825	373 664
Other	6 434	6 347	4 768	1 378	2 109	1 115	180	274	22 605
Total overnight separations	852 671	615 183	453 538	236 231	209 695	50 445	40 729	36 737	2 495 229

TABLE 11A.8

Table 11A.8 Same-day and overnight separations by broad category of service, public hospitals (a)

	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total separations									
Childbirth	71 682	51 379	42 360	20 227	14 396	3 993	4 049	3 013	211 099
Specialist mental health	35 057	19 740	21 841	9 613	7 719	635	1 357	866	96 828
Emergency									
Surgical	77 806	57 756	36 927	26 024	18 674	2 491	5 776	3 924	229 378
Medical	564 988	428 034	333 032	159 910	142 213	12 550	24 748	28 391	1 693 866
Other	20 918	13 479	7 882	5 662	4 988	685	1 042	852	55 508
Non-emergency									
Surgical	194 559	202 571	114 266	65 927	63 427	18 005	9 810	6 435	675 000
Medical	508 155	563 156	327 645	180 355	121 308	55 329	38 344	54 704	1 848 996
Other	69 803	88 548	39 017	38 191	10 330	7 985	3 230	1 509	258 613
Total	1 542 968	1 424 663	922 970	505 909	383 055	101 673	88 356	99 694	5 069 288
Same day separations (% of total separations)									
Childbirth	3.3	2.0	4.2	3.3	3.3	3.9	7.6	6.4	3.3
Specialist mental health	12.5	2.2	21.6	6.1	10.1	2.5	12.2	8.2	11.5
Emergency									
Surgical	9.7	9.8	6.5	7.7	6.6	8.2	12.0	3.1	8.7
Medical	22.8	34.0	32.9	25.6	22.2	17.8	33.7	26.9	28.0
Other	8.9	7.0	7.0	9.8	3.7	26.9	10.2	2.6	7.9
Non-emergency									
Surgical	49.7	54.1	46.2	53.8	54.8	45.2	44.0	59.0	51.2
Medical	75.8	82.4	80.4	84.7	79.2	60.4	79.9	91.2	79.8
Other	90.8	92.8	87.8	96.4	79.6	86.0	94.4	81.8	91.3

TABLE 11A.8

Table 11A.8 Same-day and overnight separations by broad category of service, public hospitals (a)

	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2010-11									
Same-day separations									
Childbirth	2 521	1 053	2 018	604	485	139	295	172	7 287
Specialist mental health	4 054	478	4 689	461	790	7	131	31	10 641
Emergency									
Surgical	7 389	5 907	2 480	2 224	1 246	434	842	164	20 686
Medical	126 629	171 859	113 517	53 409	32 461	3 523	8 679	8 204	518 281
Other	1 585	677	529	588	245	125	124	13	3 886
Non-emergency									
Surgical	99 826	109 628	54 476	37 527	35 393	7 389	4 477	3 890	352 606
Medical	395 545	469 718	277 515	157 769	98 613	30 203	31 761	52 110	1 513 234
Other	70 250	90 726	36 313	39 841	8 500	7 810	3 587	1 500	258 527
Total same-day separations	707 799	850 046	491 537	292 423	177 733	49 630	49 896	66 084	2 685 148
Overnight separations									
Childbirth	69 745	51 012	40 436	20 253	14 098	3 877	3 836	2 876	206 133
Specialist mental health	31 383	19 788	17 609	9 851	7 723	2 166	1 214	832	90 566
Emergency									
Surgical	72 491	54 112	37 342	25 808	18 292	5 337	5 535	4 238	223 155
Medical	454 462	300 851	236 543	130 372	110 240	20 886	18 536	22 058	1 293 948
Other	19 670	12 367	7 891	5 623	4 819	1 326	1 019	850	53 565
Non-emergency									
Surgical	100 550	94 549	62 142	32 440	29 169	7 109	5 935	2 615	334 509
Medical	120 144	106 682	65 653	30 036	26 001	8 538	7 582	4 626	369 262
Other	6 560	6 634	5 196	1 466	2 079	464	192	255	22 846
Total overnight separations	875 005	645 995	472 812	255 849	212 421	49 703	43 849	38 350	2 593 984

TABLE 11A.8

Table 11A.8 Same-day and overnight separations by broad category of service, public hospitals (a)

	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total separations									
Childbirth	72 266	52 065	42 454	20 857	14 583	4 016	4 131	3 048	213 420
Specialist mental health	35 437	20 266	22 298	10 312	8 513	2 173	1 345	863	101 207
Emergency									
Surgical	79 880	60 019	39 822	28 032	19 538	5 771	6 377	4 402	243 841
Medical	581 091	472 710	350 060	183 781	142 701	24 409	27 215	30 262	1 812 229
Other	21 255	13 044	8 420	6 211	5 064	1 451	1 143	863	57 451
Non-emergency									
Surgical	200 376	204 177	116 618	69 967	64 562	14 498	10 412	6 505	687 115
Medical	515 689	576 400	343 168	187 805	124 614	38 741	39 343	56 736	1 882 496
Other	76 810	97 360	41 509	41 307	10 579	8 274	3 779	1 755	281 373
Total	1 582 804	1 496 041	964 349	548 272	390 154	99 333	93 745	104 434	5 279 132
Same day separations (% of total separations)									
Childbirth	3.5	2.0	4.8	2.9	3.3	3.5	7.1	5.6	3.4
Specialist mental health	11.4	2.4	21.0	4.5	9.3	0.3	9.7	3.6	10.5
Emergency									
Surgical	9.3	9.8	6.2	7.9	6.4	7.5	13.2	3.7	8.5
Medical	21.8	36.4	32.4	29.1	22.7	14.4	31.9	27.1	28.6
Other	7.5	5.2	6.3	9.5	4.8	8.6	10.8	1.5	6.8
Non-emergency									
Surgical	49.8	53.7	46.7	53.6	54.8	51.0	43.0	59.8	51.3
Medical	76.7	81.5	80.9	84.0	79.1	78.0	80.7	91.8	80.4
Other	91.5	93.2	87.5	96.5	80.3	94.4	94.9	85.5	91.9

TABLE 11A.8

Table 11A.8 Same-day and overnight separations by broad category of service, public hospitals (a)

	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2011-12									
Same-day separations									
Childbirth	2 921	1 104	2 070	673	564	124	369	209	8 034
Specialist mental health	8 351	930	4 856	491	1 180	5	101	53	15 967
Emergency									
Surgical	8 436	6 486	2 494	2 372	1 298	522	656	139	22 403
Medical	133 043	182 590	124 801	63 325	34 079	3 559	9 847	9 210	560 454
Other	1 873	762	734	588	231	119	133	17	4 457
Non-emergency									
Surgical	102 433	108 908	55 086	38 606	36 677	8 120	4 674	4 004	358 508
Medical	409 794	492 295	282 218	170 483	105 379	30 260	32 984	58 879	1 582 292
Other	69 443	89 854	32 341	40 739	8 963	7 803	3 553	1 982	254 678
Total same-day separations	736 294	882 929	504 600	317 277	188 371	50 512	52 317	74 493	2 806 793
Overnight separations									
Childbirth	69 968	53 259	41 364	20 943	14 581	3 731	4 040	2 983	210 869
Specialist mental health	32 074	20 562	18 626	10 059	7 640	2 169	1 343	857	93 330
Emergency									
Surgical	76 568	56 058	40 147	26 938	18 950	5 381	5 944	4 491	234 477
Medical	469 321	308 907	247 201	139 147	112 626	22 154	19 924	22 416	1 341 696
Other	20 473	12 655	8 398	5 781	4 954	1 245	1 108	893	55 507
Non-emergency									
Surgical	102 891	92 821	63 338	33 019	29 735	6 460	5 822	2 645	336 731
Medical	146 616	110 235	71 888	33 398	28 225	7 568	6 762	4 270	408 962
Other	6 397	6 347	5 653	1 581	2 233	412	195	309	23 127
Total overnight separations	924 308	660 844	496 615	270 866	218 944	49 120	45 138	38 864	2 704 699

TABLE 11A.8

Table 11A.8 Same-day and overnight separations by broad category of service, public hospitals (a)

	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total separations									
Childbirth	72 889	54 363	43 434	21 616	15 145	3 855	4 409	3 192	218 903
Specialist mental health	40 425	21 492	23 482	10 550	8 820	2 174	1 444	910	109 297
<i>Emergency</i>									
Surgical	85 004	62 544	42 641	29 310	20 248	5 903	6 600	4 630	256 880
Medical	602 364	491 497	372 002	202 472	146 705	25 713	29 771	31 626	1 902 150
Other	22 346	13 417	9 132	6 369	5 185	1 364	1 241	910	59 964
<i>Non-emergency</i>									
Surgical	205 324	201 729	118 424	71 625	66 412	14 580	10 496	6 649	695 239
Medical	556 410	602 530	354 106	203 881	133 604	37 828	39 746	63 149	1 991 254
Other	75 840	96 201	37 994	42 320	11 196	8 215	3 748	2 291	277 805
Total	1 660 602	1 543 773	1 001 215	588 143	407 315	99 632	97 455	113 357	5 511 492
Same day separations (% of total separations)									
Childbirth	4.0	2.0	4.8	3.1	3.7	3.2	8.4	6.5	3.7
Specialist mental health	20.7	4.3	20.7	4.7	13.4	0.2	7.0	5.8	14.6
<i>Emergency</i>									
Surgical	9.9	10.4	5.8	8.1	6.4	8.8	9.9	3.0	8.7
Medical	22.1	37.1	33.5	31.3	23.2	13.8	33.1	29.1	29.5
Other	8.4	5.7	8.0	9.2	4.5	8.7	10.7	1.9	7.4
<i>Non-emergency</i>									
Surgical	49.9	54.0	46.5	53.9	55.2	55.7	44.5	60.2	51.6
Medical	73.6	81.7	79.7	83.6	78.9	80.0	83.0	93.2	79.5
Other	91.6	93.4	85.1	96.3	80.1	95.0	94.8	86.5	91.7

TABLE 11A.8

Table 11A.8 Same-day and overnight separations by broad category of service, public hospitals (a)

	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2012-13									
Same-day separations									
Childbirth	2 986	1 263	2 402	742	619	193	459	172	8 836
Specialist mental health	7 982	1 782	4 382	453	936	8	115	54	15 712
Emergency									
Surgical	8 614	5 183	2 747	2 244	1 469	621	733	130	21 741
Medical	144 356	82 596	160 619	63 585	37 051	4 479	9 617	9 915	512 218
Other	2 257	677	946	684	242	137	106	10	5 059
Non-emergency									
Surgical	104 578	108 729	55 371	40 481	36 417	7 958	4 929	4 345	362 808
Medical	428 746	497 409	268 829	176 215	105 138	35 621	30 183	62 570	1 604 711
Other	69 821	89 926	27 810	42 614	9 376	6 809	3 946	2 293	252 595
Total same-day separations	769 340	787 565	523 106	327 018	191 248	55 826	50 088	79 489	2 783 680
Overnight separations									
Childbirth	70 511	54 836	41 693	22 043	14 883	3 650	4 340	3 022	214 978
Specialist mental health	33 461	21 596	19 923	10 878	6 835	2 913	1 438	949	97 993
Emergency									
Surgical	77 439	56 624	42 864	27 707	19 213	5 200	5 789	4 303	239 139
Medical	481 991	286 679	265 820	142 674	115 703	23 095	19 479	22 127	1 357 568
Other	21 019	13 040	9 698	6 097	4 949	1 370	1 163	1 036	58 372
Non-emergency									
Surgical	104 352	92 269	61 634	33 778	28 808	6 351	5 675	2 825	335 692
Medical	151 938	110 432	74 368	35 034	30 032	7 562	6 530	4 261	420 157
Other	6 738	6 412	4 905	1 580	2 085	391	210	295	22 616
Total overnight separations	947 449	641 888	520 905	279 791	222 508	50 532	44 624	38 818	2 746 515

TABLE 11A.8

Table 11A.8 Same-day and overnight separations by broad category of service, public hospitals (a)

	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total separations									
Childbirth	73 497	56 099	44 095	22 785	15 502	3 843	4 799	3 194	223 814
Specialist mental health	41 443	23 378	24 305	11 331	7 771	2 921	1 553	1 003	113 705
<i>Emergency</i>									
Surgical	86 053	61 807	45 611	29 951	20 682	5 821	6 522	4 433	260 880
Medical	626 347	369 275	426 439	206 259	152 754	27 574	29 096	32 042	1 869 786
Other	23 276	13 717	10 644	6 781	5 191	1 507	1 269	1 046	63 431
<i>Non-emergency</i>									
Surgical	208 930	200 998	117 005	74 259	65 225	14 309	10 604	7 170	698 500
Medical	580 684	607 841	343 197	211 249	135 170	43 183	36 713	66 831	2 024 868
Other	76 559	96 338	32 715	44 194	11 461	7 200	4 156	2 588	275 211
Total	1 716 789	1 429 453	1 044 011	606 809	413 756	106 358	94 712	118 307	5 530 195
Same day separations (% of total separations)									
Childbirth	4.1	2.3	5.4	3.3	4.0	5.0	9.6	5.4	3.9
Specialist mental health	19.3	7.6	18.0	4.0	12.0	0.3	7.4	5.4	13.8
<i>Emergency</i>									
Surgical	10.0	8.4	6.0	7.5	7.1	10.7	11.2	2.9	8.3
Medical	23.0	22.4	37.7	30.8	24.3	16.2	33.1	30.9	27.4
Other	9.7	4.9	8.9	10.1	4.7	9.1	8.4	1.0	8.0
<i>Non-emergency</i>									
Surgical	50.1	54.1	47.3	54.5	55.8	55.6	46.5	60.6	51.9
Medical	73.8	81.8	78.3	83.4	77.8	82.5	82.2	93.6	79.3
Other	91.2	93.3	85.0	96.4	81.8	94.6	94.9	88.6	91.8

Table 11A.8 **Same-day and overnight separations by broad category of service, public hospitals (a)**

	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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(a) Separations for which care type was reported as Newborn with no qualified days and records for Hospital boarder or Posthumous organ procurement have been excluded.

(b) There was a change in Victorian admission policy from 1 July 2012 that has impacted the separation time series.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra.

TABLE 11A.9

Table 11A.9 Separations in public hospitals, by age group (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09										
Age group										
Under 1	'000	47.4	29.4	23.5	10.3	9.2	2.1	2.2	2.5	126.5
1 to 4	'000	46.3	32.7	29.1	13.6	12.1	2.0	2.0	3.1	141.0
5 to 14	'000	57.3	44.8	39.4	18.6	13.3	3.3	3.0	3.3	182.9
15 to 24	'000	105.1	93.5	80.7	37.6	29.0	7.7	6.4	7.7	367.7
25 to 34	'000	154.3	142.3	102.5	49.7	37.6	9.5	9.6	10.5	515.9
35 to 44	'000	144.2	144.8	94.2	51.8	40.1	10.0	10.1	16.4	511.7
45 to 54	'000	159.2	161.8	108.3	59.2	42.4	12.9	9.6	20.7	574.1
55 to 64	'000	194.3	203.4	128.5	68.0	48.5	14.3	14.5	18.6	690.0
65 to 74	'000	237.9	231.1	128.7	71.1	54.8	15.1	14.0	9.5	762.3
75 to 84	'000	252.6	219.3	109.1	63.9	62.2	12.9	13.5	2.5	735.8
85 and over	'000	107.4	76.5	39.4	23.7	25.4	5.1	5.0	0.5	283.0
Total	'000	1 506.0	1 379.6	883.3	467.4	374.5	94.9	89.9	95.4	4 891.0
Proportion of total separations										
Under 1	%	3.1	2.1	2.7	2.2	2.4	2.2	2.4	2.6	2.6
1 to 4	%	3.1	2.4	3.3	2.9	3.2	2.1	2.2	3.3	2.9
5 to 14	%	3.8	3.3	4.5	4.0	3.5	3.5	3.3	3.4	3.7
15 to 24	%	7.0	6.8	9.1	8.1	7.7	8.1	7.2	8.1	7.5
25 to 34	%	10.2	10.3	11.6	10.6	10.0	10.0	10.7	11.0	10.5
35 to 44	%	9.6	10.5	10.7	11.1	10.7	10.5	11.3	17.2	10.5
45 to 54	%	10.6	11.7	12.3	12.7	11.3	13.6	10.7	21.8	11.7
55 to 64	%	12.9	14.7	14.5	14.5	12.9	15.1	16.1	19.5	14.1
65 to 74	%	15.8	16.8	14.6	15.2	14.6	15.9	15.5	10.0	15.6
75 to 84	%	16.8	15.9	12.4	13.7	16.6	13.6	15.0	2.6	15.0
85 and over	%	7.1	5.5	4.5	5.1	6.8	5.3	5.6	0.5	5.8
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2009-10										
Age group										
Under 1	'000	46.9	27.3	23.5	10.7	9.2	2.9	2.2	2.8	125.4
1 to 4	'000	47.0	33.1	30.6	14.6	12.2	2.3	1.9	2.9	144.6
5 to 14	'000	58.2	45.2	39.0	18.3	14.0	3.4	3.1	3.2	184.4
15 to 24	'000	104.8	95.5	80.6	39.1	29.5	7.5	6.2	7.5	370.8
25 to 34	'000	154.8	142.5	104.3	52.4	37.7	9.2	9.6	10.7	521.1
35 to 44	'000	145.8	147.0	97.9	54.4	39.3	10.3	9.5	17.4	521.6
45 to 54	'000	161.3	171.2	114.1	64.8	43.0	13.7	9.5	22.3	599.9
55 to 64	'000	203.5	211.9	135.8	75.8	49.9	15.4	14.0	20.9	727.2
65 to 74	'000	247.6	242.5	138.2	77.7	56.9	16.8	14.2	9.1	802.9
75 to 84	'000	259.9	227.3	116.8	71.3	64.2	14.6	12.9	2.2	769.2

TABLE 11A.9

Table 11A.9 Separations in public hospitals, by age group (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
85 and over	'000	113.3	81.2	42.3	26.8	27.3	5.4	5.4	0.5	302.2
Total	'000	1 543.0	1 424.7	923.0	505.9	383.1	101.7	88.4	99.7	5 069.3
Proportion of total separations										
Under 1	%	3.0	1.9	2.5	2.1	2.4	2.9	2.5	2.8	2.5
1 to 4	%	3.0	2.3	3.3	2.9	3.2	2.3	2.2	2.9	2.9
5 to 14	%	3.8	3.2	4.2	3.6	3.7	3.4	3.5	3.2	3.6
15 to 24	%	6.8	6.7	8.7	7.7	7.7	7.4	7.0	7.6	7.3
25 to 34	%	10.0	10.0	11.3	10.4	9.8	9.0	10.9	10.7	10.3
35 to 44	%	9.5	10.3	10.6	10.7	10.3	10.2	10.7	17.4	10.3
45 to 54	%	10.5	12.0	12.4	12.8	11.2	13.5	10.7	22.4	11.8
55 to 64	%	13.2	14.9	14.7	15.0	13.0	15.2	15.8	21.0	14.3
65 to 74	%	16.0	17.0	15.0	15.4	14.9	16.5	16.1	9.2	15.8
75 to 84	%	16.8	16.0	12.7	14.1	16.8	14.4	14.5	2.3	15.2
85 and over	%	7.3	5.7	4.6	5.3	7.1	5.3	6.2	0.5	6.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2010-11										
Age group										
Under 1	'000	40.8	28.4	23.5	12.2	9.1	2.3	2.3	2.6	121.3
1 to 4	'000	47.3	34.6	29.5	16.3	11.7	2.2	2.1	2.9	146.5
5 to 14	'000	59.2	47.2	38.4	20.9	13.4	3.2	3.4	3.3	189.0
15 to 24	'000	106.0	101.7	81.8	42.8	28.8	7.0	7.0	8.1	383.1
25 to 34	'000	157.5	150.8	105.7	56.3	38.3	9.2	10.0	11.9	539.7
35 to 44	'000	146.5	153.5	101.6	58.5	37.5	10.0	10.4	17.3	535.3
45 to 54	'000	166.1	176.1	119.0	68.9	44.0	13.2	10.0	23.2	620.5
55 to 64	'000	209.2	224.1	143.8	82.1	52.6	15.0	14.1	21.8	762.5
65 to 74	'000	256.6	251.1	150.4	83.8	58.3	17.0	15.4	10.1	842.8
75 to 84	'000	269.4	239.5	124.0	75.6	66.3	14.9	12.8	2.8	805.2
85 and over	'000	124.3	89.0	46.5	30.9	30.1	5.4	6.3	0.5	333.1
Total	'000	1 582.7	1 496.0	964.3	548.3	390.2	99.3	93.7	104.4	5 279.0
Proportion of total separations										
Under 1	%	2.6	1.9	2.4	2.2	2.3	2.3	2.5	2.5	2.3
1 to 4	%	3.0	2.3	3.1	3.0	3.0	2.2	2.2	2.8	2.8
5 to 14	%	3.7	3.2	4.0	3.8	3.4	3.2	3.6	3.1	3.6
15 to 24	%	6.7	6.8	8.5	7.8	7.4	7.1	7.4	7.7	7.3
25 to 34	%	10.0	10.1	11.0	10.3	9.8	9.3	10.7	11.4	10.2
35 to 44	%	9.3	10.3	10.5	10.7	9.6	10.0	11.1	16.6	10.1
45 to 54	%	10.5	11.8	12.3	12.6	11.3	13.3	10.6	22.2	11.8
55 to 64	%	13.2	15.0	14.9	15.0	13.5	15.1	15.0	20.8	14.4
65 to 74	%	16.2	16.8	15.6	15.3	15.0	17.1	16.4	9.7	16.0

TABLE 11A.9

Table 11A.9 Separations in public hospitals, by age group (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
75 to 84	%	17.0	16.0	12.9	13.8	17.0	15.0	13.6	2.7	15.3
85 and over	%	7.9	6.0	4.8	5.6	7.7	5.4	6.7	0.5	6.3
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2011-12										
Age group										
Under 1	'000	61.9	29.8	24.8	13.2	9.2	2.5	2.4	2.6	146.5
1 to 4	'000	46.9	34.5	29.9	16.6	11.7	2.1	2.3	3.0	147.0
5 to 14	'000	61.0	47.9	40.3	21.9	14.0	3.2	3.2	3.6	195.1
15 to 24	'000	108.4	105.9	86.2	43.9	29.7	6.7	7.1	8.7	396.5
25 to 34	'000	160.8	157.4	113.4	61.5	39.8	8.9	10.7	12.7	565.1
35 to 44	'000	150.1	155.9	104.1	62.3	38.5	10.1	10.9	19.0	550.9
45 to 54	'000	168.4	178.9	123.3	74.0	47.4	12.8	10.9	24.5	640.2
55 to 64	'000	219.3	228.4	145.0	87.5	55.1	15.2	14.0	24.9	789.4
65 to 74	'000	270.6	265.2	154.0	89.0	60.1	17.2	16.1	10.7	883.0
75 to 84	'000	280.9	245.0	130.2	82.5	69.9	15.6	12.9	3.0	839.9
85 and over	'000	132.3	94.9	50.1	35.8	31.9	5.3	7.0	0.6	357.9
Total	'000	1 660.6	1 543.8	1 001.2	588.1	407.3	99.6	97.5	113.4	5 511.5
Proportion of total separations										
Under 1	%	3.7	1.9	2.5	2.2	2.3	2.5	2.5	2.3	2.7
1 to 4	%	2.8	2.2	3.0	2.8	2.9	2.1	2.4	2.6	2.7
5 to 14	%	3.7	3.1	4.0	3.7	3.4	3.3	3.3	3.2	3.5
15 to 24	%	6.5	6.9	8.6	7.5	7.3	6.7	7.2	7.7	7.2
25 to 34	%	9.7	10.2	11.3	10.5	9.8	8.9	11.0	11.2	10.3
35 to 44	%	9.0	10.1	10.4	10.6	9.5	10.1	11.2	16.8	10.0
45 to 54	%	10.1	11.6	12.3	12.6	11.6	12.9	11.1	21.6	11.6
55 to 64	%	13.2	14.8	14.5	14.9	13.5	15.2	14.3	22.0	14.3
65 to 74	%	16.3	17.2	15.4	15.1	14.8	17.3	16.5	9.5	16.0
75 to 84	%	16.9	15.9	13.0	14.0	17.2	15.6	13.3	2.7	15.2
85 and over	%	8.0	6.1	5.0	6.1	7.8	5.4	7.2	0.5	6.5
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2012-13										
Age group										
Under 1	'000	62.5	28.9	26.5	13.9	9.6	2.6	2.4	2.5	148.9
1 to 4	'000	47.4	31.2	31.8	17.1	12.2	2.4	2.2	2.8	147.0
5 to 14	'000	62.6	42.0	42.3	22.5	15.1	3.3	3.2	3.3	194.4
15 to 24	'000	112.4	86.9	93.8	45.1	29.8	7.0	6.9	8.1	389.9
25 to 34	'000	167.2	139.6	118.9	64.7	40.5	9.2	10.7	13.8	564.6
35 to 44	'000	152.7	138.9	110.1	63.4	39.1	10.0	10.3	19.1	543.6
45 to 54	'000	174.7	162.8	124.3	74.2	47.3	13.6	9.9	26.8	633.6
55 to 64	'000	224.0	211.7	147.1	89.0	55.4	16.6	12.7	25.4	781.8

TABLE 11A.9

Table 11A.9 Separations in public hospitals, by age group (a)

	Unit	NSW	Vic (b)	Qld	WA	SA	Tas	ACT	NT	Aust
65 to 74	'000	283.4	257.7	157.2	94.0	61.5	19.5	16.3	12.0	901.7
75 to 84	'000	289.7	238.4	135.5	83.7	69.3	16.4	13.2	3.8	850.0
85 and over	'000	140.2	91.4	56.6	39.3	33.9	5.7	6.8	0.7	374.7
Total	'000	1 716.8	1 429.5	1 044.0	606.8	413.8	106.4	94.7	118.3	5 530.2
Proportion of total separations										
Under 1	%	3.6	2.0	2.5	2.3	2.3	2.5	2.5	2.1	2.7
1 to 4	%	2.8	2.2	3.0	2.8	2.9	2.3	2.3	2.4	2.7
5 to 14	%	3.6	2.9	4.0	3.7	3.7	3.1	3.4	2.8	3.5
15 to 24	%	6.5	6.1	9.0	7.4	7.2	6.6	7.2	6.8	7.1
25 to 34	%	9.7	9.8	11.4	10.7	9.8	8.7	11.3	11.6	10.2
35 to 44	%	8.9	9.7	10.5	10.5	9.4	9.4	10.9	16.1	9.8
45 to 54	%	10.2	11.4	11.9	12.2	11.4	12.8	10.4	22.7	11.5
55 to 64	%	13.0	14.8	14.1	14.7	13.4	15.6	13.4	21.5	14.1
65 to 74	%	16.5	18.0	15.1	15.5	14.9	18.3	17.2	10.2	16.3
75 to 84	%	16.9	16.7	13.0	13.8	16.7	15.4	14.0	3.2	15.4
85 and over	%	8.2	6.4	5.4	6.5	8.2	5.4	7.2	0.6	6.8
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement.

(b) There was a change in Victorian admission policy from 1 July 2012 that has impacted the separation time series.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra.

TABLE 11A.10

Table 11A.10 Separations by hospital sector and Indigenous status of patient (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (d)</i>
2008-09										
Public hospitals										
Aboriginal and Torres Strait Islander Australians	no.	56 753	12 680	68 708	40 978	18 453	2 452	1 987	66 189	263 761
Other Australians	no.	1 434 823	1 357 081	797 701	426 455	339 592	89 994	86 244	29 165	4 384 817
Not reported	no.	14 393	9 863	16 931	–	16 495	2 446	1 638	2	57 684
Total	no.	1 505 969	1 379 624	883 340	467 433	374 540	94 892	89 869	95 356	4 706 262
Private hospitals										
Aboriginal and Torres Strait Islander Australians	no.	1 459	710	4 426	14 443	1 018	np	np	np	22 056
Other Australians	no.	885 960	800 180	733 180	347 719	240 286	np	np	np	3 007 325
Not reported	no.	19 795	10 130	76 335	–	14 196	np	np	np	120 456
Total	no.	907 214	811 020	813 941	362 162	255 500	np	np	np	3 149 837
Indigenous separations (% of total separations)										
Public hospitals	%	3.8	0.9	7.8	8.8	4.9	2.6	2.2	69.4	5.6
Private hospitals	%	0.2	0.1	0.5	4.0	0.4	np	np	np	0.7
All hospitals	%	2.4	0.6	4.3	6.7	3.1	np	np	np	3.6
Separations in public hospitals (% of total separations)										
Aboriginal and Torres Strait Islander Australians	%	97.5	94.7	93.9	73.9	94.8	np	np	np	92.3
Other Australians	%	61.8	62.9	52.1	55.1	58.6	np	np	np	59.3
2009-10										
Public hospitals										
Aboriginal and Torres Strait Islander Australians	no.	59 468	14 034	73 598	45 197	19 702	3 018	1 893	69 431	281 430
Other Australians	no.	1 469 511	1 401 247	834 350	460 712	344 117	96 445	84 771	30 259	4 540 196
Not reported	no.	13 989	9 382	15 022	–	19 236	2 210	1 692	4	57 633

TABLE 11A.10

Table 11A.10 Separations by hospital sector and Indigenous status of patient (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (d)</i>
Total	no.	1 542 968	1 424 663	922 970	505 909	383 055	101 673	88 356	99 694	4 879 259
Private hospitals										
Aboriginal and Torres Strait Islander Australians	no.	1 535	1 142	3 699	16 405	771	np	np	np	23 552
Other Australians	no.	936 936	871 026	764 773	364 895	239 686	np	np	np	3 177 316
Not reported	no.	22 235	13 608	76 481	–	29 558	np	np	np	141 882
Total	no.	960 706	885 776	844 953	381 300	270 015	np	np	np	3 342 750
Indigenous separations (% of total separations)										
Public hospitals	%	3.9	1.0	8.0	8.9	5.1	3.0	2.1	69.6	5.8
Private hospitals	%	0.2	0.1	0.4	4.3	0.3	np	np	np	0.7
All hospitals	%	2.4	0.7	4.4	6.9	3.1	np	np	np	3.7
Separations in public hospitals (% of total separations)										
Aboriginal and Torres Strait Islander Australians	%	97.5	92.5	95.2	73.4	96.2	np	np	np	92.3
Other Australians	%	61.1	61.7	52.2	55.8	58.9	np	np	np	58.8
2010-11										
Public hospitals										
Aboriginal and Torres Strait Islander Australians	no.	62 385	16 416	78 263	50 135	20 826	2 837	2 128	72 920	300 945
Other Australians	no.	1 507 520	1 468 985	872 535	498 137	351 331	94 652	90 172	31 513	4 730 021
Not reported	no.	12 899	10 640	13 551	–	17 997	1 844	1 445	1	55 088
Total	no.	1 582 804	1 496 041	964 349	548 272	390 154	99 333	93 745	104 434	5 086 054
Private hospitals										
Aboriginal and Torres Strait Islander Australians	no.	1 885	2 696	3 491	17 809	609	np	np	np	26 490
Other Australians	no.	980 483	862 310	790 644	399 952	244 411	np	np	np	3 277 800
Not reported	no.	29 519	10 464	65 067	–	38 261	np	np	np	143 311

TABLE 11A.10

Table 11A.10 Separations by hospital sector and Indigenous status of patient (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (d)</i>
Total	no.	1 011 887	875 470	859 202	417 761	283 281	np	np	np	3 447 601
Indigenous separations (% of total separations)										
Public hospitals	%	3.9	1.1	8.1	9.1	5.3	2.9	2.3	69.8	5.9
Private hospitals	%	0.2	0.3	0.4	4.3	0.2	np	np	np	0.8
All hospitals	%	2.5	0.8	4.5	7.0	3.2	np	np	np	3.8
Separations in public hospitals (% of total separations)										
Aboriginal and Torres Strait Islander Australians	%	97.1	85.9	95.7	73.8	97.2	np	np	np	91.9
Other Australians	%	60.6	63.0	52.5	55.5	59.0	np	np	np	59.1
2011-12										
Public hospitals										
Aboriginal and Torres Strait Islander Australians	no.	69 850	18 741	84 708	55 720	22 831	3 258	2 191	79 649	336 948
Other Australians	no.	1 579 067	1 511 411	905 093	532 423	366 676	94 973	94 151	33 707	5 117 501
Not reported	no.	11 685	13 621	11 414	–	17 808	1 401	1 113	1	57 043
Total	no.	1 660 602	1 543 773	1 001 215	588 143	407 315	99 632	97 455	113 357	5 511 492
Private hospitals										
Aboriginal and Torres Strait Islander Australians	no.	2 639	1 718	3 959	19 586	535	np	np	np	29 170
Other Australians	no.	1 032 182	909 183	832 185	416 733	265 931	np	np	np	3 557 459
Not reported	no.	35 319	6 909	65 044	–	23 514	np	np	np	158 048
Total	no.	1 070 140	917 810	901 188	436 319	289 980	np	np	np	3 744 677
Indigenous separations (% of total separations)										
Public hospitals	%	4.2	1.2	8.5	9.5	5.6	3.3	2.2	70.3	6.1
Private hospitals	%	0.2	0.2	0.4	4.5	0.2	np	np	np	0.8
All hospitals	%	2.7	0.8	4.7	7.4	3.4	np	np	np	4.0
Separations in public hospitals (% of total separations)										

TABLE 11A.10

Table 11A.10 Separations by hospital sector and Indigenous status of patient (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (d)</i>
Aboriginal and Torres Strait Islander Australians	%	96.4	91.6	95.5	74.0	97.7	np	np	np	92.0
Other Australians	%	60.5	62.4	52.1	56.1	58.0	np	np	np	59.0
2012-13										
Public hospitals										
Aboriginal and Torres Strait Islander Australians	no.	75 512	17 735	90 486	56 789	23 492	3 646	2 046	83 122	352 828
Other Australians	no.	1 632 944	1 398 497	942 770	550 013	372 687	101 444	89 574	35 182	5 123 111
Not reported	no.	8 333	13 221	10 755	7	17 577	1 268	3 092	3	54 256
Total	no.	1 716 789	1 429 453	1 044 011	606 809	413 756	106 358	94 712	118 307	5 530 195
Private hospitals										
Aboriginal and Torres Strait Islander Australians	no.	3 135	1 545	4 019	21 149	600	np	np	np	31 810
Other Australians	no.	1 045 488	936 139	866 174	430 793	281 789	np	np	np	3 674 987
Not reported	no.	33 877	5 697	63 468	–	15 770	np	np	np	136 534
Total	no.	1 082 500	943 381	933 661	451 942	298 159	np	np	np	3 843 331
Indigenous separations (% of total separations)										
Public hospitals	%	4.4	1.2	8.7	9.4	5.7	3.4	2.2	70.3	6.4
Private hospitals	%	0.3	0.2	0.4	4.7	0.2	np	np	np	0.8
All hospitals	%	2.8	0.8	4.8	7.4	3.4	np	np	np	4.1
Separations in public hospitals (% of total separations)										
Aboriginal and Torres Strait Islander Australians	%	96.0	92.0	95.7	72.9	97.5	np	np	np	91.7
Other Australians	%	61.0	59.9	52.1	56.1	56.9	np	np	np	58.2

(a) Separations for which the care type was reported as newborn with no qualified days, and records for hospital boarders and posthumous organ procurement have been excluded.

(b) Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete and completeness varies among the jurisdictions.

Table 11A.10 **Separations by hospital sector and Indigenous status of patient (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (d)</i>
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(c) There was a change in Victorian admission policy from 1 July 2012 that has impacted the separation time series.

(d) Total includes data only for NSW, Victoria, Queensland, WA, SA and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. In addition, these jurisdictions are not necessarily representative of the excluded jurisdictions.

– Nil or rounded to zero. **np** Not published.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra.

Table 11A.11 Separations per 1000 people, by Indigenous status of patient (number) (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA (c)</i>	<i>SA</i>	<i>Tas (d)</i>	<i>ACT (d)</i>	<i>NT (d)</i>	<i>Total (e)</i>
2003-04									
Public hospitals									
Aboriginal and Torres Strait Islander people	np	np	710.9	789.3	853.9	np	np	1 286.2	np
All people	np	np	189.3	191.0	235.9	np	np	428.9	np
Private Hospitals									
Aboriginal and Torres Strait Islander people	np	np	70.7	198.3	51.2	np	np	np	np
All people	np	np	167.8	149.8	124.8	np	np	np	np
2004-05									
Public hospitals									
Aboriginal and Torres Strait Islander people	np	np	733.6	821.5	822.2	np	np	1 441.0	907.0
All people	193.3	238.3	188.1	195.2	225.3	np	np	456.2	208.1
Private Hospitals									
Aboriginal and Torres Strait Islander people	np	np	np	np	np	np	np	np	np
All people	106.6	136.1	172.4	155.7	126.5	np	np	np	133.9
2005-06									
Public hospitals									
Aboriginal and Torres Strait Islander people	495.6	np	745.4	845.2	875.0	np	np	1 548.0	792.1
All people	203.2	243.4	186.2	196.4	228.4	np	np	479.1	213.6
Private Hospitals									
Aboriginal and Torres Strait Islander people	np	np	np	np	np	np	np	np	np
All people	108.6	136.4	175.2	157.2	129.2	np	np	np	np
2006-07									
Public hospitals									
Aboriginal and Torres Strait Islander people	528.0	624.3	756.7	876.5	929.3	np	np	1 584.8	787.5
All people	206.0	246.7	190.2	218.4	232.6	np	np	480.1	218.8
Private Hospitals									
Aboriginal and Torres Strait Islander people	np	np	np	np	np	np	np	np	np
All people	112.9	141.3	177.9	138.4	132.5	np	np	np	141.4
2007-08									
Public hospitals									

TABLE 11A.11

Table 11A.11 **Separations per 1000 people, by Indigenous status of patient (number) (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA (c)</i>	<i>SA</i>	<i>Tas (d)</i>	<i>ACT (d)</i>	<i>NT (d)</i>	<i>Total (e)</i>
Aboriginal and Torres Strait Islander people	550.5	629.8	785.7	869.4	908.9	np	np	1 670.7	807.7
All people	202.8	247.8	195.7	215.1	216.4	np	np	486.4	217.6
Private Hospitals									
Aboriginal and Torres Strait Islander people	15.0	53.7	82.0	315.3	91.3	np	np	np	95.1
All people	117.6	145.5	181.5	150.9	138.3	np	np	np	147.0
2008-09									
Public hospitals									
Aboriginal and Torres Strait Islander people	511.5	535.8	732.5	817.3	950.5	np	np	1 656.0	763.3
All people	205.6	249.5	204.4	215.8	217.7	np	np	495.5	221.3
Private Hospitals									
Aboriginal and Torres Strait Islander people	17.3	44.1	64.6	373.1	67.4	np	np	np	81.7
All people	122.9	145.3	186.6	165.3	143.4	np	np	np	145.6
2009-10									
Public hospitals									
Aboriginal and Torres Strait Islander people	522.5	558.1	752.8	901.8	1 005.2	np	np	1 663.8	813.4
All people	207.1	251.4	206.7	225.4	219.9	np	np	500.2	224.3
Private Hospitals									
Aboriginal and Torres Strait Islander people	15.4	62.5	47.4	411.8	52.0	np	np	np	84.0
All people	127.7	155.4	188.0	168.8	149.0	np	np	np	152.6
2010-11									
Public hospitals									
Aboriginal and Torres Strait Islander people	540.7	636.4	765.2	986.6	1 059.5	np	np	1 704.3	848.0
All people	207.3	258.0	211.5	238.3	218.2	np	np	510.6	227.9
Private Hospitals									
Aboriginal and Torres Strait Islander people	18.5	135.5	40.5	453.0	37.7	np	np	np	93.2
All people	131.3	149.6	186.5	180.4	152.8	np	np	np	152.3
2011-12									
Public hospitals									

Table 11A.11 Separations per 1000 people, by Indigenous status of patient (number) (a), (b)

	NSW	Vic	Qld	WA (c)	SA	Tas (d)	ACT (d)	NT (d)	Total (e)
Aboriginal and Torres Strait Islander people	589.5	715.3	794.9	1 074.5	1 129.1	223.5	652.5	1 778.7	877.4
All people	216.1	264.9	220.3	248.8	227.6	179.9	278.8	544.7	236.4
Private Hospitals									
Aboriginal and Torres Strait Islander people	24.6	91.9	43.7	488.0	33.2	np	np	np	95.5
All people	137.7	155.9	195.2	183.1	155.5	np	np	np	158.2
2012-13									
Public hospitals									
Aboriginal and Torres Strait Islander people	650.2	701.3	874.8	1 095.8	1 193.5	244.5	626.6	1 906.4	938.6
All people	223.2	244.7	229.7	256.7	231.1	191.0	271.9	579.7	237.0
Private Hospitals									
Aboriginal and Torres Strait Islander people	29.6	79.0	45.1	523.1	42.9	np	np	np	103.1
All people	139.2	160.0	202.5	189.6	159.2	np	np	np	162.3

(a) Directly age standardised to the Australian population at 30 June 2001.

(b) Identification of Aboriginal and Torres Strait Islander patients has varied among jurisdictions and over time. From 2011-12 Indigenous data are of acceptable quality for all states and territories in public hospitals. From 2006-07 data for NSW, Victoria, Queensland, SA, WA and the NT (public only) were of acceptable quality. For 2005-06 NSW, Queensland, SA, WA and the NT (public only) were of acceptable quality. Prior to this Queensland, SA, WA and the NT (public only) were of acceptable quality. Data for these jurisdictions should be interpreted with caution as there are jurisdictional differences in data quality and changes in hospitalisation rates for Indigenous people over time may include a component due to improved identification. Indigenous status should therefore be interpreted cautiously.

(c) In WA, separations for public patients at Joondalup and Peel Health Campuses are included from 2006-07 public hospitals figures but not in those for previous years.

(d) Private hospital data are suppressed for confidentiality reasons.

(e) The totals include data only for the states and territories that had acceptable data quality. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality.

np Not published.

Source: AIHW (unpublished), National Hospital Morbidity Database.

TABLE 11A.12

Table 11A.12 **Average full time equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals) (a)**

	<i>NSW (b)</i>	<i>Vic (c)</i>	<i>Qld (d)</i>	<i>WA(e)</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
2003-04									
Salaried medical officers	1.0	1.1	1.0	1.0	1.1	0.8	1.0	1.2	1.0
Nurses	4.8	4.9	3.9	4.1	5.1	3.8	4.5	4.7	4.6
Registered nurses	na	na	3.3	3.7	4.0	3.3	3.8	4.5	na
Other nurses	na	na	0.6	0.4	1.1	0.4	0.7	0.2	na
Other personal care staff	na	na	0.2	0.0	na	na	0.4	0.1	na
Diagnostic and allied health	1.5	2.2	0.9	1.1	1.3	0.7	1.1	1.3	1.5
Administrative and clerical	1.7	1.8	1.2	1.6	1.8	1.0	1.6	1.8	1.6
Domestic and other staff	1.8	1.3	1.6	1.9	1.4	2.0	0.6	2.4	1.6
Total staff	10.8	11.4	8.7	9.7	10.7	8.3	9.1	11.5	10.4
2004-05									
Salaried medical officers	1.1	1.1	1.0	1.0	1.1	0.9	1.1	1.3	1.1
Nurses	5.0	4.9	3.9	4.2	5.2	4.5	4.6	5.1	4.7
Registered nurses	na	na	3.3	3.8	4.0	3.9	3.9	4.9	na
Other nurses	na	na	0.6	0.5	1.1	0.5	0.7	0.2	na
Other personal care staff	na	na	0.2	na	na	0.4	0.5	0.1	na
Diagnostic and allied health	1.5	2.3	0.9	1.2	1.3	0.9	1.2	1.4	1.5
Administrative and clerical	1.8	1.8	1.1	1.7	1.8	1.2	1.9	1.9	1.6
Domestic and other staff	1.7	1.4	1.6	1.9	1.3	1.8	0.6	2.6	1.6
Total staff	11.1	11.6	8.6	9.9	10.7	9.7	10.0	12.3	10.6
2005-06									
Salaried medical officers	1.2	1.1	1.0	1.0	1.3	1.0	1.2	1.5	1.1
Nurses	5.3	5.0	4.0	4.3	5.7	4.7	5.0	5.7	4.9
Registered nurses	na	na	3.4	4.0	4.4	4.2	4.3	5.0	na
Other nurses	na	na	0.6	0.3	1.2	0.5	0.8	0.7	na
Other personal care staff	na	na	0.2	na	na	0.2	0.5	0.1	na
Diagnostic and allied health	1.6	2.4	0.9	1.2	1.4	0.9	1.3	1.4	1.6
Administrative and clerical	1.8	1.9	1.2	1.6	1.9	1.3	1.8	2.0	1.7
Domestic and other staff	1.7	1.4	1.6	1.9	1.5	2.1	0.5	2.6	1.6
Total staff	11.5	11.8	8.9	10.1	11.7	10.2	10.4	13.2	10.9
2006-07									
Salaried medical officers	1.1	1.2	1.2	1.2	1.4	1.1	1.3	1.6	1.2
Nurses	5.4	5.2	4.3	4.6	5.6	4.6	5.2	5.7	5.0
Registered nurses	na	na	3.7	4.4	4.4	4.1	4.3	5.1	na
Other nurses	na	na	0.6	0.2	1.2	0.5	0.9	0.7	na
Other personal care staff	na	na	0.2	0.0	0.5	0.2	0.5	0.1	na
Diagnostic and allied health	1.7	2.4	1.1	1.3	1.2	0.9	1.3	1.4	1.7
Administrative and clerical	1.8	2.0	1.4	1.9	2.0	1.5	1.7	2.1	1.8
Domestic and other staff	1.7	1.3	1.8	2.0	1.3	2.0	0.5	2.6	1.6
Total staff	11.7	12.0	10.0	11.0	12.0	10.2	10.5	13.5	11.4

TABLE 11A.12

Table 11A.12 **Average full time equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals) (a)**

	<i>NSW (b)</i>	<i>Vic (c)</i>	<i>Qld (d)</i>	<i>WA(e)</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
2007-08									
Salaried medical officers	1.2	1.3	1.4	1.2	1.4	1.0	1.5	1.6	1.3
Nurses	5.3	5.2	4.6	4.5	5.8	4.5	5.7	5.6	5.1
Registered nurses	na	na	4.0	4.3	4.6	4.0	4.7	5.0	na
Other nurses	na	na	0.6	0.2	1.2	0.5	1.0	0.6	na
Other personal care staff	na	na	0.2	na	0.5	na	0.5	0.1	na
Diagnostic and allied health	1.8	2.4	1.2	1.4	1.3	1.1	1.4	1.5	1.7
Administrative and clerical	1.6	2.1	1.5	1.9	1.9	1.3	1.8	2.0	1.8
Domestic and other staff	1.4	1.3	1.8	2.0	1.2	2.0	0.5	2.6	1.5
Total staff	11.4	12.2	10.6	11.0	12.1	9.9	11.4	13.3	11.4
2008-09									
Salaried medical officers	1.2	1.4	1.4	1.3	1.5	1.5	1.8	1.7	1.4
Nurses	5.4	5.4	4.6	4.7	6.1	4.9	5.8	6.1	5.2
Registered nurses	na	na	na	na	na	na	na	na	na
Other nurses	na	na	na	na	na	na	na	na	na
Other personal care staff	na	na	0.2	na	0.5	na	0.5	0.1	na
Diagnostic and allied health	1.7	2.4	1.1	1.4	1.2	1.0	1.5	1.5	1.7
Administrative and clerical	1.6	2.1	1.5	1.9	1.9	1.6	2.0	2.0	1.8
Domestic and other staff	1.3	1.2	1.7	1.9	1.2	2.2	0.5	2.6	1.4
Total staff	11.1	12.5	10.5	11.2	12.3	11.2	12.2	14.0	11.5
2009-10									
Salaried medical officers	1.3	1.4	1.4	1.4	1.6	1.8	1.7	1.7	1.4
Nurses	5.2	5.5	4.6	4.7	6.3	5.3	5.8	6.7	5.2
Registered nurses	na	na	na	na	na	na	na	na	na
Other nurses	na	na	na	na	na	na	na	na	na
Other personal care staff	na	na	0.2	na	0.5	na	0.5	0.0	0.1
Diagnostic and allied health	1.6	2.5	1.1	1.2	1.2	1.0	1.5	1.6	1.6
Administrative and clerical	1.6	2.1	1.5	1.9	1.8	2.0	2.0	2.1	1.7
Domestic and other staff	1.3	1.3	1.7	1.8	1.1	2.1	0.5	2.7	1.4
Total staff	10.9	12.7	10.5	11.0	12.6	12.3	12.0	14.9	11.5
2010-11									
Salaried medical officers	1.3	1.5	1.6	1.4	1.6	1.9	1.8	1.9	1.5
Nurses	5.2	5.7	5.1	4.8	6.4	5.5	5.9	6.7	5.4
Registered nurses	na	na	na	na	na	na	na	na	na
Other nurses	na	na	na	na	na	na	na	na	na
Other personal care staff	na	na	0.3	na	0.6	na	0.6	0.0	0.1
Diagnostic and allied health	1.5	2.6	1.2	1.2	1.2	1.1	1.6	1.6	1.7
Administrative and clerical	1.6	2.1	1.7	2.0	2.1	2.1	2.1	2.0	1.9
Domestic and other staff	1.1	1.3	1.8	1.9	1.1	2.1	0.5	2.7	1.4
Total staff	10.8	13.2	11.6	11.2	12.9	12.7	12.4	15.0	11.9

Table 11A.12 Average full time equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals) (a)

	<i>NSW (b)</i>	<i>Vic (c)</i>	<i>Qld (d)</i>	<i>WA(e)</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
2011-12									
Salaried medical officers	1.4	1.5	1.7	1.5	1.7	1.7	1.8	2.0	1.5
Nurses	5.4	5.7	5.1	4.9	6.5	5.3	6.7	6.9	5.5
Registered nurses	na	na	na	na	na	na	na	na	na
Other nurses	na	na	na	na	na	na	na	na	na
Other personal care staff	na	na	0.3	na	0.5	na	0.6	0.0	0.1
Diagnostic and allied health	1.4	2.6	1.2	1.3	1.1	1.1	2.5	1.7	1.7
Administrative and clerical	1.6	2.2	1.7	2.0	2.0	2.2	2.6	2.1	1.9
Domestic and other staff	1.1	1.3	1.8	1.8	1.0	2.1	0.0	2.8	1.4
Total staff	11.0	13.3	11.9	11.5	12.7	12.4	14.2	15.6	12.0
2012-13									
Salaried medical officers	1.4	1.5	1.6	1.5	1.7	1.5	2.1	2.1	1.5
Nurses	5.6	5.6	4.7	5.0	6.5	5.1	7.2	7.1	5.4
Registered nurses	na	na	na	na	na	na	na	na	na
Other nurses	na	na	na	na	na	na	na	na	na
Other personal care staff	na	–	0.2	–	0.5	na	0.8	0.0	0.1
Diagnostic and allied health	1.6	2.5	1.1	1.3	1.1	1.2	2.8	1.7	1.7
Administrative and clerical	1.7	2.1	1.5	2.1	2.0	2.2	2.1	2.1	1.9
Domestic and other staff	1.1	1.3	1.7	1.9	0.9	2.1	0.2	2.7	1.4
Total staff	11.5	13.0	10.8	11.8	12.8	12.1	15.1	15.7	12.0

- (a) Where average FTE staff numbers are not available for a financial year, staff numbers on the last day of the financial year are used (for example, 30 June 2009, for 2008-09). Staff contracted to provide products (rather than labour) are not included. Numbers per 1000 people are calculated from population estimates for each financial year (table AA.2).
- (b) For NSW, 'other personal care staff' are included in 'diagnostic and allied health' and 'domestic and other staff'.
- (c) For Victoria, FTEs may be slightly understated. 'Other personal care staff' are included in 'domestic and other staff'.
- (d) Queensland pathology services staff employed by the state pathology service are not included.
- (e) Many WA hospitals were unable to provide a split between nurse categories and these have been reported as registered nurses.

Table 11A.12 **Average full time equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals) (a)**

	NSW (b)	Vic (c)	Qld (d)	WA (e)	SA	Tas (f)	ACT (g)	NT	Aust
(f)	In Tasmania in 2006-07 data for two small hospitals are not included. Tasmanian 'other personal care' staff are included in 'domestic and other staff'.								
(g)	Caution should be used in comparing data for the ACT with other jurisdictions as the ACT workforce serves many residents of southern NSW in addition to ACT residents, while only ACT residents are captured in the denominator.								

na Not available.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra; ABS (unpublished), Australian Demographic Statistics, December Quarter 2012, Cat. no. 3101.0; table AA.2.

TABLE 11A.13

Table 11A.13 Separations, by type of episode of care, public hospitals (including psychiatric), 2012-13 (a)

	Unit	NSW	Vic (b)	Qld	WA	SA	Tas	ACT	NT	Aust
2008-09										
Number of separations										
Acute care	no.	1 437 796	1 332 252	842 765	450 300	359 088	91 658	82 785	93 271	4 689 915
Rehabilitation care	no.	26 400	13 821	17 574	8 923	6 907	1 168	2 681	401	77 875
Palliative care	no.	9 345	5 652	5 457	1 245	1 298	304	609	352	24 262
Geriatric evaluation										
and management	no.	2 348	12 250	1 336	708	377	44	1 244	–	18 307
Psychogeriatric care	no.	669	2 001	525	716	265	165	53	–	4 394
Maintenance care	no.	6 391	802	5 547	1 895	2 767	464	1 369	402	19 637
Newborn total	no.	77 150	54 476	45 160	22 143	15 450	3 934	4 136	3 478	225 927
Newborn — unqualified										
days only	no.	54 139	41 630	35 353	18 497	11 612	2 845	3 009	2 566	169 651
Other admitted care	no.	–	–	329	–	–	–	1	18	348
Not reported	no.	9	–	–	–	–	–	–	–	9
Total (c)	no.	1 560 108	1 421 254	918 693	485 930	386 152	97 737	92 878	97 922	5 060 674
Total (d)	no.	1 505 969	1 379 624	883 340	467 433	374 540	94 892	89 869	95 356	4 891 023
Proportion of total separations										
Acute care	%	95.5	96.6	95.4	96.3	95.9	96.6	92.1	97.8	95.9
Rehabilitation care	%	1.8	1.0	2.0	1.9	1.8	1.2	3.0	0.4	1.6
Palliative care	%	0.6	0.4	0.6	0.3	0.3	0.3	0.7	0.4	0.5
Geriatric evaluation										
and management	%	0.2	0.9	0.2	0.2	0.1	–	1.4	–	0.4
Psychogeriatric care	%	–	0.1	0.1	0.2	0.1	0.2	0.1	–	0.1
Maintenance care	%	0.4	0.1	0.6	0.4	0.7	0.5	1.5	0.4	0.4
Newborn excluding unqualified days	%	1.5	0.9	1.1	0.8	1.0	1.1	1.3	1.0	1.2

TABLE 11A.13

Table 11A.13 Separations, by type of episode of care, public hospitals (including psychiatric), 2012-13 (a)

	Unit	NSW	Vic (b)	Qld	WA	SA	Tas	ACT	NT	Aust
Other admitted care	%	–	–	–	–	–	–	–	–	–
Not reported	%	–	–	–	–	–	–	–	–	–
Total (d)	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2009-10										
Number of separations										
Acute care	no.	1 468 941	1 377 417	880 728	489 249	366 576	97 527	81 422	97 365	4 859 225
Rehabilitation care	no.	29 312	14 796	18 786	8 511	6 510	1 358	2 788	614	82 675
Palliative care	no.	10 279	6 208	5 953	1 284	1 627	310	651	321	26 633
Geriatric evaluation										
and management	no.	3 689	13 250	1 671	668	1 327	35	639	31	21 310
Psychogeriatric care	no.	744	–	544	708	260	48	31	1	2 336
Maintenance care	no.	6 936	811	5 150	1 430	2 794	479	1 640	384	19 624
Newborn total	no.	76 982	55 875	45 393	22 467	15 454	4 364	4 453	3 487	228 475
Newborn — unqualified										
days only	no.	53 920	43 694	35 515	18 408	11 493	2 533	3 268	2 544	171 375
Other admitted care	no.	–	–	260	–	–	85	–	35	380
Not reported	no.	5	–	–	–	–	–	–	–	5
Total (c)	no.	1 596 888	1 468 357	958 485	524 317	394 548	104 206	91 624	102 238	5 240 663
Total (d)	no.	1 542 968	1 424 663	922 970	505 909	383 055	101 673	88 356	99 694	5 069 288
Proportion of total separations										
Acute care	%	95.2	96.7	95.4	96.7	95.7	95.9	92.2	97.7	95.9
Rehabilitation care	%	1.9	1.0	2.0	1.7	1.7	1.3	3.2	0.6	1.6
Palliative care	%	0.7	0.4	0.6	0.3	0.4	0.3	0.7	0.3	0.5
Geriatric evaluation										
and management	%	0.2	0.9	0.2	0.1	0.3	–	0.7	–	0.4
Psychogeriatric care	%	–	–	0.1	0.1	0.1	–	–	–	–

TABLE 11A.13

Table 11A.13 Separations, by type of episode of care, public hospitals (including psychiatric), 2012-13 (a)

	Unit	NSW	Vic (b)	Qld	WA	SA	Tas	ACT	NT	Aust
Maintenance care	%	0.4	0.1	0.6	0.3	0.7	0.5	1.9	0.4	0.4
Newborn excluding unqualified days	%	1.5	0.9	1.1	0.8	1.0	1.8	1.3	0.9	1.1
Other admitted care	%	—	—	—	—	—	0.1	—	—	—
Not reported	%	—	—	—	—	—	—	—	—	—
Total (d)	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2010-11										
Number of separations										
Acute care	no.	1 510 980	1 446 301	919 598	529 774	371 880	96 124	86 828	102 340	5 063 825
Rehabilitation care	no.	30 832	14 776	19 385	9 496	7 664	1 114	2 718	441	86 426
Palliative care	no.	10 919	6 659	6 599	1 234	1 678	217	629	320	28 255
Geriatric evaluation										
and management	no.	5 624	15 293	2 172	804	1 701	141	707	42	26 484
Psychogeriatric care	no.	808	—	596	730	288	1	21	1	2 445
Maintenance care	no.	7 919	621	5 863	1 384	2 803	437	1 570	292	20 889
Newborn total	no.	77 737	56 535	45 530	23 273	15 693	4 548	4 557	3 545	231 418
Newborn — unqualified										
days only	no.	62 019	44 278	35 563	18 423	11 553	3 267	3 286	2 623	181 012
Other admitted care	no.	—	—	169	—	—	14	1	76	260
Not reported	no.	4	134	—	—	—	4	—	—	142
Total (c)	no.	1 644 823	1 540 319	999 912	566 695	401 707	102 600	97 031	107 057	5 460 144
Total (d)	no.	1 582 804	1 496 041	964 349	548 272	390 154	99 333	93 745	104 434	5 279 132
Proportion of total separations										
Acute care	%	95.5	96.7	95.4	96.6	95.3	96.8	92.6	98.0	95.9
Rehabilitation care	%	1.9	1.0	2.0	1.7	2.0	1.1	2.9	0.4	1.6
Palliative care	%	0.7	0.4	0.7	0.2	0.4	0.2	0.7	0.3	0.5

TABLE 11A.13

Table 11A.13 Separations, by type of episode of care, public hospitals (including psychiatric), 2012-13 (a)

	Unit	NSW	Vic (b)	Qld	WA	SA	Tas	ACT	NT	Aust
Geriatric evaluation										
and management	%	0.4	1.0	0.2	0.1	0.4	0.1	0.8	–	0.5
Psychogeriatric care	%	0.1	–	0.1	0.1	0.1	–	–	–	–
Maintenance care	%	0.5	–	0.6	0.3	0.7	0.4	1.7	0.3	0.4
Newborn excluding unqualified days	%	1.0	0.8	1.0	0.9	1.1	1.3	1.4	0.9	1.0
Other admitted care	%	–	–	–	–	–	–	–	0.1	–
Not reported	%	–	–	–	–	–	–	–	–	–
Total (d)	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2011-12										
Number of separations										
Acute care	no.	1 564 100	1 490 776	947 980	566 072	387 421	95 999	91 177	111 520	5 255 045
Rehabilitation care	no.	31 964	14 954	24 068	11 511	9 205	910	2 603	347	95 562
Palliative care	no.	12 371	7 191	7 333	1 456	1 492	476	648	293	31 260
Geriatric evaluation										
and management	no.	5 907	16 963	3 712	1 554	1 597	324	374	20	30 451
Psychogeriatric care	no.	827	–	472	732	255	54	42	–	2 382
Maintenance care	no.	8 671	553	6 859	1 411	3 037	384	1 210	146	22 271
Newborn total	no.	78 731	58 981	46 498	24 112	16 258	4 132	4 862	3 704	237 278
Newborn — unqualified days only	no.	42 116	45 672	35 804	18 705	11 950	2 670	3 483	2 806	163 206
Other admitted care	no.	135	–	97	–	–	13	22	133	400
Not reported	no.	12	27	–	–	–	10	–	–	49
Total (c)	no.	1 702 718	1 589 445	1 037 019	606 848	419 265	102 302	100 938	116 163	5 674 698
Total (d)	no.	1 660 602	1 543 773	1 001 215	588 143	407 315	99 632	97 455	113 357	5 511 492
Proportion of total separations										

TABLE 11A.13

Table 11A.13 Separations, by type of episode of care, public hospitals (including psychiatric), 2012-13 (a)

	Unit	NSW	Vic (b)	Qld	WA	SA	Tas	ACT	NT	Aust
Acute care	%	94.2	96.6	94.7	96.2	95.1	96.4	93.6	98.4	95.3
Rehabilitation care	%	1.9	1.0	2.4	2.0	2.3	0.9	2.7	0.3	1.7
Palliative care	%	0.7	0.5	0.7	0.2	0.4	0.5	0.7	0.3	0.6
Geriatric evaluation and management	%	0.4	1.1	0.4	0.3	0.4	0.3	0.4	–	0.6
Psychogeriatric care	%	–	–	–	0.1	0.1	0.1	–	–	–
Maintenance care	%	0.5	–	0.7	0.2	0.7	0.4	1.2	0.1	0.4
Newborn excluding unqualified days	%	2.2	0.9	1.1	0.9	1.1	1.5	1.4	0.8	1.3
Other admitted care	%	–	–	–	–	–	–	–	0.1	–
Not reported	%	–	–	–	–	–	–	–	–	–
Total (d)	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2012-13										
Number of separations										
Acute care	no.	1 614 570	1 375 204	984 757	583 629	393 762	102 023	88 879	116 574	5 259 398
Rehabilitation care	no.	35 533	15 264	27 012	11 564	10 069	911	2 608	259	103 220
Palliative care	no.	13 129	7 342	8 404	1 518	1 411	553	600	315	33 272
Geriatric evaluation and management	no.	6 497	17 920	4 606	1 964	1 479	266	456	96	33 284
Psychogeriatric care	no.	809	–	472	792	268	114	28	2	2 485
Maintenance care	no.	9 590	470	7 494	1 412	2 290	866	777	163	23 062
Newborn total	no.	78 805	60 763	47 382	25 544	16 726	4 045	5 166	3 665	242 096
Newborn — unqualified days only	no.	42 145	47 510	36 118	19 614	12 249	2 467	3 807	2 832	166 742
Other admitted care	no.	1	–	2	–	–	6	5	65	79
Not reported	no.	–	–	–	–	–	41	–	–	41

TABLE 11A.13

Table 11A.13 Separations, by type of episode of care, public hospitals (including psychiatric), 2012-13 (a)

	Unit	NSW	Vic (b)	Qld	WA	SA	Tas	ACT	NT	Aust
Total (c)	no.	1 758 934	1 476 963	1 080 129	626 423	426 005	108 825	98 519	121 139	5 696 937
Total (d)	no.	1 716 789	1 429 453	1 044 011	606 809	413 756	106 358	94 712	118 307	5 530 195
Proportion of total separations										
Acute care	%	94.0	96.2	94.3	96.2	95.2	95.9	93.8	98.5	95.1
Rehabilitation care	%	2.1	1.1	2.6	1.9	2.4	0.9	2.8	0.2	1.9
Palliative care	%	0.8	0.5	0.8	0.3	0.3	0.5	0.6	0.3	0.6
Geriatric evaluation										
and management	%	0.4	1.3	0.4	0.3	0.4	0.3	0.5	0.1	0.6
Psychogeriatric care	%	–	–	–	0.1	0.1	0.1	–	–	–
Maintenance care	%	0.6	–	0.7	0.2	0.6	0.8	0.8	0.1	0.4
Newborn excluding unqualified days	%	2.1	0.9	1.1	1.0	1.1	1.5	1.4	0.7	1.4
Other admitted care	%	–	–	–	–	–	–	–	0.1	–
Not reported	%	–	–	–	–	–	–	–	–	–
Total (d)	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Excludes records for hospital boarders or posthumous organ procurement.

(b) There was a change in Victorian admission policy from 1 July 2012 that has impacted the separation time series.

(c) Total separations include 'newborn unqualified days only', which are not normally included as admitted patient care.

(d) Total separations exclude 'newborn unqualified days only', which are not normally included as admitted patient care.

– Nil or rounded to zero.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra.

TABLE 11A.14

Table 11A.14 Same-day acute separations(a), for the 50 most common principal diagnoses, public hospitals, states and territories, 2012-13 (a)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Separations (no.)									
Z49 Care involving dialysis	322 117	284 187	165 015	104 156	66 702	16 179	21 917	57 277	1 037 550
Z51 Other medical care	3 942	88 490	13 001	30 660	593	3 422	816	670	141 594
R07 Pain in throat and chest	14 435	13 593	15 186	7 434	4 337	592	1 595	589	57 761
H26 Other cataract	18 460	14 451	6 315	9 152	5 770	1 177	1 222	736	57 283
R10 Abdominal and pelvic pain	11 336	8 218	9 542	5 711	1 968	569	798	523	38 665
C44 Other malignant neoplasms of skin	5 334	6 214	6 236	2 391	2 764	690	179	183	23 991
Z08 Follow-up examination after treatment for malignant neoplasms	5 544	6 779	3 682	2 761	1 332	430	161	108	20 797
Z45 Adjustment and management of implanted device	2 257	4 937	5 543	2 028	703	2 854	558	131	19 011
K92 Other diseases of digestive system	7 540	3 958	2 536	3 521	319	413	172	203	18 662
D50 Iron deficiency anaemia	4 004	5 987	2 552	2 877	1 302	641	270	161	17 794
Z09 Follow-up examination after treatment for conditions other than malignant neoplasms	4 814	5 807	2 624	2 957	683	407	251	132	17 675
A09 Other gastroenteritis and colitis of infectious and unspecified origin	4 357	2 828	3 844	2 003	809	94	231	148	14 314
K21 Gastro-oesophageal reflux disease	4 451	3 994	1 691	2 442	262	324	242	148	13 554
R19 Other symptoms and signs involving the digestive system and abdomen	4 648	3 490	1 298	2 902	40	385	105	181	13 049
G35 Multiple sclerosis	1 679	6 952	1 436	1 454	162	887	340	47	12 957
D64 Other anaemias	3 103	4 484	1 425	2 025	1 222	373	50	83	12 765
Z46 Fitting and adjustment of other devices	2 725	4 281	2 705	1 394	825	401	166	112	12 609
D12 Benign neoplasm of colon, rectum, anus and anal canal	4 336	4 393	1 028	1 831	29	276	138	159	12 190
K29 Gastritis and duodenitis	3 852	3 577	2 179	1 547	272	108	98	327	11 960
K02 Dental caries	3 154	3 230	2 349	1 101	1 281	442	135	245	11 937

TABLE 11A.14

Table 11A.14 Same-day acute separations(a), for the 50 most common principal diagnoses, public hospitals, states and territories, 2012-13 (a)

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
G56	Mononeuropathies of upper limb	3 521	3 340	1 932	1 125	1 373	293	111	92	11 787
N92	Excessive, frequent and irregular menstruation	3 168	3 195	2 423	1 014	1 113	261	171	139	11 484
M54	Dorsalgia	2 563	3 201	2 735	1 512	1 024	80	187	95	11 397
S01	Open wound of head	3 205	2 146	2 952	1 651	683	87	188	425	11 337
I48	Atrial fibrillation and flutter	3 027	2 434	2 359	1 427	1 098	153	284	91	10 873
K50	Crohn's disease [regional enteritis]	1 711	4 595	1 720	1 018	536	338	782	92	10 792
S62	Fracture at wrist and hand level	4 209	2 947	1 471	813	380	272	533	133	10 758
Z47	Other orthopaedic follow-up care	3 314	2 551	2 589	1 060	501	200	251	157	10 623
I20	Angina pectoris	2 703	2 052	2 846	1 357	925	194	248	92	10 417
Z12	Special screening examination for neoplasms	3 272	3 404	869	2 343	na	256	114	92	10 350
N20	Calculus of kidney and ureter	3 502	2 882	2 100	1 019	467	157	168	50	10 345
Z30	Contraceptive management	2 461	3 016	1 093	1 651	1 521	371	34	104	10 251
N39	Other disorders of urinary system	2 729	2 277	2 858	1 249	706	111	190	104	10 224
I84	Haemorrhoids	3 346	3 254	979	1 492	590	240	157	136	10 194
O99	Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium	3 196	727	4 124	938	484	57	73	369	9 968
M23	Internal derangement of knee	2 806	2 881	1 226	1 143	1 359	245	130	96	9 886
S52	Fracture of forearm	3 847	1 153	2 459	972	475	76	401	131	9 514
R55	Syncope and collapse	2 638	1 987	2 434	1 086	942	80	217	68	9 452
F32	Depressive episode	2 528	2 544	1 713	779	987	678	24	77	9 330
G61	Inflammatory polyneuropathy	2 162	3 506	1 511	1 162	303	260	115	35	9 054
R31	Unspecified haematuria	2 013	2 471	1 640	1 374	837	218	133	39	8 725
D80	Immunodeficiency with predominantly antibody defects	2 466	3 003	1 298	854	382	290	323	23	8 639
E83	Disorders of mineral metabolism	1 003	4 406	631	1 283	90	530	38	287	8 268
O80	Single spontaneous delivery	2 774	1 171	2 288	673	574	177	403	169	8 229

TABLE 11A.14

Table 11A.14 Same-day acute separations(a), for the 50 most common principal diagnoses, public hospitals, states and territories, 2012-13 (a)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
O04 Medical abortion	655	2 646	112	593	3 349	39	34	701	8 129
K57 Diverticular disease of intestine	2 466	3 127	1 171	870	109	162	78	106	8 089
J45 Asthma	2 108	1 803	2 409	562	633	212	111	102	7 940
K01 Embedded and impacted teeth	1 430	3 129	1 070	632	1 251	183	184	6	7 885
F10 Mental and behavioural disorders due to use of alcohol	1 362	692	2 673	1 790	703	26	101	528	7 875
S61 Open wound of wrist and hand	3 213	1 742	1 260	586	243	117	287	147	7 595
Other	246 349	229 230	202 463	102 312	70 081	18 738	13 784	12 576	895 533
Total	757 835	787 362	509 595	326 687	185 094	55 765	49 298	79 425	2 751 061
Separations (per cent)									
Z49 Care involving dialysis	42.5	36.1	32.4	31.9	36.0	29.0	44.5	72.1	37.7
Z51 Other medical care	0.5	11.2	2.6	9.4	0.3	6.1	1.7	0.8	5.1
R07 Pain in throat and chest	1.9	1.7	3.0	2.3	2.3	1.1	3.2	0.7	2.1
H26 Other cataract	2.4	1.8	1.2	2.8	3.1	2.1	2.5	0.9	2.1
R10 Abdominal and pelvic pain	1.5	1.0	1.9	1.7	1.1	1.0	1.6	0.7	1.4
C44 Other malignant neoplasms of skin	0.7	0.8	1.2	0.7	1.5	1.2	0.4	0.2	0.9
Z08 Follow-up examination after treatment for malignant neoplasms	0.7	0.9	0.7	0.8	0.7	0.8	0.3	0.1	0.8
Z45 Adjustment and management of implanted device	0.3	0.6	1.1	0.6	0.4	5.1	1.1	0.2	0.7
K92 Other diseases of digestive system	1.0	0.5	0.5	1.1	0.2	0.7	0.3	0.3	0.7
D50 Iron deficiency anaemia	0.5	0.8	0.5	0.9	0.7	1.1	0.5	0.2	0.6
Z09 Follow-up examination after treatment for conditions other than malignant neoplasms	0.6	0.7	0.5	0.9	0.4	0.7	0.5	0.2	0.6
A09 Other gastroenteritis and colitis of infectious and unspecified origin	0.6	0.4	0.8	0.6	0.4	0.2	0.5	0.2	0.5

TABLE 11A.14

Table 11A.14 **Same-day acute separations(a), for the 50 most common principal diagnoses, public hospitals, states and territories, 2012-13 (a)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
K21	Gastro-oesophageal reflux disease	0.6	0.5	0.3	0.7	0.1	0.6	0.5	0.2	0.5
R19	Other symptoms and signs involving the digestive system and abdomen	0.6	0.4	0.3	0.9	0.0	0.7	0.2	0.2	0.5
G35	Multiple sclerosis	0.2	0.9	0.3	0.4	0.1	1.6	0.7	0.1	0.5
D64	Other anaemias	0.4	0.6	0.3	0.6	0.7	0.7	0.1	0.1	0.5
Z46	Fitting and adjustment of other devices	0.4	0.5	0.5	0.4	0.4	0.7	0.3	0.1	0.5
D12	Benign neoplasm of colon, rectum, anus and anal canal	0.6	0.6	0.2	0.6	0.0	0.5	0.3	0.2	0.4
K29	Gastritis and duodenitis	0.5	0.5	0.4	0.5	0.1	0.2	0.2	0.4	0.4
K02	Dental caries	0.4	0.4	0.5	0.3	0.7	0.8	0.3	0.3	0.4
G56	Mononeuropathies of upper limb	0.5	0.4	0.4	0.3	0.7	0.5	0.2	0.1	0.4
N92	Excessive, frequent and irregular menstruation	0.4	0.4	0.5	0.3	0.6	0.5	0.3	0.2	0.4
M54	Dorsalgia	0.3	0.4	0.5	0.5	0.6	0.1	0.4	0.1	0.4
S01	Open wound of head	0.4	0.3	0.6	0.5	0.4	0.2	0.4	0.5	0.4
I48	Atrial fibrillation and flutter	0.4	0.3	0.5	0.4	0.6	0.3	0.6	0.1	0.4
K50	Crohn's disease [regional enteritis]	0.2	0.6	0.3	0.3	0.3	0.6	1.6	0.1	0.4
S62	Fracture at wrist and hand level	0.6	0.4	0.3	0.2	0.2	0.5	1.1	0.2	0.4
Z47	Other orthopaedic follow-up care	0.4	0.3	0.5	0.3	0.3	0.4	0.5	0.2	0.4
I20	Angina pectoris	0.4	0.3	0.6	0.4	0.5	0.3	0.5	0.1	0.4
Z12	Special screening examination for neoplasms	0.4	0.4	0.2	0.7	na	0.5	0.2	0.1	0.4
N20	Calculus of kidney and ureter	0.5	0.4	0.4	0.3	0.3	0.3	0.3	0.1	0.4
Z30	Contraceptive management	0.3	0.4	0.2	0.5	0.8	0.7	0.1	0.1	0.4
N39	Other disorders of urinary system	0.4	0.3	0.6	0.4	0.4	0.2	0.4	0.1	0.4
I84	Haemorrhoids	0.4	0.4	0.2	0.5	0.3	0.4	0.3	0.2	0.4
O99	Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium	0.4	0.1	0.8	0.3	0.3	0.1	0.1	0.5	0.4

TABLE 11A.14

Table 11A.14 Same-day acute separations(a), for the 50 most common principal diagnoses, public hospitals, states and territories, 2012-13 (a)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
M23 Internal derangement of knee	0.4	0.4	0.2	0.3	0.7	0.4	0.3	0.1	0.4
S52 Fracture of forearm	0.5	0.1	0.5	0.3	0.3	0.1	0.8	0.2	0.3
R55 Syncope and collapse	0.3	0.3	0.5	0.3	0.5	0.1	0.4	0.1	0.3
F32 Depressive episode	0.3	0.3	0.3	0.2	0.5	1.2	0.0	0.1	0.3
G61 Inflammatory polyneuropathy	0.3	0.4	0.3	0.4	0.2	0.5	0.2	0.0	0.3
R31 Unspecified haematuria	0.3	0.3	0.3	0.4	0.5	0.4	0.3	0.0	0.3
D80 Immunodeficiency with predominantly antibody defects	0.3	0.4	0.3	0.3	0.2	0.5	0.7	0.0	0.3
E83 Disorders of mineral metabolism	0.1	0.6	0.1	0.4	0.0	1.0	0.1	0.4	0.3
O80 Single spontaneous delivery	0.4	0.1	0.4	0.2	0.3	0.3	0.8	0.2	0.3
O04 Medical abortion	0.1	0.3	0.0	0.2	1.8	0.1	0.1	0.9	0.3
K57 Diverticular disease of intestine	0.3	0.4	0.2	0.3	0.1	0.3	0.2	0.1	0.3
J45 Asthma	0.3	0.2	0.5	0.2	0.3	0.4	0.2	0.1	0.3
K01 Embedded and impacted teeth	0.2	0.4	0.2	0.2	0.7	0.3	0.4	0.0	0.3
F10 Mental and behavioural disorders due to use of alcohol	0.2	0.1	0.5	0.5	0.4	0.0	0.2	0.7	0.3
S61 Open wound of wrist and hand	0.4	0.2	0.2	0.2	0.1	0.2	0.6	0.2	0.3
Total	67.5	70.9	60.3	68.7	62.1	66.4	72.0	84.2	67.4

(a) Includes separations for which the care type was reported as 'acute' or 'newborn with qualified days', or was not reported.

na Not available.

Source: AIHW 2014, *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145, AIHW, Canberra.

TABLE 11A.15

Table 11A.15 **Overnight acute separations, for the 50 most common principal diagnoses, public hospitals, states and territories, 2012-13 (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Patient days (no.)									
O80 Single spontaneous delivery	39 449	29 411	24 196	11 567	7 716	1 933	2 137	1 799	118 208
O82 Single delivery by caesarean section	18 483	15 390	11 118	6 123	4 476	1 014	1 199	772	58 575
R07 Pain in throat and chest	20 380	11 503	13 368	4 957	6 026	642	602	688	58 166
J44 Other chronic obstructive pulmonary disease	18 104	10 292	9 416	4 022	4 446	1 159	554	780	48 773
J18 Pneumonia, organism unspecified	16 632	11 498	8 497	4 703	4 014	1 003	743	937	48 027
R10 Abdominal and pelvic pain	13 642	9 442	6 638	3 661	3 151	710	585	418	38 247
I21 Acute myocardial infarction	12 037	8 597	8 686	3 710	2 872	899	758	429	37 988
L03 Cellulitis	12 771	8 028	7 831	3 750	2 565	593	527	799	36 864
K80 Cholelithiasis	12 496	9 120	6 917	3 483	2 686	786	562	388	36 438
I50 Heart failure	13 176	8 639	6 084	3 299	3 023	863	430	451	35 965
N39 Other disorders of urinary system	13 218	7 216	7 313	3 608	3 087	472	550	398	35 862
I48 Atrial fibrillation and flutter	10 551	5 681	5 083	2 219	2 404	446	363	331	27 078
I20 Angina pectoris	9 355	5 054	6 286	2 450	2 658	582	303	339	27 027
K35 Acute appendicitis	8 414	6 193	5 426	2 844	1 848	513	550	338	26 126
J45 Asthma	9 215	6 344	4 007	2 115	2 299	330	325	304	24 939
O81 Single delivery by forceps and vacuum extractor	7 498	7 310	3 777	2 838	1 719	426	629	238	24 435
A09 Other gastroenteritis and colitis of infectious and unspecified origin	9 473	5 182	4 182	2 276	2 021	344	238	441	24 157
S52 Fracture of forearm	8 324	5 203	3 799	2 370	1 541	453	517	450	22 657
T81 Complications of procedures, not elsewhere classified	7 662	5 175	4 142	2 597	1 706	492	419	399	22 592
S72 Fracture of femur	8 276	5 168	3 785	2 259	1 636	576	430	162	22 292
F20 Schizophrenia	6 907	4 769	4 437	2 043	1 657	445	242	333	20 833
R55 Syncope and collapse	7 724	4 306	3 890	1 631	2 387	394	266	149	20 747
S82 Fracture of lower leg, including ankle	6 902	4 728	3 806	2 334	1 355	461	477	368	20 431

TABLE 11A.15

Table 11A.15 **Overnight acute separations, for the 50 most common principal diagnoses, public hospitals, states and territories, 2012-13 (a)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
P07	Disorders related to short gestation and low birth weight, not elsewhere classified	5 417	4 616	3 580	2 122	1 585	350	493	305	18 468
K56	Paralytic ileus and intestinal obstruction without hernia	6 617	4 147	3 141	1 618	1 396	355	295	143	17 712
F10	Mental and behavioural disorders due to use of alcohol	6 497	2 664	3 314	2 596	1 386	287	473	412	17 629
F32	Depressive episode	5 362	4 106	2 670	2 345	2 097	319	214	130	17 243
J22	Unspecified acute lower respiratory infection	6 142	2 995	2 780	2 587	1 552	238	175	392	16 861
J21	Acute bronchiolitis	6 079	2 775	3 024	1 815	1 464	267	253	433	16 110
E11	Type 2 diabetes mellitus	5 066	3 606	3 242	1 780	1 557	245	188	394	16 078
F43	Reaction to severe stress, and adjustment disorders	5 911	2 454	2 525	3 051	1 575	315	111	136	16 078
G47	Sleep disorders	2 328	7 288	3 221	1 044	1 452	435	72	38	15 878
K57	Diverticular disease of intestine	5 385	3 782	3 124	1 614	1 199	293	299	130	15 826
M17	Gonarthrosis [arthrosis of knee]	5 937	3 401	2 477	1 990	1 212	289	277	108	15 691
K40	Inguinal hernia	5 636	4 029	2 430	1 474	1 196	312	242	122	15 441
I63	Cerebral infarction	5 258	4 086	2 273	1 405	1 389	408	222	87	15 128
A41	Other sepsis	6 188	3 964	2 235	1 195	639	296	284	150	14 951
L02	Cutaneous abscess, furuncle and carbuncle	4 111	2 205	3 577	2 218	852	118	153	1 283	14 517
M54	Dorsalgia	5 168	3 751	2 552	1 169	1 201	260	144	64	14 309
K85	Acute pancreatitis	4 679	3 412	2 632	1 612	893	311	239	320	14 098
J35	Chronic diseases of tonsils and adenoids	4 107	4 054	2 045	1 365	1 551	281	201	185	13 789
K92	Other diseases of digestive system	5 331	3 009	2 276	1 131	1 075	262	167	125	13 376
S06	Intracranial injury	4 403	2 966	2 837	1 360	1 071	245	236	187	13 305
K59	Other functional intestinal disorders	4 397	2 938	2 504	1 496	1 128	222	167	100	12 952
S42	Fracture of shoulder and upper arm	4 538	3 274	2 226	1 306	867	238	292	165	12 906
Z38	Liveborn infants according to place of birth	12 042	247	85	356	61	12	19	35	12 857
R56	Convulsions, not elsewhere classified	3 864	2 712	2 249	1 292	861	253	158	297	11 686

TABLE 11A.15

Table 11A.15 **Overnight acute separations, for the 50 most common principal diagnoses, public hospitals, states and territories, 2012-13 (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
G45 Transient cerebral ischaemic attacks and related syndromes	4 495	2 450	2 233	984	842	207	178	83	11 472
B34 Viral infection of unspecified site	4 332	2 225	1 977	1 657	820	113	122	143	11 389
N20 Calculus of kidney and ureter	3 417	2 597	2 460	1 018	1 090	181	225	70	11 058
Other	459 999	317 093	254 053	138 413	113 841	25 229	21 635	20 234	1 350 497
Total	893 395	601 095	486 426	262 872	213 145	47 877	40 940	37 982	2 583 732

Patient days (per cent)

O80 Single spontaneous delivery	4.4	4.9	5.0	4.4	3.6	4.0	5.2	4.7	4.6
O82 Single delivery by caesarean section	2.1	2.6	2.3	2.3	2.1	2.1	2.9	2.0	2.3
R07 Pain in throat and chest	2.3	1.9	2.7	1.9	2.8	1.3	1.5	1.8	2.3
J44 Other chronic obstructive pulmonary disease	2.0	1.7	1.9	1.5	2.1	2.4	1.4	2.1	1.9
J18 Pneumonia, organism unspecified	1.9	1.9	1.7	1.8	1.9	2.1	1.8	2.5	1.9
R10 Abdominal and pelvic pain	1.5	1.6	1.4	1.4	1.5	1.5	1.4	1.1	1.5
I21 Acute myocardial infarction	1.3	1.4	1.8	1.4	1.3	1.9	1.9	1.1	1.5
L03 Cellulitis	1.4	1.3	1.6	1.4	1.2	1.2	1.3	2.1	1.4
K80 Cholelithiasis	1.4	1.5	1.4	1.3	1.3	1.6	1.4	1.0	1.4
I50 Heart failure	1.5	1.4	1.3	1.3	1.4	1.8	1.1	1.2	1.4
N39 Other disorders of urinary system	1.5	1.2	1.5	1.4	1.4	1.0	1.3	1.0	1.4
I48 Atrial fibrillation and flutter	1.2	0.9	1.0	0.8	1.1	0.9	0.9	0.9	1.0
I20 Angina pectoris	1.0	0.8	1.3	0.9	1.2	1.2	0.7	0.9	1.0
K35 Acute appendicitis	0.9	1.0	1.1	1.1	0.9	1.1	1.3	0.9	1.0
J45 Asthma	1.0	1.1	0.8	0.8	1.1	0.7	0.8	0.8	1.0
O81 Single delivery by forceps and vacuum extractor	0.8	1.2	0.8	1.1	0.8	0.9	1.5	0.6	0.9
A09 Other gastroenteritis and colitis of infectious and unspecified origin	1.1	0.9	0.9	0.9	0.9	0.7	0.6	1.2	0.9

TABLE 11A.15

Table 11A.15 **Overnight acute separations, for the 50 most common principal diagnoses, public hospitals, states and territories, 2012-13 (a)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
S52	Fracture of forearm	0.9	0.9	0.8	0.9	0.7	0.9	1.3	1.2	0.9
T81	Complications of procedures, not elsewhere classified	0.9	0.9	0.9	1.0	0.8	1.0	1.0	1.1	0.9
S72	Fracture of femur	0.9	0.9	0.8	0.9	0.8	1.2	1.1	0.4	0.9
F20	Schizophrenia	0.8	0.8	0.9	0.8	0.8	0.9	0.6	0.9	0.8
R55	Syncope and collapse	0.9	0.7	0.8	0.6	1.1	0.8	0.6	0.4	0.8
S82	Fracture of lower leg, including ankle	0.8	0.8	0.8	0.9	0.6	1.0	1.2	1.0	0.8
P07	Disorders related to short gestation and low birth weight, not elsewhere classified	0.6	0.8	0.7	0.8	0.7	0.7	1.2	0.8	0.7
K56	Paralytic ileus and intestinal obstruction without hernia	0.7	0.7	0.6	0.6	0.7	0.7	0.7	0.4	0.7
F10	Mental and behavioural disorders due to use of alcohol	0.7	0.4	0.7	1.0	0.7	0.6	1.2	1.1	0.7
F32	Depressive episode	0.6	0.7	0.5	0.9	1.0	0.7	0.5	0.3	0.7
J22	Unspecified acute lower respiratory infection	0.7	0.5	0.6	1.0	0.7	0.5	0.4	1.0	0.7
J21	Acute bronchiolitis	0.7	0.5	0.6	0.7	0.7	0.6	0.6	1.1	0.6
E11	Type 2 diabetes mellitus	0.6	0.6	0.7	0.7	0.7	0.5	0.5	1.0	0.6
F43	Reaction to severe stress, and adjustment disorders	0.7	0.4	0.5	1.2	0.7	0.7	0.3	0.4	0.6
G47	Sleep disorders	0.3	1.2	0.7	0.4	0.7	0.9	0.2	0.1	0.6
K57	Diverticular disease of intestine	0.6	0.6	0.6	0.6	0.6	0.6	0.7	0.3	0.6
M17	Gonarthrosis [arthrosis of knee]	0.7	0.6	0.5	0.8	0.6	0.6	0.7	0.3	0.6
K40	Inguinal hernia	0.6	0.7	0.5	0.6	0.6	0.7	0.6	0.3	0.6
I63	Cerebral infarction	0.6	0.7	0.5	0.5	0.7	0.9	0.5	0.2	0.6
A41	Other sepsis	0.7	0.7	0.5	0.5	0.3	0.6	0.7	0.4	0.6
L02	Cutaneous abscess, furuncle and carbuncle	0.5	0.4	0.7	0.8	0.4	0.2	0.4	3.4	0.6
M54	Dorsalgia	0.6	0.6	0.5	0.4	0.6	0.5	0.4	0.2	0.6
K85	Acute pancreatitis	0.5	0.6	0.5	0.6	0.4	0.6	0.6	0.8	0.5
J35	Chronic diseases of tonsils and adenoids	0.5	0.7	0.4	0.5	0.7	0.6	0.5	0.5	0.5

TABLE 11A.15

Table 11A.15 **Overnight acute separations, for the 50 most common principal diagnoses, public hospitals, states and territories, 2012-13 (a)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
K92	Other diseases of digestive system	0.6	0.5	0.5	0.4	0.5	0.5	0.4	0.3	0.5
S06	Intracranial injury	0.5	0.5	0.6	0.5	0.5	0.5	0.6	0.5	0.5
K59	Other functional intestinal disorders	0.5	0.5	0.5	0.6	0.5	0.5	0.4	0.3	0.5
S42	Fracture of shoulder and upper arm	0.5	0.5	0.5	0.5	0.4	0.5	0.7	0.4	0.5
Z38	Liveborn infants according to place of birth	1.3	0.0	0.0	0.1	0.0	0.0	0.0	0.1	0.5
R56	Convulsions, not elsewhere classified	0.4	0.5	0.5	0.5	0.4	0.5	0.4	0.8	0.5
G45	Transient cerebral ischaemic attacks and related syndromes	0.5	0.4	0.5	0.4	0.4	0.4	0.4	0.2	0.4
B34	Viral infection of unspecified site	0.5	0.4	0.4	0.6	0.4	0.2	0.3	0.4	0.4
N20	Calculus of kidney and ureter	0.4	0.4	0.5	0.4	0.5	0.4	0.5	0.2	0.4
Total		48.5	47.2	47.8	47.3	46.6	47.3	47.2	46.7	47.7

(a) Includes separations for which the care type was reported as 'acute' or 'newborn with qualified days', or was not reported.

Source: AIHW 2014, *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145, AIHW, Canberra.

TABLE 11A.16

Table 11A.16 Patient days, by care type, public and private hospitals, 2012-13

	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Public hospitals									
Acute care	5 196 801	3 675 744	2 461 885	1 520 263	1 231 434	298 002	258 686	271 400	14 914 215
Rehabilitation care	586 645	319 336	357 686	226 604	126 010	23 042	27 838	9 767	1 676 928
Palliative care	135 920	94 384	64 327	14 658	16 092	5 182	6 820	3 361	340 744
Geriatric evaluation and management	80 517	369 653	63 899	19 209	24 878	4 883	5 605	2 056	570 700
Psychogeriatric care	44 535	–	15 218	36 754	10 328	7 879	306	2	115 022
Maintenance care	175 861	47 564	242 288	52 668	148 395	8 609	16 755	8 197	700 337
Newborn–qualified days	166 734	123 035	89 939	50 109	42 973	11 348	11 697	8 095	503 930
Newborn–unqualified days	112 153	116 998	74 727	47 314	33 493	5 939	8 178	7 556	406 358
Newborn total	278 887	240 033	164 666	97 423	76 466	17 287	19 875	15 651	910 288
Other admitted patient care	1	–	8	–	–	52	21	102	184
Not reported	–	–	–	–	–	763	–	–	763
Total (b)	6 387 014	4 629 716	3 295 250	1 920 265	1 600 110	359 760	327 728	302 980	18 822 823
Private hospitals									
Acute care	1 935 943	1 977 705	1 956 758	804 114	558 285	np	np	np	7 512 905
Rehabilitation total	483 208	269 820	169 232	55 077	70 727	np	np	np	1 088 903
Palliative care	3 982	8 199	26 133	24 725	3 363	np	np	np	68 483
Geriatric evaluation and management	–	–	2 523	–	407	np	np	np	3 013
Psychogeriatric care	–	32 100	93	12 156	–	np	np	np	44 349
Maintenance care	1 269	665	38 243	2 848	937	np	np	np	44 002
Newborn–qualified days	39 938	22 249	26 645	12 024	5 700	np	np	np	110 577
Newborn–unqualified days	73 954	11 055	62 418	38 658	3 217	np	np	np	203 182
Newborn total	113 892	33 304	89 063	50 682	8 917	np	np	np	313 759
Other admitted patient care	–	–	–	–	–	np	np	np	11
Not reported	–	–	–	–	–	np	np	np	703
Total (b)	2 464 340	2 310 738	2 219 627	910 944	639 419	np	np	np	8 872 946

Table 11A.16 **Patient days, by care type, public and private hospitals, 2012-13**

	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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(a) The reporting of Newborns (with unqualified days only) is not compulsory for the Victorian private sector, resulting in a low number of separations in this category.

(b) Total patient days exclude unqualified days for Newborns.

– Nil or rounded to zero. **np** Not published.

Source: AIHW 2014, *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145, AIHW, Canberra.

TABLE 11A.17

Table 11A.17 **Non-admitted patient occasions of service, by type of non-admitted patient care, public hospitals, 2012-13 (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust (d)</i>
Public acute hospitals										
Individual occasions of service										
Accident and emergency	no.	2 580 878	1 658 736	1 746 928	966 901	546 588	159 701	118 975	145 534	7 924 241
Dialysis	no.	22 667	127 656	..	..	..	..	..	5 262	155 585
Pathology	no.	3 244 984	877 350	3 840 715	837 049	..	..	683 066	132 045	9 615 209
Radiology and organ imaging	no.	631 210	644 895	986 772	434 404	193 615	..	41 577	91 673	3 024 146
Endoscopy and related procedures	no.	24 381	3 497	8 307	..	26 901	..	3 139	1 104	67 329
Other medical/surgical/obstetric (e)	no.	5 716 157	2 047 090	2 607 998	1 072 772	960 493	242 194	387 671	171 096	13 205 471
Mental health	no.	1 017 711	..	30 782	96 596	12 908	4 105	262 860	..	1 424 962
Alcohol and drug	no.	1 293 842	87 747	39 694	..	..	..	..	..	1 421 283
Dental	no.	439 492	455 473	..	12 832	9 135	..	..	..	916 932
Pharmacy (f)	no.	3 765 178	421 723	539 330	234 006	..	..	42 880	35 283	5 038 400
Allied health	no.	759 428	1 009 769	671 857	890 159	171 262	62 666	159 522	17 590	3 742 253
Other non-admitted services										
Community health	no.	2 543 707	426 022	227 451	1 058 187	..	13 580	170 128	..	4 439 075
District nursing (g)	no.	1 636 103	159 594	..	114 674	..	..	..	..	1 910 371
Other outreach	no.	736 574	5 644	134 817	105 650	247 098	..	..	..	1 229 783
Total (individual)	no.	24 412 312	7 925 196	10 834 651	5 823 230	2 168 000	482 246	1 869 818	599 587	54 115 040
Group sessions										
Outpatient care										
Allied health	no.	10 621	34 212	11 940	130 233	6 757	..	14 042	261	208 066
Dental	no.	46	..	..	..	..	..	..	..	46
Other medical/surgical/obstetric (e)	no.	32 944	2 879	7 162	7 496	6 472	..	3 145	511	60 609

TABLE 11A.17

Table 11A.17 **Non-admitted patient occasions of service, by type of non-admitted patient care, public hospitals, 2012-13 (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust (d)</i>
Mental health	no.	34 543	..	2	20 720	460	..	5 648	..	61 373
Alcohol & drug	no.	292	..	165	..	..	..	..	..	457
Community health	no.	25 161	1 836	12 538	31 033	..	..	38 241	..	108 809
District nursing	no.	2 608	36	..	758	..	..	..	..	3 402
Other outreach	no.	2 568	..	136	1 439	69 094	..	..	..	73 237
Other	no.	98	32	..	..	..	..	..	..	130
Total (group sessions)	no.	108 881	38 995	31 943	191 679	82 783	..	61 076	772	516 129
Public acute hospitals										
Accident and emergency	%	10.6	20.9	16.1	16.6	25.2	33.1	6.4	24.3	14.6
Outpatient services										
Dialysis	%	0.1	1.6	..	..	..	..	..	0.9	0.3
Pathology	%	13.3	11.1	35.4	14.4	..	..	36.5	22.0	17.8
Radiology and organ imaging	%	2.6	8.1	9.1	7.5	8.9	..	2.2	15.3	5.6
Endoscopy and related procedures	%	0.1	—	0.1	..	1.2	..	0.2	0.2	0.1
Other medical/surgical/obstetric (e)	%	23.4	25.8	24.1	18.4	44.3	50.2	20.7	28.5	24.4
Mental health	%	4.2	..	0.3	1.7	0.6	0.9	14.1	..	2.6
Alcohol and drug	%	5.3	1.1	0.4	..	..	..	..	..	2.6
Dental	%	1.8	5.7	..	0.2	0.4	..	..	..	1.7
Pharmacy (f)	%	15.4	5.3	5.0	4.0	..	..	2.3	5.9	9.3
Allied health	%	3.1	12.7	6.2	15.3	7.9	13.0	8.5	2.9	6.9
Other non-admitted services										
Community health	%	10.4	5.4	2.1	18.2	..	2.8	9.1	..	8.2
District nursing (g)	%	6.7	2.0	..	2.0	..	..	..	..	3.5
Other outreach	%	3.0	0.1	1.2	1.8	11.4	..	..	..	2.3

TABLE 11A.17

Table 11A.17 **Non-admitted patient occasions of service, by type of non-admitted patient care, public hospitals, 2012-13 (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust (d)</i>
Total (individual)	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Group sessions										
Allied health	%	9.8	87.7	37.4	67.9	8.2	..	23.0	33.8	40.3
Dental	%	–	–
Other medical/surgical/obstetric (e)	%	30.3	7.4	22.4	3.9	7.8	..	5.1	66.2	11.7
Mental health	%	31.7	..	–	10.8	0.6	..	9.2	..	11.9
Alcohol & drug	%	0.3	..	0.5	..	..	..	..	..	0.1
Community health	%	23.1	4.7	39.3	16.2	..	..	62.6	..	21.1
District nursing	%	2.4	0.1	..	0.4	..	..	..	..	0.7
Other outreach	%	2.4	..	0.4	0.8	83.5	..	..	..	14.2
Other	%	0.1	0.1	..	..	..	..	..	..	–
Total (group sessions)	%	100.0	100.0	100.0	100.0	100.0	..	100.0	100.0	100.0

(a) Reporting arrangements have varied significantly across years and across jurisdictions.

(b) Includes data for the Mersey Community Hospital.

(c) Radiology figures for the NT are underestimated and pathology figures relate only to three of the five hospitals.

(d) Includes only those states and territories for which data are available.

(e) Other includes the outpatient services of Gynaecology, Obstetrics, Cardiology, Endocrinology, Oncology, Respiratory, Gastroenterology, Medical, General practice primary care, Paediatric, Plastic surgery, Urology, Orthopaedic surgery, Ophthalmology, Ear, nose and throat, Chemotherapy, Paediatric surgery and Renal medical.

(f) Justice Health (formerly known as Corrections Health) in New South Wales reported a large number of occasions of service that may not be typical of Pharmacy.

(g) Justice Health (formerly known as Corrections Health) in New South Wales reported a large number of occasions of service that may not be typical of District nursing.

na Not available. .. Not applicable. – Nil or rounded to zero.

Source: AIHW 2014, *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145, AIHW, Canberra.

TABLE 11A.18

Table 11A.18 **Emergency department waiting times, by triage category, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA Tas (a)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
2004-05										
Proportion of patients seen on time (b) (c)										
1 – Resuscitation	%	100	100	100	98	99	96	100	100	100
2 – Emergency	%	75	86	71	75	72	76	70	61	76
3 – Urgent	%	60	81	54	67	58	67	50	61	64
4 – Semi-urgent	%	66	73	57	65	62	64	52	55	65
5 – Non-urgent	%	87	89	85	91	89	91	83	86	88
Total	%	68	79	59	70	63	68	58	62	69
Estimated proportion of occasions of service ending in admission (c) (d)										
1 – Resuscitation	%	82	90	72	66	77	85	70	57	79
2 – Emergency	%	67	73	58	47	57	64	43	62	63
3 – Urgent	%	46	53	34	33	39	41	37	42	43
4 – Semi-urgent	%	19	22	11	12	13	14	12	14	17
5 – Non-urgent	%	6	5	3	2	6	3	2	6	5
Total	%	30	33	22	21	28	26	21	24	28
Proportion of occasions of service (c)										
1 – Resuscitation	%	1	1	1	1	1	1	1	1	1
2 – Emergency	%	8	8	8	10	11	7	8	6	8
3 – Urgent	%	33	28	35	29	35	33	29	27	32
4 – Semi-urgent	%	44	48	48	49	48	51	47	52	47
5 – Non-urgent	%	14	15	9	11	5	7	16	14	12
Total	%	100	100	100	100	100	100	100	100	100
Data coverage										
Estimated proportion of presentations with episode-level data (e)	%	76	88	64	68	68	84	100	100	76
Hospitals reporting emergency department episode-level data	no.	57	38	21	13	8	4	2	5	148
2005-06										
Proportion of patients seen on time (b) (c)										
1 – Resuscitation	%	100	100	100	98	99	95	100	100	99
2 – Emergency	%	81	83	66	77	69	68	71	59	77
3 – Urgent	%	61	79	55	69	56	57	44	59	64
4 – Semi-urgent	%	66	71	58	67	62	59	47	53	65
5 – Non-urgent	%	87	89	86	90	85	89	84	87	87
Total	%	69	77	60	71	62	62	52	60	69
Estimated proportion of occasions of service ending in admission (c) (d)										
1 – Resuscitation	%	82	91	73	68	75	84	81	52	80
2 – Emergency	%	66	74	57	51	59	61	57	67	64

TABLE 11A.18

Table 11A.18 **Emergency department waiting times, by triage category, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (a)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
3 – Urgent	%	44	53	33	37	40	40	43	44	43
4 – Semi-urgent	%	18	22	10	13	13	13	13	16	17
5 – Non-urgent	%	5	5	3	5	6	3	3	6	5
Total	%	30	32	22	23	28	26	25	25	28
Proportion of occasions of service (c)										
1 – Resuscitation	%	1	1	1	1	1	1	1	1	1
2 – Emergency	%	8	8	8	10	11	8	6	6	8
3 – Urgent	%	33	29	36	28	34	34	32	27	32
4 – Semi-urgent	%	44	48	47	50	48	49	49	51	47
5 – Non-urgent	%	14	15	9	11	5	7	12	15	12
Total	%	100	100	100	100	100	100	100	100	100
Data coverage										
Estimated proportion of presentations with episode-level data (e)	%	81	89	65	68	68	86	100	100	78
Hospitals reporting emergency department episode-level data	no.	62	38	21	14	8	3	2	5	153
2006-07										
Proportion of patients seen on time (b) (c)										
1 – Resuscitation	%	100	100	98	98	99	96	100	100	99
2 – Emergency	%	87	82	67	71	72	72	77	56	78
3 – Urgent	%	71	73	57	59	56	62	47	54	65
4 – Semi-urgent	%	74	67	60	61	63	61	49	48	66
5 – Non-urgent	%	89	88	87	87	87	87	81	87	88
Total	%	76	74	61	64	63	64	54	55	70
Estimated proportion of occasions of service ending in admission (c) (d)										
1 – Resuscitation	%	81	92	71	67	71	82	73	70	79
2 – Emergency	%	64	74	56	46	58	57	58	64	62
3 – Urgent	%	43	53	31	33	40	38	42	43	42
4 – Semi-urgent	%	18	22	10	11	13	13	14	14	16
5 – Non-urgent	%	5	5	3	4	6	3	4	7	5
Total	%	28	33	22	21	32	25	25	25	27
Proportion of occasions of service (c)										
1 – Resuscitation	%	1	1	1	1	1	1	1	1	1
2 – Emergency	%	8	8	9	10	12	8	7	6	8
3 – Urgent	%	32	29	37	29	36	34	33	29	32
4 – Semi-urgent	%	45	48	46	51	47	50	48	52	47
5 – Non-urgent	%	15	15	8	9	4	7	11	12	12
Total	%	100	100	100	100	100	100	100	100	100

TABLE 11A.18

Table 11A.18 **Emergency department waiting times, by triage category, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA Tas (a)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Data coverage										
Estimated proportion of presentations with episode-level data (e)	%	81	89	64	72	69	96	100	100	78
Hospitals reporting emergency department episode-level data	no.	71	38	21	16	8	3	2	5	164
2007-08										
Proportion of patients seen on time (b) (c)										
1 – Resuscitation	%	100	100	98	99	100	99	100	100	100
2 – Emergency	%	81	79	69	69	72	74	81	59	76
3 – Urgent	%	69	71	56	56	54	54	52	47	63
4 – Semi-urgent	%	75	65	61	59	60	58	51	47	66
5 – Non-urgent	%	90	86	87	86	80	86	78	86	87
Total	%	76	71	63	61	61	60	58	52	69
Estimated proportion of occasions of service ending in admission (c) (d)										
1 – Resuscitation	%	80	92	71	65	73	84	73	67	78
2 – Emergency	%	61	75	55	45	60	58	60	64	61
3 – Urgent	%	40	53	32	33	42	38	42	42	41
4 – Semi-urgent	%	16	21	10	11	14	13	13	13	16
5 – Non-urgent	%	5	4	3	4	6	5	3	5	4
Total	%	26	33	22	20	29	25	25	24	27
Proportion of occasions of service (c)										
1 – Resuscitation	%	1	1	1	1	1	1	1	1	1
2 – Emergency	%	8	8	9	10	11	8	8	6	9
3 – Urgent	%	31	30	37	29	35	35	32	30	32
4 – Semi-urgent	%	45	47	44	52	46	50	45	53	46
5 – Non-urgent	%	15	14	9	8	6	7	14	10	12
Total	%	100	100	100	100	100	100	100	100	100
Data coverage										
Estimated proportion of presentations with episode-level data (e)	%	81	89	64	72	67	88	100	100	78
Hospitals reporting emergency department episode-level data	no.	71	38	22	16	8	3	2	5	165
2008-09										
Proportion of patients seen on time (b) (c)										
1 – Resuscitation	%	100	100	99	99	100	99	100	100	100
2 – Emergency	%	80	82	72	69	75	76	86	62	77

TABLE 11A.18

Table 11A.18 **Emergency department waiting times, by triage category, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA Tas (a)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
3 – Urgent	%	68	74	59	53	59	54	53	48	64
4 – Semi-urgent	%	73	68	65	62	62	61	53	49	67
5 – Non-urgent	%	90	86	88	89	83	87	78	89	88
Total	%	75	73	66	62	64	62	60	54	70
Estimated proportion of occasions of service ending in admission (c) (d)										
1 – Resuscitation	%	81	92	69	67	78	82	77	72	79
2 – Emergency	%	62	74	53	48	58	58	63	61	61
3 – Urgent	%	41	52	30	34	42	38	44	43	40
4 – Semi-urgent	%	17	21	10	12	15	13	15	14	16
5 – Non-urgent	%	5	4	3	4	5	5	3	4	5
Total	%	26	33	22	22	30	25	27	25	27
Proportion of occasions of service (c)										
1 – Resuscitation	%	1	1	1	1	1	1	1	1	1
2 – Emergency	%	8	9	10	11	12	7	9	7	9
3 – Urgent	%	31	30	39	30	35	34	31	30	32
4 – Semi-urgent	%	44	47	43	51	44	50	44	53	46
5 – Non-urgent	%	16	13	8	8	8	8	15	10	12
Total	%	100	100	100	100	100	100	100	100	100
Data coverage										
Estimated proportion of presentations with episode-level data (e)	%	83	88	72	72	67	89	100	100	80
Hospitals reporting emergency department episode-level data	no.	85	38	26	16	8	4	2	5	184
2009-10										
Proportion of patients seen on time (b) (c)										
1 – Resuscitation	%	100	100	99	99	100	99	100	100	100
2 – Emergency	%	82	80	77	71	78	71	83	63	78
3 – Urgent	%	70	71	60	55	63	52	57	49	65
4 – Semi-urgent	%	73	67	66	64	63	63	56	51	68
5 – Non-urgent	%	89	85	89	92	85	88	77	91	88
Total	%	75	72	66	64	67	63	62	56	70
Estimated proportion of occasions of service ending in admission (c) (d)										
1 – Resuscitation	%	81	90	69	68	78	79	72	72	78
2 – Emergency	%	62	73	54	49	59	54	55	61	61
3 – Urgent	%	41	51	32	35	41	32	38	44	40
4 – Semi-urgent	%	17	21	10	11	16	10	13	14	16
5 – Non-urgent	%	5	4	3	4	7	4	3	6	5
Total	%	27	33	23	23	30	21	24	26	27
Proportion of occasions of service (c)										

TABLE 11A.18

Table 11A.18 **Emergency department waiting times, by triage category, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA Tas (a)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
1 – Resuscitation	%	1	1	1	1	1	1	0	1	
2 – Emergency	%	8	9	10	11	12	8	9	7	
3 – Urgent	%	30	31	40	31	36	35	31	28	
4 – Semi-urgent	%	45	47	42	50	44	46	46	53	
5 – Non-urgent	%	16	13	7	7	7	11	13	10	
Total	%	100	100	100	100	100	100	100	100	
Data coverage										
Estimated proportion of presentations with episode-level data (e)	%	83	90	72	73	67	89	100	100	81
Hospitals reporting emergency department episode-level data	no.	84	39	26	16	8	4	2	5	184
2010-11										
Proportion of patients seen on time (b) (c)										
1 – Resuscitation	%	100	100	100	99	100	100	100	100	100
2 – Emergency	%	83	81	78	71	78	72	78	65	79
3 – Urgent	%	71	70	60	50	66	55	48	53	65
4 – Semi-urgent	%	73	65	67	65	70	63	48	54	68
5 – Non-urgent	%	88	86	90	92	88	83	75	90	88
Total	%	76	71	67	63	71	62	55	58	70
Estimated proportion of occasions of service ending in admission (c) (d)										
1 – Resuscitation	%	81	87	67	72	76	77	75	76	77
2 – Emergency	%	62	69	52	54	58	53	54	62	60
3 – Urgent	%	41	49	32	38	40	32	37	46	40
4 – Semi-urgent	%	18	21	10	13	16	11	14	15	16
5 – Non-urgent	%	6	5	3	4	8	4	4	5	5
Total	%	27	33	24	26	30	21	24	26	28
Proportion of occasions of service (c)										
1 – Resuscitation	%	1	1	1	1	1	0	0	1	1
2 – Emergency	%	9	9	11	11	13	7	10	6	10
3 – Urgent	%	30	32	41	32	37	35	31	26	33
4 – Semi-urgent	%	45	47	41	49	42	48	46	56	45
5 – Non-urgent	%	15	11	6	7	7	9	13	10	11
Total	%	100	100	100	100	100	100	100	100	100
Data coverage										
Estimated proportion of presentations with episode-level data (e)	%	83	90	72	74	68	93	100	100	81

TABLE 11A.18

Table 11A.18 **Emergency department waiting times, by triage category, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (a)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Hospitals reporting emergency department episode-level data	no.	86	39	26	16	8	4	2	5	186
2011-12										
Proportion of patients seen on time (b) (c)										
1 – Resuscitation	%	100	100	100	99	100	100	100	100	100
2 – Emergency	%	82	83	82	76	79	77	76	64	80
3 – Urgent	%	71	72	63	52	70	64	50	49	66
4 – Semi-urgent	%	74	67	69	67	77	71	47	49	70
5 – Non-urgent	%	89	87	90	94	92	88	81	89	89
Total	%	76	72	69	65	76	71	55	54	72
Estimated proportion of occasions of service ending in admission (c) (d)										
1 – Resuscitation	%	88	93	69	69	78	83	77	71	80
2 – Emergency	%	64	75	50	53	59	51	56	58	61
3 – Urgent	%	42	54	30	36	40	33	38	44	41
4 – Semi-urgent	%	18	23	9	13	15	11	15	16	17
5 – Non-urgent	%	6	6	3	4	6	4	3	5	5
Total	%	29	36	23	25	29	21	26	26	29
Proportion of occasions of service (c)										
1 – Resuscitation	%	1	0	1	1	1	1	0	1	1
2 – Emergency	%	9	9	11	11	12	8	11	7	10
3 – Urgent	%	32	33	42	32	36	34	33	29	34
4 – Semi-urgent	%	44	48	40	48	43	48	44	54	45
5 – Non-urgent	%	14	10	6	7	7	10	11	9	10
Total	%	100	100	100	100	100	100	100	100	100
Data coverage										
Estimated proportion of presentations with episode-level data (e)	%	88	91	72	78	80	92	100	100	84
Hospitals reporting emergency department episode-level data	no.	95	40	26	17	14	4	2	5	203
2012-13										
Proportion of patients seen on time (b) (c)										
1 – Resuscitation	%	100	100	100	100	100	100	100	100	100
2 – Emergency	%	83	84	84	81	75	83	74	66	82
3 – Urgent	%	73	72	68	52	66	65	43	52	68
4 – Semi-urgent	%	77	68	74	67	78	70	46	52	72
5 – Non-urgent	%	92	87	92	93	92	90	79	89	91
Total	%	78	73	74	66	75	71	51	57	73

TABLE 11A.18

Table 11A.18 **Emergency department waiting times, by triage category, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA Tas (a)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Estimated proportion of occasions of service ending in admission (c) (d)										
1 – Resuscitation	%	80	74	72	69	79	80	81	72	76
2 – Emergency	%	63	58	52	50	59	52	56	57	58
3 – Urgent	%	42	41	32	35	41	33	36	44	38
4 – Semi-urgent	%	18	17	10	13	15	11	16	16	15
5 – Non-urgent	%	6	4	3	4	6	4	4	5	5
Total	%	29	28	25	24	30	21	26	26	27
Proportion of occasions of service (c)										
1 – Resuscitation	%	1	0	1	1	1	1	0	1	1
2 – Emergency	%	11	10	12	12	13	8	11	9	11
3 – Urgent	%	32	34	42	33	36	35	34	28	35
4 – Semi-urgent	%	44	47	40	47	42	48	45	53	44
5 – Non-urgent	%	12	9	5	7	7	9	10	9	9
Total	%	100	100	100	100	100	100	100	100	100
Data coverage										
Estimated proportion of presentations with episode-level data (e)	%	88	92	74	78	83	92	100	100	85
Hospitals reporting emergency department episode-level data	no.	95	40	27	17	14	4	2	5	204
2013-14										
Proportion of patients seen on time (b) (c)										
1 – Resuscitation	%	100	100	100	100	100	100	100	100	100
2 – Emergency	%	83	84	80	86	74	85	83	61	82
3 – Urgent	%	76	73	67	58	65	66	50	51	70
4 – Semi-urgent	%	80	71	75	71	77	71	57	53	75
5 – Non-urgent	%	94	88	92	94	92	90	86	89	92
Total	%	81	75	73	70	73	72	61	57	75
Estimated proportion of occasions of service ending in admission (c) (d)										
1 – Resuscitation	%	79	74	78	68	80	77	80	74	77
2 – Emergency	%	62	60	60	50	59	58	58	56	59
3 – Urgent	%	41	43	39	35	40	37	39	43	40
4 – Semi-urgent	%	16	19	13	12	15	13	17	16	16
5 – Non-urgent	%	5	5	4	3	6	4	5	5	5
Total	%	28	30	30	24	30	25	27	27	29
Proportion of occasions of service (c)										
1 – Resuscitation	%	1	0	1	1	1	1	0	1	1
2 – Emergency	%	11	10	12	12	13	8	10	10	11
3 – Urgent	%	32	35	42	34	37	35	34	29	35

Table 11A.18 **Emergency department waiting times, by triage category, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA Tas (a)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
4 – Semi-urgent	%	44	45	40	46	42	47	42	51	44
5 – Non-urgent	%	13	9	5	7	7	9	13	9	9
Total	%	100	100	100	100	100	100	100	100	100
Data coverage										
Estimated proportion of presentations with episode-level data (e)	%	99	92	74	78	83	92	100	100	88
Hospitals reporting emergency department episode-level data	no.	180	40	27	17	14	4	2	5	289

- (a) Includes data for the Mersey Community Hospital.
- (b) The proportion of occasions of service for which the waiting time to service delivery was within the time specified in the definition of the triage category. For the triage category Resuscitation, an occasion of service was classified as 'seen on time' if the waiting time to service was reported as less than or equal to 2 minutes.
- (c) Values are derived from all hospitals that reported to the non-admitted patient emergency department care database, including all principal referral and specialist women's and children's hospitals, large hospitals and public hospitals that were classified to other peer groups.
- (d) The proportion of occasions of service for which the emergency department departure status was reported as 'admitted to this hospital'.
- (e) The number of presentations reported to the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD) divided by the number of emergency occasions of service reported to the National Public Hospital Establishments Database (NPHEd) as a percentage.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra; AIHW (2014), *Australian hospital statistics 2013–14: emergency department care*, Health services series no. 58. Cat. no. HSE 153. Canberra: AIHW, Canberra; AIHW (2013), *Australian hospital statistics 2012–13: emergency department care*, Health services series no. 52. Cat. no. HSE 142. Canberra: AIHW, Canberra; AIHW (2012), *Australian hospital statistics 2011–12: emergency department care*, Health services series no. 45. Cat. no. HSE 126. Canberra: AIHW, (2010), *Australian hospital statistics 2009–10: emergency department care and elective surgery waiting times*. Health services series no. 38. Cat. no. HSE 93. Canberra: AIHW

TABLE 11A.19

Table 11A.19 **Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory (a), (b)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
2010-11											<i>no.</i>
Peer group A hospitals											
Triage category 1	%	100	100	100	100	100	100	100	100	100	36 426
Triage category 2	%	83	81	77	68	77	67	78	65	79	453 165
Triage category 3	%	68	68	58	46	63	41	48	50	62	1 455 076
Triage category 4	%	70	65	65	63	68	49	48	48	65	1 652 580
Triage category 5	%	84	87	89	91	87	76	75	83	85	318 925
Total (d)	%	73	70	65	60	69	50	55	52	67	3 916 284
Total number (d), (e)	<i>no.</i>	1 172 976	974 641	859 878	356 158	276 139	81 910	100 989	93 593	3 916 284	
Peer group B hospitals											
Triage category 1	%	100	100	97	95	100	100	..	..	98	4 133
Triage category 2	%	83	78	88	73	80	86	..	..	80	86 771
Triage category 3	%	76	74	71	52	76	82	..	..	70	353 537
Triage category 4	%	74	64	77	64	79	82	..	..	70	545 735
Triage category 5	%	89	82	93	91	97	94	..	..	88	112 954
Total (d)	%	77	70	77	63	80	84	..	..	72	1 103 156
Total number (d), (e)	<i>no.</i>	341 772	289 132	144 541	238 044	41 977	47 690	..	..	1 103 156	
Total (Peer group A and B hospitals)											
Triage category 1	%	100	100	100	99	100	100	100	100	100	40 559
Triage category 2	%	83	81	78	70	77	72	78	65	79	539 936
Triage category 3	%	70	69	59	49	65	55	48	50	63	1 808 613

TABLE 11A.19

Table 11A.19 **Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory (a), (b)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Triage category 4	%	71	64	67	63	70	63	48	48	66	2 198 315
Triage category 5	%	85	85	90	91	88	83	75	83	86	431 879
Total (d)	%	74	70	66	61	71	62	55	52	68	5 019 440
Total number (d), (e)	<i>no.</i>	1 514 748	1 263 773	1 004 419	594 202	318 116	129 600	100 989	93 593	5 019 440	
2011-12											
Peer group A hospitals											
Triage category 1	%	100	100	100	100	100	100	100	100	100	35 924
Triage category 2	%	82	82	81	75	77	73	76	62	80	498 947
Triage category 3	%	69	69	62	47	65	54	50	45	64	1 565 049
Triage category 4	%	72	66	68	65	72	61	47	40	67	1 724 027
Triage category 5	%	86	87	90	93	88	86	81	78	87	313 518
Total (d)	%	74	71	68	62	71	63	55	46	69	4 137 593
Total number (d), (e)	<i>no.</i>	1 253 722	1 003 224	939 721	385 412	266 275	83 890	109 724	95 625	4 137 593	
Peer group B hospitals											
Triage category 1	%	100	100	100	96	100	99	–	–	99	4 200
Triage category 2	%	81	83	89	76	82	89	–	–	81	89 750
Triage category 3	%	74	77	65	54	74	84	–	–	69	355 354
Triage category 4	%	74	67	70	66	75	84	–	–	70	531 070
Triage category 5	%	89	86	91	93	94	94	–	–	89	98 670
Total (d)	%	76	73	71	65	77	85	–	–	72	1 079 077
Total number (d), (e)	<i>no.</i>	321 640	303 713	110 690	262 245	34 560	46 229	–	–	1 079 077	

TABLE 11A.19

Table 11A.19 **Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory (a), (b)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Total (Peer group A and B hospitals)											
Triage category 1	%	100	100	100	99	100	100	100	100	100	40 124
Triage category 2	%	82	82	82	75	78	77	76	62	80	588 697
Triage category 3	%	70	71	62	50	66	64	50	45	65	1 920 403
Triage category 4	%	72	66	69	65	72	71	47	40	68	2 255 097
Triage category 5	%	87	86	90	93	89	88	81	78	88	412 188
Total (d)	%	74	71	69	63	72	71	55	46	70	5 216 670
Total number (d), (e)	<i>no.</i>	1 575 362	1 306 937	1 050 411	647 657	300 835	130 119	109 724	95 625	5 216 670	
2012-13											
Peer group A hospitals											
Triage category 1	%	100	100	100	100	100	100	100	100	100	39 049
Triage category 2	%	83	84	84	80	74	83	74	64	82	557 883
Triage category 3	%	70	70	69	44	62	58	43	48	65	1 660 721
Triage category 4	%	74	67	75	59	73	64	46	44	69	1 813 051
Triage category 5	%	90	87	93	89	88	88	79	80	89	295 722
Total (d)	%	76	72	74	59	70	66	51	50	71	4 366 426
Total number (d), (e)	<i>no.</i>	1 306 601	1 010 140	985 292	487 333	281 965	88 764	109 697	96 776	4 366 568	
Peer group B hospitals											
Triage category 1	%	100	100	100	100	100	100	–	–	100	3 757
Triage category 2	%	82	84	86	83	72	84	–	–	83	96 734

TABLE 11A.19

Table 11A.19 **Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory (a), (b)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Triage category 3	%	74	77	56	66	64	79	–	–	71	375 392
Triage category 4	%	77	68	64	74	73	79	–	–	72	509 328
Triage category 5	%	92	86	88	95	91	95	–	–	90	94 939
Total (d)	%	78	73	64	74	71	81	–	–	74	1 080 150
Total number (d), (e)	no.	364 374	325 427	130 386	162 211	50 243	47 544	–	–	1 080 185	
Total (Peer group A and B hospitals)											
Triage category 1	%	100	100	100	100	100	100	100	100	100	42 806
Triage category 2	%	83	84	84	80	74	83	74	64	82	654 617
Triage category 3	%	71	71	67	49	62	65	43	48	66	2 036 113
Triage category 4	%	75	67	74	63	73	70	46	44	70	2 322 379
Triage category 5	%	91	86	92	91	89	90	79	80	89	390 661
Total (d)	%	76	72	73	63	70	71	51	50	72	5 446 576
Total number (d), (e)	no.	1 670 975	1 335 567	1 115 678	649 544	332 208	136 308	109 697	96 776	5 446 753	
2013-14											
Peer group A hospitals											
Triage category 1	%	100	100	100	100	100	100	100	100	100	39 008
Triage category 2	%	83	84	81	85	71	86	83	59	82	595 561
Triage category 3	%	74	72	70	52	60	59	50	46	68	1 726 893
Triage category 4	%	78	70	76	66	72	65	57	46	72	1 847 126
Triage category 5	%	93	88	93	93	88	88	86	80	91	302 671
Total (d)	%	79	74	75	65	68	67	61	50	73	4 511 259

TABLE 11A.19

Table 11A.19 **Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory (a), (b)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Total number (d), (e)	no.	1 370 694	1 061 659	987 179	491 226	289 337	93 101	119 136	99 129	4 511 461	
Peer group B hospitals											
Triage category 1	%	100	100	100	100	100	100	0	0	100	3 721
Triage category 2	%	85	85	85	89	90	82	0	0	86	101 774
Triage category 3	%	77	77	56	73	69	81	0	0	73	376 220
Triage category 4	%	79	71	68	80	76	82	0	0	75	518 748
Triage category 5	%	93	86	90	96	92	95	0	0	90	96 648
Total (d)	%	80	76	66	80	76	82	0	0	77	1 097 111
Total number (d), (e)	no.	376 263	328 117	135 830	158 728	51 728	46 482	–	–	1 097 148	
Total (Peer group A and B hospitals)											
Triage category 1	%	100	100	100	100	100	100	100	100	100	42 729
Triage category 2	%	84	84	81	86	73	85	83	59	82	697 335
Triage category 3	%	75	73	68	57	61	66	50	46	69	2 103 113
Triage category 4	%	78	70	75	70	72	71	57	46	73	2 365 874
Triage category 5	%	93	87	93	94	89	90	86	80	91	399 319
Total (d)	%	79	74	74	69	69	72	61	50	74	5 608 370
Total number (d), (e)	no.	1 746 957	1 389 776	1 123 009	649 954	341 065	139 583	119 136	99 129	5 608 609	

(a) The proportion of presentations for which the waiting time to commencement of clinical care was within the time specified in the definition of the triage category. Records were excluded from the calculation of waiting time statistics if the triage category was unknown, if the patient did not wait or was dead on arrival, or if the waiting time was missing or otherwise invalid.

(b) It should be noted that the data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Peer group A and B hospitals provided over 80 per cent of Emergency Department services.

Table 11A.19 **Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
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(c) For National Healthcare agreement purposes, the Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B).

(d) The totals exclude records for which the waiting time to service was invalid, and records for which the episode end status was either 'Did not wait to be attended by a health care professional' or 'Dead on arrival, not treated in emergency department'.

(e) The totals include records for which the triage category was not assigned or not reported.

.. Not applicable.

Source: AIHW (unpublished) National Non-admitted Patient Emergency Department Care Database.

TABLE 11A.20

Table 11A.20 Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory (a), (b), (c)

		NSW	Vic	Qld	WA	SA	Tas (d)	ACT	NT	Aust	Aust (total number)
2010-11											
Total (Peer group A and B hospitals)											
Aboriginal and Torres Strait Islander Australians											<i>no.</i>
Triage category 1	%	100	100	100	98	100	100	100	100	100	1 756
Triage category 2	%	78	78	82	73	76	69	78	66	76	18 995
Triage category 3	%	66	72	66	60	64	52	43	53	62	73 151
Triage category 4	%	68	68	70	69	67	62	46	46	64	95 079
Triage category 5	%	84	87	91	92	85	84	75	78	86	17 759
Total (e)	%	71	72	71	68	69	61	52	52	67	206 745
Total number (e), (f)	<i>no.</i>	48 288	15 779	56 129	32 709	9 458	5 022	2 484	36 876	206 745	
Other Australians											
Triage category 1	%	100	100	100	99	100	100	100	100	100	38 803
Triage category 2	%	83	81	78	70	77	72	78	64	79	520 941
Triage category 3	%	70	69	59	48	65	55	48	48	63	1 735 462
Triage category 4	%	71	64	66	63	70	63	48	49	66	2 103 236
Triage category 5	%	85	85	90	91	88	83	75	86	86	414 120
Total (e)	%	74	70	66	61	71	62	55	52	69	4 812 695
Total number (e), (f)	<i>no.</i>	1 466 460	1 247 994	948 290	561 493	308 658	124 578	98 505	56 717	4 812 695	

TABLE 11A.20

Table 11A.20 Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory (a), (b), (c)

		NSW	Vic	Qld	WA	SA	Tas (d)	ACT	NT	Aust	Aust (total number)
2011-12											
Total (Peer group A and B hospitals)											
Aboriginal and Torres Strait Islander Australians											
Triage category 1	%	100	100	100	98	100	100	n.p.	100	100	1 816
Triage category 2	%	81	77	83	76	78	81	74	63	78	22 148
Triage category 3	%	67	74	67	58	65	62	49	50	63	82 090
Triage category 4	%	70	70	70	70	69	70	47	43	65	100 151
Triage category 5	%	86	89	88	93	88	87	80	76	87	17 267
Total (e)	%	72	74	71	69	71	70	54	49	67	223 473
Total number (e), (f)	no.	53 731	17 161	62 162	35 140	9 361	5 543	2 592	37 783	223 473	
Other Australians											
Triage category 1	%	100	100	100	99	100	100	100	100	100	38 308
Triage category 2	%	82	83	82	75	78	77	76	62	81	566 549
Triage category 3	%	70	71	62	49	66	64	50	41	65	1 838 313
Triage category 4	%	72	66	69	65	73	71	47	39	68	2 154 946
Triage category 5	%	87	86	90	93	89	89	81	80	88	394 921
Total (e)	%	74	71	68	63	72	71	55	44	70	4 993 197
Total number (e), (f)	no.	1 521 631	1 289 776	988 249	612 517	291 474	124 576	107 132	57 842	4 993 197	
2012-13											
Total (Peer group A and B hospitals)											
Aboriginal and Torres Strait Islander Australians											

TABLE 11A.20

Table 11A.20 **Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory (a), (b), (c)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (d)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Triage category 1	%	100	100	100	100	100	np	np	100	100	2 093
Triage category 2	%	81	81	85	84	72	84	73	65	80	26 396
Triage category 3	%	70	72	72	62	61	63	41	53	66	90 758
Triage category 4	%	74	70	74	70	68	69	44	45	67	106 794
Triage category 5	%	89	88	90	93	86	90	73	77	89	18 737
Total (e)	%	75	73	76	72	68	70	49	52	70	244 778
Total number (e), (f)	no.	62 422	18 291	68 010	39 160	10 335	6 114	2 697	37 754	244 783	
Other Australians											
Triage category 1	%	100	100	100	100	100	100	100	100	100	40 713
Triage category 2	%	83	84	84	80	74	83	74	64	82	628 221
Triage category 3	%	71	71	67	48	62	65	43	44	66	1 945 355
Triage category 4	%	75	67	74	63	73	70	46	43	70	2 215 585
Triage category 5	%	91	86	92	91	89	90	79	82	89	371 924
Total (e)	%	76	72	73	62	70	71	51	48	72	5 201 798
Total number (e), (f)	no.	1 608 553	1 317 276	1 047 668	610 384	321 873	130 194	107 000	59 022	5 201 970	
2013-14											
Total (Peer group A and B hospitals)											
Aboriginal and Torres Strait Islander Australians											
Triage category 1	%	100	100	100	100	100	np	np	100	100	2 265
Triage category 2	%	83	84	83	86	72	85	81	62	80	29 415
Triage category 3	%	73	73	72	68	61	62	48	54	68	95 511

TABLE 11A.20

Table 11A.20 **Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory (a), (b), (c)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (d)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Triage category 4	%	77	71	75	77	70	72	52	49	71	113 665
Triage category 5	%	92	88	92	95	87	90	82	77	91	19 746
Total (e)	%	78	75	76	77	68	71	57	54	73	260 602
Total number (e), (f)	<i>no.</i>	71 416	20 554	71 776	38 481	10 551	6 329	3 205	38 298	260 610	
Other Australians											
Triage category 1	%	100	100	100	100	100	100	100	100	100	40 464
Triage category 2	%	84	84	81	86	73	85	83	58	82	667 920
Triage category 3	%	75	73	68	56	61	66	50	41	69	2007 602
Triage category 4	%	78	70	75	69	73	71	57	45	73	2252 209
Triage category 5	%	93	87	93	94	89	90	86	81	91	379 573
Total (e)	%	79	74	74	69	69	72	61	47	74	5 347 768
Total number (e), (f)	<i>no.</i>	1 675 541	1 369 222	1 051 233	611 473	330 514	133 254	115 931	60 831	5 347 999	

(a) The proportion of presentations for which the waiting time to commencement of clinical care was within the time specified in the definition of the triage category. Records were excluded from the calculation of waiting time statistics if the triage category was unknown, if the patient did not wait or was dead on arrival, or if the waiting time was missing or otherwise invalid.

(b) It should be noted that the data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Peer group A and B hospitals provided over 80 per cent of Emergency Department services.

(c) The quality of the identification of Aboriginal and Torres Strait Islander patients in National Non-admitted Patient Emergency Department Care Database has not been assessed. Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete, and completeness may vary among the states and territories.

(d) For National Healthcare agreement purposes, the Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B).

(e) The totals exclude records for which the waiting time to service was invalid, and records for which the episode end status was either 'Did not wait to be attended by a health care professional' or 'Dead on arrival, not treated in emergency department'.

Table 11A.20 **Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (d)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
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(f) The totals include records for which the triage category was not assigned or not reported.

Source: AIHW (unpublished) National Non-admitted Patient Emergency Department Care Database.

TABLE 11A.21

Table 11A.21 Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)

		NSW	Vic	Qld	WA	SA	Tas (e)	ACT	NT	Aust	Aust (total number)
2010-11											
Total (Peer group A and B hospitals)											
Major cities											<i>no.</i>
Triage category 1	%	100	100	100	100	100	100	99	100	100	28 183
Triage category 2	%	85	82	76	70	77	75	77	65	79	394 923
Triage category 3	%	71	68	55	43	64	52	48	49	63	1 253 345
Triage category 4	%	72	62	65	59	69	60	48	50	65	1 446 773
Triage category 5	%	85	83	89	89	88	84	75	85	85	277 763
Total (f)	%	75	68	63	57	70	62	55	53	68	3 401 080
Total number (f), (g), (h)	<i>no.</i>	1 123 089	879 272	606 274	405 232	289 040	2 106	93 140	2 927	3 401 080	
Inner regional											
Triage category 1	%	100	100	99	96	100	100	100	100	99	6 930
Triage category 2	%	78	79	83	63	77	69	81	64	77	94 766
Triage category 3	%	66	72	66	49	65	46	48	50	65	364 134
Triage category 4	%	68	69	70	63	72	54	50	48	67	502 391
Triage category 5	%	85	89	90	92	89	79	80	90	87	110 213
Total (f)	%	71	73	71	61	72	55	57	53	69	1 078 473
Total number (f), (g), (h)	<i>no.</i>	332 026	319 572	230 655	94 289	16 934	77 781	5 871	1 345	1 078 473	
Outer regional											
Triage category 1	%	100	100	100	93	100	99	100	100	99	3 366
Triage category 2	%	78	73	84	80	78	78	84	61	79	36 492

TABLE 11A.21

Table 11A.21 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Triage category 3	%	65	75	65	79	66	69	49	42	67	135 753
Triage category 4	%	66	71	65	83	73	76	47	47	68	176 138
Triage category 5	%	84	90	89	96	89	91	75	81	90	28 208
Total (f)	%	70	75	68	83	72	75	57	48	71	379 960
Total number (f), (g), (h)	<i>no.</i>	36 254	53 100	116 708	73 002	7 485	46 829	1 592	44 990	379 960	
Remote											
Triage category 1	%	100	100	100	100	100	100	–	100	100	462
Triage category 2	%	75	74	92	76	79	75	np	70	78	5 205
Triage category 3	%	64	71	84	69	68	69	50	56	70	24 946
Triage category 4	%	70	70	83	75	74	68	57	52	69	32 569
Triage category 5	%	86	94	92	94	88	89	73	86	91	6 273
Total (f)	%	70	74	85	74	74	71	56	57	72	69 455
Total number (f), (g), (h)	<i>no.</i>	3 339	1 072	29 548	6 188	1 983	1 075	54	26 196	69 455	
Very remote											
Triage category 1	%	np	–	100	100	100	np	–	100	100	311
Triage category 2	%	72	92	86	73	73	73	np	67	72	2 496
Triage category 3	%	72	78	71	63	63	63	np	56	61	10 440
Triage category 4	%	65	71	74	73	71	61	55	47	56	12 331
Triage category 5	%	96	95	93	93	86	79	np	82	88	1 547
Total (f)	%	72	78	76	72	71	64	44	54	62	27 125
Total number (f), (g), (h)	<i>no.</i>	377	139	5 169	3 469	928	278	18	16 747	27 125	

TABLE 11A.21

Table 11A.21 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		NSW	Vic	Qld	WA	SA	Tas (e)	ACT	NT	Aust	Aust (total number)
2011-12											
Total (Peer group A and B hospitals)											
Major cities											
Triage category 1	%	100	100	100	100	100	100	100	100	100	27 327
Triage category 2	%	83	83	81	75	78	78	76	59	81	426 000
Triage category 3	%	70	70	59	44	65	65	49	44	64	1 327 802
Triage category 4	%	73	64	67	61	72	71	47	38	67	1 487 047
Triage category 5	%	87	84	90	91	89	89	81	86	87	263 221
Total (f)	%	74	70	66	59	72	73	55	45	69	3 531 540
Total number (f), (g), (h)	no.	1 173 784	904 482	628 280	446 191	272 792	1 955	101 278	2 778	3 531 540	
Inner regional											
Triage category 1	%	100	100	100	95	100	100	100	np	100	7 070
Triage category 2	%	81	82	83	71	78	75	78	61	80	103 608
Triage category 3	%	69	73	66	54	67	58	51	46	67	381 954
Triage category 4	%	71	70	70	68	76	65	48	40	70	510 172
Triage category 5	%	87	89	90	94	92	87	81	79	88	104 868
Total (f)	%	74	74	71	66	74	66	57	46	72	1 107 684
Total number (f), (g), (h)	no.	339 496	324 064	240 162	100 100	16 554	79 543	6 426	1 339	1 107 684	
Outer regional											
Triage category 1	%	100	100	100	97	100	99	100	100	100	3 583

TABLE 11A.21

Table 11A.21 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Triage category 2	%	79	81	84	80	81	81	80	59	79	43 286
Triage category 3	%	68	77	68	76	70	74	51	31	68	150 297
Triage category 4	%	70	75	71	81	79	79	47	31	69	183 028
Triage category 5	%	87	92	90	95	91	92	83	68	91	30 067
Total (f)	%	72	79	73	81	77	79	57	36	72	410 261
Total number (f), (g), (h)	<i>no.</i>	37 728	67 017	127 871	77 337	7 096	45 841	1 641	45 730	410 261	
Remote											
Triage category 1	%	100	np	100	97	100	100	–	100	100	477
Triage category 2	%	80	84	93	78	79	90	np	70	82	6 066
Triage category 3	%	62	79	81	64	73	75	57	59	70	27 180
Triage category 4	%	68	75	72	74	79	81	45	55	65	33 692
Triage category 5	%	87	90	87	95	95	88	64	89	88	4 907
Total (f)	%	69	80	78	73	78	80	52	59	70	72 322
Total number (f), (g), (h)	<i>no.</i>	3 475	1 321	30 872	6 905	1 786	1 036	61	26 866	72 322	
Very remote											
Triage category 1	%	np	np	100	100	100	np	np	100	100	274
Triage category 2	%	79	82	84	77	80	68	np	65	72	2 903
Triage category 3	%	66	77	72	62	73	66	np	54	60	11 520
Triage category 4	%	70	67	73	73	77	88	np	46	56	12 561
Triage category 5	%	82	95	92	94	91	100	np	77	86	1 520
Total (f)	%	71	75	76	72	77	78	50	53	61	28 778

TABLE 11A.21

Table 11A.21 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Total number (f), (g), (h)	<i>no.</i>	439	154	5 440	4 068	823	233	16	17 605	28 778	
2012-13											
Total (Peer group A and B hospitals)											
Major cities											
Triage category 1	%	100	100	100	100	100	np	99	np	100	29 935
Triage category 2	%	83	84	83	79	74	82	73	60	81	480 970
Triage category 3	%	71	71	63	42	61	64	43	45	64	1 438 534
Triage category 4	%	75	66	72	59	72	71	46	42	69	1 576 191
Triage category 5	%	91	85	92	89	89	92	78	84	89	251 995
Total (f)	%	76	71	70	58	69	73	51	48	70	3 777 625
Total number (f), (g), (h)	<i>no.</i>	1 269 768	934 203	686 307	492 950	287 941	2 201	101 601	2 792	3 777 763	
Inner regional											
Triage category 1	%	100	100	100	100	100	100	np	np	100	6 782
Triage category 2	%	83	83	86	85	74	83	75	62	83	105 899
Triage category 3	%	72	73	75	66	63	59	44	44	72	371 583
Triage category 4	%	75	70	78	73	75	66	48	44	73	474 318
Triage category 5	%	90	88	92	95	92	88	83	86	90	91 432
Total (f)	%	77	74	78	74	71	67	54	49	75	1 050 014
Total number (f), (g), (h)	<i>no.</i>	333 272	320 677	235 634	52 034	17 459	83 505	6 191	1 272	1 050 044	
Outer regional											

TABLE 11A.21

Table 11A.21 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Triage category 1	%	100	100	100	100	100	100	np	100	100	3 740
Triage category 2	%	83	81	87	89	82	82	79	62	82	47 634
Triage category 3	%	73	77	73	83	77	74	42	36	71	157 002
Triage category 4	%	75	75	75	88	78	76	48	37	72	182 628
Triage category 5	%	90	93	94	97	90	92	74	70	92	29 047
Total (f)	%	77	78	77	87	79	77	54	41	75	420 051
Total number (f), (g), (h)	no.	41 340	69 148	137 615	54 428	21 706	46 987	1 452	47 381	420 057	
Remote											
Triage category 1	%	np	np	100	99	np	np	–	100	100	476
Triage category 2	%	83	83	90	92	78	88	np	71	83	6 840
Triage category 3	%	69	76	79	77	70	78	np	61	71	26 234
Triage category 4	%	78	73	67	80	79	74	np	57	68	34 922
Triage category 5	%	91	89	86	95	np	np	np	90	92	6 959
Total (f)	%	76	77	75	83	77	78	np	61	73	75 431
Total number (f), (g), (h)	no.	3 173	1 356	19 800	22 078	1 744	1 213	44	26 023	75 431	
Very remote											
Triage category 1	%	np	np	100	np	np	np	–	100	100	395
Triage category 2	%	np	np	91	88	76	np	np	67	79	4 044
Triage category 3	%	68	np	81	70	67	np	np	56	68	15 040
Triage category 4	%	75	68	68	77	81	np	np	47	60	18 171
Triage category 5	%	np	np	86	94	np	np	np	77	85	2 654

TABLE 11A.21

Table 11A.21 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Total (f)	%	74	73	76	78	75	73	np	54	67	40 304
Total number (f), (g), (h)	no.	837	224	15 314	4 970	800	200	16	17 943	40 304	
2013-14											
Total (Peer group A and B hospitals)											
Major cities											
Triage category 1	%	100	100	100	100	100	np	99	np	100	29 609
Triage category 2	%	83	84	79	85	72	86	83	59	82	511 684
Triage category 3	%	75	73	64	52	60	65	50	46	68	1 493 713
Triage category 4	%	78	70	73	67	71	72	57	49	73	1 615 168
Triage category 5	%	93	86	93	93	89	92	86	88	91	266 347
Total (f)	%	79	74	71	66	68	74	61	52	73	3 916 521
Total number (f), (g), (h)	no.	1 337 791	981 111	688 366	498 622	294 878	2 346	110 524	3 050	3 916 688	
Inner regional											
Triage category 1	%	100	100	100	100	100	100	np	np	100	7 045
Triage category 2	%	86	84	84	91	73	85	85	64	85	115 531
Triage category 3	%	76	71	75	68	61	61	51	42	72	386 189
Triage category 4	%	78	70	77	77	76	67	59	50	74	477 489
Triage category 5	%	91	88	92	94	91	89	89	86	90	87 122
Total (f)	%	80	73	78	76	70	69	63	52	76	1 073 376
Total number (f), (g), (h)	no.	339 342	325 653	240 098	55 104	17 915	87 465	6 459	1 395	1 073 431	

TABLE 11A.21

Table 11A.21 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Outer regional											
Triage category 1	%	100	100	100	100	100	100	np	100	100	3 738
Triage category 2	%	83	85	85	88	79	84	np	54	80	50 539
Triage category 3	%	77	77	75	79	75	74	np	31	72	157 827
Triage category 4	%	80	75	79	86	82	78	np	36	74	185 332
Triage category 5	%	93	92	94	96	94	93	np	68	92	27 923
Total (f)	%	81	79	79	85	80	78	np	39	75	425 359
Total number (f), (g), (h)	<i>no.</i>	41 543	71 331	142 298	52 355	21 975	47 794	1 509	46 564	425 369	
Remote											
Triage category 1	%	np	np	99	100	np	np	0	100	100	550
Triage category 2	%	87	88	91	92	64	87	np	68	81	6 629
Triage category 3	%	80	76	82	80	66	76	np	63	74	25 579
Triage category 4	%	82	75	76	84	77	78	np	61	73	37 021
Triage category 5	%	95	88	90	96	np	np	np	91	93	7 126
Total (f)	%	83	78	80	85	72	79	np	64	76	76 905
Total number (f), (g), (h)	<i>no.</i>	3 045	1 393	19 895	21 637	1 742	1 285	45	27 863	76 905	
Very remote											
Triage category 1	%	np	np	100	np	np	np	0	100	100	386
Triage category 2	%	np	np	91	88	62	np	0	66	76	4 491
Triage category 3	%	77	np	83	77	61	66	np	56	69	15 102
Triage category 4	%	78	np	76	82	78	np	np	49	65	19 287

TABLE 11A.21

Table 11A.21 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Triage category 5	%	np	np	89	96	np	np	np	77	88	2 939
Total (f)	%	80	np	81	83	70	75	np	56	70	42 205
Total number (f), (g), (h)	<i>no.</i>	854	243	15 595	5 663	708	233	11	18 899	42 206	

- (a) The proportion of presentations for which the waiting time to commencement of clinical care was within the time specified in the definition of the triage category. Records were excluded from the calculation of waiting time statistics if the triage category was unknown, if the patient did not wait or was dead on arrival, or if the waiting time was missing or otherwise invalid.
- (b) It should be noted that the data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Peer group A and B hospitals provided over 80 per cent of Emergency Department services.
- (c) Area of usual residence was not reported or not mappable to remoteness areas for approximately 80 000 records.
- (d) Remoteness areas are based on the usual residential address of the patient. Not all remoteness areas are represented in each State or Territory. The remoteness area 'Major city' does not exist within Tasmania or the NT, 'Inner regional' does not exist within the NT, 'Outer regional' does not exist in the ACT, 'Remote' does not exist in the ACT and 'Very remote' does not exist in Victoria or the ACT. However, data are reported for the state/territory where the hospital was located. This means, for example, that although there is no 'major city' classification in Tasmania, Tasmanian hospitals may treat some patients whose usual residence is a major city in another jurisdiction.
- (e) For National Healthcare agreement purposes, the Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B).
- (f) The totals exclude records for which the waiting time to service was invalid, and records for which the episode end status was either 'Did not wait to be attended by a health care professional' or 'Dead on arrival, not treated in emergency department'.
- (g) The totals include records for which the triage category was not assigned or not reported.
- (h) Total includes records for which a remoteness area could not be assigned as the place of residence was unknown or not stated.
- Nil or rounded to zero. **np** Not published.

Source: AIHW (unpublished) National Non-admitted Patient Emergency Department Care Database.

TABLE 11A.22

Table 11A.22 Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
2010-11											
Total (Peer group A and B hospitals)											<i>no.</i>
Quintile 1											
Triage category 1	%	100	100	99	96	100	100	100	100	100	9 349
Triage category 2	%	83	78	80	84	79	74	81	65	80	113 956
Triage category 3	%	70	67	60	81	61	60	48	51	65	405 639
Triage category 4	%	70	61	65	84	64	67	47	46	66	458 109
Triage category 5	%	85	84	88	96	86	86	75	81	86	88 369
Total (f)	%	73	67	66	84	67	66	57	51	69	1 075 442
Total number (f), (g), (h)	<i>no.</i>	316 203	225 603	272 034	41 219	107 740	82 010	1 358	29 275	1 075 442	
Quintile 2											
Triage category 1	%	100	100	100	99	100	100	100	100	100	7 954
Triage category 2	%	79	82	80	71	77	69	82	63	78	110 475
Triage category 3	%	66	75	65	46	66	58	52	50	65	368 031
Triage category 4	%	67	69	71	59	71	67	52	47	67	467 575
Triage category 5	%	83	87	90	89	90	87	81	85	85	115 825
Total (f)	%	71	74	71	58	71	66	60	51	70	1 069 911
Total number (f), (g), (h)	<i>no.</i>	445 116	233 443	172 406	121 030	72 148	13 797	4 595	7 376	1 069 911	
Quintile 3											
Triage category 1	%	100	100	100	98	100	100	100	100	99	8 100
Triage category 2	%	83	81	78	70	76	68	76	68	78	113 383

TABLE 11A.22

Table 11A.22 Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Triage category 3	%	69	71	60	47	65	44	53	54	63	391 949
Triage category 4	%	71	65	67	63	70	52	51	51	66	525 335
Triage category 5	%	86	85	90	91	88	78	78	86	87	89 561
Total (f)	%	73	70	66	61	71	53	58	55	68	1 128 354
Total number (f), (g), (h)	<i>no.</i>	282 092	335 353	198 759	210 377	44 476	19 912	5 460	31 925	1 128 354	
Quintile 4											
Triage category 1	%	100	100	100	99	100	100	99	100	100	7 686
Triage category 2	%	83	81	75	69	78	73	77	60	78	107 432
Triage category 3	%	68	67	55	47	68	35	47	43	60	345 739
Triage category 4	%	70	63	64	61	74	40	46	47	64	389 607
Triage category 5	%	84	84	90	91	91	75	74	81	85	65 696
Total (f)	%	72	68	63	59	73	47	53	49	66	916 182
Total number (f), (g), (h)	<i>no.</i>	200 410	263 773	219 051	115 755	55 678	11 645	32 449	17 421	916 182	
Quintile 5											
Triage category 1	%	100	100	100	100	100	100	100	100	100	6 182
Triage category 2	%	91	83	79	67	75	75	78	59	81	88 770
Triage category 3	%	77	68	60	43	66	47	48	42	65	277 584
Triage category 4	%	79	63	68	61	77	61	48	46	68	329 879
Triage category 5	%	90	84	93	92	90	87	76	81	87	64 554
Total (f)	%	81	69	68	57	73	62	55	48	70	766 985
Total number (f), (g), (h)	<i>no.</i>	251 252	194 979	126 098	95 110	36 324	704	56 320	6 198	766 985	

TABLE 11A.22

Table 11A.22 Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
2011-12											
Total (Peer group A and B hospitals)											
Quintile 1											
Triage category 1	%	100	100	100	97	100	100	100	100	100	9 470
Triage category 2	%	82	80	82	81	79	78	74	63	81	127 348
Triage category 3	%	69	69	61	77	61	67	51	48	66	435 268
Triage category 4	%	71	65	66	82	67	73	48	40	68	473 740
Triage category 5	%	87	87	88	96	87	90	76	75	88	93 801
Total (f)	%	73	70	67	81	68	73	56	47	70	1 139 640
Total number (f), (g), (h)	<i>no.</i>	389 477	236 612	276 336	44 429	80 340	81 375	2 341	28 730	1 139 640	
Quintile 2											
Triage category 1	%	100	100	100	95	100	97	100	100	100	8 494
Triage category 2	%	81	81	82	71	78	72	80	63	80	123 149
Triage category 3	%	67	74	64	55	66	65	52	46	67	400 215
Triage category 4	%	70	69	69	68	72	73	48	41	69	496 351
Triage category 5	%	85	87	89	94	90	90	83	83	87	104 751
Total (f)	%	72	73	69	67	72	71	58	47	71	1 132 992
Total number (f), (g), (h)	<i>no.</i>	436 117	302 859	177 427	91 095	97 018	15 796	3 542	9 138	1 132 992	
Quintile 3											
Triage category 1	%	100	100	100	100	100	100	100	100	100	7 808

TABLE 11A.22

Table 11A.22 Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Triage category 2	%	83	82	83	77	79	73	76	67	81	123 312
Triage category 3	%	72	71	64	47	71	54	50	54	64	406 582
Triage category 4	%	73	64	71	62	74	62	47	50	67	512 527
Triage category 5	%	87	85	91	91	88	86	81	87	88	80 461
Total (f)	%	75	70	70	61	75	63	56	54	69	1 130 726
Total number (f), (g), (h)	<i>no.</i>	311 312	260 021	240 178	240 481	30 253	18 656	2 493	27 332	1 130 726	
Quintile 4											
Triage category 1	%	100	100	100	99	100	100	100	100	100	7 013
Triage category 2	%	84	84	80	75	78	88	75	59	81	110 537
Triage category 3	%	71	69	58	46	68	57	51	32	62	360 456
Triage category 4	%	73	65	67	64	76	63	47	33	66	396 981
Triage category 5	%	88	86	90	93	91	86	80	71	88	62 232
Total (f)	%	75	70	66	61	74	67	55	37	68	937 248
Total number (f), (g), (h)	<i>no.</i>	161 357	313 800	208 897	141 563	57 854	12 122	27 379	14 276	937 248	
Quintile 5											
Triage category 1	%	100	100	100	100	100	np	100	100	100	5 943
Triage category 2	%	82	85	82	73	76	86	76	58	80	97 474
Triage category 3	%	72	72	64	44	69	68	49	31	64	296 107
Triage category 4	%	76	66	72	64	79	69	48	31	68	346 779
Triage category 5	%	89	87	93	93	93	91	81	66	88	63 317
Total (f)	%	77	72	71	60	76	74	55	36	70	809 665

TABLE 11A.22

Table 11A.22 Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Total number (f), (g), (h)	<i>no.</i>	256 640	183 744	129 781	117 033	33 586	654	73 390	14 837	809 665	
2012-13											
Total (Peer group A and B hospitals)											
Quintile 1											
Triage category 1	%	100	100	100	100	100	100	np	100	100	10 295
Triage category 2	%	82	83	84	81	76	83	72	66	82	153 669
Triage category 3	%	70	70	70	53	60	67	42	52	68	500 861
Triage category 4	%	73	67	73	64	69	71	45	45	70	556 303
Triage category 5	%	90	85	90	91	86	90	77	77	89	95 550
Total (f)	%	75	72	74	65	68	72	52	52	72	1 316 678
Total number (f), (g), (h)	<i>no.</i>	439 381	268 853	324 123	87 746	96 400	73 748	1 851	24 605	1 316 707	
Quintile 2											
Triage category 1	%	100	100	100	100	100	100	np	np	100	9 332
Triage category 2	%	83	82	85	84	74	83	76	62	82	137 360
Triage category 3	%	71	74	66	60	63	66	47	46	68	430 056
Triage category 4	%	74	68	73	69	72	70	49	43	71	498 808
Triage category 5	%	90	88	92	93	89	89	78	80	90	89 533
Total (f)	%	76	73	73	70	70	72	55	48	73	1 165 089
Total number (f), (g), (h)	<i>no.</i>	390 723	298 415	196 355	139 876	100 381	20 738	3 864	14 773	1 165 125	
Quintile 3											

TABLE 11A.22

Table 11A.22 Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Triage category 1	%	100	100	100	100	100	100	np	100	100	7 807
Triage category 2	%	82	84	84	78	74	79	72	68	82	126 928
Triage category 3	%	70	71	64	46	64	61	40	56	65	392 136
Triage category 4	%	75	66	74	61	75	67	45	53	69	445 313
Triage category 5	%	90	86	92	91	90	90	80	89	89	70 407
Total (f)	%	75	72	72	60	71	68	50	58	70	1 042 591
Total number (f), (g), (h)	<i>no.</i>	288 475	283 378	229 339	143 660	41 789	22 509	7 507	25 975	1 042 632	
Quintile 4											
Triage category 1	%	100	100	100	100	100	100	99	100	100	7 520
Triage category 2	%	84	85	84	80	72	88	73	62	82	122 389
Triage category 3	%	73	71	65	47	62	57	43	36	65	380 143
Triage category 4	%	76	67	73	62	76	66	46	37	69	426 438
Triage category 5	%	91	86	93	91	92	88	77	69	89	66 146
Total (f)	%	78	72	72	61	71	68	51	42	70	1 002 636
Total number (f), (g), (h)	<i>no.</i>	226 135	305 834	216 864	118 247	65 955	15 159	34 556	19 909	1 002 659	
Quintile 5											
Triage category 1	%	100	100	100	100	100	np	100	np	100	6 365
Triage category 2	%	83	84	85	79	72	88	74	63	82	104 891
Triage category 3	%	73	71	70	43	65	63	43	36	65	304 795
Triage category 4	%	78	68	77	60	79	71	46	37	70	358 829
Triage category 5	%	92	87	95	89	94	90	79	71	90	60 307

TABLE 11A.22

Table 11A.22 **Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Total (f)	%	78	73	76	58	73	73	52	41	71	835 187
Total number (f), (g), (h)	<i>no.</i>	303 621	169 065	127 696	136 734	25 077	1 951	60 942	10 146	835 232	
2013-14											
Total (Peer group A and B hospitals)											
Quintile 1											
Triage category 1	%	100	100	100	100	100	100	np	100	100	10 551
Triage category 2	%	83	83	80	88	73	84	84	63	82	167 135
Triage category 3	%	74	71	69	62	59	68	53	51	70	514 984
Triage category 4	%	76	70	73	73	69	73	59	47	73	565 934
Triage category 5	%	92	86	91	93	87	90	86	76	90	95 645
Total (f)	%	78	73	73	72	67	74	64	52	74	1 354 249
Total number (f), (g), (h)	<i>no.</i>	458 113	280 668	329 815	85 730	97 229	75 094	2 088	25 584	1 354 321	
Quintile 2											
Triage category 1	%	100	100	100	100	100	np	np	100	100	9 173
Triage category 2	%	84	85	81	87	74	86	86	57	83	144 658
Triage category 3	%	75	75	67	64	63	67	56	43	70	439 061
Triage category 4	%	78	71	75	74	71	72	59	43	74	502 416
Triage category 5	%	92	89	92	95	89	90	88	79	91	87 705
Total (f)	%	79	75	73	74	70	73	65	46	75	1 183 013
Total number (f), (g), (h)	<i>no.</i>	406 229	308 140	192 732	133 469	102 526	21 268	3 887	14 802	1 183 053	

TABLE 11A.22

Table 11A.22 Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Quintile 3											
Triage category 1	%	100	100	100	100	100	100	np	100	100	7 837
Triage category 2	%	83	85	82	86	71	85	84	64	82	135 817
Triage category 3	%	73	72	66	55	62	64	49	59	68	406 891
Triage category 4	%	77	69	75	69	74	69	55	58	72	455 130
Triage category 5	%	92	87	93	94	90	91	83	90	90	70 225
Total (f)	%	78	74	73	68	70	70	60	60	73	1 075 900
Total number (f), (g), (h)	<i>no.</i>	298 999	295 114	230 469	147 725	44 324	23 913	7 857	27 545	1 075 946	
Quintile 4											
Triage category 1	%	100	100	100	100	100	100	99	100	100	7 412
Triage category 2	%	84	85	82	86	72	86	82	56	82	128 418
Triage category 3	%	76	72	68	54	62	59	50	31	68	393 742
Triage category 4	%	80	71	76	68	76	66	55	36	72	436 286
Triage category 5	%	94	88	94	94	92	88	85	68	90	70 976
Total (f)	%	80	74	74	67	71	68	60	39	73	1 036 834
Total number (f), (g), (h)	<i>no.</i>	238 115	319 798	215 578	122 718	67 847	16 680	37 017	19 116	1 036 869	
Quintile 5											
Triage category 1	%	100	100	100	100	100	np	100	np	100	6 348
Triage category 2	%	84	84	84	85	71	87	83	54	83	112 732
Triage category 3	%	77	75	72	51	63	56	50	32	69	323 347
Triage category 4	%	81	72	79	66	79	71	57	38	74	373 993
Triage category 5	%	94	88	95	93	93	93	86	73	92	66 736

TABLE 11A.22

Table 11A.22 **Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Aust (total number)</i>
Total (f)	%	81	76	78	65	72	71	61	40	75	883 156
Total number (f), (g), (h)	<i>no.</i>	321 017	175 928	137 454	143 591	25 246	2 147	67 093	10 720	883 196	

- (a) The proportion of presentations for which the waiting time to commencement of clinical care was within the time specified in the definition of the triage category. Records were excluded from the calculation of waiting time statistics if the triage category was unknown, if the patient did not wait or was dead on arrival, or if the waiting time was missing or otherwise invalid.
- (b) SEIFA quintiles are based on the SEIFA IRSD, with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. The SEIFA quintiles represent approximately 20 per cent of the national population, but do not necessarily represent 20 per cent of the population in each state or territory. Disaggregation by SEIFA is based on the patient's usual residence, not the location of the hospital.
- (c) It should be noted that the data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Peer group A and B hospitals provided over 80 per cent of Emergency Department services.
- (d) Area of usual residence was not reported or not mappable to SEIFA categories for approximately 80 000 records.
- (e) For National Healthcare agreement purposes, the Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B).
- (f) The totals exclude records for which the waiting time to service was invalid, and records for which the episode end status was either 'Did not wait to be attended by a health care professional' or 'Dead on arrival, not treated in emergency department'.
- (g) The totals include records for which the triage category was not assigned or not reported.
- (h) Total includes separations for which a SEIFA category could not be assigned as the place of residence was unknown or not stated.

Source: AIHW (unpublished) National Non-admitted Patient Emergency Department Care Database.

TABLE 11A.23

Table 11A.23 **Percentage of presentations where the time from presentation to physical departure (Emergency Department (ED) Stay length) is within four hours, by State and Territory (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2011-12										
Number of ED presentations where ED Stay is less than or equal to four hours	no.	1 331 758	975 275	789 155	577 182	275 963	94 076	68 357	94 403	4 206 169
Total number of ED presentations	no.	2 231 891	1 509 052	1 238 522	725 840	427 011	141 700	118 396	144 842	6 537 254
ED Stay length is within four hours	%	59.7	64.6	63.7	79.5	64.6	66.4	57.7	65.2	64.3
2012-13										
Number of ED presentations where ED Stay is less than or equal to four hours	no.	1 447 210	1 002 616	921 527	581 873	300 787	98 992	68 172	92 578	4 513 755
Total number of ED presentations	no.	2 275 808	1 528 608	1 284 158	754 119	455 220	147 064	118 931	145 532	6 709 440
ED Stay length is within four hours	%	63.6	65.6	71.8	77.2	66.1	67.3	57.3	63.6	67.3
2013-14										
Number of ED presentations where ED Stay is less than or equal to four hours	no.	1 946 951	1 084 460	1 031 765	590 031	298 650	100 372	77 844	89 438	5 219 511
Total number of ED presentations	no.	2 634 923	1 572 787	1 351 573	742 615	463 171	148 278	125 888	145 176	7 184 411
ED Stay length is within four hours	%	73.9	69.0	76.3	79.5	64.5	67.7	61.8	61.6	72.7

Table 11A.23 **Percentage of presentations where the time from presentation to physical departure (Emergency Department (ED) Stay length) is within four hours, by State and Territory (a)**

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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(a) Invalid records are excluded from the numerator and denominator. Invalid records are records for which: the length of stay is less than zero (0), the presentation date or time is missing or the physical departure date or time is missing.

(b) For National Healthcare agreement purposes, the Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B).

Source: AIHW various years, *Australian hospital statistics 2013–14: emergency department care*, Health services series no. 58. Cat. no. HSE 153. Canberra: AIHW, Canberra; AIHW (2013), *Australian hospital statistics 2012–13: emergency department care*, Health services series no. 52. Cat. no. HSE 142. Canberra: AIHW, Canberra; AIHW (2012), *Australian hospital statistics 2011–12: emergency department care*, Health services series no. 45. Cat. no. HSE 126. Canberra; AIHW (unpublished), National Non-admitted Patient Emergency Department Care Database.

TABLE 11A.24

Table 11A.24 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (b)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2004-05									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	26	19	16	4	5	2	1	2	75
Est coverage of surgical separations (e)	100	100	97	100	100	100	100	100	99
Number of admissions (f)	117 762	84 230	90 171	29 258	30 193	10 451	4 994	5 026	372 085
Days waited at 50th percentile	29	28	22	26	36	41	np	25	28
Days waited at 90th percentile	274	216	105	184	203	373	np	252	203
% waited more than 365 days	6.7	4.3	1.9	3.4	3.9	10.3	np	5.5	4.6
Large hospitals									
Number of reporting hospitals (d)	16	8	6	2	2	1	1	..	36
Est coverage of surgical separations (e)	100	73	100	48	100	66	100	..	82
Number of admissions (f)	34 153	32 307	13 272	7 696	6 511	3 354	3 623	..	100 916
Days waited at 50th percentile	41	23	22	np	30	np	np	..	29
Days waited at 90th percentile	330	159	95	np	179	np	np	..	227
% waited more than 365 days	7.6	2.3	1.5	np	4.5	np	np	..	4.8
Medium hospitals									
Number of reporting hospitals (d)	41	5	9	4	–	..	..	..	59
Est coverage of surgical separations (e)	100	37	83	75	–	..	..	..	62
Number of admissions (f)	41 509	12 668	5 433	10 220	na	..	..	..	69 830
Days waited at 50th percentile	47	34	28	23	na	..	..	..	37
Days waited at 90th percentile	316	213	137	182	na	..	..	..	272
% waited more than 365 days	7.3	6.0	1.5	4.0	na	..	..	..	6.1
Total (g)									
Number of reporting hospitals (d)	104	32	31	11	7	3	2	5	195
Est coverage of surgical separations (e)	100	79	96	72	62	90	100	100	87

TABLE 11A.24

Table 11A.24 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (b)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Number of admissions (f)	197 600	129 205	108 876	49 295	36 704	13 805	8 617	5 644	549 746
Admissions per 1000 population (h)	29.3	25.9	27.7	24.7	23.9	28.5	26.6	28.1	27.2
Days waited at 50th percentile	34	28	22	27	35	34	45	29	29
Days waited at 90th percentile	294	200	105	197	201	352	368	266	217
% waited more than 365 days	6.9	4.0	1.8	3.8	4.0	9.5	10.1	5.9	4.8
2005-06									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	28	19	16	4	5	3	1	2	78
Est coverage of surgical separations (e)	100	100	97	100	100	100	100	100	99
Number of admissions (f)	127 298	85 425	89 393	28 512	30 352	15 041	5 106	5 076	386 203
Days waited at 50th percentile	31	32	24	30	38	34	np	26	30
Days waited at 90th percentile	278	238	132	208	213	332	np	298	228
% waited more than 365 days	5.6	5.0	2.3	4.5	3.9	8.7	np	7.2	4.7
Large hospitals									
Number of reporting hospitals (d)	14	9	6	2	2	..	1	..	34
Est coverage of surgical separations (e)	100	72	100	52	100	..	100	..	81
Number of admissions (f)	29 741	37 473	12 435	8 630	5 567	..	3 970	..	97 816
Days waited at 50th percentile	43	32	26	22	40	..	np	..	35
Days waited at 90th percentile	312	222	105	224	199	..	np	..	251
% waited more than 365 days	5.4	3.9	1.4	4.5	6.1	..	np	..	4.6
Medium hospitals									
Number of reporting hospitals (d)	36	4	7	4	–	..	..	..	51
Est coverage of surgical separations (e)	100	36	86	78	–	..	..	..	62
Number of admissions (f)	38 306	11 626	4 034	9 675	na	..	..	..	63 641
Days waited at 50th percentile	48	32	28	23	na	..	..	..	38

TABLE 11A.24

Table 11A.24 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (b)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Days waited at 90th percentile	304	136	112	145	na	..	..	..	257
% waited more than 365 days	4.8	2.1	1.1	2.7	na	..	..	..	3.8
Total (g)									
Number of reporting hospitals (d)	100	32	31	11	7	3	2	5	191
Est coverage of surgical separations (e)	100	79	96	76	63	100	100	100	87
Number of admissions (f)	201 438	134 524	106 323	48 935	35 919	15 041	9 076	5 695	556 951
Admissions per 1000 population (h)	29.6	26.6	26.6	24.1	23.2	30.9	27.8	27.9	27.2
Days waited at 50th percentile	36	32	25	28	38	34	61	30	32
Days waited at 90th percentile	291	224	127	205	212	332	372	313	237
% waited more than 365 days	5.4	4.5	2.1	4.3	4.2	8.7	10.3	7.7	4.6
2006-07									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	29	20	17	5	5	3	1	2	82
Est coverage of surgical separations (e)	100	100	97	84	100	100	100	100	98
Number of admissions (f)	134 093	86 679	91 827	26 002	31 705	14 181	5 129	5 215	394 831
Days waited at 50th percentile	31	29	26	29	39	38	np	31	30
Days waited at 90th percentile	259	224	149	223	207	343	np	363	225
% waited more than 365 days	2.3	4.0	2.6	5.0	3.8	9.2	np	9.8	3.4
Large hospitals									
Number of reporting hospitals (d)	12	8	5	2	2	..	1	..	30
Est coverage of surgical separations (e)	100	70	100	42	100	..	100	..	77
Number of admissions (f)	24 825	33 713	11 658	8 571	5 489	..	4 177	..	88 433
Days waited at 50th percentile	39	33	22	23	43	..	np	..	33
Days waited at 90th percentile	266	195	96	233	201	..	np	..	224
% waited more than 365 days	1.3	2.3	1.9	3.8	4.5	..	np	..	2.7

TABLE 11A.24

Table 11A.24 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (b)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Medium hospitals									
Number of reporting hospitals (d)	37	4	7	4	–	..	..	..	52
Est coverage of surgical separations (e)	100	35	81	80	–	..	..	..	63
Number of admissions (f)	36 573	11 277	4 090	11 718	na	..	..	..	63 658
Days waited at 50th percentile	50	28	27	28	na	..	..	..	39
Days waited at 90th percentile	271	137	125	209	na	..	..	..	231
% waited more than 365 days	1.1	1.2	1.1	4.2	na	..	..	..	1.7
Total (g)									
Number of reporting hospitals (d)	99	32	31	13	7	3	2	5	192
Est coverage of surgical separations (e)	100	79	96	67	64	100	100	100	87
Number of admissions (f)	201 630	131 669	107 893	48 986	37 194	14 181	9 306	5 911	556 770
Admissions per 1000 population (h)	29.4	25.5	26.1	23.5	23.6	28.8	27.7	27.8	26.7
Days waited at 50th percentile	35	30	25	29	40	38	63	35	32
Days waited at 90th percentile	260	208	142	225	206	343	364	370	226
% waited more than 365 days	1.9	3.3	2.5	4.6	3.9	9.2	9.9	10.2	3.1
2007-08									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	29	20	18	6	5	2	1	2	83
Est coverage of surgical separations (e)	100	100	100	100	100	100	100	100	100
Number of admissions (f)	133 191	90 392	92 935	30 354	33 402	10 516	5 322	5 406	401 518
Days waited at 50th percentile	33	30	27	29	42	39	np	39	31
Days waited at 90th percentile	275	232	143	225	203	400	np	329	233
% waited more than 365 days	2.2	4.3	2.6	4.1	3.5	11.1	np	8.0	3.4
Large hospitals									
Number of reporting hospitals (d)	15	8	5	3	2	1	1	..	35

TABLE 11A.24

Table 11A.24 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (b)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Est coverage of surgical separations (e)	100	68	100	57	100	100	100	..	80
Number of admissions (f)	28 980	32 028	10 515	11 778	6 286	3 633	4 255	..	97 475
Days waited at 50th percentile	42	40	27	27	53	np	np	..	39
Days waited at 90th percentile	281	211	112	189	276	np	np	..	237
% waited more than 365 days	0.9	2.3	0.9	1.2	6.6	np	np	..	2.4
Medium hospitals									
Number of reporting hospitals (d)	36	3	7	4	1	..	..	..	51
Est coverage of surgical separations (e)	100	32	85	81	22	..	..	..	64
Number of admissions (f)	32 030	7 886	3 993	12 809	1 358	..	..	..	58 076
Days waited at 50th percentile	60	29	34	31	np	..	..	..	42
Days waited at 90th percentile	290	124	117	177	np	..	..	..	238
% waited more than 365 days	1.3	0.6	0.4	2.2	np	..	..	..	1.4
Total (g)									
Number of reporting hospitals (d)	98	31	31	14	8	3	2	5	192
Est coverage of surgical separations (e)	100	80	98	79	70	100	100	100	91
Number of admissions (f)	199 578	130 306	107 623	57 122	41 046	14 149	9 577	6 100	565 501
Admissions per 1000 population (h)	28.7	24.8	25.4	26.7	25.8	28.6	28.0	28.1	26.6
Days waited at 50th percentile	39	33	27	30	42	36	72	43	34
Days waited at 90th percentile	278	221	137	206	208	369	372	337	235
% waited more than 365 days	1.8	3.6	2.3	3.0	3.9	10.1	10.3	8.6	3.0
2008-09									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	29	20	19	6	5	2	2	2	85
Est coverage of surgical separations (e)	100	100	100	100	100	100	100	100	100
Number of admissions (f)	134 856	104 532	98 135	31 125	34 827	12 450	10 104	5 646	431 675

TABLE 11A.24

Table 11A.24 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (b)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Days waited at 50th percentile	33	28	26	29	39	49	75	38	31
Days waited at 90th percentile	273	201	133	181	208	460	378	243	216
% waited more than 365 days	2.8	3.3	1.9	2.6	2.4	13.6	11.0	5.0	3.2
Large hospitals									
Number of reporting hospitals (d)	15	8	4	4	2	1	..	..	34
Est coverage of surgical separations (e)	100	70	100	87	100	100	..	..	84
Number of admissions (f)	28 391	35 342	7 158	12 485	6 033	2 357	..	..	91 766
Days waited at 50th percentile	45	39	37	28	41	np	..	..	40
Days waited at 90th percentile	293	188	146	178	263	np	..	..	227
% waited more than 365 days	2.1	1.9	1.1	1.4	4.8	np	..	..	2.5
Medium hospitals									
Number of reporting hospitals (d)	35	3	8	4	1	1	..	..	52
Est coverage of surgical separations (e)	100	26	89	78	21	100	..	..	60
Number of admissions (f)	30 299	7 816	4 634	14 650	na	2 124	..	..	62 815
Days waited at 50th percentile	59	42	29	32	na	np	..	..	42
Days waited at 90th percentile	300	132	123	152	na	np	..	..	230
% waited more than 365 days	1.6	1.5	0.9	1.4	na	np	..	..	1.5
Total (g)									
Number of reporting hospitals (d)	98	31	32	15	8	4	2	5	195
Est coverage of surgical separations (e)	100	78	98	85	70	100	100	100	91
Number of admissions (f)	199 384	147 690	109 940	60 398	44 152	16 931	10 104	6 410	595 009
Admissions per 1000 population (h)	28.3	27.5	25.3	27.4	27.4	33.8	29.0	28.9	27.5
Days waited at 50th percentile	39	31	27	31	36	44	75	40	33
Days waited at 90th percentile	283	194	133	174	207	448	378	256	220
% waited more than 365 days	2.5	2.9	1.8	2.0	2.7	13.1	10.6	5.6	2.9

TABLE 11A.24

Table 11A.24 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (b)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2009-10									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	29	20	19	5	5	2	2	2	84
Est coverage of surgical separations (e)	100	98	100	100	96	100	97	100	100
Number of admissions (f)	135 790	109 398	100 846	29 888	34 660	12 443	9 778	5 500	438 303
Days waited at 50th percentile	37	32	27	30	36	36	73	42	33
Days waited at 90th percentile	319	193	150	176	197	363	357	256	234
% waited more than 365 days	5.0	3.2	2.5	2.1	1.2	9.9	9.6	5.3	3.7
Large hospitals									
Number of reporting hospitals (d)	14	9	4	3	2	1	–	–	33
Est coverage of surgical separations (e)	100	76	100	74	100	100	..	..	88
Number of admissions (f)	27 099	38 927	8 219	12 919	6 443	2 093	..	..	95 700
Days waited at 50th percentile	57	44	29	27	43	np	..	..	42
Days waited at 90th percentile	342	215	174	142	181	np	..	..	259
% waited more than 365 days	5.9	2.1	2.5	0.6	0.7	np	..	..	3.0
Medium hospitals									
Number of reporting hospitals (d)	34	3	8	4	1	1	–	–	51
Est coverage of surgical separations (e)	100	24	96	77	19	100	..	..	61
Number of admissions (f)	30 130	7 436	4 750	14 063	3 124	2 074	..	..	61 577
Days waited at 50th percentile	65	48	30	34	np	np	..	..	45
Days waited at 90th percentile	342	165	125	143	np	np	..	..	296
% waited more than 365 days	4.6	2.3	2.1	1.1	np	np	..	..	3.1
Total (g)									
Number of reporting hospitals (d)	96	32	32	14	8	4	2	5	193
Est coverage of surgical separations (e)	100	78	100	79	68	100	97	100	91

TABLE 11A.24

Table 11A.24 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (b)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Number of admissions (f)	198 503	155 761	113 834	61 298	44 227	16 610	9 778	6 244	606 255
Admissions per 1000 population (h)	27.6	28.3	25.4	27.0	27.1	32.9	27.6	27.4	27.4
Days waited at 50th percentile	44	36	27	32	36	36	73	44	35
Days waited at 90th percentile	330	197	150	161	189	332	357	271	246
% waited more than 365 days	4.9	2.8	2.5	1.5	1.1	8.7	9.5	5.8	3.5
2010-11									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	30	20	19	6	5	2	1	2	85
Est coverage of surgical separations (e)	100	99	100	100	99	100	100	100	100
Number of admissions (f)	142 084	112 381	100 808	34 286	35 970	12 334	6 245	5 783	449 891
Days waited at 50th percentile	39	34	29	29	38	38	np	30	34
Days waited at 90th percentile	332	188	151	171	214	332	np	211	242
% waited more than 365 days	4.0	3.0	1.4	1.8	2.1	10.8	np	3.4	3.1
Large hospitals									
Number of reporting hospitals (d)	16	9	4	3	2	1	1	–	36
Est coverage of surgical separations (e)	100	71	100	94	100	100	100	..	92
Number of admissions (f)	30 158	36 090	8 568	13 179	7 044	2 082	5 093	..	102 214
Days waited at 50th percentile	63	40	28	26	48	np	np	..	42
Days waited at 90th percentile	335	167	125	132	236	np	np	..	263
% waited more than 365 days	3.3	1.1	1.0	1.0	1.8	np	np	..	2.4
Medium hospitals									
Number of reporting hospitals (d)	30	4	8	4	1	1	–	–	48
Est coverage of surgical separations (e)	100	27	85	85	19	100	..	..	61
Number of admissions (f)	26 045	8 520	4 373	15 111	3 067	2 081	..	..	59 197
Days waited at 50th percentile	63	56	29	33	np	np	..	..	46

TABLE 11A.24

Table 11A.24 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (b)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Days waited at 90th percentile	331	165	139	148	np	np	..	..	273
% waited more than 365 days	1.7	1.0	0.7	1.2	np	np	..	..	1.6
Total (g)									
Number of reporting hospitals (d)	96	34	32	14	8	4	2	5	195
Est coverage of surgical separations (e)	100	78	98	92	71	100	100	100	93
Number of admissions (f)	204 820	157 073	113 760	64 785	46 081	16 497	11 338	6 429	620 783
Admissions per 1000 population (h)	28.2	28.1	25.0	28.0	27.9	32.4	31.3	28.0	27.6
Days waited at 50th percentile	47	36	29	29	38	38	76	33	36
Days waited at 90th percentile	333	182	148	159	208	359	378	223	252
% waited more than 365 days	3.6	2.5	1.3	1.6	2.0	9.6	10.8	3.9	2.9
2011-12									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	30	21	16	7	5	2	2	2	85
Est coverage of surgical separations (e)	100	98	89	100	100	100	100	100	97
Number of admissions (f)	146 951	114 380	98 950	37 685	37 176	11 970	11 362	6 572	465 046
Days waited at 50th percentile	43	34	26	31	35	39	63	36	35
Days waited at 90th percentile	339	193	150	173	195	418	296	212	253
% waited more than 365 days	3.9	2.7	2.1	2.2	2.0	11.9	6.2	3.1	3.2
Large hospitals									
Number of reporting hospitals (d)	14	8	4	7	2	1	..	..	36
Est coverage of surgical separations (e)	100	74	100	100	100	100	..	..	89
Number of admissions (f)	27 461	32 461	8 961	23 195	7 490	1 934	..	..	101 502
Days waited at 50th percentile	63	38	29	28	49	np	..	..	40
Days waited at 90th percentile	322	166	154	141	235	np	..	..	236
% waited more than 365 days	2.8	1.6	2.1	1.2	1.4	np	..	..	1.9

TABLE 11A.24

Table 11A.24 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (b)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Medium hospitals									
Number of reporting hospitals (d)	33	3	8	5	13	1	..	..	63
Est coverage of surgical separations (e)	100	26	86	100	100	100	..	..	78
Number of admissions (f)	31 849	7 238	4 523	14 584	16 796	1 898	..	..	76 888
Days waited at 50th percentile	64	58	29	33	30	np	..	..	44
Days waited at 90th percentile	330	207	119	160	174	np	..	..	260
% waited more than 365 days	2.1	1.9	0.1	1.4	0.7	np	..	..	1.5
Total (g)									
Number of reporting hospitals (d)	96	32	29	36	40	4	2	5	244
Est coverage of surgical separations (e)	100	80	89	100	96	100	100	100	92
Number of admissions (f)	211 452	154 079	114 328	82 248	65 186	15 802	11 362	7 250	661 707
Admissions per 1000 population (h)	29.6	28.2	25.8	35.6	40.0	31.1	31.5	31.5	30.0
Days waited at 50th percentile	49	36	27	30	34	38	63	39	36
Days waited at 90th percentile	335	189	147	159	191	348	296	219	251
% waited more than 365 days	3.4	2.4	2.0	1.7	1.5	9.4	6.2	3.5	2.7
2012-13									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	31	21	20	7	5	2	2	2	90
Est coverage of surgical separations (e)	100	98	100	100	100	100	100	100	99
Number of admissions (f)	151 744	115 578	102 656	40 325	35 664	11 654	11 628	7 119	476 368
Days waited at 50th percentile	43	35	26	30	36	45	51	37	35
Days waited at 90th percentile	340	222	168	175	175	462	277	193	269
% waited more than 365 days	3.4	3.5	2.6	2.2	1.4	12.9	4.1	3.3	3.3
Large hospitals									
Number of reporting hospitals (d)	13	8	4	7	2	1	..	..	35

TABLE 11A.24

Table 11A.24 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (b)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Est coverage of surgical separations (e)	100	70	100	100	100	100	..	..	87
Number of admissions (f)	25 784	31 223	10 661	23 359	7 639	1 816	..	..	100 482
Days waited at 50th percentile	63	32	28	30	43	np	..	..	38
Days waited at 90th percentile	323	176	140	149	227	np	..	..	238
% waited more than 365 days	1.5	2.3	2.5	0.4	1.0	np	..	..	1.6
Medium hospitals									
Number of reporting hospitals (d)	30	3	8	5	12	1	..	..	59
Est coverage of surgical separations (e)	100	26	84	100	100	100	..	..	78
Number of admissions (f)	31 177	6 614	4 255	14 673	16 922	2 005	..	..	75 646
Days waited at 50th percentile	63	80	28	32	28	np	..	..	45
Days waited at 90th percentile	326	320	115	140	188	np	..	..	287
% waited more than 365 days	1.1	3.8	0.2	1.3	0.2	np	..	..	1.3
Total (g)									
Number of reporting hospitals (d)	96	32	33	35	39	4	2	5	246
Est coverage of surgical separations (e)	100	80	98	100	97	100	100	100	93
Number of admissions (f)	216 106	153 415	119 767	84 981	64 136	15 475	11 628	7 808	673 316
Admissions per 1000 population (h)	29.4	27.0	26.0	34.4	38.6	30.2	30.6	33.0	29.4
Days waited at 50th percentile	50	36	27	30	34	41	51	40	36
Days waited at 90th percentile	335	223	163	159	182	406	277	196	265
% waited more than 365 days	2.8	3.3	2.5	1.5	1.0	11.5	4.1	3.3	2.7
2013-14									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	31	21	21	9	5	2	2	2	93
Est coverage of surgical separations (e)	100	100	100	100	100	100	100	100	100
Number of admissions (f)	151 072	127 686	114 831	50 413	35 349	11 327	11 781	6 804	509 263

TABLE 11A.24

Table 11A.24 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (b)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Days waited at 50th percentile	43	35	28	28	38	49	48	32	35
Days waited at 90th percentile	330	221	197	150	154	479	270	167	258
% waited more than 365 days	2.1	3.5	3.1	1.0	1.0	13.2	4.7	2.3	2.8
Large hospitals									
Number of reporting hospitals (d)	14	8	3	5	3	2	..	..	35
Est coverage of surgical separations (e)	100	67	100	100	100	100	..	..	85
Number of admissions (f)	28 644	34 132	7 303	15 116	8 755	3 988	..	..	97 938
Days waited at 50th percentile	62	31	31	29	47	38	..	..	39
Days waited at 90th percentile	317	185	142	139	256	330	..	..	253
% waited more than 365 days	0.7	2.6	0.5	–	1.1	6.7	..	..	1.5
Medium hospitals									
Number of reporting hospitals (d)	30	3	8	5	11	..	..	..	57
Est coverage of surgical separations (e)	100	21	83	100	100	..	..	..	73
Number of admissions (f)	29 587	8 496	3 879	15 523	14 950	..	..	..	72 435
Days waited at 50th percentile	63	68	27	31	30	..	..	..	46
Days waited at 90th percentile	332	309	124	124	195	..	..	..	289
% waited more than 365 days	0.9	1.8	0.2	0.3	0.2	..	..	..	0.7
Total (g)									
Number of reporting hospitals (d)	96	32	33	34	38	4	2	5	244
Est coverage of surgical separations (e)	100	77	98	100	97	100	100	100	93
Number of admissions (f)	216 675	170 314	127 494	86 882	62 968	15 315	11 781	7 594	699 023
Admissions per 1000 population (h)	29.0	29.4	27.2	34.1	37.5	29.8	30.7	31.3	30.0
Days waited at 50th percentile	49	35	28	29	35	45	48	36	36
Days waited at 90th percentile	329	222	186	142	180	401	270	183	262

Table 11A.24 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	NSW	Vic	Qld (b)	WA	SA	Tas (c)	ACT	NT	Aust
% waited more than 365 days	1.8	3.2	2.8	0.7	0.8	11.5	4.7	2.8	2.4

(a) Public hospitals only. Principal referral hospitals and women's and children's hospitals include major cities hospitals with > 20 000 acute casemix adjusted separations a year and regional hospitals with > 16 000 acute casemix adjusted separations a year, as well as specialised acute women's and children's hospitals with > 10 000 acute casemix adjusted separations a year. Large hospitals include major cities acute hospitals treating > 10 000 acute casemix adjusted separations a year, regional acute hospitals treating > 8000 acute casemix adjusted separations a year and remote hospitals with > 5000 acute casemix adjusted separations a year. Medium hospitals include medium acute hospitals in regional and major city areas treating between 5000 and 10 000 acute casemix adjusted separations a year and medium acute hospitals in regional and major city areas treating between 2000 and 5000 acute casemix adjusted separations per year, plus acute hospitals treating < 2000 acute casemix adjusted separations a year but with > 2000 separations a year.

(b) For Queensland, the number of admissions includes admissions that were removed from the waiting list for elective admission before the start of the collection period or separated before the end of the collection period. It is expected that these admissions would be counterbalanced overall by the number of admissions occurring in a similar way in future reporting periods.

(c) Includes data for the Mersey Community Hospital.

(d) Number of hospitals reporting to the National Elective Surgery Waiting Times Data Collection.

(e) The number of separations with urgency of admission reported as 'elective' and a surgical procedure for public hospitals reporting to the National Elective Surgery Waiting Times Data Collection as a proportion of the number of separations with urgency of admission of 'elective' and a surgical procedure for all public hospitals.

(f) Number of admissions for elective surgery reported to the National Elective Surgery Waiting Times Data Collection.

(g) Includes data for hospitals not included in the specified hospital peer groups.

(h) Crude rate based on the Australian estimated resident population as at 31 December.

na Not available. .. Not applicable. – Nil or rounded to zero. **np** Not published.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra; AIHW (2014), *Australian hospital statistics 2013–14: elective surgery waiting times*. Health services series no. 56. Cat. no. HSE 151. Canberra: AIHW; AIHW (2013), *Australian hospital statistics 2012–13: elective surgery waiting times*. Health services series no. 51. Cat. no. HSE 140. Canberra: AIHW

TABLE 11A.25

Table 11A.25 **Elective surgery waiting times, by specialty of surgeon**

	NSW	Vic	Qld (a)	WA	SA	Tas (b)	ACT	NT	Aust
2004-05									
Cardio-thoracic									
Days waited at 50th percentile	14	5	8	13	12	24	17	..	11
Days waited at 90th percentile	69	66	69	42	70	86	35	..	62
% waited more than 365 days	0.2	–	0.3	–	0.2	–	–	..	0.1
Ear, nose and throat surgery									
Days waited at 50th percentile	60	29	15	83	50	39	116	55	37
Days waited at 90th percentile	446	192	105	351	314	448	689	384	322
% waited more than 365 days	14.1	4.9	2.9	9.6	8.6	13.0	17.3	10.7	8.4
General surgery									
Days waited at 50th percentile	27	26	25	20	31	28	28	51	27
Days waited at 90th percentile	163	194	99	120	142	199	201	315	155
% waited more than 365 days	3.1	3.7	1.6	1.5	1.9	3.3	2.8	8.1	2.8
Gynaecology									
Days waited at 50th percentile	27	28	21	19	28	29	30	6	25
Days waited at 90th percentile	133	139	87	68	128	141	160	66	113
% waited more than 365 days	2.2	1.7	0.9	0.5	0.6	0.8	0.8	1.2	1.5
Neurosurgery									
Days waited at 50th percentile	21	21	11	34	21	42	70	..	22
Days waited at 90th percentile	129	149	78	134	153	436	337	..	141
% waited more than 365 days	1.9	1.2	0.4	1.2	2.0	13.7	9.0	..	1.7
Ophthalmology									
Days waited at 50th percentile	140	34	28	78	71	115	209	145	66
Days waited at 90th percentile	450	179	189	314	255	554	531	356	364
% waited more than 365 days	18.2	1.7	2.8	6.1	2.9	35.0	28.4	9.1	9.8
Orthopaedic surgery									
Days waited at 50th percentile	61	64	22	81	69	160	112	36	48
Days waited at 90th percentile	410	358	123	396	363	648	404	289	356
% waited more than 365 days	12.7	9.6	2.3	11.2	9.8	30.8	13.0	7.9	9.6
Plastic surgery									
Days waited at 50th percentile	28	24	25	25	31	22	35	39	27
Days waited at 90th percentile	140	187	97	245	213	192	463	294	162
% waited more than 365 days	2.0	3.8	1.7	5.4	7.2	5.6	13.3	8.3	3.6
Urology									
Days waited at 50th percentile	28	23	26	21	28	37	33	50	26
Days waited at 90th percentile	163	182	109	126	119	174	191	188	155
% waited more than 365 days	3.4	4.0	1.4	2.2	2.7	3.1	2.6	5.7	3.0
Vascular surgery									
Days waited at 50th percentile	18	23	16	16	8	40	23	..	18
Days waited at 90th percentile	101	298	92	66	39	203	534	..	121
% waited more than 365 days	2.4	8.4	2.3	1.2	0.6	5.2	14.2	..	3.9

TABLE 11A.25

Table 11A.25 **Elective surgery waiting times, by specialty of surgeon**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (a)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Other									
Days waited at 50th percentile	7	21	26	9	22	6	35	13	14
Days waited at 90th percentile	66	81	116	43	90	32	332	98	96
% waited more than 365 days	0.4	0.9	3.1	0.1	0.5	0.2	7.4	0.9	1.5
Total									
Days waited at 50th percentile	34	28	22	27	35	34	45	29	29
Days waited at 90th percentile	294	200	105	197	201	352	368	266	217
% waited more than 365 days	6.9	4.0	1.8	3.8	4.0	9.5	10.1	5.9	4.8
2005-06									
Cardio-thoracic									
Days waited at 50th percentile	13	7	7	14	18	36	27	..	12
Days waited at 90th percentile	73	92	78	46	72	135	100	..	73
% waited more than 365 days	–	0.2	0.1	0.2	–	–	–	..	0.1
Ear, nose and throat surgery									
Days waited at 50th percentile	70	45	20	82	46	45	140	75	47
Days waited at 90th percentile	404	229	143	320	296	491	828	623	331
% waited more than 365 days	13.0	4.9	3.7	8.2	7.8	15.4	23.0	18.4	8.3
General surgery									
Days waited at 50th percentile	29	29	26	21	31	23	27	51	28
Days waited at 90th percentile	175	203	112	132	141	193	159	324	166
% waited more than 365 days	2.3	3.7	1.7	2.5	1.5	3.9	4.2	8.4	2.6
Gynaecology									
Days waited at 50th percentile	28	29	25	16	31	32	36	6	27
Days waited at 90th percentile	126	148	94	77	113	170	186	63	119
% waited more than 365 days	1.6	1.9	0.6	0.2	0.6	1.2	2.2	1.6	1.3
Neurosurgery									
Days waited at 50th percentile	20	26	12	44	18	74	52	..	26
Days waited at 90th percentile	103	177	108	147	121	427	372	..	152
% waited more than 365 days	2.1	2.0	1.0	1.1	1.6	14.1	10.4	..	2.1
Ophthalmology									
Days waited at 50th percentile	132	38	34	71	68	41	180	189	69
Days waited at 90th percentile	362	210	247	291	291	545	504	455	326
% waited more than 365 days	9.4	1.0	3.8	6.0	4.2	30.2	22.5	19.1	6.5
Orthopaedic surgery									
Days waited at 50th percentile	66	69	23	70	77	146	137	36	54
Days waited at 90th percentile	390	392	168	370	404	538	450	340	364
% waited more than 365 days	12.0	11.2	2.9	10.2	12.3	22.4	15.3	8.4	9.9
Plastic surgery									
Days waited at 50th percentile	29	24	29	31	37	25	52	46	29
Days waited at 90th percentile	185	223	134	310	217	146	392	357	197
% waited more than 365 days	3.9	5.3	2.3	8.8	5.0	3.3	12.9	8.9	4.7

TABLE 11A.25

Table 11A.25 **Elective surgery waiting times, by specialty of surgeon**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (a)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Urology									
Days waited at 50th percentile	28	20	28	21	38	36	49	25	26
Days waited at 90th percentile	168	176	118	147	160	184	215	174	162
% waited more than 365 days	2.6	3.9	1.7	3.2	4.0	3.4	3.1	7.2	3.0
Vascular surgery									
Days waited at 50th percentile	19	33	21	17	12	42	22	..	20
Days waited at 90th percentile	122	507	84	76	47	284	552	..	175
% waited more than 365 days	2.0	14.2	2.0	0.8	0.3	4.3	13.6	..	5.0
Other									
Days waited at 50th percentile	8	23	24	14	33	12	33	11	16
Days waited at 90th percentile	64	78	111	48	110	133	199	85	91
% waited more than 365 days	0.7	0.5	2.7	–	–	–	1.9	1.2	1.0
Total									
Days waited at 50th percentile	36	32	25	28	38	34	61	30	32
Days waited at 90th percentile	291	224	127	205	212	332	372	313	237
% waited more than 365 days	5.4	4.5	2.1	4.3	4.2	8.7	10.3	7.7	4.6
2006-07									
Cardio-thoracic									
Days waited at 50th percentile	12	7	12	13	18	27	24	..	12
Days waited at 90th percentile	62	63	82	40	74	173	87	..	66
% waited more than 365 days	–	0.1	0.2	–	0.1	0.5	–	..	0.1
Ear, nose and throat surgery									
Days waited at 50th percentile	69	39	23	90	54	57	105	50	46
Days waited at 90th percentile	335	204	159	431	312	521	803	546	308
% waited more than 365 days	4.1	3.5	3.6	13.5	7.4	12.9	23.1	14.8	5.5
General surgery									
Days waited at 50th percentile	28	29	26	25	33	29	29	53	28
Days waited at 90th percentile	158	183	124	177	158	268	164	326	162
% waited more than 365 days	0.7	2.8	2.1	3.5	2.4	6.9	1.5	7.8	2.0
Gynaecology									
Days waited at 50th percentile	29	36	24	21	32	38	39	7	28
Days waited at 90th percentile	145	143	97	94	119	238	209	81	130
% waited more than 365 days	0.7	1.2	0.8	0.2	0.3	3.7	1.8	1.2	0.9
Neurosurgery									
Days waited at 50th percentile	23	21	15	42	21	38	29	..	26
Days waited at 90th percentile	130	162	158	169	89	505	296	..	154
% waited more than 365 days	0.9	1.7	4.0	1.1	0.2	11.9	7.7	..	1.9
Ophthalmology									
Days waited at 50th percentile	123	36	34	77	68	54	173	255	71
Days waited at 90th percentile	339	228	268	304	278	528	510	643	318
% waited more than 365 days	3.5	1.1	4.8	6.7	4.6	23.6	27.7	36.3	4.6

TABLE 11A.25

Table 11A.25 **Elective surgery waiting times, by specialty of surgeon**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (a)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Orthopaedic surgery									
Days waited at 50th percentile	65	63	25	52	69	123	123	49	50
Days waited at 90th percentile	330	340	175	301	345	561	403	399	318
% waited more than 365 days	4.2	8.6	3.5	6.6	9.2	22.5	12.3	11.9	6.0
Plastic surgery									
Days waited at 50th percentile	28	23	29	29	37	22	62	42	28
Days waited at 90th percentile	167	213	135	312	182	166	371	315	193
% waited more than 365 days	1.3	4.5	2.0	8.2	4.1	3.7	10.1	8.1	3.6
Urology									
Days waited at 50th percentile	28	21	27	19	44	33	52	50	26
Days waited at 90th percentile	167	151	127	133	177	148	237	407	158
% waited more than 365 days	1.4	2.7	2.3	3.1	4.1	2.1	3.4	11.8	2.3
Vascular surgery									
Days waited at 50th percentile	17	25	20	20	12	43	27	..	20
Days waited at 90th percentile	89	273	84	103	71	242	482	..	133
% waited more than 365 days	0.5	6.3	1.6	1.1	1.5	4.2	11.4	..	2.4
Other									
Days waited at 50th percentile	6	23	29	13	21	12	36	20	15
Days waited at 90th percentile	46	86	122	42	82	54	151	251	90
% waited more than 365 days	0.1	0.4	0.6	0.3	0.4	0.6	2.0	5.4	0.6
Total									
Days waited at 50th percentile	35	30	25	29	40	38	63	35	32
Days waited at 90th percentile	260	208	142	225	206	343	364	370	226
% waited more than 365 days	1.9	3.3	2.5	4.6	3.9	9.2	9.9	10.2	3.1
2007-08									
Cardio-thoracic									
Days waited at 50th percentile	14	6	10	19	14	21	18	..	12
Days waited at 90th percentile	74	85	69	55	101	131	103	..	78
% waited more than 365 days	0.1	0.1	0.3	–	–	0.5	0.4	..	0.1
Ear, nose and throat surgery									
Days waited at 50th percentile	87	48	28	106	63	50	135	73	57
Days waited at 90th percentile	346	276	161	416	350	406	610	530	335
% waited more than 365 days	4.4	3.4	3.4	14.0	9.1	11.3	30.4	18.1	6.2
General surgery									
Days waited at 50th percentile	29	34	26	27	37	25	35	44	29
Days waited at 90th percentile	165	204	109	152	180	344	218	244	170
% waited more than 365 days	0.6	2.8	1.1	1.7	2.6	9.0	1.3	5.5	1.7
Gynaecology									
Days waited at 50th percentile	32	45	25	30	29	37	53	10	31
Days waited at 90th percentile	168	158	95	138	121	195	226	110	145
% waited more than 365 days	0.9	1.4	0.9	1.1	0.4	3.3	2.3	2.3	1.1

TABLE 11A.25

Table 11A.25 **Elective surgery waiting times, by specialty of surgeon**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (a)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Neurosurgery									
Days waited at 50th percentile	25	24	21	35	21	35	39	..	25
Days waited at 90th percentile	148	185	134	187	95	343	276	..	166
% waited more than 365 days	0.7	1.5	4.3	1.8	0.2	9.9	7.6	..	1.9
Ophthalmology									
Days waited at 50th percentile	134	36	42	55	61	104	169	149	68
Days waited at 90th percentile	335	217	296	267	230	670	484	524	315
% waited more than 365 days	2.6	1.9	5.5	3.5	2.5	30.7	18.4	18.9	3.8
Orthopaedic surgery									
Days waited at 50th percentile	70	61	27	58	77	125	121	53	54
Days waited at 90th percentile	343	335	175	254	379	548	427	414	323
% waited more than 365 days	4.5	8.4	3.3	3.3	10.5	20.2	13.6	11.6	5.8
Plastic surgery									
Days waited at 50th percentile	25	22	28	18	40	13	45	42	26
Days waited at 90th percentile	147	235	148	144	187	134	347	376	186
% waited more than 365 days	0.5	5.6	2.8	1.7	3.5	2.4	9.5	10.5	3.2
Urology									
Days waited at 50th percentile	28	20	31	21	44	41	50	59	27
Days waited at 90th percentile	166	170	122	127	185	185	267	210	162
% waited more than 365 days	1.1	2.7	2.4	2.4	2.8	3.2	4.5	2.9	2.1
Vascular surgery									
Days waited at 50th percentile	18	25	22	27	14	25	25	..	21
Days waited at 90th percentile	108	364	82	145	57	242	705	..	161
% waited more than 365 days	0.5	9.9	1.3	2.6	0.9	5.6	19.6	..	3.8
Other									
Days waited at 50th percentile	7	24	27	18	21	50	35	63	19
Days waited at 90th percentile	63	88	96	72	76	795	157	383	89
% waited more than 365 days	–	1.0	0.4	0.4	–	37.1	1.5	10.2	1.4
Total									
Days waited at 50th percentile	39	33	27	30	42	36	72	43	34
Days waited at 90th percentile	278	221	137	206	208	369	372	337	235
% waited more than 365 days	1.8	3.6	2.3	3.0	3.9	10.1	10.3	8.6	3.0
2008-09									
Cardio-thoracic									
Days waited at 50th percentile	13	9	11	13	11	15	19	7	12
Days waited at 90th percentile	62	107	74	38	117	107	69	15	76
% waited more than 365 days	0.1	0.7	0.2	–	0.3	–	–	–	0.3
Ear, nose and throat surgery									
Days waited at 50th percentile	84	56	31	73	51	56	204	36	58
Days waited at 90th percentile	353	267	158	294	252	268	627	385	318
% waited more than 365 days	6.3	3.2	3.3	5.7	3.4	7.3	33.6	10.8	5.2

TABLE 11A.25

Table 11A.25 **Elective surgery waiting times, by specialty of surgeon**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (a)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
General surgery									
Days waited at 50th percentile	30	32	26	27	34	58	41	47	30
Days waited at 90th percentile	149	176	114	154	175	564	193	225	165
% waited more than 365 days	1.1	2.5	1.1	2.0	1.8	19.6	2.8	4.6	2.4
Gynaecology									
Days waited at 50th percentile	30	35	25	29	22	30	56	13	28
Days waited at 90th percentile	139	137	96	117	112	175	211	99	126
% waited more than 365 days	0.7	1.0	0.4	0.7	0.7	4.5	3.6	1.0	0.9
Neurosurgery									
Days waited at 50th percentile	26	22	18	40	26	35	43	..	24
Days waited at 90th percentile	168	165	107	167	84	265	217	..	157
% waited more than 365 days	1.5	1.5	0.8	2.5	0.1	6.2	1.6	..	1.5
Ophthalmology									
Days waited at 50th percentile	135	48	35	49	49	109	115	118	65
Days waited at 90th percentile	344	181	205	200	252	571	318	350	306
% waited more than 365 days	3.5	1.1	1.9	1.2	2.0	26.9	8.1	8.7	3.0
Orthopaedic surgery									
Days waited at 50th percentile	76	51	28	51	68	..	125	36	53
Days waited at 90th percentile	355	301	172	224	334	..	506	315	323
% waited more than 365 days	6.5	6.7	3.0	3.1	7.0	..	18.5	8.0	5.6
Plastic surgery									
Days waited at 50th percentile	22	17	26	24	31	17	48	69	22
Days waited at 90th percentile	135	193	147	147	186	126	338	520	168
% waited more than 365 days	0.7	3.7	3.4	1.9	4.4	3.1	9.1	11.7	3.0
Urology									
Days waited at 50th percentile	29	20	32	24	43	43	63	81	27
Days waited at 90th percentile	126	140	116	121	151	181	388	234	137
% waited more than 365 days	1.1	1.9	1.4	1.5	2.2	3.6	11.2	5.2	1.8
Vascular surgery									
Days waited at 50th percentile	17	27	19	28	11	44	25	208	20
Days waited at 90th percentile	104	320	79	222	47	535	382	565	175
% waited more than 365 days	0.3	8.4	1.0	4.2	0.7	12.7	11.9	32.0	3.5
Other									
Days waited at 50th percentile	10	26	14	19	26	156	42	30	21
Days waited at 90th percentile	104	82	96	79	75	475	159	137	105
% waited more than 365 days	0.1	0.2	0.6	0.5	–	20.0	1.3	2.9	1.5
Total									
Days waited at 50th percentile	39	31	27	31	36	44	75	40	33
Days waited at 90th percentile	283	194	133	174	207	448	378	256	220
% waited more than 365 days	2.5	2.9	1.8	2.0	2.7	13.1	10.6	5.6	2.9

2009-10

TABLE 11A.25

Table 11A.25 **Elective surgery waiting times, by specialty of surgeon**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (a)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Cardio-thoracic									
Days waited at 50th percentile	14	20	7	16	10	11	20	0	14
Days waited at 90th percentile	62	104	52	62	104	72	77	0	71
% waited more than 365 days	–	1.3	–	0.1	0.1	–	–	–	0.4
Ear, nose and throat surgery									
Days waited at 50th percentile	117	61	32	62	55	49	200	59	63
Days waited at 90th percentile	378	289	164	196	263	239	477	389	340
% waited more than 365 days	12.8	4.8	3.1	2.3	2.3	6.4	29.9	10.8	6.8
General surgery									
Days waited at 50th percentile	33	35	26	27	34	33	36	49	31
Days waited at 90th percentile	191	160	134	163	148	385	213	291	172
% waited more than 365 days	1.9	2.1	1.6	1.6	0.7	10.4	4.2	6.6	2.1
Gynaecology									
Days waited at 50th percentile	31	35	27	38	25	34	45	10	30
Days waited at 90th percentile	181	129	103	119	105	191	223	121	135
% waited more than 365 days	2.0	0.4	0.6	0.1	0.2	1.8	2.9	0.7	1.0
Neurosurgery									
Days waited at 50th percentile	32	30	24	39	28	55	33	6	30
Days waited at 90th percentile	235	195	139	209	87	432	211	6	197
% waited more than 365 days	2.7	2.3	1.0	3.2	–	10.3	0.9	–	2.3
Ophthalmology									
Days waited at 50th percentile	168	53	35	42	54	75	143	112	69
Days waited at 90th percentile	361	212	216	189	302	292	326	340	329
% waited more than 365 days	7.6	1.8	2.5	1.1	2.7	5.4	8.9	8.3	4.1
Orthopaedic surgery									
Days waited at 50th percentile	98	61	31	54	67	156	140	56	62
Days waited at 90th percentile	371	308	229	210	286	645	503	295	352
% waited more than 365 days	11.6	6.6	4.9	2.8	0.8	28.2	19.0	6.8	7.9
Plastic surgery									
Days waited at 50th percentile	22	19	23	24	27	16	30	59	22
Days waited at 90th percentile	163	175	133	159	146	131	311	291	164
% waited more than 365 days	1.4	3.2	3.3	2.0	1.8	3.1	7.1	8.5	2.7
Urology									
Days waited at 50th percentile	29	24	29	29	36	30	84	88	28
Days waited at 90th percentile	144	122	115	140	118	143	306	338	134
% waited more than 365 days	1.8	1.2	2.2	1.7	0.5	2.6	7.0	3.1	1.7
Vascular surgery									
Days waited at 50th percentile	17	36	18	25	9	32	22	597	20
Days waited at 90th percentile	103	374	86	170	33	529	301	948	183
% waited more than 365 days	0.7	10.4	2.3	1.6	–	14.8	6.7	64.3	3.9

TABLE 11A.25

Table 11A.25 **Elective surgery waiting times, by specialty of surgeon**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Other									
Days waited at 50th percentile	11	32	25	20	9	26	42	21	22
Days waited at 90th percentile	107	114	103	76	49	182	232	111	102
% waited more than 365 days	3.6	1.2	0.9	0.2	–	0.6	3.2	–	1.1
Total									
Days waited at 50th percentile	44	36	27	32	36	36	73	44	35
Days waited at 90th percentile	330	197	150	161	189	332	357	271	246
% waited more than 365 days	4.9	2.8	2.5	1.5	1.1	8.7	9.5	5.8	3.5
2010-11									
Cardio-thoracic									
Days waited at 50th percentile	15	21	10	16	21	25	17	..	16
Days waited at 90th percentile	65	99	57	63	110	82	51	..	77
% waited more than 365 days	0.2	0.1	0.2	–	0.4	0.2	–	..	0.2
Ear, nose and throat surgery									
Days waited at 50th percentile	100	68	32	58	50	82	255	42	64
Days waited at 90th percentile	364	316	148	215	243	280	655	415	340
% waited more than 365 days	9.0	5.3	0.8	3.3	0.9	5.5	33.4	12.1	5.6
General surgery									
Days waited at 50th percentile	34	36	29	26	34	28	46	34	32
Days waited at 90th percentile	207	158	129	142	141	273	233	200	164
% waited more than 365 days	1.7	2.2	0.6	1.8	1.7	7.9	2.9	4.1	1.8
Gynaecology									
Days waited at 50th percentile	33	36	28	34	23	29	44	11	30
Days waited at 90th percentile	189	120	104	128	109	125	199	99	133
% waited more than 365 days	1.6	0.4	0.5	0.1	0.1	0.8	2.6	0.6	0.8
Neurosurgery									
Days waited at 50th percentile	34	39	29	32	34	74	26	np	34
Days waited at 90th percentile	288	195	207	151	110	436	132	np	221
% waited more than 365 days	4.2	2.4	3.0	1.7	0.2	14.0	2.1	np	3.3
Ophthalmology									
Days waited at 50th percentile	178	49	37	35	77	168	121	98	71
Days waited at 90th percentile	358	188	298	171	349	422	294	278	335
% waited more than 365 days	5.6	0.7	2.9	0.7	6.5	20.8	4.5	3.0	3.6
Orthopaedic surgery									
Days waited at 50th percentile	97	61	34	53	73	147	179	49	64
Days waited at 90th percentile	360	293	214	237	315	622	491	273	345
% waited more than 365 days	7.4	6.1	2.9	3.5	4.0	29.2	21.5	6.1	6.2

TABLE 11A.25

Table 11A.25 **Elective surgery waiting times, by specialty of surgeon**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Plastic surgery									
Days waited at 50th percentile	29	21	26	23	29	22	10	18	24
Days waited at 90th percentile	211	154	119	161	132	223	260	101	156
% waited more than 365 days	2.4	2.3	0.9	1.6	1.8	5.6	6.4	1.6	2.1
Urology									
Days waited at 50th percentile	29	24	28	27	37	30	70	50	28
Days waited at 90th percentile	116	110	120	156	106	153	423	154	122
% waited more than 365 days	1.5	1.1	0.8	1.8	0.6	2.4	13.3	–	1.6
Vascular surgery									
Days waited at 50th percentile	17	31	18	26	12	25	24	..	21
Days waited at 90th percentile	108	305	76	145	41	315	369	..	149
% waited more than 365 days	0.8	7.5	0.3	0.7	0.1	8.1	10.4	..	2.6
Other									
Days waited at 50th percentile	11	28	37	22	21	11	42	15	23
Days waited at 90th percentile	86	82	120	82	80	29	253	303	98
% waited more than 365 days	1.3	0.2	0.8	0.3	–	–	3.2	3.4	0.6
Total									
Days waited at 50th percentile	47	36	29	29	38	38	76	33	36
Days waited at 90th percentile	333	182	148	159	208	359	378	223	252
% waited more than 365 days	3.6	2.5	1.3	1.6	2.0	9.6	10.8	3.9	2.9
2011-12									
Cardio-thoracic									
Days waited at 50th percentile	19	19	11	19	18	20	23	..	16
Days waited at 90th percentile	78	109	58	77	98	73	72	..	81
% waited more than 365 days	0.1	0.2	0.1	–	0.1	–	–	..	0.1
Ear, nose and throat surgery									
Days waited at 50th percentile	111	68	28	60	47	62	160	56	66
Days waited at 90th percentile	365	317	178	253	213	311	481	293	344
% waited more than 365 days	9.7	5.2	2.0	3.8	1.2	5.5	15.7	7.0	5.6
General surgery									
Days waited at 50th percentile	35	38	26	26	28	35	35	39	31
Days waited at 90th percentile	223	170	119	118	110	356	150	211	164
% waited more than 365 days	1.8	1.7	0.9	1.8	1.1	9.7	0.8	4.1	1.8
Gynaecology									
Days waited at 50th percentile	35	41	32	24	20	28	35	15	31
Days waited at 90th percentile	174	142	124	98	95	133	159	123	133
% waited more than 365 days	1.2	1.2	0.8	0.1	0.1	0.9	1.0	1.3	0.9

TABLE 11A.25

Table 11A.25 **Elective surgery waiting times, by specialty of surgeon**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Neurosurgery									
Days waited at 50th percentile	34	38	16	40	32	66	19	..	31
Days waited at 90th percentile	286	171	110	175	104	506	104	..	191
% waited more than 365 days	3.8	1.7	1.8	0.9	0.6	13.9	0.6	..	2.7
Ophthalmology									
Days waited at 50th percentile	181	49	40	36	70	113	131	133	74
Days waited at 90th percentile	357	188	303	190	314	531	287	274	335
% waited more than 365 days	4.8	0.7	7.3	1.2	2.4	25.3	1.2	2.9	3.6
Orthopaedic surgery									
Days waited at 50th percentile	100	66	28	48	70	121	145	42	63
Days waited at 90th percentile	359	273	211	222	294	602	428	192	338
% waited more than 365 days	7.0	5.0	3.0	2.9	4.1	22.0	15.9	3.4	5.4
Plastic surgery									
Days waited at 50th percentile	32	20	23	26	28	24	6	29	24
Days waited at 90th percentile	254	196	140	151	146	205	168	128	182
% waited more than 365 days	1.8	4.3	1.0	1.6	2.2	4.7	4.9	2.8	2.7
Urology									
Days waited at 50th percentile	28	23	26	28	35	28	46	54	27
Days waited at 90th percentile	110	111	100	157	106	151	224	210	116
% waited more than 365 days	1.0	0.9	0.8	2.2	0.6	3.1	2.6	4.9	1.2
Vascular surgery									
Days waited at 50th percentile	19	29	13	22	14	22	28	63	20
Days waited at 90th percentile	120	247	70	166	50	101	505	296	147
% waited more than 365 days	0.9	5.5	0.4	2.5	0.4	4.9	14.3	7.9	2.5
Other									
Days waited at 50th percentile	17	27	25	26	21	10	59	14	25
Days waited at 90th percentile	96	88	112	90	81	40	266	66	100
% waited more than 365 days	0.8	0.2	1.0	0.2	0.2	–	5.8	–	0.6
Total									
Days waited at 50th percentile	49	36	27	30	34	38	63	39	36
Days waited at 90th percentile	335	189	147	159	191	348	296	219	251
% waited more than 365 days	3.4	2.4	2.0	1.7	1.5	9.4	6.2	3.5	2.7
2012-13									
Cardio-thoracic									
Days waited at 50th percentile	21	18	11	14	15	37	10	..	17
Days waited at 90th percentile	75	103	75	64	69	137	54	..	80
% waited more than 365 days	0.1	0.7	0.1	–	0.2	–	–	..	0.3

TABLE 11A.25

Table 11A.25 **Elective surgery waiting times, by specialty of surgeon**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Ear, nose and throat surgery									
Days waited at 50th percentile	127	69	28	68	50	59	95	75	68
Days waited at 90th percentile	364	335	174	259	244	383	429	323	349
% waited more than 365 days	8.4	7.4	3.0	4.4	1.3	10.3	15.8	7.3	5.9
General surgery									
Days waited at 50th percentile	34	43	26	26	24	35	43	34	30
Days waited at 90th percentile	230	213	131	111	99	340	184	157	178
% waited more than 365 days	1.5	2.9	1.5	0.9	0.5	9.3	0.2	2.5	1.9
Gynaecology									
Days waited at 50th percentile	35	39	33	26	23	29	33	18	31
Days waited at 90th percentile	192	187	144	98	89	139	132	99	157
% waited more than 365 days	1.1	2.1	1.5	0.1	0.2	1.4	0.5	1.3	1.2
Neurosurgery									
Days waited at 50th percentile	33	44	14	34	28	86	20	..	30
Days waited at 90th percentile	256	217	127	182	92	429	95	..	210
% waited more than 365 days	2.7	2.1	2.2	2.9	0.6	12.2	0.9	..	2.6
Ophthalmology									
Days waited at 50th percentile	196	44	39	43	72	178	134	138	76
Days waited at 90th percentile	353	253	211	213	295	739	302	307	335
% waited more than 365 days	3.3	1.9	3.1	1.5	2.3	34.5	0.7	6.4	3.2
Orthopaedic surgery									
Days waited at 50th percentile	106	69	29	55	58	113	126	45	65
Days waited at 90th percentile	358	301	280	223	275	720	435	189	342
% waited more than 365 days	6.1	5.8	5.5	2.6	1.4	24.5	15.2	2.2	5.5
Plastic surgery									
Days waited at 50th percentile	33	20	23	24	28	22	7	43	24
Days waited at 90th percentile	277	226	127	148	137	147	79	149	187
% waited more than 365 days	1.8	5.0	1.3	1.6	1.4	2.9	0.5	3.0	2.8
Urology									
Days waited at 50th percentile	27	22	25	23	33	34	31	70	25
Days waited at 90th percentile	107	112	108	130	101	217	160	180	113
% waited more than 365 days	0.7	1.0	1.4	1.6	0.5	4.3	0.9	2.6	1.1
Vascular surgery									
Days waited at 50th percentile	20	29	15	21	13	14	21	37	20
Days waited at 90th percentile	118	284	82	151	44	92	267	197	153
% waited more than 365 days	1.0	5.1	0.5	1.8	–	2.3	5.5	4.8	2.0

TABLE 11A.25

Table 11A.25 **Elective surgery waiting times, by specialty of surgeon**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (a)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Other (c)									
Days waited at 50th percentile	15	42	21	23	22	43	36	9	25
Days waited at 90th percentile	86	114	148	103	77	403	164	79	110
% waited more than 365 days	0.6	0.4	0.7	0.3	–	11.4	1.3	1.1	0.5
Total									
Days waited at 50th percentile	50	36	27	30	34	41	51	40	36
Days waited at 90th percentile	335	223	163	159	182	406	277	196	265
% waited more than 365 days	2.8	3.3	2.5	1.5	1.0	11.5	4.1	3.3	2.7
2013-14									
Cardio-thoracic									
Days waited at 50th percentile	21	21	12	20	20	15	19	..	18
Days waited at 90th percentile	75	112	88	68	91	71	69	..	86
% waited more than 365 days	–	0.5	–	–	0.1	–	–	..	0.2
Ear, nose and throat surgery									
Days waited at 50th percentile	131	77	36	73	53	62	154	62	70
Days waited at 90th percentile	359	351	249	271	271	305	521	344	348
% waited more than 365 days	4.9	8.1	2.4	2.6	1.3	5.7	24.7	9.2	5.0
General surgery									
Days waited at 50th percentile	34	38	27	26	25	41	44	29	30
Days waited at 90th percentile	221	186	127	98	91	304	171	138	163
% waited more than 365 days	0.9	2.2	1.5	0.2	0.3	7.5	1.3	1.6	1.4
Gynaecology									
Days waited at 50th percentile	34	38	35	26	27	34	40	15	32
Days waited at 90th percentile	183	189	132	90	89	182	140	112	150
% waited more than 365 days	0.5	1.9	1.2	–	0.1	1.6	0.6	1.2	0.9
Neurosurgery									
Days waited at 50th percentile	31	36	20	38	27	60	27	..	31
Days waited at 90th percentile	228	215	192	217	95	365	83	..	214
% waited more than 365 days	2.5	2.6	4.5	4.8	1.5	9.9	2.0	..	3.2
Ophthalmology									
Days waited at 50th percentile	175	37	46	42	70	124	112	113	69
Days waited at 90th percentile	350	213	272	199	307	683	302	298	328
% waited more than 365 days	2.2	1.3	3.7	0.8	1.3	32.2	1.0	5.7	2.6
Orthopaedic surgery									
Days waited at 50th percentile	104	73	35	51	59	141	86	39	66
Days waited at 90th percentile	351	313	333	174	265	737	425	156	337
% waited more than 365 days	3.7	5.9	6.5	0.8	1.0	27.3	15.0	0.6	4.8

TABLE 11A.25

Table 11A.25 **Elective surgery waiting times, by specialty of surgeon**

	NSW	Vic	Qld (a)	WA	SA	Tas (b)	ACT	NT	Aust
Plastic surgery									
Days waited at 50th percentile	35	22	26	20	31	30	22	32	25
Days waited at 90th percentile	295	241	198	110	134	203	91	245	212
% waited more than 365 days	2.0	5.3	3.2	0.5	1.6	4.9	1.4	3.1	3.3
Urology									
Days waited at 50th percentile	28	22	24	19	33	36	29	81	25
Days waited at 90th percentile	109	112	106	98	103	221	143	207	110
% waited more than 365 days	0.4	1.2	1.2	0.6	0.9	5.1	0.3	2.7	0.9
Vascular surgery									
Days waited at 50th percentile	19	28	16	18	12	14	18	np	19
Days waited at 90th percentile	131	288	79	136	42	95	97	np	145
% waited more than 365 days	0.9	5.6	0.7	0.3	–	0.7	2.3	np	1.8
Other (c)									
Days waited at 50th percentile	13	42	18	22	26	np	29	9	23
Days waited at 90th percentile	77	135	103	111	71	np	105	44	110
% waited more than 365 days	0.4	0.8	1.1	0.4	–	np	–	–	0.5
Total									
Days waited at 50th percentile	49	35	28	29	35	45	48	36	36
Days waited at 90th percentile	329	222	186	142	180	401	270	183	262
% waited more than 365 days	1.8	3.2	2.8	0.7	0.8	11.5	4.7	2.8	2.4

(a) The total number of admissions for Queensland include 644 admissions that were removed from the waiting list for elective admission before 30 June 2005 and separated before 30 June 2006. It is expected that these admissions would be counterbalanced overall by the number of admissions occurring in a similar way in future reporting periods. The total number of admissions for Queensland includes 507 patients who were removed from the waiting list for elective admission before 30 June 2007 and separated before 30 June 2008. It is expected that these admissions would be counterbalanced overall by the number of admissions occurring in a similar way in future reporting periods.

(b) Includes data for the Mersey Community Hospital. For Tasmania in 2008-09, admissions for Orthopaedic surgery were included under the category General Surgery.

(c) Includes specialty of surgeon 'not reported'

.. Not applicable. – Nil or rounded to zero.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra; AIHW (2014), *Australian hospital statistics 2013–14: elective surgery waiting times*. Health services series no. 56. Cat. no. HSE 151. Canberra: AIHW; AIHW (2013), *Australian hospital statistics 2012–13: elective surgery waiting times*. Health services series no. 51. Cat. no. HSE 140. Canberra: AIHW

TABLE 11A.26

Table 11A.26 **Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) (a)**

	<i>Aboriginal and Torres Strait Islander Australians (b)</i>									<i>Other Australians (c)</i>								
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2010-11																		
All hospitals																		
50th percentile																		
Cataract extraction	265	41	68	43	70	np	np	133	125	226	56	47	34	87	239	141	148	86
Cholecystectomy	56	41	62	42	58	79	np	99	58	61	49	51	28	49	68	68	56	52
Coronary artery bypass graft	13	np	20	26	19	np	np	–	20	15	22	7	14	22	25	12	–	16
Cystoscopy	28	24	31	26	46	24	np	110	29	23	23	28	27	35	28	70	74	25
Haemorrhoidectomy	48	np	37	np	np	–	–	133	65	65	62	61	35	55	33	120	62	59
Hysterectomy	59	np	37	21	74	72	np	82	51	55	48	41	44	54	46	58	60	48
Inguinal herniorrhaphy	50	35	51	32	np	33	np	76	49	70	54	58	33	43	57	78	55	57
Myringoplasty	332	np	76	85	186	np	43	154	120	317	83	67	92	179	180	351	112	105
Myringotomy	70	38	48	44	np	108	np	21	48	67	49	33	43	47	123	148	22	44
Prostatectomy	67	np	76	np	–	np	np	np	59	62	28	45	33	48	78	82	60	46
Septoplasty	311	np	92	np	143	np	–	np	189	312	105	56	92	137	222	393	np	146
Tonsillectomy	176	110	81	87	74	154	352	59	98	190	96	54	78	71	112	334	65	90
Total hip replacement	153	np	60	np	np	np	np	np	134	146	107	78	77	117	197	253	141	105
Total knee replacement	310	np	110	np	np	np	np	np	227	294	144	109	94	136	399	326	220	169
Varicose veins stripping & ligation	128	np	np	np	–	np	np	np	108	100	103	63	67	204	85	333	94	94
Total (d)	50	35	34	31	33	40	67	43	39	47	36	29	29	38	36	75	30	36
90th percentile																		
Cataract extraction	362	83	309	193	301	np	np	364	354	361	179	333	158	349	425	301	282	342
Cholecystectomy	218	168	151	206	132	400	np	300	171	232	131	139	160	99	457	250	223	156
Coronary artery bypass graft	79	np	75	63	92	np	np	–	76	77	87	56	63	83	83	49	–	72

TABLE 11A.26

Table 11A.26 **Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) (a)**

	<i>Aboriginal and Torres Strait Islander Australians (b)</i>									<i>Other Australians (c)</i>								
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Cystoscopy	114	78	136	203	141	44	np	223	124	105	99	126	177	97	112	368	224	111
Haemorrhoidectomy	362	np	129	np	np	–	–	250	250	301	240	155	212	220	366	279	239	247
Hysterectomy	267	np	135	82	274	342	np	182	225	302	135	141	127	168	212	202	224	196
Inguinal herniorrhaphy	296	296	130	139	np	401	np	313	252	326	155	161	164	140	591	289	197	246
Myringoplasty	370	np	166	282	321	np	43	551	441	384	354	192	233	354	694	672	469	365
Myringotomy	177	99	118	97	np	187	np	138	119	300	138	105	115	109	197	364	105	129
Prostatectomy	114	np	442	np	–	np	np	np	173	230	158	168	120	91	195	749	135	161
Septoplasty	374	np	431	np	245	np	–	np	380	381	378	262	345	301	694	691	np	371
Tonsillectomy	366	324	190	213	290	317	564	348	354	366	330	181	210	263	293	612	396	343
Total hip replacement	358	np	447	np	np	np	np	np	357	362	335	272	236	316	629	595	261	351
Total knee replacement	366	np	374	np	np	np	np	np	370	371	392	350	306	350	717	573	404	368
Varicose veins stripping & ligation	300	np	np	np	–	np	np	np	358	350	422	302	267	409	421	597	462	359
Total (d)	337	204	155	188	167	353	363	283	260	331	176	148	158	210	349	368	212	243

2011-12

All hospitals

50th percentile

Cataract extraction	272	60	67	87	84	198	162	168	126	231	60	49	35	78	244	162	176	89
Cholecystectomy	64	63	63	43	31	111	np	86	60	60	55	45	27	42	89	57	52	51
Coronary artery bypass graft	24	21	20	65	32	np	np	–	24	23	18	5	22	18	21	21	–	15
Cystoscopy	36	23	33	44	31	29	83	71	35	26	22	25	28	32	28	52	47	25
Haemorrhoidectomy	31	np	40	46	np	np	np	121	46	71	63	57	33	38	65	83	135	58
Hysterectomy	66	59	50	35	48	109	np	47	54	57	57	53	40	40	51	60	92	52

TABLE 11A.26

Table 11A.26 **Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) (a)**

	<i>Aboriginal and Torres Strait Islander Australians (b)</i>									<i>Other Australians (c)</i>								
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Inguinal herniorrhaphy	47	76	57	16	33	80	np	53	43	73	60	51	29	34	57	73	79	56
Myringoplasty	314	np	86	92	8	np	–	90	91	315	106	78	77	74	114	393	92	109
Myringotomy	86	48	55	57	34	92	99	43	57	76	49	29	47	43	90	113	40	48
Prostatectomy	98	np	45	54	np	np	–	np	56	57	33	39	34	36	43	45	63	42
Septoplasty	262	np	178	np	np	np	np	np	135	322	98	56	100	137	200	321	110	154
Tonsillectomy	150	95	83	118	78	169	133	62	95	230	97	57	78	63	98	168	74	91
Total hip replacement	292	101	188	np	np	np	–	np	182	195	109	88	96	133	224	196	107	120
Total knee replacement	334	np	134	87	np	np	np	np	256	300	135	118	118	172	495	226	121	185
Varicose veins stripping & ligation	136	np	np	np	np	np	np	np	144	99	106	77	65	123	64	230	223	99
Total (d)	57	42	32	34	30	44	71	49	41	50	36	28	30	34	37	59	40	36
90th percentile																		
Cataract extraction	362	232	394	217	261	480	292	295	355	360	173	368	193	324	554	291	268	346
Cholecystectomy	239	204	164	147	112	645	np	274	201	248	161	126	139	103	525	169	267	172
Coronary artery bypass graft	86	36	75	181	131	np	np	–	104	85	84	55	61	78	73	71	–	75
Cystoscopy	101	120	97	188	83	134	138	194	131	102	100	96	158	93	135	224	157	107
Haemorrhoidectomy	174	np	127	112	np	np	np	234	195	304	262	163	182	122	797	314	227	246
Hysterectomy	283	184	138	93	98	217	np	145	175	306	171	167	123	176	198	229	162	205
Inguinal herniorrhaphy	325	448	208	148	359	331	np	156	265	338	173	147	151	141	524	198	330	270
Myringoplasty	376	np	323	263	296	np	–	400	349	376	352	286	238	302	565	529	381	365
Myringotomy	331	112	137	172	163	180	280	131	161	322	141	102	113	98	197	270	105	135
Prostatectomy	191	np	169	77	np	np	–	np	169	183	185	139	139	88	106	188	129	160
Septoplasty	365	np	326	np	np	np	np	np	360	372	367	296	358	316	601	543	413	369
Tonsillectomy	363	328	290	336	327	373	267	280	354	370	327	223	238	254	331	330	320	355

TABLE 11A.26

Table 11A.26 **Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) (a)**

	<i>Aboriginal and Torres Strait Islander Australians (b)</i>									<i>Other Australians (c)</i>								
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total hip replacement	372	281	289	np	np	np	–	np	378	364	300	301	266	335	660	441	239	356
Total knee replacement	378	np	328	328	np	np	np	np	377	370	352	361	342	362	868	488	477	370
Varicose veins stripping & ligation	352	np	np	np	np	np	np	np	358	342	384	349	379	363	667	627	562	361
Total (d)	339	232	177	169	162	352	286	248	260	336	186	150	157	194	348	285	219	247

2012-13

All hospitals

50th percentile

Cataract extraction	269	np	80	76	np	np	np	174	140	238	52	43	44	81	277	157	150	88
Cholecystectomy	55	np	39	np	np	np	np	np	48	56	60	46	29	30	70	66	56	50
Coronary artery bypass graft	np	np	np	np	np	np	–	–	15	28	19	8	13	15	43	np	–	16
Cystoscopy	34	np	27	30	np	np	np	np	30	25	21	24	22	30	34	34	48	23
Haemorrhoidectomy	np	np	np	np	np	np	np	np	np	68	79	56	35	19	68	np	86	59
Hysterectomy	np	np	57	np	np	np	np	np	59	59	59	55	35	43	69	55	np	53
Inguinal herniorrhaphy	49	np	np	np	np	np	np	np	41	72	71	65	34	29	104	85	54	61
Myringoplasty	np	np	np	97	np	np	–	150	121	311	132	82	83	np	np	np	np	124
Myringotomy	np	np	53	39	np	np	np	np	54	68	50	35	54	41	71	64	np	49
Prostatectomy	np	np	np	np	np	np	–	np	np	54	28	36	31	36	np	65	np	39
Septoplasty	np	np	np	np	np	np	np	np	238	328	129	75	124	99	269	np	np	196
Tonsillectomy	237	np	79	np	np	np	np	np	105	259	105	51	89	68	98	176	74	98
Total hip replacement	np	np	np	np	np	np	–	np	158	196	105	78	92	108	380	136	np	115
Total knee replacement	np	np	np	np	np	np	np	np	297	296	141	152	105	153	616	177	np	195
Varicose veins stripping & ligation	np	np	np	np	np	–	np	np	np	97	145	56	70	87	np	157	np	97

TABLE 11A.26

Table 11A.26 **Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) (a)**

	<i>Aboriginal and Torres Strait Islander Australians (b)</i>									<i>Other Australians (c)</i>								
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total (d)	56	44	28	34	28	47	39	52	40	49	36	27	30	34	41	51	35	36
90th percentile																		
Cataract extraction	360	np	334	214	np	np	np	399	357	356	248	217	208	301	755	305	239	339
Cholecystectomy	303	np	167	np	np	np	np	np	197	234	188	139	112	90	399	217	190	181
Coronary artery bypass graft	np	np	np	np	np	np	–	–	88	85	85	68	44	54	127	np	–	76
Cystoscopy	111	np	108	99	np	np	np	np	127	103	96	100	137	97	185	168	146	107
Haemorrhoidectomy	np	np	np	np	np	np	np	np	np	310	284	211	121	90	750	np	222	257
Hysterectomy	np	np	168	np	np	np	np	np	240	315	213	172	120	130	237	189	np	217
Inguinal herniorrhaphy	284	np	np	np	np	np	np	np	225	338	232	181	120	119	636	235	145	286
Myringoplasty	np	np	np	279	np	np	–	400	348	383	375	330	279	np	np	np	np	367
Myringotomy	np	np	106	165	np	np	np	np	177	337	170	102	128	95	251	254	np	139
Prostatectomy	np	np	np	np	np	np	–	np	np	211	179	170	146	107	np	139	np	167
Septoplasty	np	np	np	np	np	np	np	np	399	378	571	377	390	330	584	np	np	390
Tonsillectomy	362	np	246	np	np	np	np	np	358	366	355	212	261	271	455	377	371	359
Total hip replacement	np	np	np	np	np	np	–	np	372	362	308	346	271	317	831	373	np	357
Total knee replacement	np	np	np	np	np	np	np	np	406	368	365	462	312	343	964	445	np	373
Varicose veins stripping & ligation	np	np	np	np	np	–	np	np	np	353	403	308	342	339	np	545	np	356
Total (d)	342	247	173	174	167	328	217	259	277	335	223	162	158	182	409	278	174	264
2013-14																		
All hospitals																		
50th percentile																		
Cataract extraction	232	np	69	55	np	np	np	126	107	218	41	51	43	78	171	125	111	78

TABLE 11A.26

Table 11A.26 **Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) (a)**

	<i>Aboriginal and Torres Strait Islander Australians (b)</i>									<i>Other Australians (c)</i>								
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Cholecystectomy	54	np	41	np	np	np	np	np	46	55	47	42	27	34	71	67	45	46
Coronary artery bypass graft	np	np	np	np	np	np	np	np	18	25	21	10	20	21	18	np	–	18
Cystoscopy	32	np	24	31	np	np	np	np	29	27	21	23	18	31	31	29	47	23
Haemorrhoidectomy	np	np	np	np	np	np	np	np	np	64	69	52	40	21	np	np	61	58
Hysterectomy	np	np	64	np	np	np	np	np	57	55	63	56	33	47	70	64	np	52
Inguinal herniorrhaphy	58	np	np	np	np	np	np	np	45	69	57	56	35	33	84	62	42	56
Myringoplasty	np	np	np	74	np	np	np	157	117	320	140	85	84	np	np	np	np	132
Myringotomy	np	np	70	41	np	np	np	np	58	71	62	43	57	35	72	79	np	54
Prostatectomy	np	np	np	np	np	np	np	np	64	60	34	40	26	41	np	np	np	43
Septoplasty	np	np	np	np	np	np	np	np	np	324	138	86	136	139	np	381	np	218
Tonsillectomy	203	95	81	np	np	np	np	np	105	237	104	55	100	70	115	338	70	98
Total hip replacement	np	np	np	np	np	np	np	np	129	191	112	76	69	103	364	111	np	106
Total knee replacement	np	np	np	np	np	np	np	np	244	290	160	145	83	161	535	150	np	194
Varicose veins stripping & ligation	np	np	np	np	np	np	np	np	np	122	126	64	83	61	np	73	np	97
Total (d)	54	40	30	31	29	55	61	50	41	49	35	28	29	35	45	47	31	36
90th percentile																		
Cataract extraction	359	np	319	183	np	np	np	377	346	351	205	288	192	310	716	302	232	332
Cholecystectomy	154	np	138	np	np	np	np	np	147	227	148	121	90	83	342	211	147	148
Coronary artery bypass graft	np	np	np	np	np	np	np	np	78	79	90	93	66	81	76	np	–	83
Cystoscopy	133	np	106	118	np	np	np	np	140	106	89	98	104	99	135	135	187	100
Haemorrhoidectomy	np	np	np	np	np	np	np	np	np	224	262	237	116	89	np	np	160	221
Hysterectomy	np	np	159	np	np	np	np	np	185	268	254	165	104	145	225	205	np	212
Inguinal herniorrhaphy	339	np	np	np	np	np	np	np	282	335	193	155	104	105	439	223	134	246

TABLE 11A.26

Table 11A.26 **Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) (a)**

	<i>Aboriginal and Torres Strait Islander Australians (b)</i>									<i>Other Australians (c)</i>								
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Myringoplasty	np	np	np	221	np	np	np	440	379	412	435	345	265	np	np	np	np	383
Myringotomy	np	np	271	156	np	np	np	np	232	325	194	169	180	87	182	220	np	186
Prostatectomy	np	np	np	np	np	np	np	np	184	162	198	145	92	97	np	np	np	157
Septoplasty	np	np	np	np	np	np	np	np	np	365	447	383	362	336	np	765	np	385
Tonsillectomy	358	335	339	np	np	np	np	np	353	360	356	303	295	280	322	480	353	354
Total hip replacement	np	np	np	np	np	np	np	np	377	357	317	363	204	313	761	434	np	354
Total knee replacement	np	np	np	np	np	np	np	np	389	362	390	426	277	321	878	486	np	365
Varicose veins stripping & ligation	np	np	np	np	np	np	np	np	np	353	410	332	299	182	np	306	np	353
Total (d)	335	224	233	155	146	356	320	245	275	328	222	183	141	181	406	269	158	262

(a) Data are suppressed where there are fewer than 10 elective surgery admissions in the category.

(b) The quality of the data reported for Indigenous status in the National Elective Surgery Waiting Times Data Collection (NESWTDC) has not been formally assessed; therefore, caution should be exercised when interpreting these data. Data for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed. The Australian totals for Aboriginal and Torres Strait islander Australians and Other Australians do not include data for Tasmania and the ACT for 2010-11 and 2011-12.

(c) Other Australians includes records for which the Indigenous status was Not reported.

(d) Total includes all removals for elective surgery procedures, including but not limited to the procedures listed above.

.. Not applicable. **np** Not published. – Nil or rounded to zero.

Source: AIHW (unpublished) linked National Hospital Morbidity Database; AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.27

Table 11A.27 **Waiting times for elective surgery in public hospitals, by State and Territory, by remoteness area (days) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
All hospitals									
2010-11									
50th percentile									
Major cities	42	37	28	31	41	48	77	4	36
Inner regional	56	32	29	27	33	35	63	np	38
Outer regional	61	28	34	29	29	38	np	29	39
Remote	43	36	28	32	28	38	np	33	32
Very remote	27	32	35	27	26	55	np	50	35
90th percentile									
Major cities	316	176	140	162	221	222	367	50	229
Inner regional	345	177	157	138	162	353	370	np	289
Outer regional	349	189	166	165	156	342	np	236	303
Remote	338	195	157	182	150	350	np	173	223
Very remote	233	182	185	156	151	425	np	278	221
2011-12									
50th percentile									
Major cities	46	37	28	30	38	np	59	8	36
Inner regional	58	35	28	28	32	37	66	np	38
Outer regional	65	29	32	31	30	39	46	40	36
Remote	38	35	27	29	26	31	np	39	29
Very remote	46	30	28	33	21	48	0	56	35
90th percentile									
Major cities	322	188	147	161	210	np	283	320	232
Inner regional	349	182	143	152	215	384	291	np	287
Outer regional	350	179	182	160	147	304	290	236	267
Remote	341	216	166	137	119	269	np	174	166
Very remote	315	207	161	165	127	296	0	247	186
2012-13									
50th percentile									
Major cities	45	36	27	31	38	np	51	np	36
Inner regional	57	36	28	30	31	42	43	np	40
Outer regional	62	29	32	31	27	40	np	39	37
Remote	52	28	28	30	21	36	np	40	30
Very remote	62	np	28	30	16	np	np	56	35
90th percentile									
Major cities	326	224	161	160	194	np	269	np	248
Inner regional	343	223	175	156	214	413	231	np	305

Table 11A.27 **Waiting times for elective surgery in public hospitals, by State and Territory, by remoteness area (days) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Outer regional	345	218	218	166	165	403	np	185	293
Remote	344	181	194	132	106	383	np	180	171
Very remote	341	np	214	173	119	np	np	272	222

- (a) The data presented for this indicator are sourced from linked records in the National Hospital Morbidity Database and National Elective Surgery Waiting Times Data Collection. The linked records represent about 97 per cent of all records in the National Elective Surgery Waiting Times Data Collection for 2010-11 and 2011-12 and about 96 per cent of all records for 2012-13.
- (b) Disaggregation by remoteness area is by the patient's usual residence, not the location of hospital. Data are reported by jurisdiction of hospitalisation, regardless of the jurisdiction of usual residence. Hence, the data represent the waiting times for patients living in each remoteness area (regardless of their jurisdiction of residence) in the reporting jurisdiction.
- (c) Data are suppressed where there are fewer than 10 elective surgery admissions in the category.

np Not published.

Source: AIHW (unpublished) linked National Hospital Morbidity Database and National Elective Surgery Waiting Times Data Collection.

TABLE 11A.28

Table 11A.28 **Waiting times for elective surgery in public hospitals, by State and Territory, by SEIFA IRSD quintiles (days) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
All hospitals									
2010-11									
50th percentile									
Quintile 1	52	41	30	29	40	37	61	42	41
Quintile 2	56	35	28	30	40	37	75	39	41
Quintile 3	42	38	29	29	37	34	72	29	35
Quintile 4	43	35	29	31	35	32	78	30	35
Quintile 5	28	30	25	29	35	np	73	34	30
90th percentile									
Quintile 1	338	196	159	170	225	353	370	278	286
Quintile 2	343	180	153	163	211	336	379	237	297
Quintile 3	322	176	146	147	207	352	388	150	209
Quintile 4	319	175	145	168	173	323	367	235	214
Quintile 5	207	150	129	164	183	np	364	223	184
2011-12									
50th percentile									
Quintile 1	56	41	28	34	32	39	64.5	50	40
Quintile 2	59	37	28	29	36	35	52	45	41
Quintile 3	43	38	29	30	31	38	64	38	34
Quintile 4	45	34	28	30	34	36	65	36	34
Quintile 5	32	32	25	30	35	np	57	40	31
90th percentile									
Quintile 1	343	200	154	178	192	322	283	254	285
Quintile 2	346	195	158	150	207	304	298	223	290
Quintile 3	321	185	151	155	176	430	305	186	210
Quintile 4	318	183	145	159	182	462	289	225	204
Quintile 5	215	156	142	161	170	np	277	229	184
2012-13									
50th percentile									
Quintile 1	56	40	29	29	34	41	37	50	41
Quintile 2	55	37	29	33	33	42	48	40	39
Quintile 3	47	36	28	30	33	40	52	40	35
Quintile 4	45	35	28	31	35	35	52	41	35
Quintile 5	35	29	24	29	32	38	49	37	31
90th percentile									
Quintile 1	342	245	188	160	196	409	220	258	301
Quintile 2	340	224	186	167	176	387	261	175	282

Table 11A.28 **Waiting times for elective surgery in public hospitals, by State and Territory, by SEIFA IRSD quintiles (days) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Quintile 3	335	221	154	155	176	451	289	177	246
Quintile 4	320	217	163	162	179	326	273	189	230
Quintile 5	273	203	154	152	167	305	256	170	210

(a) The data presented for this indicator are sourced from linked records in the National Hospital Morbidity Database and National Elective Surgery Waiting Times Data Collection. The linked records represent about 97 per cent of all records in the National Elective Surgery Waiting Times Data Collection for 2010-11 and 2011-12 and about 96 per cent of all records for 2012-13.

(b) Socio-Economic Indexes for Areas (SEIFA) quintiles are based on the ABS Index of Relative Socio-Economic Disadvantage (IRSD), with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. Each SEIFA quintile represents approximately 20 per cent of the national population, but does not necessarily represent 20 per cent of the population in each state or territory. Disaggregation by SEIFA is by the patient's usual residence, not the location of the hospital. Data are reported by jurisdiction of hospitalisation, regardless of the jurisdiction of usual residence. Hence, the data represent the waiting times for patients in each SEIFA quintile (regardless of their jurisdiction of residence) in the reporting jurisdiction.

(c) Data are suppressed where there are fewer than 10 elective surgery admissions in the category.

np Not published.

Source: AIHW (unpublished) linked National Hospital Morbidity Database and National Elective Surgery Waiting Times Data Collection.

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
2004-05									
Cataract extraction									
Days waited at 50th percentile	182	44	33	94	99	368	240	167	92
Days waited at 90th percentile	475	187	209	317	272	595	531	365	388
% waited more than 365 days	21.2	1.9	2.6	6.1	2.9	51.1	29.9	9.7	12.1
Cholecystectomy									
Days waited at 50th percentile	50	49	40	28	40	64	57	92	46
Days waited at 90th percentile	274	236	104	165	132	217	334	367	217
% waited more than 365 days	6.1	4.4	1.2	2.2	0.8	3.5	6.6	10.6	4.2
Coronary artery bypass graft									
Days waited at 50th percentile	17	7	11	20	20	28	12	..	14
Days waited at 90th percentile	94	129	84	53	78	86	33	..	89
% waited more than 365 days	0.1	0.1	0.4	–	–	–	–	..	0.2
Cystoscopy									
Days waited at 50th percentile	27	23	29	23	22	37	44	47	27
Days waited at 90th percentile	146	174	160	187	100	179	197	182	158
% waited more than 365 days	2.2	3.6	1.4	3.5	1.6	3.0	2.5	3.4	2.6
Haemorrhoidectomy									
Days waited at 50th percentile	49	58	40	33	35	104	105	np	45
Days waited at 90th percentile	338	308	201	170	92	638	370	np	294
% waited more than 365 days	8.7	7.6	6.3	4.3	0.8	27.8	12.1	np	7.4
Hysterectomy									
Days waited at 50th percentile	40	35	34	25	53	45	44	43	36
Days waited at 90th percentile	189	173	105	78	168	161	186	389	153
% waited more than 365 days	3.7	2.2	0.8	0.8	1.1	1.6	2.0	11.5	2.4
Inguinal herniorrhaphy									
Days waited at 50th percentile	47	48	38	25	45	72	77	84	43
Days waited at 90th percentile	246	255	111	151	153	273	311	379	216
% waited more than 365 days	4.7	5.3	1.5	2.6	1.1	5.6	3.5	11.3	4.0
Myringoplasty									
Days waited at 50th percentile	210	64	46	123	115	38	96	49	88
Days waited at 90th percentile	629	434	489	419	544	489	1 093	730	550
% waited more than 365 days	32.5	12.4	12.6	14.1	26.1	15.0	30.0	23.8	19.9
Myringotomy									
Days waited at 50th percentile	34	23	21	77	43	46	127	65	29
Days waited at 90th percentile	200	80	103	168	111	157	241	263	119
% waited more than 365 days	3.3	0.6	1.0	0.9	–	–	3.9	4.8	0.9
Prostatectomy									
Days waited at 50th percentile	40	25	28	28	39	36	30	53	32
Days waited at 90th percentile	265	267	98	123	155	52	162	188	216
% waited more than 365 days	6.9	6.5	1.9	1.1	3.1	–	3.7	3.2	5.2

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Septoplasty									
Days waited at 50th percentile	179	63	46	176	173	np	354	149	96
Days waited at 90th percentile	662	565	1 031	649	614	np	952	433	642
% waited more than 365 days	30.4	19.0	20.4	29.0	24.7	np	50.0	13.0	24.2
Tonsillectomy									
Days waited at 50th percentile	110	39	28	127	73	75	173	76	62
Days waited at 90th percentile	516	205	128	406	306	402	734	369	360
% waited more than 365 days	19.1	3.1	2.0	14.0	7.0	15.0	22.4	10.5	9.8
Total hip replacement									
Days waited at 50th percentile	106	141	50	114	125	355	173	96	102
Days waited at 90th percentile	481	400	179	377	375	668	427	402	433
% waited more than 365 days	18.9	12.8	4.0	10.5	10.9	48.5	15.1	16.7	14.4
Total knee replacement									
Days waited at 50th percentile	218	176	60	165	140	411	207	217	152
Days waited at 90th percentile	604	463	267	450	418	747	587	503	542
% waited more than 365 days	33.1	17.6	7.2	17.8	14.2	57.9	28.7	33.3	23.5
Varicose veins stripping and ligation									
Days waited at 50th percentile	68	90	68	29	169	96	519	243	78
Days waited at 90th percentile	483	1,145	808	147	668	510	1,087	876	775
% waited more than 365 days	13.8	27.9	20.0	4.8	26.1	22.2	67.1	47.6	21.1
Not available/Not stated									
Days waited at 50th percentile	25	23	19	21	29	27	29	21	23
Days waited at 90th percentile	173	174	93	150	163	245	262	212	154
% waited more than 365 days	3.6	3.3	1.4	3.0	3.8	6.4	5.6	4.7	3.1
Total									
Days waited at 50th percentile	34	28	22	27	35	34	45	29	29
Days waited at 90th percentile	294	200	105	197	201	352	368	266	217
% waited more than 365 days	6.9	4.0	1.8	3.8	4.0	9.5	10.1	5.9	4.8
2005-06									
Cataract extraction									
Days waited at 50th percentile	161	49	41	83	96	389	182	246	93
Days waited at 90th percentile	368	225	272	293	314	566	496	464	342
% waited more than 365 days	10.5	0.8	4.2	5.9	4.5	50.8	22.7	21.6	7.5
Cholecystectomy									
Days waited at 50th percentile	50	48	41	31	29	47	48	71	45
Days waited at 90th percentile	261	210	138	175	96	264	169	568	211
% waited more than 365 days	4.4	3.3	1.5	3.3	–	4.9	6.4	15.0	3.4
Coronary artery bypass graft									
Days waited at 50th percentile	16	10	8	20	25	45	22	..	15
Days waited at 90th percentile	90	159	93	62	79	138	98	..	100
% waited more than 365 days	–	0.2	0.1	–	–	–	–	..	0.1

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Cystoscopy									
Days waited at 50th percentile	24	21	32	23	35	38	55	51	25
Days waited at 90th percentile	141	159	140	198	137	180	216	211	155
% waited more than 365 days	1.8	2.8	1.7	4.8	3.5	2.7	2.9	5.0	2.5
Haemorrhoidectomy									
Days waited at 50th percentile	54	70	42	32	47	53	70	np	51
Days waited at 90th percentile	292	366	171	322	105	353	379	np	286
% waited more than 365 days	5.3	10.0	3.3	8.3	–	8.5	12.5	np	6.3
Hysterectomy									
Days waited at 50th percentile	41	40	39	26	54	48	49	47	40
Days waited at 90th percentile	209	161	110	90	138	184	276	372	157
% waited more than 365 days	3.4	1.9	0.7	0.2	0.2	1.3	4.2	11.6	2.1
Inguinal herniorrhaphy									
Days waited at 50th percentile	51	56	41	24	44	41	47	71	48
Days waited at 90th percentile	259	257	133	148	142	308	202	517	233
% waited more than 365 days	3.5	5.6	2.1	3.1	0.8	5.3	3.3	17.9	3.8
Myringoplasty									
Days waited at 50th percentile	190	83	60	99	72	69	631	364	98
Days waited at 90th percentile	574	361	376	440	367	1 903	1 000	1 144	463
% waited more than 365 days	26.7	9.4	10.2	10.4	10.0	38.9	61.1	45.7	16.3
Myringotomy									
Days waited at 50th percentile	40	34	29	75	38	23	144	30	37
Days waited at 90th percentile	210	107	118	220	117	153	329	187	139
% waited more than 365 days	1.8	0.2	2.7	0.3	0.2	–	6.5	–	1.1
Prostatectomy									
Days waited at 50th percentile	48	21	28	25	50	41	52	62	35
Days waited at 90th percentile	281	278	126	116	324	70	239	250	246
% waited more than 365 days	6.0	7.8	3.0	1.5	7.5	–	3.9	9.1	5.9
Septoplasty									
Days waited at 50th percentile	266	96	66	147	130	np	312	130	128
Days waited at 90th percentile	613	430	945	503	522	np	847	468	542
% waited more than 365 days	32.9	14.7	19.0	16.2	20.1	np	41.8	19.4	22.4
Tonsillectomy									
Days waited at 50th percentile	129	56	40	119	74	57	203	118	72
Days waited at 90th percentile	406	215	182	390	231	648	894	389	336
% waited more than 365 days	13.6	3.9	3.9	11.3	2.0	26.5	30.3	13.3	8.1
Total hip replacement									
Days waited at 50th percentile	119	154	61	99	106	238	149	120	111
Days waited at 90th percentile	418	408	187	359	418	552	477	345	406
% waited more than 365 days	16.0	13.0	3.3	9.2	14.9	32.2	16.8	8.3	13.3
Total knee replacement									

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Days waited at 50th percentile	242	188	74	138	193	326	219	137	178
Days waited at 90th percentile	519	463	287	498	505	639	633	1,060	492
% waited more than 365 days	29.1	18.6	6.4	20.0	26.0	41.0	29.6	22.2	23.1
Varicose veins stripping and ligation									
Days waited at 50th percentile	70	182	71	33	203	52	241	352	98
Days waited at 90th percentile	358	726	699	416	504	252	927	635	596
% waited more than 365 days	9.5	29.1	19.9	10.3	29.4	3.9	46.3	47.6	19.6
Not available/Not stated									
Days waited at 50th percentile	27	26	21	23	32	28	36	22	25
Days waited at 90th percentile	191	195	109	167	176	253	290	237	174
% waited more than 365 days	3.3	4.1	1.6	3.6	3.7	5.7	6.7	5.6	3.3
Total									
Days waited at 50th percentile	36	32	25	28	38	34	61	30	32
Days waited at 90th percentile	291	224	127	205	212	332	372	313	237
% waited more than 365 days	5.4	4.5	2.1	4.3	4.2	8.7	10.3	7.7	4.6
2006-07									
Cataract extraction									
Days waited at 50th percentile	152	50	40	85	96	111	177	320	93
Days waited at 90th percentile	343	237	292	297	288	625	516	641	330
% waited more than 365 days	3.9	0.8	5.8	6.3	3.9	35.7	29.3	40.3	5.0
Cholecystectomy									
Days waited at 50th percentile	47	45	38	32	36	61	71	111	43
Days waited at 90th percentile	202	170	133	279	107	258	239	503	182
% waited more than 365 days	1.2	1.8	1.1	5.2	–	6.4	2.9	14.1	1.7
Coronary artery bypass graft									
Days waited at 50th percentile	15	9	15	26	24	43	19	..	17
Days waited at 90th percentile	76	80	91	67	83	196	77	..	88
% waited more than 365 days	0.1	0.2	0.1	–	–	0.4	–	..	0.1
Cystoscopy									
Days waited at 50th percentile	25	21	29	16	42	35	66	48	25
Days waited at 90th percentile	151	141	168	167	195	146	257	260	157
% waited more than 365 days	1.0	2.0	3.1	3.4	5.1	0.9	4.0	7.5	2.1
Haemorrhoidectomy									
Days waited at 50th percentile	44	53	42	36	32	94	81	np	44
Days waited at 90th percentile	237	265	201	359	158	298	160	np	241
% waited more than 365 days	2.1	3.7	4.8	8.2	0.7	8.8	–	np	3.3
Hysterectomy									
Days waited at 50th percentile	45	43	36	32	52	62	53	32	43
Days waited at 90th percentile	204	146	116	118	154	241	252	129	165
% waited more than 365 days	1.0	1.1	1.2	0.4	0.4	3.2	4.4	4.8	1.1
Inguinal herniorrhaphy									

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Days waited at 50th percentile	48	45	40	32	47	77	77	45	
Days waited at 90th percentile	231	198	168	232	141	424	224	362	217
% waited more than 365 days	1.2	2.4	2.4	5.0	1.5	13.6	1.4	9.5	2.4
Myringoplasty									
Days waited at 50th percentile	125	62	62	143	186	154	252	440	93
Days waited at 90th percentile	354	278	379	485	434	1 106	952	863	378
% waited more than 365 days	6.5	6.2	11.0	14.8	22.6	28.6	35.7	58.3	11.4
Myringotomy									
Days waited at 50th percentile	42	28	38	68	49	37	61	13	39
Days waited at 90th percentile	232	92	150	301	133	114	321	116	152
% waited more than 365 days	1.1	0.2	1.1	5.5	0.6	–	6.1	5.0	1.3
Prostatectomy									
Days waited at 50th percentile	44	23	28	23	55	51	30	45	35
Days waited at 90th percentile	223	225	128	122	232	83	218	441	206
% waited more than 365 days	2.6	5.2	1.9	1.9	4.3	–	5.1	15.4	3.4
Septoplasty									
Days waited at 50th percentile	203	75	56	159	129	np	167	205	113
Days waited at 90th percentile	370	376	545	561	354	np	851	1 814	405
% waited more than 365 days	11.4	10.7	16.9	19.1	9.5	np	29.4	42.9	13.6
Tonsillectomy									
Days waited at 50th percentile	123	53	42	112	80	117	194	154	75
Days waited at 90th percentile	345	199	183	461	364	1 278	943	683	332
% waited more than 365 days	4.3	2.0	3.8	17.5	9.8	35.5	35.8	20.2	6.1
Total hip replacement									
Days waited at 50th percentile	134	132	62	83	111	244	140	164	106
Days waited at 90th percentile	356	361	245	326	468	617	330	413	358
% waited more than 365 days	5.9	9.4	5.3	7.1	16.5	38.3	8.1	27.3	8.6
Total knee replacement									
Days waited at 50th percentile	221	170	74	115	171	392	233	203	162
Days waited at 90th percentile	365	437	343	399	559	654	527	434	390
% waited more than 365 days	9.9	15.6	9.0	12.0	28.5	54.0	24.1	36.4	13.4
Varicose veins stripping and ligation									
Days waited at 50th percentile	59	109	77	51	284	39	218	305	83
Days waited at 90th percentile	230	431	770	336	747	254	957	1,269	426
% waited more than 365 days	1.9	14.0	22.6	8.9	35.5	3.3	41.3	46.7	12.8
Not available/Not stated									
Days waited at 50th percentile	26	26	21	24	33	32	38	26	26
Days waited at 90th percentile	184	189	114	183	163	280	239	246	174
% waited more than 365 days	1.2	3.3	1.8	3.8	2.7	6.9	5.1	5.9	2.4
Total									
Days waited at 50th percentile	35	30	25	29	40	38	63	35	32

Table 11A.29 Elective surgery waiting times, by indicator procedure

	NSW	Vic Qld (a)	WA	SA Tas (b)	ACT	NT	Aust		
Days waited at 90th percentile	260	208	142	225	206	343	364	370	226
% waited more than 365 days	1.9	3.3	2.5	4.6	3.9	9.2	9.9	10.2	3.1
2007-08									
Cataract extraction									
Days waited at 50th percentile	168	43	48	59	73	417	175	184	87
Days waited at 90th percentile	340	231	317	265	225	737	484	498	326
% waited more than 365 days	2.9	1.7	6.0	3.3	1.2	51.5	18.5	20.1	4.3
Cholecystectomy									
Days waited at 50th percentile	53	50	37	33	50	78	83	76	47
Days waited at 90th percentile	202	194	117	194	154	420	227	384	188
% waited more than 365 days	0.7	1.4	0.7	1.8	0.6	13.8	1.8	10.5	1.4
Coronary artery bypass graft									
Days waited at 50th percentile	14	11	9	24	20	31	13	..	14
Days waited at 90th percentile	102	151	67	56	113	140	84	..	97
% waited more than 365 days	0.1	0.2	0.2	–	–	0.8	–	..	0.2
Cystoscopy									
Days waited at 50th percentile	26	21	33	20	35	49	51	52	26
Days waited at 90th percentile	156	163	137	146	119	174	279	181	157
% waited more than 365 days	0.9	2.0	3.0	3.1	1.1	2.4	4.0	3.5	1.8
Haemorrhoidectomy									
Days waited at 50th percentile	50	65	37	39	48	68	72	79	50
Days waited at 90th percentile	249	260	167	245	168	440	168	307	245
% waited more than 365 days	1.9	4.2	2.5	2.9	1.7	12.5	–	6.1	2.8
Hysterectomy									
Days waited at 50th percentile	52	52	36	42	54	66	85	78	49
Days waited at 90th percentile	239	161	121	161	167	221	308	158	192
% waited more than 365 days	1.8	1.2	0.7	1.1	0.8	3.5	4.1	3.4	1.4
Inguinal herniorrhaphy									
Days waited at 50th percentile	56	52	40	35	51	98	90	74	50
Days waited at 90th percentile	231	232	145	196	201	424	237	461	225
% waited more than 365 days	0.8	4.1	0.9	1.5	2.4	15.5	1.8	11.5	2.2
Myringoplasty									
Days waited at 50th percentile	177	63	62	166	200	441	417	406	104
Days waited at 90th percentile	365	322	358	408	551	1 432	860	1 043	411
% waited more than 365 days	9.8	5.9	9.9	15.8	32.2	60.0	64.0	55.6	14.5
Myringotomy									
Days waited at 50th percentile	63	39	36	73	57	44	94	44	48
Days waited at 90th percentile	315	113	168	355	159	150	418	106	182
% waited more than 365 days	2.4	0.5	0.9	9.4	0.7	–	13.8	3.6	2.4
Prostatectomy									
Days waited at 50th percentile	47	22	36	28	58	39	45	50	36

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Days waited at 90th percentile	232	234	155	105	217	135	178	160	203
% waited more than 365 days	1.7	5.6	3.0	0.9	2.5	–	3.0	–	3.0
Septoplasty									
Days waited at 50th percentile	224	105	68	156	148	507	196	153	141
Days waited at 90th percentile	369	364	625	382	459	1 557	645	1 913	389
% waited more than 365 days	11.3	9.7	14.5	12.3	18.6	60.4	32.4	21.1	13.1
Tonsillectomy									
Days waited at 50th percentile	148	67	40	146	109	96	289	95	88
Days waited at 90th percentile	350	271	188	443	399	539	677	385	349
% waited more than 365 days	4.1	2.9	3.8	18.0	14.3	15.7	43.2	11.2	7.1
Total hip replacement									
Days waited at 50th percentile	134	121	62	84	114	294	185	129	107
Days waited at 90th percentile	357	405	230	246	484	679	478	928	359
% waited more than 365 days	6.3	12.7	3.3	3.1	16.4	39.6	21.3	21.7	8.9
Total knee replacement									
Days waited at 50th percentile	235	166	77	118	207	381	226	292	160
Days waited at 90th percentile	367	505	294	307	656	762	496	618	386
% waited more than 365 days	10.5	18.7	6.9	5.7	34.9	53.9	25.2	37.5	13.6
Varicose veins stripping and ligation									
Days waited at 50th percentile	71	140	57	66	258	46	401	123	91
Days waited at 90th percentile	290	480	353	397	603	331	867	987	430
% waited more than 365 days	2.7	20.3	9.4	12.9	34.3	9.1	53.6	27.1	13.8
Not available/Not stated									
Days waited at 50th percentile	27	27	22	25	35	28	42	28	27
Days waited at 90th percentile	200	203	113	160	175	263	261	229	181
% waited more than 365 days	1.2	3.4	1.8	2.2	2.7	6.2	6.1	5.6	2.3
Total									
Days waited at 50th percentile	39	33	27	30	42	36	72	43	34
Days waited at 90th percentile	278	221	137	206	208	369	372	337	235
% waited more than 365 days	1.8	3.6	2.3	3.0	3.9	10.1	10.3	8.6	3.0
2008-09									
Cataract extraction									
Days waited at 50th percentile	168	56	42	49	59	197	121	146	84
Days waited at 90th percentile	348	190	224	190	259	570	339	372	320
% waited more than 365 days	3.8	1.0	2.2	0.8	1.3	30.4	8.8	10.2	3.6
Cholecystectomy									
Days waited at 50th percentile	53	47	40	32	44	59	85	82	47
Days waited at 90th percentile	189	175	117	149	148	426	226	253	170
% waited more than 365 days	1.8	1.5	0.7	0.9	0.5	14.1	3.5	4.9	1.8
Coronary artery bypass graft									
Days waited at 50th percentile	15	15	10	15	17	29	11	..	14

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Days waited at 90th percentile	80	184	74	35	119	142	51	..	93
% waited more than 365 days	–	1.3	0.1	–	0.2	–	–	..	0.4
Cystoscopy									
Days waited at 50th percentile	26	19	33	22	35	36	80	49	25
Days waited at 90th percentile	118	126	145	161	100	158	394	213	133
% waited more than 365 days	0.8	1.2	1.4	2.5	1.1	1.2	12.1	3.0	1.5
Haemorrhoidectomy									
Days waited at 50th percentile	51	68	42	30	38	204	84	73	51
Days waited at 90th percentile	191	248	166	178	179	591	164	318	216
% waited more than 365 days	1.6	5.0	2.1	1.4	3.4	30.8	–	8.0	3.3
Hysterectomy									
Days waited at 50th percentile	50	48	41	56	50	55	77	56	48
Days waited at 90th percentile	215	141	119	160	184	280	235	208	171
% waited more than 365 days	1.6	0.6	0.5	1.1	1.0	4.3	3.5	1.1	1.2
Inguinal herniorrhaphy									
Days waited at 50th percentile	58	52	47	32	48	68	87	80	52
Days waited at 90th percentile	241	214	145	156	217	622	272	206	218
% waited more than 365 days	2.3	3.4	1.2	0.9	1.1	22.7	5.7	1.5	3.0
Myringoplasty									
Days waited at 50th percentile	190	82	70	101	153	71	273	82	92
Days waited at 90th percentile	366	316	328	381	451	450	689	593	370
% waited more than 365 days	10.9	6.9	8.1	11.4	16.3	15.0	40.0	16.2	10.8
Myringotomy									
Days waited at 50th percentile	45	43	33	58	48	49	119	35	44
Days waited at 90th percentile	195	120	119	212	109	154	353	128	141
% waited more than 365 days	1.1	0.3	1.2	2.5	0.4	1.0	8.9	2.5	1.2
Prostatectomy									
Days waited at 50th percentile	55	23	40	28	56	51	42	108	41
Days waited at 90th percentile	182	227	121	72	136	109	467	216	172
% waited more than 365 days	2.2	4.8	1.7	0.1	2.4	–	13.3	–	2.8
Septoplasty									
Days waited at 50th percentile	237	86	69	110	106	136	420	105	128
Days waited at 90th percentile	369	353	413	336	337	909	728	1 203	378
% waited more than 365 days	12.3	8.5	12.6	8.6	7.7	29.0	58.5	30.3	12.6
Tonsillectomy									
Days waited at 50th percentile	145	80	48	101	74	113	346	66	85
Days waited at 90th percentile	361	281	168	301	277	244	560	413	335
% waited more than 365 days	8.2	2.6	3.5	5.8	1.8	7.4	46.1	11.2	5.7
Total hip replacement									
Days waited at 50th percentile	125	107	68	68	102	370	170	59	100
Days waited at 90th percentile	364	348	242	218	374	757	489	391	364

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
% waited more than 365 days	8.9	9.2	4.0	1.8	11.0	50.5	22.0	12.5	9.6
Total knee replacement									
Days waited at 50th percentile	223	143	86	83	182	493	249	172	147
Days waited at 90th percentile	376	463	343	271	429	825	589	409	393
% waited more than 365 days	14.0	17.1	7.9	4.2	19.0	69.9	37.3	11.1	14.9
Varicose veins stripping and ligation									
Days waited at 50th percentile	69	110	55	91	116	104	298	118	87
Days waited at 90th percentile	270	486	275	393	344	584	749	524	373
% waited more than 365 days	2.2	17.0	5.9	12.4	7.9	13.9	35.4	21.1	10.6
Not available/Not stated									
Days waited at 50th percentile	28	25	22	26	29	32	44	25	26
Days waited at 90th percentile	194	172	113	149	172	315	256	181	168
% waited more than 365 days	1.7	2.6	1.5	1.9	2.4	8.4	6.3	3.9	2.3
Total									
Days waited at 50th percentile	39	31	27	31	36	44	75	40	33
Days waited at 90th percentile	283	194	133	174	207	448	378	256	220
% waited more than 365 days	2.5	2.9	1.8	2.0	2.7	13.1	10.6	5.6	2.9
2009-10									
Cataract extraction									
Days waited at 50th percentile	211	63	37	41	61	100	162	123	86
Days waited at 90th percentile	363	228	224	183	313	297	371	341	336
% waited more than 365 days	8.4	1.4	2.2	0.5	1.6	4.6	10.9	8.7	4.3
Cholecystectomy									
Days waited at 50th percentile	62	50	40	31	47	76	72	65	51
Days waited at 90th percentile	233	156	138	171	117	562	273	259	186
% waited more than 365 days	2.5	1.2	0.8	1.6	0.5	16.5	6.6	–	2.2
Coronary artery bypass graft									
Days waited at 50th percentile	19	23	5	20	12	16	16	..	15
Days waited at 90th percentile	69	122	53	70	132	75	55	..	80
% waited more than 365 days	–	2.7	–	–	0.3	–	–	..	0.7
Cystoscopy									
Days waited at 50th percentile	25	22	30	28	30	26	85	88	25
Days waited at 90th percentile	130	108	117	162	90	103	274	247	126
% waited more than 365 days	1.3	0.7	1.5	2.5	0.2	0.4	5.4	6.5	1.3
Haemorrhoidectomy									
Days waited at 50th percentile	68	77	60	33	46	51	111	69	66
Days waited at 90th percentile	284	245	190	220	189	931	320	315	260
% waited more than 365 days	2.0	4.3	3.7	2.9	0.5	21.3	8.3	6.8	3.5
Hysterectomy									
Days waited at 50th percentile	52	52	39	49	56	59	70	89	50
Days waited at 90th percentile	284	149	134	150	176	259	275	263	196

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
% waited more than 365 days	3.6	0.4	1.1	0.1	0.2	4.3	4.3	2.6	1.9
Inguinal herniorrhaphy									
Days waited at 50th percentile	72	52	47	37	50	63	88	75	57
Days waited at 90th percentile	319	170	155	198	162	461	270	265	250
% waited more than 365 days	4.3	1.9	1.6	0.8	0.3	13.3	3.9	5.0	3.1
Myringoplasty									
Days waited at 50th percentile	291	85	66	100	132	56	372	78	103
Days waited at 90th percentile	418	294	280	350	386	907	708	597	382
% waited more than 365 days	20.9	5.1	5.5	7.8	15.7	17.1	57.1	22.1	12.5
Myringotomy									
Days waited at 50th percentile	71	48	34	59	50	50	148	31	48
Days waited at 90th percentile	319	147	120	149	108	137	376	134	151
% waited more than 365 days	5.0	0.6	0.9	0.6	0.3	–	11.0	–	1.2
Prostatectomy									
Days waited at 50th percentile	61	31	40	41	56	55	71	109	47
Days waited at 90th percentile	227	198	179	111	114	127	672	462	188
% waited more than 365 days	3.7	2.2	4.6	0.1	0.6	–	14.0	13.9	2.9
Septoplasty									
Days waited at 50th percentile	311	104	56	81	98	153	373	173	144
Days waited at 90th percentile	460	381	368	317	342	931	676	403	413
% waited more than 365 days	28.4	11.0	10.3	7.0	3.9	25.6	52.8	10.3	16.3
Tonsillectomy									
Days waited at 50th percentile	220	86	53	76	77	73	331	143	91
Days waited at 90th percentile	387	318	213	181	331	247	498	474	357
% waited more than 365 days	15.7	6.0	4.0	1.3	3.9	3.8	43.0	12.7	8.4
Total hip replacement									
Days waited at 50th percentile	167	119	69	78	120	291	222	134	116
Days waited at 90th percentile	391	352	269	209	327	740	505	360	373
% waited more than 365 days	16.2	8.9	5.2	1.7	1.3	40.2	28.1	6.9	11.1
Total knee replacement									
Days waited at 50th percentile	301	155	93	100	162	431	366	172	180
Days waited at 90th percentile	415	417	368	277	337	896	568	494	414
% waited more than 365 days	24.6	14.5	10.3	5.9	1.2	59.6	50.0	15.0	18.1
Varicose veins stripping and ligation									
Days waited at 50th percentile	77	119	70	70	144	113	254	119	96
Days waited at 90th percentile	338	474	386	308	343	680	435	471	389
% waited more than 365 days	5.6	19.9	13.4	6.1	5.3	20.9	30.7	11.4	12.8
Not available/Not stated									
Days waited at 50th percentile	29	28	23	27	29	29	42	30	28
Days waited at 90th percentile	258	169	128	144	147	283	275	223	184
% waited more than 365 days	3.2	2.5	2.2	1.4	0.9	7.2	6.1	4.5	2.7

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Total									
Days waited at 50th percentile	44	36	27	32	36	73	44	35	
Days waited at 90th percentile	330	197	150	161	189	332	271	246	
% waited more than 365 days	4.9	2.8	2.5	1.5	1.1	8.7	5.8	3.5	
2010-11									
Cataract extraction									
Days waited at 50th percentile	227	57	48	35	87	246	140	126	90
Days waited at 90th percentile	361	196	333	159	349	435	300	285	343
% waited more than 365 days	6.3	0.6	3.7	0.4	6.1	27.3	5.1	3.3	4.1
Cholecystectomy									
Days waited at 50th percentile	61	50	52	28	49	68	70	68	54
Days waited at 90th percentile	240	137	141	163	99	454	261	234	171
% waited more than 365 days	2.1	0.9	0.4	1.9	0.2	14.7	3.4	3.3	1.8
Coronary artery bypass graft									
Days waited at 50th percentile	16	22	7	14	23	28	13	..	17
Days waited at 90th percentile	77	87	58	63	88	86	49	..	75
% waited more than 365 days	0.2	0.2	–	–	0.5	0.5	–	..	0.2
Cystoscopy									
Days waited at 50th percentile	23	23	28	27	35	28	73	83	25
Days waited at 90th percentile	105	99	126	176	98	112	380	224	115
% waited more than 365 days	1.2	0.6	0.7	2.6	0.4	0.6	11.1	4.4	1.3
Haemorrhoidectomy									
Days waited at 50th percentile	66	63	61	34	55	33	126	60	60
Days waited at 90th percentile	310	248	155	212	220	366	286	250	255
% waited more than 365 days	3.8	4.0	1.0	3.6	2.2	11.1	–	–	3.4
Hysterectomy									
Days waited at 50th percentile	55	49	40	43	54	48	55	71	49
Days waited at 90th percentile	300	137	141	127	169	210	218	224	201
% waited more than 365 days	3.6	0.4	1.1	0.1	0.2	1.4	3.3	–	1.7
Inguinal herniorrhaphy									
Days waited at 50th percentile	70	54	58	33	43	54	82	58	57
Days waited at 90th percentile	329	161	159	168	136	587	290	241	259
% waited more than 365 days	3.3	1.3	0.7	2.3	1.0	15.7	5.2	5.0	2.6
Myringoplasty									
Days waited at 50th percentile	316	84	68	90	182	180	317	147	108
Days waited at 90th percentile	383	356	190	246	354	694	672	539	369
% waited more than 365 days	19.0	9.7	1.1	4.9	7.3	21.7	46.7	23.2	10.7
Myringotomy									
Days waited at 50th percentile	68	49	35	43	48	119	164	22	47
Days waited at 90th percentile	297	139	108	114	110	197	384	106	139
% waited more than 365 days	2.9	0.6	0.2	1.0	–	1.6	11.6	–	0.9

TABLE 11A.29

Table 11A.29 Elective surgery waiting times, by indicator procedure

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Prostatectomy									
Days waited at 50th percentile	62	29	45	33	49	82	56	47	
Days waited at 90th percentile	222	174	169	119	91	191	154	170	
% waited more than 365 days	3.1	2.9	1.4	0.3	0.8	–	23.4	2.0	2.5
Septoplasty									
Days waited at 50th percentile	312	110	58	94	137	231	404	277	159
Days waited at 90th percentile	385	384	263	349	301	721	894	489	382
% waited more than 365 days	18.7	12.2	2.8	9.4	2.5	31.9	55.0	36.4	13.7
Tonsillectomy									
Days waited at 50th percentile	192	97	56	78	71	120	336	64	94
Days waited at 90th percentile	370	330	183	210	263	302	637	385	351
% waited more than 365 days	11.6	5.3	0.9	1.7	0.9	3.3	42.4	13.1	6.5
Total hip replacement									
Days waited at 50th percentile	149	98	78	80	118	194	253	148	108
Days waited at 90th percentile	363	323	273	237	312	635	581	273	357
% waited more than 365 days	8.0	6.9	4.2	2.9	3.3	33.2	28.6	–	7.6
Total knee replacement									
Days waited at 50th percentile	295	133	109	94	136	377	328	213	173
Days waited at 90th percentile	372	382	350	306	351	717	585	404	376
% waited more than 365 days	13.8	11.7	7.7	5.1	5.7	51.0	42.7	28.8	12.6
Varicose veins stripping and ligation									
Days waited at 50th percentile	101	104	63	68	204	85	319	94	100
Days waited at 90th percentile	350	434	305	274	411	421	584	462	368
% waited more than 365 days	5.3	13.8	4.1	4.8	18.9	19.4	33.8	11.1	10.2
Not available/Not stated									
Days waited at 50th percentile	31	29	25	27	29	29	41	24	28
Days waited at 90th percentile	276	164	126	143	153	272	305	165	184
% waited more than 365 days	2.6	2.4	1.0	1.5	1.6	7.1	7.0	2.9	2.2
Total									
Days waited at 50th percentile	47	36	29	29	38	38	76	33	36
Days waited at 90th percentile	333	182	148	159	208	359	378	223	252
% waited more than 365 days	3.6	2.5	1.3	1.6	2.0	9.6	10.8	3.9	2.9
2011-12									
Cataract extraction									
Days waited at 50th percentile	225	61	51	38	78	244	162	170	91
Days waited at 90th percentile	359	192	363	191	323	551	291	280	344
% waited more than 365 days	5.0	0.5	9.7	0.8	2.3	35.2	1.1	3.1	4.0
Cholecystectomy									
Days waited at 50th percentile	60	54	44	28	42	89	57	63	51
Days waited at 90th percentile	252	161	127	148	104	521	167	267	176
% waited more than 365 days	2.2	1.4	0.4	2.3	0.6	18.0	0.7	3.2	2.0

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Coronary artery bypass graft									
Days waited at 50th percentile	23	18	8	25	18	21	20	..	16
Days waited at 90th percentile	85	83	56	78	84	72	70	..	76
% waited more than 365 days	0.1	–	–	–	–	–	–	..	0.1
Cystoscopy									
Days waited at 50th percentile	25	21	24	29	32	27	55	48	25
Days waited at 90th percentile	101	97	93	176	93	132	230	166	108
% waited more than 365 days	0.6	0.5	1.1	2.9	0.4	1.6	2.2	2.6	1.0
Haemorrhoidectomy									
Days waited at 50th percentile	70	63	52	34	36	52	83	131	57
Days waited at 90th percentile	304	263	154	181	120	781	306	228	245
% waited more than 365 days	3.3	4.1	1.3	2.8	0.5	25.4	2.3	0.5	3.2
Hysterectomy									
Days waited at 50th percentile	58	57	55	39	40	53	60	74	53
Days waited at 90th percentile	307	171	167	120	174	200	217	158	207
% waited more than 365 days	3.2	1.6	1.2	0.2	0.2	1.4	1.5	1.8	1.8
Inguinal herniorrhaphy									
Days waited at 50th percentile	73	60	54	29	33	58	73	73	57
Days waited at 90th percentile	342	175	152	151	142	516	198	283	277
% waited more than 365 days	4.1	1.3	1.1	2.7	1.4	14.9	1.6	7.4	3.1
Myringoplasty									
Days waited at 50th percentile	314	108	82	84	63	130	399	92	106
Days waited at 90th percentile	376	355	290	259	295	702	588	399	364
% waited more than 365 days	18.8	8.7	4.1	2.0	2.6	23.5	56.3	12.5	9.5
Myringotomy									
Days waited at 50th percentile	76	49	31	48	43	91	116	43	49
Days waited at 90th percentile	322	144	110	123	98	194	270	122	145
% waited more than 365 days	2.6	1.6	1.1	0.2	0.5	–	2.0	1.4	1.1
Prostatectomy									
Days waited at 50th percentile	56	33	38	34	36	46	45	55	42
Days waited at 90th percentile	178	187	139	135	90	97	188	106	160
% waited more than 365 days	1.7	2.3	1.4	1.9	0.8	–	3.6	–	1.7
Septoplasty									
Days waited at 50th percentile	320	101	60	99	133	200	323	110	160
Days waited at 90th percentile	372	370	298	358	316	601	552	414	370
% waited more than 365 days	16.0	11.0	4.7	9.0	2.9	22.9	39.6	18.5	11.8
Tonsillectomy									
Days waited at 50th percentile	221	98	61	78	64	103	177	73	97
Days waited at 90th percentile	370	333	253	243	254	336	335	301	358
% waited more than 365 days	13.5	6.3	3.5	3.3	1.7	5.1	5.4	4.3	7.2
Total hip replacement									

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Days waited at 50th percentile	193	99	81	95	130	229	193	98	116
Days waited at 90th percentile	365	288	285	266	337	669	434	233	357
% waited more than 365 days	9.6	4.8	4.6	3.4	6.1	30.7	18.6	3.0	7.2
Total knee replacement									
Days waited at 50th percentile	303	123	120	119	173	476	216	123	184
Days waited at 90th percentile	372	343	362	342	362	833	444	490	371
% waited more than 365 days	13.7	8.0	9.2	8.7	8.9	52.2	20.7	14.3	11.6
Varicose veins stripping and ligation									
Days waited at 50th percentile	100	112	77	66	119	66	256	236	103
Days waited at 90th percentile	343	417	356	379	363	667	660	562	365
% waited more than 365 days	3.7	13.3	6.9	11.5	8.2	23.1	33.2	35.9	10.0
Not available/Not stated									
Days waited at 50th percentile	33	29	23	27	28	30	33	27	28
Days waited at 90th percentile	280	175	122	129	137	264	265	158	181
% waited more than 365 days	2.4	2.4	1.2	1.3	1.2	6.7	5.8	3.0	2.1
Total									
Days waited at 50th percentile	49	36	27	30	34	38	63	39	36
Days waited at 90th percentile	335	189	147	159	191	348	296	219	251
% waited more than 365 days	3.4	2.4	2.0	1.7	1.5	9.4	6.2	3.5	2.7
2012-13									
Cataract extraction									
Days waited at 50th percentile	232	52	44	45	82	275	157	156	91
Days waited at 90th percentile	355	249	219	208	302	753	305	308	338
% waited more than 365 days	3.2	0.8	3.3	1.1	2.5	40.3	0.6	6.6	3.1
Cholecystectomy									
Days waited at 50th percentile	56	60	46	29	30	71	63	58	50
Days waited at 90th percentile	235	188	141	112	90	399	217	170	181
% waited more than 365 days	1.7	1.8	0.9	0.6	0.1	13.0	–	3.4	1.7
Coronary artery bypass graft									
Days waited at 50th percentile	27	20	8	13	15	45	7	..	16
Days waited at 90th percentile	85	85	69	43	55	134	56	..	77
% waited more than 365 days	0.2	0.3	0.2	–	–	–	–	..	0.2
Cystoscopy									
Days waited at 50th percentile	25	21	24	22	30	34	34	50	23
Days waited at 90th percentile	104	96	100	136	97	182	168	158	108
% waited more than 365 days	0.6	0.5	1.5	2.2	0.5	1.8	0.5	3.2	0.9
Haemorrhoidectomy									
Days waited at 50th percentile	67	79	56	36	19	68	86	75	58
Days waited at 90th percentile	310	284	210	121	90	754	235	226	257
% waited more than 365 days	3.0	4.4	3.6	0.2	0.2	22.8	–	6.6	3.5
Hysterectomy									

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Days waited at 50th percentile	60	60	55	35	42	70	55	60	53
Days waited at 90th percentile	316	213	171	120	131	237	189	254	218
% waited more than 365 days	2.3	2.6	1.8	–	–	4.1	0.7	6.6	1.9
Inguinal herniorrhaphy									
Days waited at 50th percentile	71	71	65	34	29	99	81	52	60
Days waited at 90th percentile	337	232	181	120	119	633	232	133	284
% waited more than 365 days	3.4	2.7	2.2	0.8	0.2	25.9	0.7	0.7	3.1
Myringoplasty									
Days waited at 50th percentile	303	131	84	87	68	80	399	143	123
Days waited at 90th percentile	383	374	322	279	364	553	525	386	365
% waited more than 365 days	15.3	11.3	6.2	3.4	9.2	16.7	62.5	10.3	9.7
Myringotomy									
Days waited at 50th percentile	68	51	36	51	42	71	59	73	49
Days waited at 90th percentile	329	171	103	133	96	266	296	177	141
% waited more than 365 days	2.3	2.0	0.9	0.2	0.2	4.7	4.7	2.3	1.3
Prostatectomy									
Days waited at 50th percentile	53	27	36	31	36	52	65	63	39
Days waited at 90th percentile	198	179	168	147	107	121	139	157	167
% waited more than 365 days	1.8	1.8	2.3	1.0	0.5	–	1.9	–	1.7
Septoplasty									
Days waited at 50th percentile	327	129	76	124	100	272	340	117	197
Days waited at 90th percentile	377	569	379	390	331	584	572	443	389
% waited more than 365 days	16.6	18.7	12.2	13.6	2.3	31.9	31.8	22.9	15.7
Tonsillectomy									
Days waited at 50th percentile	258	105	56	88	69	96	170	75	98
Days waited at 90th percentile	366	354	216	259	279	448	377	363	359
% waited more than 365 days	10.1	8.4	4.3	4.6	1.5	16.4	13.4	9.6	7.3
Total hip replacement									
Days waited at 50th percentile	195	105	78	92	108	372	136	107	115
Days waited at 90th percentile	362	309	347	271	317	831	373	281	357
% waited more than 365 days	7.4	5.8	7.8	4.2	3.0	50.8	10.7	2.2	7.5
Total knee replacement									
Days waited at 50th percentile	297	141	153	105	153	615	177	121	196
Days waited at 90th percentile	368	368	462	312	342	962	448	366	374
% waited more than 365 days	11.3	10.1	18.2	5.6	3.3	66.7	19.0	11.1	12.1
Varicose veins stripping and ligation									
Days waited at 50th percentile	97	144	56	70	88	39	157	98	96
Days waited at 90th percentile	353	403	317	342	339	273	545	387	356
% waited more than 365 days	4.7	12.5	4.9	7.3	3.4	3.6	14.7	11.1	7.7
Not available/Not stated									
Days waited at 50th percentile	32	29	23	26	28	29	29	26	28

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Days waited at 90th percentile	283	209	139	132	129	225	211	139	195
% waited more than 365 days	2.1	3.3	1.9	1.2	0.7	5.8	3.9	1.9	2.2
Total									
Days waited at 50th percentile	50	36	27	30	34	41	51	40	36
Days waited at 90th percentile	335	223	163	159	182	406	277	196	265
% waited more than 365 days	2.8	3.3	2.5	1.5	1.0	11.5	4.1	3.3	2.7
2013-14									
Cataract extraction									
Days waited at 50th percentile	218	41	52	43	78	167	125	116	79
Days waited at 90th percentile	351	205	292	191	309	716	303	298	333
% waited more than 365 days	2.1	0.3	4.0	0.4	1.0	36.1	0.5	5.0	2.4
Cholecystectomy									
Days waited at 50th percentile	55	47	42	27	34	71	67	49	46
Days waited at 90th percentile	224	147	122	90	83	335	211	170	148
% waited more than 365 days	0.7	0.7	0.4	0.1	–	7.0	1.8	2.8	0.7
Coronary artery bypass graft									
Days waited at 50th percentile	25	21	10	20	18	18	np	..	18
Days waited at 90th percentile	79	90	90	63	81	76	np	..	82
% waited more than 365 days	–	0.2	–	–	–	–	np	..	–
Cystoscopy									
Days waited at 50th percentile	27	21	23	19	31	31	29	47	23
Days waited at 90th percentile	106	89	98	104	99	138	136	184	100
% waited more than 365 days	0.3	0.6	0.9	0.8	1.0	1.9	0.5	1.7	0.6
Haemorrhoidectomy									
Days waited at 50th percentile	64	69	53	40	21	np	np	70	59
Days waited at 90th percentile	230	262	237	116	89	np	np	171	222
% waited more than 365 days	1.0	3.6	3.7	0.2	0.3	np	np	4.8	2.3
Hysterectomy									
Days waited at 50th percentile	55	63	56	33	47	71	63	np	52
Days waited at 90th percentile	268	254	165	103	143	230	206	np	211
% waited more than 365 days	0.9	2.8	1.4	–	0.1	3.1	1.3	np	1.4
Inguinal herniorrhaphy									
Days waited at 50th percentile	69	57	56	34	33	84	62	42	56
Days waited at 90th percentile	335	192	156	104	104	452	214	138	246
% waited more than 365 days	1.8	2.3	2.0	–	–	13.4	0.8	1.3	1.8
Myringoplasty									
Days waited at 50th percentile	316	140	88	81	np	np	np	155	128
Days waited at 90th percentile	402	443	352	253	np	np	np	439	383
% waited more than 365 days	17.0	14.7	7.7	2.1	np	np	np	20.9	11.8
Myringotomy									
Days waited at 50th percentile	71	61	47	55	35	72	80	61	55

TABLE 11A.29

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
Days waited at 90th percentile	324	195	195	171	88	215	204	195	191
% waited more than 365 days	1.7	1.7	0.6	0.4	–	2.2	1.6	1.6	1.0
Prostatectomy									
Days waited at 50th percentile	60	34	40	26	41	np	np	np	43
Days waited at 90th percentile	162	198	145	92	97	np	np	np	157
% waited more than 365 days	0.6	2.8	1.6	–	0.4	np	np	np	1.3
Septoplasty									
Days waited at 50th percentile	324	138	87	139	138	np	380	np	221
Days waited at 90th percentile	365	446	384	360	336	np	730	np	385
% waited more than 365 days	9.1	16.3	13.1	9.6	2.0	np	54.1	np	12.8
Tonsillectomy									
Days waited at 50th percentile	233	104	56	98	71	114	342	67	99
Days waited at 90th percentile	360	355	309	293	286	321	483	277	354
% waited more than 365 days	4.3	8.1	2.3	2.4	1.4	5.0	26.3	7.6	5.0
Total hip replacement									
Days waited at 50th percentile	191	111	76	69	104	366	110	np	106
Days waited at 90th percentile	357	316	363	205	313	761	455	np	354
% waited more than 365 days	4.7	6.1	9.4	0.9	1.7	50.2	16.6	np	6.5
Total knee replacement									
Days waited at 50th percentile	290	160	146	83	161	540	151	np	194
Days waited at 90th percentile	362	389	428	276	321	881	491	np	365
% waited more than 365 days	6.8	12.2	16.3	1.4	1.0	64.0	19.8	np	9.9
Varicose veins stripping and ligation									
Days waited at 50th percentile	122	126	64	83	60	np	73	np	97
Days waited at 90th percentile	353	410	340	295	182	np	306	np	353
% waited more than 365 days	4.6	12.7	6.3	1.2	0.3	np	8.8	np	7.2
Not available/Not stated									
Days waited at 50th percentile	33	29	24	26	29	35	31	25	28
Days waited at 90th percentile	281	210	152	119	126	284	199	131	199
% waited more than 365 days	1.4	3.3	2.4	0.6	0.8	7.3	3.9	1.4	2.1
Total									
Days waited at 50th percentile	49	35	28	29	35	45	48	36	36
Days waited at 90th percentile	329	222	186	142	180	401	270	183	262
% waited more than 365 days	1.8	3.2	2.8	0.7	0.8	11.5	4.7	2.8	2.4

(a) The total number of admissions for Queensland includes 644 admissions that were removed from the waiting list for elective admission before 30 June 2005 and separated before 30 June 2006. It is expected that these admissions would be counterbalanced overall by the number of admissions occurring in a similar way in future reporting periods. The total number of admissions for Queensland includes 507 patients who were removed from the waiting list for elective admission before 30 June 2007 and separated before 30 June 2008. It is expected that these admissions would be counterbalanced overall by the number of admissions occurring in a similar way in future reporting periods.

(b) Includes data for the Mersey Community Hospital.

Table 11A.29 **Elective surgery waiting times, by indicator procedure**

	<i>NSW</i>	<i>Vic Qld (a)</i>	<i>WA</i>	<i>SA Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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.. Not applicable. – Nil or rounded to zero. **np** Not published.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra; AIHW (2014), *Australian hospital statistics 2013–14: elective surgery waiting times*. Health services series no. 56. Cat. no. HSE 151. Canberra: AIHW; AIHW (2013), *Australian hospital statistics 2012–13: elective surgery waiting times*. Health services series no. 51. Cat. no. HSE 140. Canberra: AIHW

TABLE 11A.30

Table 11A.30 **Classification of elective surgery patients, by clinical urgency category (per cent) (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
2004-05								
Patients on waiting lists								
Category 1	10.9	1.7	7.1	8.0	7.2	na	2.7	8.0
Category 2	30.6	43.4	33.9	29.3	21.9	na	45.0	34.6
Category 3	58.6	54.9	59.0	62.7	70.9	na	52.3	57.4
Total	100.0	100.0	100.0	100.0	100.0	na	100.0	100.0
Patients admitted from waiting lists								
Category 1	42.5	21.3	35.2	35.6	35.0	na	37.7	42.1
Category 2	29.7	46.2	44.4	25.3	24.7	na	40.0	35.8
Category 3	27.9	32.6	20.4	39.1	40.3	na	22.2	22.1
Total	100.0	100.0	100.0	100.0	100.0	na	100.0	100.0
2005-06								
Patients on waiting lists								
Category 1	6.8	2.4	8.0	5.9	8.4	8.0	2.4	9.7
Category 2	32.4	44.0	36.7	35.0	22.8	47.0	47.5	37.2
Category 3	60.8	53.6	55.3	59.1	68.9	45.0	50.0	53.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Patients admitted from waiting lists								
Category 1	41.5	22.4	36.2	35.3	34.6	45.0	29.9	48.9
Category 2	30.6	46.9	44.8	26.7	27.4	34.0	46.1	33.0
Category 3	28.0	30.7	19.0	38.0	37.9	21.0	24.0	18.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2006-07								
Patients on waiting lists								
Category 1	4.1	2.5	8.5	7.9	7.9	6.6	2.7	10.1
Category 2	28.3	43.9	39.3	34.7	24.6	49.6	50.2	41.6
Category 3	67.7	53.6	52.3	57.4	67.5	43.8	47.1	48.3
Total	100.0	100.0	100.1	100.0	100.0	100.0	100.0	100.0
Patients admitted from waiting lists								
Category 1	33.2	24.5	38.1	33.0	33.8	42.2	29.7	47.7
Category 2	33.0	47.8	43.8	29.2	27.7	37.5	47.5	35.1
Category 3	33.8	27.7	18.1	37.8	38.5	20.3	22.8	17.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2007-08								
Patients on waiting lists								
Category 1	3.7	2.8	9.2	6.2	8.6	6.9	3.1	9.4
Category 2	22.1	47.4	42.1	34.2	23.8	48.4	53.7	43.2
Category 3	74.2	49.8	48.7	59.6	67.5	44.7	43.2	47.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

TABLE 11A.30

Table 11A.30 **Classification of elective surgery patients, by clinical urgency category (per cent) (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
Patients admitted from waiting lists								
Category 1	30.1	26.1	38.6	31.8	35.8	44.5	28.7	42.7
Category 2	35.0	46.4	43.5	33.7	29.9	35.8	49.7	39.9
Category 3	34.9	27.5	17.9	34.5	34.3	19.7	21.6	17.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2008-09								
Patients on waiting lists								
Category 1	3.4	3.3	8.6	8.5	5.1	7.5	2.3	12.6
Category 2	17.7	47.3	46.1	35.5	23.3	54.5	54.0	47.2
Category 3	78.9	49.4	45.3	56.0	71.6	38.0	43.7	40.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Patients admitted from waiting lists								
Category 1	28.3	27.6	39.6	30.6	33.2	36.6	28.3	45.6
Category 2	32.4	46.3	44.0	34.0	31.6	35.9	50.1	36.6
Category 3	39.3	26.1	16.4	35.4	35.1	27.5	21.6	17.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2009-10								
Patients on waiting lists								
Category 1	3.0	4.0	9.2	6.1	5.1	9.5	2.8	9.4
Category 2	16.6	46.3	53.7	34.2	23.4	53.7	53.6	38.2
Category 3	80.4	49.7	37.1	59.6	71.5	36.8	43.6	52.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Patients admitted from waiting lists								
Category 1	27.7	26.6	39.0	28.4	31.8	39.3	29.8	42.4
Category 2	31.6	48.1	44.3	35.7	34.5	40.9	49.7	39.4
Category 3	40.7	25.3	16.7	35.9	33.6	19.8	20.4	18.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	99.9	100.0
2010-11								
Patients on waiting lists								
Category 1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Category 2	3.1	4.0	10.1	6.4	6.4	9.8	4.1	7.7
Category 3	16.8	45.8	48.0	30.6	25.0	54.9	54.9	38.7
Category 3	80.2	50.2	41.9	62.9	68.6	35.3	41.0	53.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Patients admitted from waiting lists								
Category 1	26.9	28.2	39.0	26.1	33.6	40.8	29.1	42.3
Category 2	32.3	47.6	45.6	35.3	34.2	42.5	48.6	38.3
Category 3	40.8	24.2	15.4	38.6	32.2	16.7	22.3	19.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

TABLE 11A.30

Table 11A.30 **Classification of elective surgery patients, by clinical urgency category (per cent) (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
2011-12								
Patients on waiting lists								
Category 1	2.8	3.5	8.9	5.5	5.0	6.2	3.5	4.7
Category 2	16.4	46.6	47.1	31.0	23.0	52.5	47.2	42.9
Category 3	80.8	49.9	44.0	63.5	72.0	41.3	49.3	52.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Patients admitted from waiting lists								
Category 1	25.5	30.3	40.0	23.4	27.1	39.0	30.2	38.8
Category 2	33.2	46.9	44.6	34.8	33.3	44.0	48.6	41.4
Category 3	41.3	22.8	15.4	41.8	39.6	17.0	21.2	19.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2012-13								
Patients on waiting lists								
Category 1	2.6	3.6	5.5	4.4	5.1	6.0	4.2	4.8
Category 2	16.7	48.8	41.0	28.8	24.0	52.6	39.3	35.8
Category 3	80.7	47.6	53.5	66.7	70.9	41.4	56.5	59.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Patients admitted from waiting lists								
Category 1	24.2	31.1	40.5	25.1	26.4	39.5	31.6	29.1
Category 2	32.4	46.5	43.7	35.0	35.7	40.6	44.8	49.3
Category 3	43.3	22.4	15.8	39.9	37.9	19.9	23.6	21.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2013-14								
Patients on waiting lists								
Category 1	2.5	4.1	7.6	5.1	4.2	5.7	4.4	5.3
Category 2	16.0	50.1	34.9	27.7	22.4	50.9	35.9	41.0
Category 3	81.5	45.8	57.5	67.1	73.4	43.4	59.7	53.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Patients admitted from waiting lists								
Category 1	23.5	28.9	39.0	24.9	25.5	38.2	29.3	29.8
Category 2	33.2	47.7	41.8	37.1	36.0	42.0	44.5	48.5
Category 3	43.3	23.3	19.1	38.0	38.5	19.8	26.3	21.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Data for 2010-11 and prior years are sourced from state and territory governments. Data for 2011-12 and after were sourced from the AIHW. Some differences in data may occur between these periods due to the different data sources.

na Not available.

Source: State and Territory governments (unpublished); AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.31

Table 11A.31 **NSW elective surgery waiting times by clinical urgency category, public hospitals (per cent) (a), (b), (c)**

	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Per cent of patients on waiting lists with extended waits (d)										
Category 1 (over 30 days)	38.9	15.7	5.1	1.5	3.3	0.1	0.3	1.2	0.1	0.3
Category 2 (over 90 days)	40.2	38.7	28.9	16.2	7.4	1.2	0.4	0.9	1.7	1.5
Category 3 (over 12 months)	10.6	0.1	0.2	0.1	1.3	2.0	0.2	0.3	0.9	0.6
All patients	22.7	13.7	8.5	3.7	2.5	1.8	0.2	0.4	1.0	0.7
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	21.7	22.8	12.9	7.9	7.2	7.9	7.4	6.3	2.6	0.3
Category 2 (over 90 days)	28.8	29.5	25.5	24.3	14.5	15.9	10.3	9.8	6.1	3.1
Category 3 (over 12 months)	20.8	15.8	4.4	4.6	6.4	12.1	8.8	8.4	6.5	4.1
All patients	23.6	22.9	14.2	12.5	9.2	12.1	8.9	8.3	5.4	2.9
Waiting time data coverage										
Per cent of elective surgery separations	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Waiting times are counted as the time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1.

(b) There is no specified or agreed desirable wait for category 3 patients, so the term 'extended wait' is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data for 2010-11 and prior years are were sourced from the NSW Government. Data for 2011-12 and after were sourced from the AIHW. Some differences in data may occur between these periods due to the different data sources.

(d) Data show patients on the waiting list at 30 June.

na Not available.

Source: NSW Government (unpublished); AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.32

Table 11A.32 **NSW elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio-thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynaecology</i>	<i>Neuro-surgery</i>	<i>Ophthalmology</i>	<i>Orthopaedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Waiting time at Census date											
Category 1											
No. patients on waiting list	73	88	695	268	42	57	95	63	377	97	34
No. of extended wait patients	3	–	1	1	–	–	–	–	–	–	–
% overdue	4.1	–	0.1	0.4	–	–	–	–	–	–	–
Category 2											
No. patients on waiting list	205	670	3 784	1 884	249	887	1 092	526	2 357	224	77
No. of extended wait patients	5	29	66	11	6	1	16	1	43	3	2
% overdue	2.4	4.3	1.7	0.6	2.4	0.1	1.5	0.2	1.8	1.3	2.6
Category 3											
No. patients on waiting list	75	8 689	8 875	4 304	817	15 494	17 586	1 709	2 543	625	124
No. of extended wait patients	2	100	83	2	3	10	119	14	21	–	–
% overdue	2.7	1.2	0.9	0.0	0.4	0.1	0.7	0.8	0.8	–	–
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	1 761	2 314	17 592	7 511	1 345	1 843	5 228	2 563	6 805	3 051	953
No. of extended wait patients	37	7	38	16	3	2	6	5	31	5	6
% overdue	2.1	0.3	0.2	0.2	0.2	0.1	0.1	0.2	0.5	0.2	0.6
Category 2											
No. patients admitted from waiting list	1 760	4 131	22 316	12 559	1 571	4 890	6 475	3 018	12 806	1 789	662
No. of extended wait patients	74	232	630	187	73	130	281	118	448	36	17
% overdue	4.2	5.6	2.8	1.5	4.6	2.7	4.3	3.9	3.5	2.0	2.6

TABLE 11A.32

Table 11A.32 **NSW elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio-thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynaecology</i>	<i>Neuro-surgery</i>	<i>Ophthalmology</i>	<i>Orthopaedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Waiting time at Census date											
Category 3											
No. patients admitted from waiting list	291	9 906	16 914	8 652	1 482	21 309	21 579	3 255	8 541	1 336	467
No. of extended wait patients	1	796	533	150	110	605	1 247	178	116	58	9
% overdue	0.3	8.0	3.2	1.7	7.4	2.8	5.8	5.5	1.4	4.3	1.9

– Nil or rounded to zero.

Source: AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.33

Table 11A.33 **Victorian elective surgery waiting times by clinical urgency category, public hospitals (per cent) (a), (b), (c)**

	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Per cent of patients on waiting lists with extended waits (d)										
Category 1 (over 30 days)	0.7	–	–	–	–	–	–	–	–	–
Category 2 (over 90 days)	42.3	36.8	34.0	35.1	32.9	29.9	28.0	34.0	37.5	34.7
Category 3 (over 12 months)	20.8	14.2	10.5	9.3	9.3	6.8	6.8	9.4	17.0	14.0
All patients	29.7	23.8	20.5	21.3	20.3	17.4	16.3	20.6	26.4	23.8
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	0.0	–	–	–	–	–	–	–	–	–
Category 2 (over 90 days)	23.6	27.7	25.3	29.9	27.0	27.0	25.4	27.7	34.3	31.4
Category 3 (over 12 months)	8.7	10.3	8.5	9.7	7.9	8.0	7.4	8.5	11.0	9.9
All patients	13.7	16.2	14.5	16.5	14.6	15.1	13.9	14.9	18.4	17.3
Waiting time data coverage										
Per cent of elective surgery separations	77.0	77.9	77.9	78.1	79.2	79.6	78.0	77.0	76.9	78.7

(a) Waiting times are counted as the time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1.

(b) There is no specified or agreed desirable wait for category 3 patients, so the term 'extended wait' is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data for 2010-11 and prior years were sourced from the Victorian Government. Data for 2011-12 and after were sourced from the AIHW. Some differences in data may occur between these periods due to the different data sources.

(d) Data show patients on the waiting list at 30 June.

– Nil or rounded to zero.

Source: Victorian Government (unpublished); AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.34

Table 11A.34 **Victorian elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio- thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynae- cology</i>	<i>Neuro- surgery</i>	<i>Ophthal- mology</i>	<i>Ortho- paedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Waiting time at Census date											
Category 1											
No. patients on waiting list	62	61	326	190	29	41	76	232	489	41	28
No. of extended wait patients	–	–	–	–	–	–	–	–	–	–	–
% overdue	–	–	–	–	–	–	–	–	–	–	–
Category 2											
No. patients on waiting list	293	2 439	3 898	2 239	499	664	4 992	1 387	2 067	334	374
No. of extended wait patients	58	1 113	902	596	172	64	2 419	539	601	152	38
% overdue	19.8	45.6	23.1	26.6	34.5	9.6	48.5	38.9	29.1	45.5	10.2
Category 3											
No. patients on waiting list	90	3 269	2 615	1 435	224	2 793	3 628	2 073	653	577	202
No. of extended wait patients	4	540	298	142	11	49	643	523	36	200	11
% overdue	4.4	16.5	11.4	9.9	4.9	1.8	17.7	25.2	5.5	34.7	5.4
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	1 631	2 355	10 459	6 043	911	2 014	3 263	8 437	11 883	1 311	995
No. of extended wait patients	–	–	–	–	–	–	–	–	–	–	–
% overdue	–	–	–	–	–	–	–	–	–	–	–
Category 2											
No. patients admitted from waiting list	1 482	7 628	19 057	10 277	1 887	4 748	13 628	6 807	12 077	1 201	2 489
No. of extended wait patients	337	3 510	5 267	4 044	651	329	5 913	2 054	2 570	372	485
% overdue	22.7	46.0	27.6	39.4	34.5	6.9	43.4	30.2	21.3	31.0	19.5

TABLE 11A.34

Table 11A.34 **Victorian elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio- thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynae- cology</i>	<i>Neuro- surgery</i>	<i>Ophthal- mology</i>	<i>Ortho- paedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Waiting time at Census date											
Category 3											
No. patients admitted from waiting list	176	5 224	6 605	2 149	463	12 820	4 759	3 006	3 075	844	610
No. of extended wait patients	8	1 075	570	307	43	248	703	688	126	139	32
% overdue	4.5	20.6	8.6	14.3	9.3	1.9	14.8	22.9	4.1	16.5	5.2

– Nil or rounded to zero.

Source: AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.35

Table 11A.35 **Queensland elective surgery waiting times, by clinical urgency category, public hospitals (per cent) (a), (b), (c)**

	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Per cent of patients on waiting lists with extended waits (d)										
Category 1 (over 30 days)	5.4	11.0	6.4	8.0	6.4	8.4	10.4	7.8	7.2	1.1
Category 2 (over 90 days)	11.3	20.5	20.5	21.4	22.1	28.2	21.1	26.6	33.5	7.8
Category 3 (over 12 months)	30.5	32.8	32.5	24.4	15.5	1.1	3.4	8.0	9.9	0.9
All patients	22.2	26.5	25.6	21.6	17.8	16.3	12.6	16.8	19.4	3.3
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	10.4	14.3	13.2	14.7	13.0	12.8	13.5	12.3	8.3	5.0
Category 2 (over 90 days)	9.4	15.6	17.7	16.9	18.4	21.3	24.9	22.5	23.1	19.5
Category 3 (over 12 months)	8.5	10.2	11.7	11.2	8.7	11.3	6.2	10.2	12.1	11.4
All patients	9.6	14.1	14.9	15.0	14.7	16.3	17.6	16.5	15.4	12.3
Waiting time data coverage										
Per cent of elective surgery separations	95.0	95.0	95.0	98.0	98.0	98.0	98.0	98.0	97.9	97.9

(a) Waiting times are counted as the time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1.

(b) There is no specified or agreed desirable wait for category 3 patients, so the term 'extended wait' is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data for 2010-11 and prior years were sourced from the Queensland Government. Data for 2011-12 and after were sourced from the AIHW. Some differences in data may occur between these periods due to the different data sources.

(d) Data show patients on the waiting list at 30 June.

Source: Queensland Government (unpublished); AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.36

Table 11A.36 **Queensland elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio-thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynae-cology</i>	<i>Neuro-surgery</i>	<i>Ophthal-mology</i>	<i>Ortho-paedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Waiting time at Census date											
Category 1											
No. patients on waiting list	72	95	650	322	38	42	229	170	350	66	31
No. of extended wait patients	–	–	3	3	–	–	3	3	7	3	–
% overdue	–	–	0.5	0.9	–	–	1.3	1.8	2.0	4.5	–
Category 2											
No. patients on waiting list	96	795	2 429	1 435	184	1 056	1 596	717	882	136	125
No. of extended wait patients	–	52	147	29	42	87	150	132	94	4	–
% overdue	–	6.5	6.1	2.0	22.8	8.2	9.4	18.4	10.7	2.9	–
Category 3											
No. patients on waiting list	39	2 195	2 055	1 577	98	3 029	5 218	687	411	73	218
No. of extended wait patients	–	4	17	3	9	34	40	23	14	–	–
% overdue	–	0.2	0.8	0.2	9.2	1.1	0.8	3.3	3.4	–	–
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	2 125	3 534	13 550	6 567	1 074	1 212	9 006	4 367	5 860	1 726	749
No. of extended wait patients	39	131	575	270	95	43	189	481	564	74	19
% overdue	1.8	3.7	4.2	4.1	8.8	3.5	2.1	11.0	9.6	4.3	2.5
Category 2											
No. patients admitted from waiting list	949	5 190	14 298	8 585	838	4 637	8 749	3 421	4 477	998	1 187
No. of extended wait patients	226	821	2 687	1 607	313	541	2 202	910	967	100	40
% overdue	23.8	15.8	18.8	18.7	37.4	11.7	25.2	26.6	21.6	10.0	3.4

TABLE 11A.36

Table 11A.36 **Queensland elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio-thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynae-cology</i>	<i>Neuro-surgery</i>	<i>Ophthalmology</i>	<i>Orthopaedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Category 3											
No. patients admitted from waiting list	118	3 157	3 917	2 227	125	5 283	7 095	1 173	727	163	410
No. of extended wait patients	1	276	352	214	22	388	1 189	184	105	18	24
% overdue	0.8	8.7	9.0	9.6	17.6	7.3	16.8	15.7	14.4	11.0	5.9

– Nil or rounded to zero.

Source: AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.37

Table 11A.37 **WA elective surgery waiting times, by clinical urgency category, public hospitals (per cent) (a), (b), (c)**

	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Per cent of patients on waiting lists with extended waits (d)										
Category 1 (over 30 days)	40.9	27.4	26.2	13.9	21.1	11.7	16.4	14.5	3.8	1.8
Category 2 (over 90 days)	52.4	53.0	46.2	40.1	30.1	28.8	25.2	23.8	9.1	7.7
Category 3 (over 12 months)	24.9	19.7	6.5	4.1	3.1	2.6	3.5	4.1	1.6	0.8
All patients	34.2	31.8	21.9	17.0	14.2	12.1	11.0	10.8	3.9	2.8
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	17.8	18.9	28.8	12.3	14.1	14.5	12.7	15.4	8.2	2.2
Category 2 (over 90 days)	31.8	32.1	44.0	30.2	24.7	24.1	19.3	17.4	15.0	8.2
Category 3 (over 12 months)	7.6	8.3	24.3	5.4	4.5	3.1	3.2	3.5	3.3	1.7
All patients	17.3	18.4	31.6	16.0	14.3	13.8	11.3	11.1	8.6	4.2
Waiting time data coverage										
Per cent of elective surgery separations	72.0	76.0	67.0	79.0	78.0	79.0	92.0	100.0	100.0	100.0

(a) Waiting times are counted as the time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1.

(b) There is no specified or agreed desirable wait for category 3 patients, so the term 'extended wait' is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data for 2010-11 and prior years were sourced from the WA Government. Data for 2011-12 and after were sourced from the AIHW. Some differences in data may occur between these periods due to the different data sources.

(d) Data show patients on the waiting list at 30 June.

Source: WA Government (unpublished); AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.38

Table 11A.38 **WA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio-thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynaecology</i>	<i>Neurosurgery</i>	<i>Ophthalmology</i>	<i>Orthopaedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Waiting time at Census date											
Category 1											
No. patients on waiting list	17	26	171	52	12	40	65	130	169	10	138
No. of extended wait patients	1	–	1	2	1	1	1	3	4	–	1
% overdue	5.9	–	0.6	3.8	8.3	2.5	1.5	2.3	2.4	–	0.7
Category 2											
No. patients on waiting list	45	344	763	358	41	344	950	356	700	109	489
No. of extended wait patients	2	42	20	–	5	6	53	94	82	10	33
% overdue	4.4	12.2	2.6	–	12.2	1.7	5.6	26.4	11.7	9.2	6.7
Category 3											
No. patients on waiting list	21	2 105	1 446	497	77	2 497	2 273	376	735	225	637
No. of extended wait patients	–	21	4	–	3	10	13	18	11	1	8
% overdue	–	1.0	0.3	–	3.9	0.4	0.6	4.8	1.5	0.4	1.3
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	400	847	4 208	1 938	259	757	2 106	2 590	3 673	423	4 467
No. of extended wait patients	10	10	38	22	10	22	20	52	98	9	187
% overdue	2.5	1.2	0.9	1.1	3.9	2.9	0.9	2.0	2.7	2.1	4.2
Category 2											
No. patients admitted from waiting list	331	2 159	6 532	2 966	356	2 890	5 072	1 731	4 955	889	4 355
No. of extended wait patients	17	212	236	31	64	328	578	230	379	64	499
% overdue	5.1	9.8	3.6	1.0	18.0	11.3	11.4	13.3	7.6	7.2	11.5

TABLE 11A.38

Table 11A.38 **WA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio-thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynaecology</i>	<i>Neuro-surgery</i>	<i>Ophthalmology</i>	<i>Orthopaedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Category 3											
No. patients admitted from waiting list	64	3 053	4 885	2 819	361	9 360	5 137	777	3 530	441	2 551
No. of extended wait patients	–	154	33	–	42	101	94	23	65	4	37
% overdue	–	5.0	0.7	–	11.6	1.1	1.8	3.0	1.8	0.9	1.5

– Nil or rounded to zero.

Source: AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.39

Table 11A.39 SA elective surgery waiting times, by clinical urgency category, public hospitals (a), (b), (c)

	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Per cent of patients on waiting lists with extended waits (d)										
Category 1 (over 30 days)	19.8	22.9	21.6	26.0	0.8	2.5	0.1	–	–	–
Category 2 (over 90 days)	27.9	20.8	16.8	11.2	1.1	1.1	0.1	–	–	0.2
Category 3 (over 12 months)	13.5	12.2	11.3	6.5	0.1	0.1	–	–	–	0.0
All patients	17.1	15.1	13.5	9.3	0.3	0.5	–	–	–	0.1
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	20.0	22.4	22.5	21.5	17.4	11.2	13.2	9.9	7.8	6.7
Category 2 (over 90 days)	24.9	22.9	22.1	27.1	15.6	10.9	12.7	16.8	7.7	7.7
Category 3 (over 12 months)	9.4	10.5	9.5	11.4	7.2	3.1	6.1	3.9	2.6	2.1
All patients	16.9	18.0	17.4	19.2	13.2	8.4	10.7	7.8	5.8	5.3
Waiting time data coverage										
Per cent of elective surgery separations	62.2	60.4	61.6	67.7	70.6	70.7	70.7	100.0	96.7	96.7

(a) For 2004-05, waiting times are counted as time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1. In previous periods, SA counted the waiting time in all urgency categories.

(b) There is no specified or agreed desirable wait for category 3 patients, so the term 'extended wait' is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data for 2010-11 and prior years are were sourced from the SA Government. Data for 2011-12 and after were sourced from the AIHW. Some differences in data may occur between these periods due to the different data sources.

(d) Data show patients on the waiting list at 30 June.

– Nil or rounded to zero.

Source: SA Government (unpublished); AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.40

Table 11A.40 **SA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio-thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynaecology</i>	<i>Neuro-surgery</i>	<i>Ophthalmology</i>	<i>Orthopaedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Waiting time at Census date											
Category 1											
No. patients on waiting list	24	43	185	88	5	25	27	99	93	23	2
No. of extended wait patients	–	–	–	–	–	–	–	–	–	–	–
% overdue	–	–	–	–	–	–	–	–	–	–	–
Category 2											
No. patients on waiting list	43	421	655	513	53	260	311	502	456	20	24
No. of extended wait patients	1	–	–	–	–	–	4	–	–	–	–
% overdue	2.3	–	–	–	–	–	1.3	–	–	–	–
Category 3											
No. patients on waiting list	22	1 371	1 251	915	45	2 940	2 851	849	411	22	16
No. of extended wait patients	–	–	–	–	–	–	5	–	–	–	–
% overdue	–	–	–	–	–	–	0.2	–	–	–	–
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	679	1 064	4 094	3 189	212	640	1 291	2 127	1 887	765	104
No. of extended wait patients	123	60	146	63	9	17	18	137	465	35	–
% overdue	18.1	5.6	3.6	2.0	4.2	2.7	1.4	6.4	24.6	4.6	–
Category 2											
No. patients admitted from waiting list	286	2 509	5 935	3 811	349	1 477	2 034	2 464	3 286	168	327
No. of extended wait patients	63	225	214	86	30	156	99	301	562	9	–
% overdue	22.0	9.0	3.6	2.3	8.6	10.6	4.9	12.2	17.1	5.4	–

Table 11A.40 **SA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio-thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynaecology</i>	<i>Neurosurgery</i>	<i>Ophthalmology</i>	<i>Orthopaedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Category 3											
No. patients admitted from waiting list	32	2 720	3 940	2 407	57	6 453	5 458	1 390	1 691	55	67
No. of extended wait patients	1	81	43	11	9	112	88	97	64	–	–
% overdue	3.1	3.0	1.1	0.5	15.8	1.7	1.6	7.0	3.8	–	–

– Nil or rounded to zero. .. Not applicable.

Source: AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.41

Table 11A.41 **Tasmanian elective surgery waiting times, by clinical urgency category, public hospitals (a), (b), (c)**

	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Per cent of patients on waiting lists with extended waits (d)										
Category 1 (over 30 days)	na	52.0	39.7	46.4	48.0	55.3	55.6	39.0	32.4	33.5
Category 2 (over 90 days)	na	66.0	64.8	68.5	68.6	66.7	66.7	70.0	66.9	61.6
Category 3 (over 12 months)	na	31.0	32.0	40.3	27.2	22.7	25.6	34.0	30.5	22.6
All patients	na	49.0	48.8	54.4	51.3	49.4	51.1	53.0	49.7	43.1
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	na	28.0	25.0	23.4	27.1	23.3	28.0	24.0	26.1	24.8
Category 2 (over 90 days)	na	43.0	46.1	51.2	48.2	45.3	39.0	40.0	42.5	50.3
Category 3 (over 12 months)	na	23.0	22.6	28.8	28.5	19.8	28.0	28.0	27.0	24.7
All patients	na	32.0	32.4	34.4	35.1	31.6	33.0	32.0	33.0	35.5
Waiting time data coverage										
Per cent of elective surgery separations	na	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Waiting times are counted as time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1.

(b) There is no specified or agreed desirable wait for category 3 patients, so the term 'extended wait' is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data for 2010-11 and prior years were sourced from the Tasmanian Government. Data for 2011-12 and after were sourced from the AIHW. Some differences in data may occur between these periods due to the different data sources.

(d) Data show patients on the waiting list at 30 June.

na Not available.

Source: Tasmanian Government (unpublished); AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.42

Table 11A.42 **Tasmania elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio- thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynae- cology</i>	<i>Neuro- surgery</i>	<i>Ophthal- mology</i>	<i>Ortho- paedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Waiting time at Census date											
Category 1											
No. patients on waiting list	36	15	98	71	43	8	21	122	62	11	2
No. of extended wait patients	15	3	18	10	29	6	4	52	20	6	1
% overdue	41.7	20.0	18.4	14.1	67.4	75.0	19.0	42.6	32.3	54.5	50.0
Category 2											
No. patients on waiting list	–	261	993	433	119	834	983	229	478	26	4
No. of extended wait patients	–	134	583	146	74	608	703	144	285	8	1
% overdue	..	51.3	58.7	33.7	62.2	72.9	71.5	62.9	59.6	30.8	25.0
Category 3											
No. patients on waiting list	–	427	744	340	14	898	699	223	348	22	4
No. of extended wait patients	–	32	297	25	5	103	195	86	98	1	–
% overdue	..	7.5	39.9	7.4	35.7	11.5	27.9	38.6	28.2	4.5	–
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	351	231	1 584	969	227	217	358	884	863	147	14
No. of extended wait patients	108	59	352	146	124	24	52	299	268	14	2
% overdue	30.8	25.5	22.2	15.1	54.6	11.1	14.5	33.8	31.1	9.5	14.3
Category 2											
No. patients admitted from waiting list	–	511	1 521	1 026	106	851	1 211	338	762	90	15
No. of extended wait patients	–	198	748	345	80	500	821	190	330	21	3
% overdue	..	38.7	49.2	33.6	75.5	58.8	67.8	56.2	43.3	23.3	20.0

Table 11A.42 **Tasmania elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio-thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynaecology</i>	<i>Neuro-surgery</i>	<i>Ophthalmology</i>	<i>Orthopaedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Category 3											
No. patients admitted from waiting list	–	212	606	349	11	1 014	327	81	364	64	11
No. of extended wait patients	–	39	110	38	5	320	147	34	56	1	1
% overdue	..	18.4	18.2	10.9	45.5	31.6	45.0	42.0	15.4	1.6	9.1

– Nil or rounded to zero. .. Not applicable.

Source: AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.43

Table 11A.43 **ACT elective surgery waiting times, by clinical urgency category, public hospitals (a), (b), (c)**

	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Per cent of patients on waiting lists with extended waits (d)										
Category 1 (over 30 days)	0.8	0.9	6.8	6.6	0.8	6.6	1.1	–	1.2	0.5
Category 2 (over 90 days)	60.9	54.2	54.0	54.5	51.2	58.3	50.1	41.1	34.0	29.9
Category 3 (over 12 months)	34.2	34.1	24.3	20.9	15.4	20.2	14.6	5.7	8.0	11.0
All patients	45.3	42.8	38.7	38.5	34.4	40.2	33.5	22.2	17.9	17.3
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	9.2	3.7	7.2	4.1	5.9	6.4	9.8	2.5	1.6	1.5
Category 2 (over 90 days)	55.6	48.3	49.1	53.4	54.9	56.3	55.1	49.3	39.6	26.2
Category 3 (over 12 months)	30.2	27.0	30.4	29.0	24.8	22.0	23.6	14.7	9.7	12.8
All patients	32.5	29.9	32.4	34.0	34.5	34.4	34.9	27.9	20.5	15.4
Waiting time data coverage										
Per cent of elective surgery separations	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Waiting times are counted as time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1.

(b) There is no specified or agreed desirable wait for category 3 patients, so the term 'extended wait' is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data for 2010-11 and prior years were sourced from the ACT Government. Data for 2011-12 and after were sourced from the AIHW. Some differences in data may occur between these periods due to the different data sources.

(d) Data show patients on the waiting list at 30 June.

– Nil or rounded to zero.

Source: ACT Government (unpublished); AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.44

Table 11A.44 **ACT elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio-thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynaecology</i>	<i>Neuro-surgery</i>	<i>Ophthalmology</i>	<i>Orthopaedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Waiting time at Census date											
Category 1											
No. patients on waiting list	3	6	23	23	2	8	5	16	72	16	10
No. of extended wait patients	–	–	–	–	–	–	–	–	1	–	–
% overdue	–	–	–	–	–	–	–	–	1.4	–	–
Category 2											
No. patients on waiting list	22	127	224	167	27	77	472	68	174	10	137
No. of extended wait patients	3	50	59	18	9	3	227	18	29	1	33
% overdue	13.6	39.4	26.3	10.8	33.3	3.9	48.1	26.5	16.7	10.0	24.1
Category 3											
No. patients on waiting list	–	771	153	129	5	557	530	46	111	143	58
No. of extended wait patients	–	162	8	2	–	1	82	–	1	19	–
% overdue	..	21.0	5.2	1.6	–	0.2	15.5	–	0.9	13.3	–
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	87	105	556	401	81	130	198	423	707	344	414
No. of extended wait patients	4	–	8	3	1	–	1	3	27	3	2
% overdue	4.6	–	1.4	0.7	1.2	–	0.5	0.7	3.8	0.9	0.5
Category 2											
No. patients admitted from waiting list	86	385	984	679	153	428	901	225	849	81	471
No. of extended wait patients	6	141	279	142	14	58	419	42	166	6	98
% overdue	7.0	36.6	28.4	20.9	9.2	13.6	46.5	18.7	19.6	7.4	20.8

Table 11A.44 **ACT elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio-thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynaecology</i>	<i>Neuro-surgery</i>	<i>Ophthalmology</i>	<i>Orthopaedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Category 3											
No. patients admitted from waiting list	–	468	263	158	19	1 098	457	48	290	99	193
No. of extended wait patients	–	215	12	8	1	16	116	9	6	12	–
% overdue	..	45.9	4.6	5.1	5.3	1.5	25.4	18.8	2.1	12.1	–

– Nil or rounded to zero. **np** Not published. .. Not applicable.

Source: AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.45

Table 11A.45 **NT elective surgery waiting times, by clinical urgency category, public hospitals (a), (b), (c)**

	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Per cent of patients on waiting lists with extended waits (d)										
Category 1 (over 30 days)	61.4	53.6	53.7	57.0	49.7	37.2	23.7	15.6	15.7	14.8
Category 2 (over 90 days)	64.2	57.0	51.7	52.4	50.0	42.9	38.4	30.4	19.2	35.7
Category 3 (over 12 months)	42.2	42.6	39.3	35.8	24.2	15.0	16.7	6.1	13.3	20.0
All patients	55.9	49.0	45.9	44.9	39.1	27.7	25.6	17.0	15.5	26.2
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	17.2	16.7	19.2	19.6	24.3	23.5	18.6	16.1	9.5	9.8
Category 2 (over 90 days)	30.5	31.0	43.0	37.9	41.6	47.8	41.2	32.8	27.5	24.7
Category 3 (over 12 months)	14.9	22.7	39.9	29.1	19.7	19.1	17.9	16.3	13.2	12.5
All patients	21.5	22.5	31.1	28.6	29.8	32.2	27.1	23.0	19.2	17.6
Waiting time data coverage (e)										
Per cent of elective surgery separations	71.7	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Waiting times are counted as time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1.

(b) Extended waits include those patients overdue in any category, that is, it is not restricted to patients waiting greater than 365 days. There is no specified or agreed desirable wait for category 3 patients, so the term 'extended wait' is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data for 2010-11 and prior years are were sourced from the NT Government. Data for 2011-12 and after were sourced from the AIHW. Some differences in data may occur between these periods due to the different data sources.

(d) Data show patients on the waiting list at 30 June.

(e) In previous reports, waiting times coverage data were derived including scopes. Data from 2004-05 exclude these scopes.

Source: NT Government (unpublished); AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.46

Table 11A.46 NT elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14

	<i>Cardio- thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynae- cology</i>	<i>Neuro- surgery</i>	<i>Ophthal- mology</i>	<i>Ortho- paedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Waiting time at Census date											
Category 1											
No. patients on waiting list	–	5	76	23	–	6	11	12	–	7	2
No. of extended wait patients	–	–	8	4	–	2	1	–	–	5	1
% overdue	..	–	10.5	17.4	..	33.3	9.1	–	..	71.4	50.0
Category 2											
No. patients on waiting list	–	228	366	153	–	189	80	29	34	11	10
No. of extended wait patients	–	119	147	39	–	60	12	5	2	6	3
% overdue	..	52.2	40.2	25.5	..	31.7	15.0	17.2	5.9	54.5	30.0
Category 3											
No. patients on waiting list	–	493	226	105	–	357	142	59	52	8	–
No. of extended wait patients	–	189	32	12	–	41	3	11	1	–	–
% overdue	..	38.3	14.2	11.4	..	11.5	2.1	18.6	1.9	–	..
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	–	181	1 154	386	–	57	221	125	25	39	78
No. of extended wait patients	–	7	114	35	–	9	27	6	3	14	7
% overdue	..	3.9	9.9	9.1	..	15.8	12.2	4.8	12.0	35.9	9.0
Category 2											
No. patients admitted from waiting list	–	435	1 134	1 031	–	396	381	107	107	33	59
No. of extended wait patients	–	191	281	156	–	163	50	20	39	10	1
% overdue	..	43.9	24.8	15.1	..	41.2	13.1	18.7	36.4	30.3	1.7

TABLE 11A.46

Table 11A.46 **NT elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2013-14**

	<i>Cardio- thoracic</i>	<i>Ear, Nose & Throat</i>	<i>General</i>	<i>Gynae- cology</i>	<i>Neuro- surgery</i>	<i>Ophthal- mology</i>	<i>Ortho- paedic</i>	<i>Plastic</i>	<i>Urology</i>	<i>Vascular</i>	<i>Other</i>
Waiting time at Census date											
Category 3											
No. patients admitted from waiting list	–	158	403	125	–	641	177	54	55	11	21
No. of extended wait patients	–	67	39	19	–	59	5	9	5	2	–
% overdue	..	42.4	9.7	15.2	..	9.2	2.8	16.7	9.1	18.2	–

– Nil or rounded to zero. **na** Not available.

Source: AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

TABLE 11A.47

Table 11A.47 Proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission, public hospitals, (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2011-12									
Principal referral and specialist women's and children's hospitals									
Resuscitation	43	53	42	61	52	59	61	53	48
Emergency	21	34	22	53	30	29	41	23	29
Urgent	16	27	19	49	24	18	28	21	24
Semi-urgent	19	29	22	51	28	20	27	19	26
Non-urgent	36	48	42	60	42	33	44	35	41
Total (c)	19	30	21	51	28	22	32	22	26
Large hospitals									
Resuscitation	42	56	47	59	40	81	..	..	49
Emergency	28	35	23	57	57	42	..	..	36
Urgent	21	32	21	51	52	36	..	..	30
Semi-urgent	21	34	29	48	51	44	..	..	30
Non-urgent	51	66	49	66	61	86	..	..	58
Total (c)	23	34	23	52	53	41	..	..	32
All hospitals (d)									
Resuscitation	44	53	43	61	53	62	61	53	49
Emergency	25	35	24	54	36	30	41	28	32
Urgent	21	29	20	50	33	21	28	28	27
Semi-urgent	23	30	25	51	37	24	27	29	29
Non-urgent	43	53	46	62	52	43	44	60	48
Total (c)	24	31	23	52	36	25	32	29	29
2012-13									
Principal referral and specialist women's and children's hospitals									
Resuscitation	43	57	54	59	53	56	62	49	51
Emergency	28	44	37	49	35	31	40	20	36
Urgent	23	36	36	42	29	18	24	19	31
Semi-urgent	27	35	43	44	32	19	28	16	33
Non-urgent	46	50	60	52	51	36	40	33	49
Total (c)	26	38	38	45	32	22	29	19	33
Large hospitals									
Resuscitation	44	44	54	54	39	69	..	..	48
Emergency	36	40	55	56	52	37	..	..	45
Urgent	29	31	51	42	44	34	..	..	37
Semi-urgent	31	33	57	41	44	42	..	..	36
Non-urgent	64	58	66	53	61	77	..	..	62
Total (c)	32	34	53	46	46	38	..	..	39
All hospitals (d)									

Table 11A.47 Proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission, public hospitals, (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Resuscitation	44	56	54	59	55	56	62	48	52
Emergency	32	44	40	52	41	32	40	23	39
Urgent	27	36	39	43	38	22	24	23	34
Semi-urgent	30	36	45	45	43	24	28	24	35
Non-urgent	53	53	62	55	61	47	40	50	54
Total (c)	30	38	41	46	41	25	29	24	36
2013-14									
Principal referral and specialist women's and children's hospitals									
Resuscitation	52	61	62	72	52	55	66	49	58
Emergency	42	49	53	65	38	33	47	17	47
Urgent	38	49	51	62	33	24	29	11	44
Semi-urgent	44	50	58	63	38	27	32	11	47
Non-urgent	61	60	65	64	61	37	39	10	59
Total (c)	42	50	53	63	37	28	34	14	46
Large hospitals									
Resuscitation	48	53	56	55	50	64	53	40	52
Emergency	39	46	51	47	25	29	39	21	43
Urgent	33	39	51	34	21	22	30	21	38
Semi-urgent	35	41	57	36	24	26	37	19	40
Non-urgent	58	60	70	48	33	64	61	44	58
Total (c)	36	41	53	39	23	25	34	21	40
All hospitals (d)									
Resuscitation	51	57	59	66	54	58	63	46	56
Emergency	43	49	53	58	37	33	45	21	47
Urgent	40	44	51	51	35	25	29	21	43
Semi-urgent	44	45	57	52	42	28	33	22	46
Non-urgent	65	60	68	60	59	44	45	50	62
Total (c)	42	46	53	53	38	28	34	22	45

(a) Includes presentations for all Types of visit.

(b) Length of stay is calculated as the length of time between presentation to the emergency department and physical departure.

(c) The total includes presentations for which the triage category was not reported.

(d) Data for 2012-13 includes Principal referral and specialist women's and children's hospitals, Large hospitals and hospitals in other peer groups that reported to the National Non-Admitted Patient Emergency Department Care Database. Data for 2013-14 includes Principal referral and Women's and children's hospitals, Public acute group A hospitals, Public acute group B hospitals and hospitals in other peer groups that reported to the National Non-Admitted Patient Emergency Department Care Database.

.. Not applicable.

Table 11A.47 Proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission, public hospitals, (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Source:</i>	AIHW (2012), <i>Australian hospital statistics 2011–12: emergency department care</i> , Health services series no. 45. Cat. no. HSE 126. Canberra; AIHW (2013), <i>Australian hospital statistics 2012–13: emergency department care</i> , Health services series no. 52. Cat. no. HSE 142. Canberra; AIHW (2014), <i>Australian hospital statistics 2013–14: emergency department care</i> , Health services series no. 58. Cat. no. HSE 153. Canberra.								

TABLE 11A.48

Table 11A.48 Separation statistics for selected hospital procedures per 1000 people, all hospitals 2012-13 (a), (b), (c)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Cataract extraction									
Hospital sector									
Public	2.7	3.0	1.6	4.7	3.4	2.0	4.1	6.7	2.8
Private	6.1	5.5	7.9	6.3	5.0	np	np	np	6.2
Indigenous status (d)									
Aboriginal and Torres Strait Islander Australians	8.6	7.1	7.4	9.0	11.0	np	np	np	8.7
Other Australians	8.6	8.5	9.3	10.7	8.3	np	np	np	8.9
Remoteness of residence (e)									
Major cities	8.3	8.3	9.7	11.9	7.9	..	6.1	..	8.8
Inner regional	9.6	9.1	9.0	8.0	8.2	11.2	np	..	9.3
Outer regional	9.4	9.1	9.8	9.5	10.8	10.0	..	9.9	9.8
Remote	8.6	11.7	6.9	9.3	8.6	16.1	..	8.0	8.7
Very remote	15.1	..	12.3	6.1	6.9	6.9	..	11.4	10.1
Socioeconomic status of area of residence (f)									
1–Lowest	10.1	8.8	8.7	21.3	6.9	8.7	44.9	7.1	9.3
2	6.0	9.3	12.7	12.4	11.0	24.0	23.1	18.6	8.8
3	11.2	8.8	10.9	7.2	8.8	9.2	23.7	9.0	9.7
4	8.8	9.3	7.7	11.3	9.2	12.5	6.6	8.7	9.0
5–Highest	8.8	6.7	8.4	12.9	5.6	..	5.7	23.3	8.3
Total	8.7	8.5	9.5	11.0	8.4	np	np	np	9.1
Cholecystectomy									
Hospital sector									
Public	1.4	1.5	1.2	1.2	1.5	1.4	1.4	1.2	1.4
Private	0.8	0.9	1.1	0.9	0.8	np	np	np	0.9
Indigenous status (d)									
Aboriginal and Torres Strait Islander Australians	3.6	4.2	2.8	2.9	3.4	np	np	np	3.1
Other Australians	2.2	2.3	2.3	2.1	2.3	np	np	np	2.3
Remoteness of residence (e)									
Major cities	2.2	2.2	2.4	2.3	2.3	..	2.1	..	2.2
Inner regional	2.3	2.8	2.5	1.7	1.8	2.3	np	..	2.4
Outer regional	2.7	3.0	2.1	1.9	3.0	2.5	..	1.6	2.4
Remote	2.3	3.1	2.1	2.2	2.7	2.2	..	1.8	2.2
Very remote	4.3	..	2.7	1.3	2.6	1.9	..	1.8	2.0
Socioeconomic status of area of residence (f)									
1–Lowest	2.8	2.7	2.7	4.0	2.3	2.1	27.2	1.5	2.7
2	1.7	2.9	2.9	2.3	3.1	5.1	7.8	4.4	2.4
3	2.7	2.4	2.6	1.6	2.2	2.1	7.6	1.8	2.4

TABLE 11A.48

Table 11A.48 Separation statistics for selected hospital procedures per 1000 people, all hospitals 2012-13 (a), (b), (c)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
4	2.0	2.5	1.9	2.1	2.2	2.1	2.4	1.2	2.2
5-Highest	1.8	1.5	1.9	2.4	1.2	..	2.0	2.8	1.8
Total	2.2	2.4	2.4	2.1	2.3	np	np	np	2.3
Coronary angioplasty									
Hospital sector									
Public	0.9	0.8	0.8	0.8	0.9	1.0	2.0	..	0.9
Private	0.6	0.7	0.7	0.7	0.5	np	np	..	0.7
Indigenous status (d)									
Aboriginal and Torres Strait Islander Australians	2.1	2.2	2.6	2.3	5.2	np	np	..	2.2
Other Australians	1.5	1.5	1.5	1.4	1.3	np	np	..	1.5
Remoteness of residence (e)									
Major cities	1.6	1.6	1.6	1.6	1.3	..	2.1	..	1.6
Inner regional	1.2	1.6	1.5	0.8	1.1	1.1	np	..	1.4
Outer regional	1.2	1.5	1.6	1.3	2.0	1.2	..	..	1.5
Remote	1.6	1.3	1.4	1.3	1.8	1.2	..	..	1.3
Very remote	3.1	..	1.9	1.1	3.5	1.5	..	..	1.5
Socioeconomic status of area of residence (f)									
1-Lowest	1.5	1.7	1.6	3.0	1.2	1.0	118.3	..	1.5
2	1.0	1.8	2.3	1.5	1.9	2.4	32.7	..	1.5
3	2.0	1.6	1.8	1.1	1.3	1.1	13.9	..	1.6
4	1.6	1.8	1.2	1.4	1.5	1.1	2.2	..	1.5
5-Highest	1.6	1.1	1.2	1.7	0.9	..	1.9	..	1.4
Total	1.5	1.6	1.6	1.5	1.4	np	np	..	1.5
Coronary artery bypass graft									
Hospital sector									
Public	0.3	0.3	0.3	0.2	0.3	0.3	0.5	..	0.3
Private	0.2	0.2	0.3	0.2	0.2	np	np	..	0.2
Indigenous status (d)									
Aboriginal and Torres Strait Islander Australians	0.9	0.9	1.3	1.1	4.0	0.3	2.4	..	1.1
Other Australians	0.5	0.5	0.5	0.4	0.5	np	np	..	0.5
Remoteness of residence (e)									
Major cities	0.5	0.5	0.5	0.4	0.5	..	0.4	..	0.5
Inner regional	0.4	0.6	0.6	0.3	0.4	0.3	np	..	0.5
Outer regional	0.5	0.6	0.6	0.3	0.9	0.3	..	..	0.5
Remote	0.8	0.8	0.6	0.5	1.2	0.1	..	..	0.6
Very remote	0.9	..	0.8	0.4	2.2	0.3	..	..	0.7
Socioeconomic status of area of residence (f)									

TABLE 11A.48

Table 11A.48 Separation statistics for selected hospital procedures per 1000 people, all hospitals 2012-13 (a), (b), (c)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
1–Lowest	0.6	0.6	0.6	0.7	0.6	0.2	33.5	..	0.6
2	0.3	0.6	0.8	0.5	0.8	0.5	7.8	..	0.5
3	0.6	0.6	0.6	0.3	0.5	0.3	3.5	..	0.5
4	0.5	0.6	0.4	0.4	0.6	0.6	0.6	..	0.5
5–Highest	0.4	0.3	0.4	0.4	0.3	..	0.4	..	0.4
Total	0.5	0.5	0.5	0.4	0.6	np	np	..	0.5
Cystoscopy									
Hospital sector									
Public	1.6	2.9	2.0	3.3	2.7	1.6	3.0	2.0	2.3
Private	2.4	3.0	3.5	4.3	3.5	np	np	1.1	3.1
Indigenous status (d)									
Aboriginal and Torres Strait Islander Australians	3.4	6.0	3.1	4.5	3.4	np	np	np	3.6
Other Australians	4.1	5.9	5.4	7.6	6.2	np	np	np	5.4
Remoteness of residence (e)									
Major cities	4.1	6.0	5.6	8.5	6.5	..	5.0	..	5.6
Inner regional	4.0	5.8	5.2	5.3	4.9	6.1	np	..	5.0
Outer regional	3.9	4.8	5.4	6.4	6.0	4.0	..	3.4	4.9
Remote	3.9	7.3	3.7	6.2	5.3	3.5	..	2.1	4.6
Very remote	6.6	..	3.9	3.9	5.9	3.0	..	2.7	4.0
Socioeconomic status of area of residence (f)									
1–Lowest	4.5	5.8	5.0	14.0	4.6	3.7	98.6	2.3	5.0
2	2.8	6.0	7.0	7.9	8.0	10.9	20.7	6.1	5.1
3	5.0	6.1	6.1	5.2	6.3	5.1	22.6	2.2	5.7
4	4.5	7.1	4.5	7.7	7.6	8.1	5.6	2.8	5.8
5–Highest	4.1	4.7	5.2	9.6	4.8	..	4.6	8.1	5.2
Total	4.1	5.9	5.5	7.7	6.2	np	np	np	5.4
Haemorrhoidectomy									
Hospital sector									
Public	1.0	0.8	0.3	0.5	0.5	0.6	0.3	0.9	0.7
Private	1.9	1.0	1.3	0.6	0.9	np	np	np	1.3
Indigenous status (d)									
Aboriginal and Torres Strait Islander Australians	2.0	2.5	0.7	0.6	0.9	np	np	np	1.2
Other Australians	2.8	1.8	1.6	1.2	1.4	np	np	np	2.0
Remoteness of residence (e)									
Major cities	2.8	1.5	1.6	1.1	1.3	..	0.9	..	1.9
Inner regional	2.8	2.8	2.1	1.3	1.0	2.0	np	..	2.4
Outer regional	3.4	2.3	1.2	1.5	2.5	2.1	..	3.0	2.2
Remote	2.3	3.0	1.0	1.0	1.5	2.7	..	2.0	1.5

Table 11A.48 Separation statistics for selected hospital procedures per 1000 people, all hospitals 2012-13 (a), (b), (c)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Very remote	2.6	..	0.9	0.6	0.8	1.6	..	1.2	0.9
Socioeconomic status of area of residence (f)									
1–Lowest	3.2	2.1	1.5	1.9	1.1	1.5	5.8	1.2	2.2
2	2.1	2.3	2.0	1.5	1.7	4.0	1.3	5.7	2.1
3	3.2	1.7	1.8	0.8	1.5	2.4	2.5	2.5	2.0
4	2.9	1.7	1.4	1.1	1.6	2.5	1.0	2.7	1.9
5–Highest	2.7	1.2	1.5	1.4	1.3	..	0.9	4.9	1.8
Total	2.8	1.8	1.6	1.2	1.4	np	np	np	2.0
Hip replacement									
Hospital sector									
Public	0.6	0.7	0.5	0.8	0.7	0.7	1.0	0.6	0.6
Private	0.8	1.0	0.9	1.0	1.0	np	np	np	0.9
Indigenous status (d)									
Aboriginal and Torres Strait Islander Australians	0.8	1.5	0.7	0.8	1.2	np	np	np	0.8
Other Australians	1.4	1.6	1.4	1.8	1.7	np	np	np	1.5
Remoteness of residence (e)									
Major cities	1.4	1.5	1.4	1.9	1.6	..	1.8	..	1.5
Inner regional	1.4	1.9	1.4	1.5	1.7	2.0	np	..	1.6
Outer regional	1.5	2.1	1.3	2.1	2.2	1.9	..	0.8	1.7
Remote	1.4	3.4	1.0	1.9	1.8	1.7	..	0.7	1.5
Very remote	1.5	..	1.2	0.7	1.6	1.6	..	0.8	1.1
Socioeconomic status of area of residence (f)									
1–Lowest	1.4	1.5	1.4	3.6	1.3	1.5	46.4	0.6	1.5
2	1.0	1.8	1.9	2.1	2.2	3.6	19.0	1.4	1.5
3	1.7	1.7	1.6	1.2	1.7	1.8	7.4	1.0	1.6
4	1.5	1.8	1.1	1.8	2.0	3.0	2.0	0.7	1.6
5–Highest	1.6	1.3	1.1	2.0	1.2	..	1.7	1.3	1.5
Total	1.4	1.6	1.4	1.8	1.7	np	np	np	1.5
Hysterectomy, females aged 15–69 (g)									
Hospital sector									
Public	1.0	1.1	1.0	1.0	1.2	1.2	0.9	0.8	1.0
Private	1.1	1.1	1.6	1.7	1.2	np	np	np	1.3
Indigenous status (d)									
Aboriginal and Torres Strait Islander Australians	2.4	2.2	2.2	1.8	2.5	np	np	np	2.1
Other Australians	2.0	2.0	2.5	3.5	1.6	np	np	np	2.2
Remoteness of residence (e)									
Major cities	2.0	1.9	2.5	2.7	2.3	..	2.0	..	2.1

Table 11A.48 Separation statistics for selected hospital procedures per 1000 people, all hospitals 2012-13 (a), (b), (c)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Inner regional	2.5	3.1	3.0	1.9	2.5	2.5	np	..	2.7
Outer regional	2.8	3.3	2.7	2.0	3.5	2.8	..	1.7	2.7
Remote	2.4	5.5	2.4	2.4	2.9	2.1	..	1.2	2.3
Very remote	2.5	..	3.2	1.8	1.3	2.6	..	1.5	2.2
Socioeconomic status of area of residence (f)									
1–Lowest	2.5	2.4	2.6	3.6	2.0	1.8	40.6	1.3	2.4
2	1.6	2.9	3.6	2.3	3.3	6.1	7.2	2.2	2.4
3	2.7	2.2	3.0	1.8	2.8	2.5	8.7	1.0	2.5
4	2.0	2.3	2.2	2.3	2.9	3.0	2.0	1.9	2.2
5–Highest	1.8	1.4	2.2	3.5	1.4	..	2.1	2.4	2.0
Total	2.1	2.2	2.6	2.7	2.5	np	np	np	2.3
Inguinal herniorrhaphy									
Hospital sector									
Public	1.0	1.0	0.8	1.0	1.0	1.0	1.0	1.0	1.0
Private	1.1	1.1	1.4	1.3	1.0	np	np	np	1.2
Indigenous status (d)									
Aboriginal and Torres Strait Islander Australians	1.8	2.0	1.2	1.1	0.9	np	np	np	1.4
Other Australians	2.2	2.1	2.2	2.3	2.0	np	np	np	2.2
Remoteness of residence (e)									
Major cities	2.2	2.1	2.3	2.5	1.9	..	2.0	..	2.2
Inner regional	2.0	2.3	2.2	1.5	1.9	2.4	np	..	2.1
Outer regional	2.3	2.5	2.3	2.1	2.2	2.2	..	2.2	2.3
Remote	2.5	3.1	1.7	2.0	2.1	2.4	..	1.8	2.0
Very remote	4.7	..	2.0	1.7	2.0	2.3	..	0.9	1.8
Socioeconomic status of area of residence (f)									
1–Lowest	2.4	2.1	2.1	3.7	1.6	1.7	43.0	1.0	2.1
2	1.5	2.3	2.8	2.3	2.6	4.6	5.5	4.0	2.1
3	2.6	2.1	2.6	1.5	1.9	2.4	6.3	2.3	2.2
4	2.2	2.5	1.8	2.2	2.4	3.3	2.2	1.9	2.2
5–Highest	2.3	1.7	1.9	3.1	1.4	..	2.1	3.5	2.1
Total	2.2	2.1	2.2	2.3	2.0	np	np	np	2.2
Knee replacement									
Hospital sector									
Public	0.7	0.5	0.5	0.7	0.6	0.4	0.7	0.5	0.6
Private	1.2	1.1	1.4	1.5	1.5	np	np	np	1.3
Indigenous status (d)									
Aboriginal and Torres Strait Islander Australians	1.7	1.1	1.1	0.8	1.3	np	np	np	1.2

Table 11A.48 Separation statistics for selected hospital procedures per 1000 people, all hospitals 2012-13 (a), (b), (c)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Other Australians	1.9	1.6	1.9	2.2	2.0	np	np	np	1.9
Remoteness of residence (e)									
Major cities	1.9	1.4	1.7	2.3	1.8	..	1.7	..	1.8
Inner regional	2.0	2.1	2.2	1.7	1.9	1.8	np	..	2.0
Outer regional	2.0	2.3	2.3	2.5	3.2	1.4	..	1.0	2.2
Remote	2.0	1.7	1.6	2.3	2.4	2.5	..	0.9	1.9
Very remote	3.3	..	1.7	1.1	2.7	0.9	..	0.6	1.5
Socioeconomic status of area of residence (f)									
1–Lowest	2.2	1.6	2.0	4.9	1.8	1.2	45.6	0.5	2.0
2	1.3	1.9	2.8	2.6	2.7	3.7	16.4	2.0	1.9
3	2.5	1.7	2.1	1.5	2.2	1.6	9.0	0.8	2.0
4	2.1	1.7	1.5	2.2	2.2	2.3	2.0	1.2	1.8
5–Highest	1.8	1.2	1.4	2.4	1.3	..	1.7	1.1	1.6
Total	1.9	1.6	1.9	2.2	2.0	np	np	np	1.9
Myringotomy									
Hospital sector									
Public	0.5	0.7	0.6	0.8	1.4	0.5	0.5	0.6	0.7
Private	1.1	1.1	1.0	1.6	1.7	np	np	np	1.2
Indigenous status (d)									
Aboriginal and Torres Strait Islander Australians	1.8	2.6	1.7	2.3	2.3	np	np	np	1.8
Other Australians	1.6	1.8	1.7	2.3	3.0	np	np	np	1.8
Remoteness of residence (e)									
Major cities	1.6	1.6	1.7	2.6	3.2	..	1.9	..	1.9
Inner regional	1.5	2.2	1.6	1.8	2.6	1.6	np	..	1.8
Outer regional	1.4	2.3	1.4	1.6	2.8	1.2	..	1.2	1.6
Remote	2.1	4.2	1.7	2.3	2.7	0.7	..	0.8	1.9
Very remote	2.6	..	2.7	2.1	1.3	1.0	..	0.6	1.8
Socioeconomic status of area of residence (f)									
1–Lowest	1.5	1.5	1.6	3.7	2.0	1.1	77.6	0.8	1.6
2	1.0	1.9	1.8	2.0	3.8	2.9	8.0	1.8	1.7
3	2.0	1.8	1.9	1.4	3.3	1.7	8.5	0.7	1.9
4	1.6	2.0	1.5	2.4	4.3	1.9	1.9	0.9	1.9
5–Highest	2.1	1.7	1.6	3.9	2.2	..	1.9	1.8	2.1
Total	1.6	1.8	1.7	2.3	3.0	np	np	np	1.8
Prostatectomy (h)									
Hospital sector									
Public	0.9	1.0	0.7	0.9	1.0	0.8	1.1	0.5	0.9
Private	1.8	2.0	1.9	1.7	1.4	np	np	np	1.8
Indigenous status (d)									

TABLE 11A.48

Table 11A.48 Separation statistics for selected hospital procedures per 1000 people, all hospitals 2012-13 (a), (b), (c)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Aboriginal and Torres Strait Islander Australians	2.2	2.1	1.3	1.2	1.4	np	np	np	1.6
Other Australians	2.6	2.9	2.6	3.0	1.9	np	np	np	2.6
Remoteness of residence (e)									
Major cities	2.7	3.0	2.6	2.8	2.3	..	2.8	..	2.8
Inner regional	2.5	2.9	2.8	2.0	2.1	3.3	np	..	2.7
Outer regional	2.7	3.0	2.5	2.3	3.0	2.4	..	0.7	2.6
Remote	3.0	2.7	1.2	1.9	2.4	2.6	..	0.7	1.9
Very remote	6.4	..	3.1	0.5	1.3	4.2	..	0.4	2.0
Socioeconomic status of area of residence (f)									
1–Lowest	2.7	2.6	2.4	4.3	1.9	2.1	51.9	0.6	2.5
2	1.8	2.9	3.5	2.8	2.9	5.4	24.1	2.1	2.5
3	3.2	3.3	2.9	1.7	2.3	3.1	14.1	0.3	2.8
4	2.8	3.6	2.0	2.7	2.9	4.6	2.7	0.5	2.9
5–Highest	3.0	2.6	2.7	3.2	2.0	..	2.8	1.1	2.8
Total	2.7	3.0	2.6	2.6	2.4	np	np	np	2.7
Septoplasty									
Hospital sector									
Public	0.3	0.4	0.2	0.2	0.5	0.1	0.3	0.2	0.3
Private	0.8	0.9	0.7	0.7	1.0	np	np	np	0.8
Indigenous status (d)									
Aboriginal and Torres Strait Islander Australians	0.5	0.9	0.3	0.2	0.7	np	np	np	0.4
Other Australians	1.1	1.3	0.9	1.0	1.5	np	np	np	1.1
Remoteness of residence (e)									
Major cities	1.2	1.3	0.9	1.1	1.6	..	0.8	..	1.2
Inner regional	0.9	1.5	0.8	0.6	1.1	0.6	np	..	1.0
Outer regional	0.8	1.5	1.2	0.7	1.2	0.6	..	0.7	1.0
Remote	0.5	1.1	0.6	0.7	0.7	0.3	..	0.4	0.6
Very remote	1.0	..	0.7	0.4	0.6	0.3	..	0.1	0.5
Socioeconomic status of area of residence (f)									
1–Lowest	1.1	1.2	0.7	1.1	0.9	0.4	15.8	0.2	1.0
2	0.7	1.4	1.1	0.8	2.0	1.3	4.1	1.5	1.1
3	1.3	1.2	1.0	0.6	1.5	0.4	4.0	0.7	1.1
4	1.2	1.5	0.8	1.0	2.1	0.8	0.8	0.4	1.2
5–Highest	1.4	1.3	1.0	1.5	1.2	..	0.8	0.9	1.3
Total	1.1	1.3	0.9	1.0	1.5	np	np	np	1.1
Tonsillectomy									
Hospital sector									

Table 11A.48 Separation statistics for selected hospital procedures per 1000 people, all hospitals 2012-13 (a), (b), (c)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Public	0.9	1.3	0.8	0.9	1.5	0.7	0.8	1.0	1.0
Private	1.5	1.2	1.5	1.9	1.6	np	np	np	1.5
Indigenous status (d)									
Aboriginal and Torres Strait Islander Australians	2.2	2.8	1.3	0.9	1.8	np	np	np	1.6
Other Australians	2.4	2.5	2.4	2.9	3.1	np	np	np	2.5
Remoteness of residence (e)									
Major cities	2.3	2.1	2.3	3.1	2.9	..	3.1	..	2.4
Inner regional	2.5	3.7	2.8	2.3	2.7	1.9	np	..	2.8
Outer regional	2.7	4.5	2.2	2.4	3.9	1.7	..	1.6	2.7
Remote	2.4	6.2	1.9	2.1	3.5	1.7	..	1.6	2.2
Very remote	4.2	..	1.5	1.1	2.7	3.5	..	0.9	1.4
Socioeconomic status of area of residence (f)									
1–Lowest	2.5	2.7	2.1	3.6	2.2	1.3	146.8	0.9	2.3
2	1.8	3.1	2.8	2.4	3.9	4.2	10.7	3.6	2.5
3	2.7	2.5	2.8	1.9	3.2	2.0	13.0	1.8	2.5
4	2.3	2.6	2.1	2.9	4.1	2.0	3.2	1.2	2.5
5–Highest	2.5	1.8	2.2	4.4	2.1	..	3.1	2.4	2.5
Total	2.4	2.5	2.4	2.8	3.0	np	np	np	2.5
Varicose veins, stripping and ligation									
Hospital sector									
Public	0.2	0.3	0.1	0.1	0.3	<0.1	0.5	0.2	0.2
Private	0.4	0.4	0.4	0.4	0.3	np	np	np	0.4
Indigenous status (d)									
Aboriginal and Torres Strait Islander Australians	0.3	0.6	0.1	0.2	0.1	0.1	0.9	0.1	0.2
Other Australians	0.6	0.7	0.5	0.6	0.6	np	np	np	0.6
Remoteness of residence (e)									
Major cities	0.6	0.7	0.5	0.6	0.5	..	0.9	..	0.6
Inner regional	0.6	0.8	0.5	0.5	0.6	0.4	np	..	0.6
Outer regional	0.5	0.8	0.4	0.6	0.8	0.4	..	0.4	0.5
Remote	0.3	1.5	0.3	0.4	0.8	0.3	..	0.2	0.4
Very remote	0.6	..	0.2	0.2	0.2	0.9	..	0.3	0.3
Socioeconomic status of area of residence (f)									
1–Lowest	0.6	0.7	0.4	0.6	0.4	0.2	10.6	0.2	0.5
2	0.4	0.9	0.6	0.5	0.7	1.1	4.2	1.0	0.6
3	0.7	0.7	0.6	0.4	0.6	0.4	3.9	0.4	0.6
4	0.5	0.9	0.4	0.7	0.7	0.7	0.9	0.3	0.6
5–Highest	0.7	0.6	0.6	0.9	0.5	..	1.0	0.7	0.7

Table 11A.48 Separation statistics for selected hospital procedures per 1000 people, all hospitals 2012-13 (a), (b), (c)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total	0.6	0.7	0.5	0.6	0.6	np	np	np	0.6

(a) Separations for which the care type was reported as Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement were excluded.

(b) Rates per 1000 population were directly age-standardised.

(c) The procedures and diagnoses are defined using ICD-10-AM codes.

(d) Other Australians includes records for which the Indigenous status was Not reported.

(e) Disaggregation by remoteness area is by usual residence, not remoteness of hospital. However, state/territory data are reported by jurisdiction of the hospital, regardless of the jurisdiction of residence.

(f) Socioeconomic status of area of residence is based on the ABS Index of Relative Socio-economic Disadvantage (IRSD), with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. These socioeconomic groups represent approximately 20 per cent of the national population, but do not necessarily represent 20 per cent of the population in each state or territory. Disaggregation by socioeconomic group is based on the patient's usual residence, not the location of the hospital.

(g) For Hysterectomy, the rate per 1000 population was calculated for the estimated resident female population aged 15 to 69 years.

(h) For Prostatectomy, the rate per 1000 population was calculated for the estimated resident male population.

Source: AIHW 2014, *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145, AIHW, Canberra.

TABLE 11A.49

Table 11A.49 Separation statistics for selected hospital procedures, all hospitals, 2012-13

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Cataract extraction										
Separations	no.	71 471	52 494	43 624	25 125	17 269	6 974	2 270	1 224	220 451
Separations not within state of residence	%	2.0	2.0	3.0	–	3.0	–	24.0	3.0	2.0
Proportion of separations public patients (a)	%	29.0	32.0	16.0	40.0	36.0	18.0	55.0	63.0	29.0
Separation rate (b)	per 1000	8.7	8.5	9.5	11.0	8.4	10.9	7.4	9.8	9.1
Standardised separation rate ratio	Ratio	1.0	0.9	1.0	1.2	0.9	1.2	0.8	1.1	
Cholecystectomy										
Separations	no.	16 695	13 556	10 766	5 086	4 003	1 297	910	368	52 681
Separations not within state of residence	%	2.0	2.0	2.0	–	2.0	–	22.0	5.0	2.0
Proportion of separations public patients (a)	%	53.0	54.0	49.0	51.0	58.0	53.0	53.0	67.0	53.0
Separation rate (b)	per 1000	2.2	2.4	2.4	2.1	2.3	2.4	2.5	1.7	2.3
Standardised separation rate ratio	Ratio	1.0	1.0	1.0	0.9	1.0	1.0	1.1	0.7	
Coronary angioplasty										
Separations	no.	12 319	9 535	7 412	3 550	2 742	737	1 104	..	37 399
Separations not within state of residence	%	1.0	4.0	8.0	2.0	10.0	1.0	45.0	..	5.0
Proportion of separations public patients (a)	%	45.0	45.0	45.0	44.0	51.0	55.0	48.0	..	46.0
Separation rate (b)	per 1000	1.5	1.6	1.6	1.5	1.4	1.2	3.3	..	1.5
Standardised separation rate ratio	Ratio	1.0	1.0	1.0	1.0	0.9	0.8	2.2	..	
Coronary artery bypass graft										
Separations	no.	3 902	3 252	2 556	911	1 163	204	245	..	12 233
Separations not within state of residence	%	4.0	4.0	9.0	2.0	13.0	1.0	53.0	..	6.0
Proportion of separations public patients (a)	%	52.0	51.0	47.0	48.0	53.0	47.0	54.0	..	51.0
Separation rate (b)	per 1000	0.5	0.5	0.5	0.4	0.6	0.3	0.8	..	0.5
Standardised separation rate ratio	Ratio	1.0	1.1	1.1	0.8	1.2	0.6	1.5	..	
Cystoscopy										

TABLE 11A.49

Table 11A.49 Separation statistics for selected hospital procedures, all hospitals, 2012-13

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Separations	no.	32 809	35 591	25 372	18 130	12 079	3 290	2 085	446	129 802
Separations not within state of residence	%	2.0	2.0	3.0	–	1.0	–	27.0	3.0	2.0
Proportion of separations public patients (a)	%	36.0	45.0	35.0	39.0	39.0	28.0	48.0	62.0	39.0
Separation rate (b)	per 1000	4.1	5.9	5.5	7.7	6.2	5.3	6.2	3.1	5.4
Standardised separation rate ratio	Ratio	0.8	1.1	1.0	1.4	1.2	1.0	1.2	0.6	
Haemorrhoidectomy										
Separations	no.	21 485	10 252	7 473	2 847	2 560	1 156	356	516	46 645
Separations not within state of residence	%	1.0	2.0	2.0	–	1.0	–	17.0	1.0	1.0
Proportion of separations public patients (a)	%	30.0	41.0	19.0	40.0	30.0	27.0	32.0	34.0	31.0
Separation rate (b)	per 1000	2.8	1.8	1.6	1.2	1.4	2.1	1.0	2.4	2.0
Standardised separation rate ratio	Ratio	1.4	0.9	0.8	0.6	0.7	1.0	0.5	1.2	
Hip replacement										
Separations	no.	11 586	10 102	6 574	4 283	3 460	1 285	802	104	38 196
Separations not within state of residence	%	2.0	3.0	5.0	–	4.0	1.0	33.0	6.0	3.0
Proportion of separations public patients (a)	%	36.0	35.0	34.0	39.0	35.0	28.0	39.0	71.0	36.0
Separation rate (b)	per 1000	1.4	1.6	1.4	1.8	1.7	2.0	2.4	0.8	1.5
Standardised separation rate ratio	Ratio	0.9	1.1	0.9	1.2	1.1	1.3	1.6	0.5	
Hysterectomy, females aged 15–69										
Separations	no.	7 780	6 231	6 029	2 943	2 131	674	443	175	26 406
Separations not within state of residence	%	2.0	2.0	4.0	–	3.0	–	21.0	3.0	3.0
Proportion of separations public patients (a)	%	42.0	46.0	36.0	35.0	47.0	43.0	36.0	47.0	41.0
Separation rate (b)	per 1000	2.1	2.2	2.6	2.7	2.5	2.6	2.4	1.6	2.3
Standardised separation rate ratio	Ratio	0.9	0.9	1.1	1.2	1.1	1.1	1.0	0.7	
Inguinal herniorrhaphy										
Separations	no.	16 729	12 562	10 278	5 394	3 575	1 363	834	379	51 114

TABLE 11A.49

Table 11A.49 Separation statistics for selected hospital procedures, all hospitals, 2012-13

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Separations not within state of residence	%	1.0	2.0	3.0	–	1.0	–	21.0	4.0	2.0
Proportion of separations public patients (a)	%	41.0	41.0	35.0	39.0	43.0	40.0	39.0	45.0	40.0
Separation rate (b)	per 1000	2.2	2.1	2.2	2.3	2.0	2.3	2.4	1.9	2.2
Standardised separation rate ratio	Ratio	1.0	1.0	1.0	1.0	0.9	1.1	1.1	0.9	
Knee replacement										
Separations	no.	15 974	9 895	9 211	5 255	4 115	1 120	811	129	46 510
Separations not within state of residence	%	1.0	3.0	5.0	–	5.0	–	36.0	1.0	3.0
Proportion of separations public patients (a)	%	33.0	31.0	25.0	31.0	26.0	24.0	31.0	54.0	30.0
Separation rate (b)	per 1000	1.9	1.6	1.9	2.2	2.0	1.7	2.4	0.9	1.9
Standardised separation rate ratio	Ratio	1.0	0.9	1.0	1.2	1.1	0.9	1.3	0.5	
Myringotomy (with insertion of tube)										
Separations	no.	11 193	9 403	7 454	5 375	4 450	713	796	251	39 635
Separations not within state of residence	%	2.0	3.0	3.0	–	1.0	–	26.0	–	2.0
Proportion of separations public patients (a)	%	28.0	36.0	37.0	32.0	41.0	30.0	23.0	57.0	34.0
Separation rate (b)	per 1000	1.6	1.8	1.7	2.3	3.0	1.5	2.3	1.0	1.8
Standardised separation rate ratio	Ratio	0.9	1.0	0.9	1.3	1.6	0.8	1.2	0.5	
Prostatectomy										
Separations	no.	10 444	8 617	6 064	2 924	2 284	934	572	46	31 885
Separations not within state of residence	%	3.0	3.0	5.0	–	2.0	–	30.0	np	3.0
Proportion of separations public patients (a)	%	31.0	31.0	27.0	32.0	31.0	25.0	28.0	np	30.0
Separation rate (b)	per 1000	2.7	3.0	2.6	2.6	2.4	3.0	3.7	np	2.7
Standardised separation rate ratio	Ratio	1.0	1.1	1.0	0.9	0.9	1.1	1.4	np	
Septoplasty										
Separations	no.	8 161	7 426	4 089	2 285	2 479	293	395	125	25 253
Separations not within state of residence	%	3.0	2.0	4.0	–	2.0	–	27.0	–	3.0

TABLE 11A.49

Table 11A.49 Separation statistics for selected hospital procedures, all hospitals, 2012-13

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Proportion of separations public patients (a)	%	25.0	29.0	20.0	22.0	30.0	23.0	28.0	24.0	25.0
Separation rate (b)	per 1000	1.1	1.3	0.9	1.0	1.5	0.6	1.0	0.5	1.1
Standardised separation rate ratio	Ratio	1.0	1.2	0.8	0.9	1.3	0.5	0.9	0.5	
Tonsillectomy										
Separations	no.	15 962	12 705	10 368	6 332	4 451	844	1 284	351	52 297
Separations not within state of residence	%	2.0	4.0	3.0	—	2.0	—	24.0	1.0	3.0
Proportion of separations public patients (a)	%	36.0	47.0	33.0	32.0	44.0	35.0	22.0	63.0	38.0
Separation rate (b)	per 1000	2.4	2.5	2.4	2.8	3.0	1.8	3.6	1.4	2.5
Standardised separation rate ratio	Ratio	1.0	1.0	1.0	1.1	1.2	0.7	1.5	0.6	
Varicose veins, stripping and ligation										
Separations	no.	4 223	4 301	2 309	1 417	1 002	222	426	79	13 979
Separations not within state of residence	%	1.0	1.0	2.0	—	2.0	—	27.0	np	2.0
Proportion of separations public patients (a)	%	33.0	36.0	21.0	23.0	42.0	14.0	42.0	np	32.0
Separation rate (b)	per 1000	0.6	0.7	0.5	0.6	0.6	0.4	1.2	np	0.6
Standardised separation rate ratio	Ratio	0.9	1.2	0.8	1.0	1.0	0.7	1.9	np	

(a) Ophthalmological services purchased from the private sector rather than being provided by public hospitals will result in a understating of Cataract extraction separation rates in the public sector.

(b) Separations per 1000 population was directly age-standardised.

.. Not applicable. **np** Not published. — Nil or rounded to Zero

Source: AIHW 2014, *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145, AIHW, Canberra.

TABLE 11A.50

Table 11A.50 **Unplanned hospital readmissions rates (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>	<i>Aust (c)</i>
	<i>rate per 1000 separations</i>									<i>no.</i>
2009-10										
Surgical procedure prior to separation										
Knee replacement	24.5	26.0	37.1	15.0	16.1	27.6	np	np	26.2	240
Hip replacement	16.0	18.0	21.9	14.6	np	26.1	np	np	16.4	118
Tonsillectomy and Adenoidectomy	20.1	26.0	30.4	30.7	33.3	52.5	np	np	26.5	525
Hysterectomy	30.8	31.5	36.4	30.8	23.2	65.7	np	np	31.3	307
Prostatectomy	33.1	23.5	33.6	44.3	34.4	np	np	np	30.9	217
Cataract surgery	4.0	3.3	4.1	4.1	4.4	7.8	np	10.9	3.8	179
Appendicectomy	21.6	25.8	24.9	29.5	36.4	20.0	25.9	50.6	25.1	519
2010-11										
Surgical procedure prior to separation										
Knee replacement	21.7	22.0	37.5	31.1	19.6	31.7	np	np	24.4	242
Hip replacement	16.5	20.8	14.2	14.7	10.3	np	np	np	16.5	119
Tonsillectomy and Adenoidectomy	22.9	23.9	31.0	34.4	31.3	37.6	19.3	np	26.3	516
Hysterectomy	29.1	28.9	34.7	33.5	28.1	40.1	np	np	30.5	284
Prostatectomy	27.2	20.9	25.8	38.0	21.9	np	np	np	25.1	174
Cataract surgery	3.2	3.9	4.0	4.3	4.0	–	–	np	3.5	166
Appendicectomy	24.8	25.6	19.6	30.8	22.8	19.9	37.7	40.2	24.2	548
2011-12										
Surgical procedure prior to separation										
Knee replacement	18.5	19.1	26.9	17.4	17.7	np	np	np	20.0	204
Hip replacement	17.7	17.4	14.2	22.5	23.7	np	np	np	17.7	129
Tonsillectomy and Adenoidectomy	24.8	23.7	32.6	33.3	33.7	60.6	18.3	np	27.8	557
Hysterectomy	27.9	32.4	33.2	31.5	28.1	28.1	np	np	30.9	281

TABLE 11A.50

Table 11A.50 **Unplanned hospital readmissions rates (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>	<i>Aust (c)</i>
Prostatectomy	22.7	26.4	36.3	50.3	25.9	np	np	np	27.2	181
Cataract surgery	2.8	3.2	4.0	2.6	3.3	7.2	–	np	3.2	156
Appendectomy	23.5	24.5	20.4	31.3	36.0	29.8	26.3	49.6	24.7	623
2012-13										
Surgical procedure prior to separation										
Knee replacement	21.6	15.1	35.1	22.3	18.6	37.0	–	np	22.4	227
Hip replacement	18.0	16.1	16.1	15.9	19.3	29.6	12.9	np	17.5	130
Tonsillectomy and Adenoidectomy	30.3	29.1	35.7	42.4	37.5	51.9	44.7	83.0	33.1	673
Hysterectomy	31.6	25.9	31.8	43.6	28.7	52.0	23.1	np	30.6	277
Prostatectomy	27.3	26.5	40.7	33.9	28.9	57.8	np	np	31.1	198
Cataract surgery	3.4	3.0	4.6	2.6	2.9	4.4	0.9	6.0	3.4	167
Appendectomy	22.4	22.8	22.0	29.0	27.0	26.5	20.4	43.5	23.1	584

(a) The reported rate is the number of unplanned/unexpected readmissions per 1000 separations.

(b) This indicator is limited to public hospitals.

(c) Total rates and numbers for 2009-10 for Australia do not include WA and Tasmania. Total rates and numbers for 2010-11, 2011-12 and 2012-13 for Australia do not include WA.

– Nil or rounded to zero. **np** Not published.

Source: AIHW (unpublished) National Hospital Morbidity Database; WA Health (unpublished).

Table 11A.51 **Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2012-13 (a), (b)**

	<i>Rate</i>	<i>Number</i>
Knee replacement		
Hospital peer group		
Peer group A	25.0	181
Peer group B	np	30
Other peer groups	np	16
Indigenous status (d)		
Indigenous	np	5
Other Australians	22.2	222
Remoteness of residence (e)		
Major cities	19.4	111
Inner regional	np	69
Outer regional	np	42
Remote & Very remote	np	4
SEIFA of residence (f)		
Quintile 1	np	83
Quintile 2	np	56
Quintile 3	np	46
Quintile 4	np	27
Quintile 5	np	14
Hip replacement		
Hospital peer group		
Peer group A	20.1	110
Peer group B	np	11
Other peer groups	np	9
Indigenous status (d)		
Indigenous	-	0
Other Australians	17.7	130
Remoteness of residence (e)		
Major cities	np	76
Inner regional	np	32
Outer regional	np	21
Remote & Very remote	np	1
SEIFA of residence (f)		
Quintile 1	np	44
Quintile 2	np	34
Quintile 3	np	23
Quintile 4	np	20
Quintile 5	np	9

Table 11A.51 **Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2012-13 (a), (b)**

	<i>Rate</i>	<i>Number</i>
Tonsillectomy and Adenoidectomy		
Hospital peer group		
Peer group A	41.3	571
Peer group B	np	62
Other peer groups	np	40
Indigenous status (d)		
Indigenous	np	37
Other Australians	33.5	636
Remoteness of residence (e)		
Major cities	36.9	438
Inner regional	30.1	162
Outer regional	np	60
Remote & Very remote	np	13
SEIFA of residence (f)		
Quintile 1	31.2	189
Quintile 2	32.5	174
Quintile 3	30.2	122
Quintile 4	36.9	115
Quintile 5	np	73
Hysterectomy		
Hospital peer group		
Peer group A	33.3	221
Peer group B	np	38
Other peer groups	np	18
Indigenous status (d)		
Indigenous	np	15
Other Australians	30.0	262
Remoteness of residence (e)		
Major cities	29.1	149
Inner regional	np	81
Outer regional	np	44
Remote & Very remote	np	2
SEIFA of residence (f)		
Quintile 1	np	85
Quintile 2	np	76
Quintile 3	np	56
Quintile 4	np	34
Quintile 5	np	25

Table 11A.51 **Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2012-13 (a), (b)**

	<i>Rate</i>	<i>Number</i>
Prostatectomy		
Hospital peer group		
Peer group A	35.0	164
Peer group B	np	17
Other peer groups	np	17
Indigenous status (d)		
Indigenous	np	np
Other Australians	30.9	194
Remoteness of residence (e)		
Major cities	np	99
Inner regional	np	76
Outer regional	np	19
Remote & Very remote	np	4
SEIFA of residence (f)		
Quintile 1	np	68
Quintile 2	np	60
Quintile 3	np	33
Quintile 4	np	22
Quintile 5	np	15
Cataract surgery		
Hospital peer group		
Peer group A	np	88
Peer group B	np	38
Other peer groups	np	41
Indigenous status (d)		
Indigenous	np	6
Other Australians	3.3	161
Remoteness of residence (e)		
Major cities	4.4	117
Inner regional	np	26
Outer regional	np	16
Remote & Very remote	np	6
SEIFA of residence (f)		
Quintile 1	np	48
Quintile 2	np	35
Quintile 3	np	35
Quintile 4	np	28
Quintile 5	np	19

Table 11A.51 **Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2012-13 (a), (b)**

	<i>Rate</i>	<i>Number</i>
Appendicectomy		
Hospital peer group		
Peer group A	24.3	505
Peer group B	np	57
Other peer groups	np	22
Indigenous status (d)		
Indigenous	np	32
Other Australians	22.7	552
Remoteness of residence (e)		
Major cities	22.3	367
Inner regional	24.5	132
Outer regional	np	62
Remote & Very remote	np	15
SEIFA of residence (f)		
Quintile 1	28.4	164
Quintile 2	24.4	136
Quintile 3	22.0	111
Quintile 4	np	98
Quintile 5	np	67

(a) This indicator is limited to public hospitals.

(b) Cells have been suppressed to protect confidentiality where the presentation could identify a patient or service provider or where rates are likely to be highly volatile, for example, where the denominator is very small. See the Data Quality Statement for further details.

(c) Total rates and numbers for Australia do not include WA.

(d) Other Australians' includes separations for non-Indigenous people and those for whom Indigenous status was not stated.

(e) Disaggregation by remoteness area is by the patient's usual residence, not the location of hospital. Hence, rates represent the number of separations for patients living in each remoteness area divided by the total number of separations for people living in that remoteness area and hospitalised in the reporting jurisdiction.

(f) Socio-Economic Indexes for Areas (SEIFA) quintiles are based on the ABS Index of Relative Socio-Economic Disadvantage (IRSD), with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. Each SEIFA quintile represents approximately 20 per cent of the national population, but does not necessarily represent 20 per cent of the population in each state or territory. Disaggregation by SEIFA is by the patient's usual residence, not the location of the hospital. Hence, rates represent the number of separations for patients in each SEIFA quintile divided by the total number of separations for people living in that SEIFA quintile and hospitalised in the reporting jurisdiction.

Source: AIHW (unpublished) National Hospital Morbidity Database; WA Health (unpublished).

Table 11A.52 Proportion of accredited beds in public hospitals (per cent) (a)

	<i>NSW</i>	<i>Vic</i>	<i>Qld (b)</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total beds accredited by ACHS or other agency									
2003-04	91	99	97	76	97	82	100	96	93
2004-05	95	100	97	93	98	83	100	100	96
2005-06	93	100	97	96	98	83	100	100	96
2006-07	85	100	94	100	97	83	100	100	93
2007-08	85	100	97	100	98	82	100	100	93
2008-09	95	100	98	100	98	80	100	100	97
2009-10	82	100	97	100	98	83	100	100	93
2010-11	95	100	100	100	98	87	100	100	98
2011-12	97	100	100	100	100	87	100	100	99
2012-13	97	100	95	100	100	87	100	100	98

(a) Accreditation status at 30 June. Where average available beds for various years were not available, bed numbers at 30 June were used.

(b) Accreditation status for three Queensland hospitals was not provided.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra.

TABLE 11A.53

Table 11A.53 **Episodes of Staphylococcus aureus (including MRSA) bacteraemia (SAB) in acute care hospitals, by MRSA and MSSA (a)**

	<i>unit</i>	<i>NSW (b)</i>	<i>Vic</i>	<i>Qld (c)</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
2010-11										
<i>Infection rates</i>										
Methicillin resistant Staphylococcus aureus	<i>rate per 10 000 patient days</i>	0.4	0.2	0.3	0.1	0.2	0.2	0.2	0.5	0.3
Methicillin sensitive Staphylococcus aureus	<i>rate per 10 000 patient days</i>	0.9	0.7	0.9	0.8	0.7	1.0	0.7	0.9	0.8
Total (e)	<i>rate per 10 000 patient days</i>	1.3	0.9	1.2	0.9	0.9	1.1	0.9	1.5	1.1
<i>Number of infections</i>										
Methicillin resistant Staphylococcus aureus	<i>no.</i>	233	118	72	23	31	6	6	16	505
Methicillin sensitive Staphylococcus aureus	<i>no.</i>	536	322	218	117	91	37	23	27	1371
<i>Total</i>	<i>no.</i>	769	440	290	140	122	43	29	43	1876
Coverage (f), (g)	<i>%</i>	94	99	77	94	81	100	98	100	92
2011-12										
<i>Infection rates</i>										
Methicillin resistant Staphylococcus aureus	<i>rate per 10 000 patient days</i>	0.3	0.2	0.2	0.1	0.3	0.1	0.2	0.5	0.2
Methicillin sensitive Staphylococcus aureus	<i>rate per 10 000 patient days</i>	0.7	0.8	0.7	0.5	0.6	0.6	0.9	0.8	0.7
Total (e)	<i>rate per 10 000 patient days</i>	1.0	1.0	0.9	0.6	0.9	0.7	1.1	1.3	0.9
<i>Number of infections</i>										
Methicillin resistant Staphylococcus aureus	<i>no.</i>	201	82	51	23	42	4	6	15	424
Methicillin sensitive Staphylococcus aureus	<i>no.</i>	473	379	220	82	85	23	31	24	1317

TABLE 11A.53

Table 11A.53 **Episodes of Staphylococcus aureus (including MRSA) bacteraemia (SAB) in acute care hospitals, by MRSA and MSSA (a)**

	<i>unit</i>	<i>NSW (b)</i>	<i>Vic</i>	<i>Qld (c)</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
Total	no.	674	461	271	105	127	27	37	39	1741
Coverage (f), (g)	%	97	99	98	95	80	100	98	100	96
2012-13										
Infection rates										
Methicillin resistant <i>Staphylococcus aureus</i>	<i>rate per 10 000 patient days</i>	0.3	0.2	0.1	0.1	0.2	0.1	0.1	0.2	0.2
Methicillin sensitive <i>Staphylococcus aureus</i>	<i>rate per 10 000 patient days</i>	0.7	0.7	0.8	0.6	0.6	0.8	1.1	0.5	0.7
Total (e)	<i>rate per 10 000 patient days</i>	1.0	0.9	1.0	0.8	0.8	0.8	1.2	0.7	0.9
Number of infections										
Methicillin resistant <i>Staphylococcus aureus</i>	no.	206	81	47	22	23	2	3	7	391
Methicillin sensitive <i>Staphylococcus aureus</i>	no.	447	345	260	106	91	29	37	15	1330
Total	no.	653	426	307	128	114	31	40	22	1721
Coverage (f), (g)	%	98	99	96	95	92	100	100	100	97
2013-14										
Infection rates										
Methicillin resistant <i>Staphylococcus aureus</i>	<i>rate per 10 000 patient days</i>	0.3	0.2	0.1	0.2	0.2	0.1	0.2	0.3	0.2
Methicillin sensitive <i>Staphylococcus aureus</i>	<i>rate per 10 000 patient days</i>	0.6	0.6	0.8	0.8	0.4	0.8	0.7	0.7	0.7
Total (e)	<i>rate per 10 000 patient days</i>	0.9	0.8	0.9	0.9	0.6	0.9	0.8	1.0	0.9

TABLE 11A.53

Table 11A.53 **Episodes of *Staphylococcus aureus* (including MRSA) bacteraemia (SAB) in acute care hospitals, by MRSA and MSSA (a)**

	<i>unit</i>	<i>NSW (b)</i>	<i>Vic</i>	<i>Qld (c)</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
Number of infections										
Methicillin resistant <i>Staphylococcus aureus</i>	no.	180	95	46	24	24	3	6	11	389
Methicillin sensitive <i>Staphylococcus aureus</i>	no.	409	307	258	124	57	32	23	22	1232
Total	no.	589	402	304	148	81	35	29	33	1621
Coverage (f), (g)	%	98	99	99	95	95	100	100	100	98

(a) The SAB patient episodes were associated with both admitted patient care and with non-admitted patient care (including emergency departments and outpatient clinics). The comparability of the SAB rates among jurisdictions and over time is limited because of coverage differences and because the count of patient days reflects the amount of admitted patient activity, but does not necessarily reflect the amount of non-admitted patient activity.

(b) NSW data do not comply with the agreed specification, therefore NSW data are not comparable with data from other jurisdictions. Refer to the Data Quality Statement for further details.

(c) For 2010-11, Qld data only include patients 14 years of age and over.

(d) Australian totals include NSW.

(e) Total may not equal sum of components due to rounding.

(f) Coverage estimates may be preliminary.

(g) Coverage is the number of patient days for hospitals included in the SAB surveillance arrangements as a proportion of total patient days for all public hospitals.

Source: AIHW 2014 *Staphylococcus aureus* bacteraemia in Australian public hospitals 2013–14: Australian hospital statistics. Health services series no. 59. Cat. no. HSE 155. Canberra: AIHW.

TABLE 11A.54

Table 11A.54 Separations with an adverse event, public hospitals (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2009-10										
Number of events										
External cause of injury and poisoning										
<i>Adverse effects of drugs, medicaments and biological substances</i>	<i>no.</i>	na	na	na	na	na	na	na	na	na
<i>Misadventures to patients during surgical and medical care</i>	<i>no.</i>	na	na	na	na	na	na	na	na	na
Procedures causing abnormal reactions/complications	<i>no.</i>	na	na	na	na	na	na	na	na	na
<i>Other external causes of adverse events</i>	<i>no.</i>	na	na	na	na	na	na	na	na	na
Place of occurrence of injury and poisoning										
Place of occurrence: Health service area	<i>no.</i>	na	na	na	na	na	na	na	na	na
Diagnoses										
Selected post-procedural disorders	<i>no.</i>	na	na	na	na	na	na	na	na	na
Haemorrhage and haematoma complicating a procedure	<i>no.</i>	na	na	na	na	na	na	na	na	na
Infection following a procedure	<i>no.</i>	na	na	na	na	na	na	na	na	na
Complications of internal prosthetic devices	<i>no.</i>	na	na	na	na	na	na	na	na	na
<i>Other diagnoses of complications of medical and surgical care</i>	<i>no.</i>	na	na	na	na	na	na	na	na	na
Total (any of the above) (c)	<i>no.</i>	na	na	na	na	na	na	na	na	na
Events per 100 separations (d)										
External cause of injury and poisoning										
<i>Adverse effects of drugs, medicaments and biological substances</i>	<i>Rate</i>	2.1	2.0	1.8	2.1	2.3	1.7	1.8	np	2.0
<i>Misadventures to patients during surgical and medical care</i>	<i>Rate</i>	0.2	0.3	0.3	0.3	0.2	0.3	0.4	np	0.3
<i>Procedures causing abnormal reactions/complications</i>	<i>Rate</i>	3.2	3.1	3.1	3.3	3.6	4.2	3.5	np	3.2
<i>Other external causes of adverse events</i>	<i>Rate</i>	0.1	0.1	0.1	0.1	0.2	0.1	0.2	np	0.1
Place of occurrence of injury and poisoning										

TABLE 11A.54

Table 11A.54 Separations with an adverse event, public hospitals (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Place of occurrence: Health service area	<i>Rate</i>	5.7	5.6	5.3	5.9	6.1	6.6	5.8	np	5.6
Diagnoses										
Selected post-procedural disorders	<i>Rate</i>	0.9	0.6	0.7	0.9	1.1	0.9	1.1	np	0.8
Haemorrhage and haematoma complicating a procedure	<i>Rate</i>	0.4	0.6	0.4	0.5	0.4	0.5	0.5	np	0.5
Infection following a procedure	<i>Rate</i>	0.5	0.4	0.4	0.4	0.4	0.6	0.5	np	0.5
Complications of internal prosthetic devices	<i>Rate</i>	1.2	1.2	1.2	1.1	1.1	1.1	1.4	np	1.2
<i>Other diagnoses of complications of medical and surgical care</i>	<i>Rate</i>	0.7	1.0	0.8	0.9	0.8	1.1	0.8	np	0.8
Total (any of the above) (c)	<i>Rate</i>	6.0	5.8	5.6	6.0	6.5	6.6	5.9	np	5.9

2010-11

Number of events

External cause of injury and poisoning

*Adverse effects of drugs, medicaments and biological substances**no.*

na

na

na

na

na

na

na

na

na

*Misadventures to patients during surgical and medical care**no.*

na

na

na

na

na

na

na

na

na

Procedures causing abnormal reactions/complications

no.

na

na

na

na

na

na

na

na

na

*Other external causes of adverse events**no.*

na

na

na

na

na

na

na

na

na

Place of occurrence of injury and poisoning

Place of occurrence: Health service area

no.

na

na

na

na

na

na

na

na

na

Diagnoses

Selected post-procedural disorders

no.

na

na

na

na

na

na

na

na

na

Haemorrhage and haematoma complicating a procedure

no.

na

na

na

na

na

na

na

na

na

Infection following a procedure

no.

na

na

na

na

na

na

na

na

na

Complications of internal prosthetic devices

no.

na

na

na

na

na

na

na

na

na

TABLE 11A.54

Table 11A.54 **Separations with an adverse event, public hospitals (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Other diagnoses of complications of medical and surgical care</i>	<i>no.</i>	na	na	na	na	na	na	na	na	na
Total (any of the above) (c)	<i>no.</i>	na	na	na	na	na	na	na	na	na
Events per 100 separations (d)										
External cause of injury and poisoning										
<i>Adverse effects of drugs, medicaments and biological substances</i>	<i>Rate</i>	2.3	2.1	1.9	2.2	2.4	2.2	1.8	np	2.1
Misadventures to patients during surgical and medical care	<i>Rate</i>	0.2	0.3	0.3	0.3	0.3	0.3	0.3	np	0.3
<i>Procedures causing abnormal reactions/complications</i>	<i>Rate</i>	3.1	3.1	3.2	3.2	3.6	4.1	3.5	np	3.2
<i>Other external causes of adverse events</i>	<i>Rate</i>	0.1	0.1	0.1	0.1	0.2	0.1	0.2	np	0.1
Place of occurrence of injury and poisoning										
Place of occurrence: Health service area	<i>Rate</i>	5.9	5.7	5.5	5.8	6.3	7.0	5.8	np	5.7
Diagnoses										
Selected post-procedural disorders	<i>Rate</i>	0.9	0.6	0.7	0.9	1.1	1.1	1.1	np	0.8
Haemorrhage and haematoma complicating a procedure	<i>Rate</i>	0.4	0.5	0.4	0.5	0.4	0.5	0.5	np	0.5
Infection following a procedure	<i>Rate</i>	0.5	0.4	0.4	0.4	0.4	0.5	0.5	np	0.4
Complications of internal prosthetic devices	<i>Rate</i>	1.2	1.2	1.3	1.2	1.2	1.2	1.3	np	1.2
<i>Other diagnoses of complications of medical and surgical care</i>	<i>Rate</i>	0.7	1.0	0.8	0.8	0.8	0.9	0.8	np	0.8
Total (any of the above) (c)	<i>Rate</i>	6.1	5.8	5.7	6.0	6.6	7.1	6.0	np	5.9

2011-12

Number of events

External cause of injury and poisoning

Adverse effects of drugs, medicaments and biological substances

<i>no.</i>	39 674	32 632	21 282	13 369	10 061	2 393	2 159	973	122 543
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Misadventures to patients during surgical and medical care

<i>no.</i>	3 864	5 188	3 257	1 482	1 012	422	285	159	15 669
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TABLE 11A.54

Table 11A.54 Separations with an adverse event, public hospitals (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Procedures causing abnormal reactions/complications	<i>no.</i>	52 902	51 360	32 805	18 641	14 405	4 444	3 458	2 257	180 272
<i>Other external causes of adverse events</i>	<i>no.</i>	2 093	2 633	1 261	412	953	128	194	90	7 764
Place of occurrence of injury and poisoning										
Place of occurrence: Health service area	<i>no.</i>	101 761	91 565	59 278	34 598	26 368	7 544	5 968	3 444	330 526
Diagnoses										
Selected post-procedural disorders	<i>no.</i>	15 433	10 457	7 673	4 719	4 435	1 233	1 073	401	45 424
Haemorrhage and haematoma complicating a procedure	<i>no.</i>	7 731	8 025	4 419	2 746	1 797	487	502	326	26 033
Infection following a procedure	<i>no.</i>	8 185	5 709	4 514	2 369	1 578	488	351	437	23 631
Complications of internal prosthetic devices	<i>no.</i>	19 505	20 253	12 774	6 571	4 825	1 237	1 410	893	67 468
<i>Other diagnoses of complications of medical and surgical care</i>	<i>no.</i>	11 387	16 630	8 262	4 474	3 344	1 065	721	704	46 587
Total (any of the above) (c)	<i>no.</i>	103 896	94 060	60 429	35 373	27 435	7 652	6 142	3 592	338 579
Events per 100 separations (d)										
External cause of injury and poisoning										
<i>Adverse effects of drugs, medicaments and biological substances</i>	<i>Rate</i>	2.4	2.1	2.1	2.3	2.5	2.4	2.2	0.9	2.2
Misadventures to patients during surgical and medical care	<i>Rate</i>	0.2	0.3	0.3	0.3	0.2	0.4	0.3	0.1	0.3
<i>Procedures causing abnormal reactions/complications</i>	<i>Rate</i>	3.2	3.3	3.3	3.2	3.5	4.5	3.5	2.0	3.3
<i>Other external causes of adverse events</i>	<i>Rate</i>	0.1	0.2	0.1	0.1	0.2	0.1	0.2	0.1	0.1
Place of occurrence of injury and poisoning										
Place of occurrence: Health service area	<i>Rate</i>	6.1	5.9	5.9	5.9	6.5	7.6	6.1	3.0	6.0
Diagnoses										
Selected post-procedural disorders	<i>Rate</i>	0.9	0.7	0.8	0.8	1.1	1.2	1.1	0.4	0.8
Haemorrhage and haematoma complicating a procedure	<i>Rate</i>	0.5	0.5	0.4	0.5	0.4	0.5	0.5	0.3	0.5
Infection following a procedure	<i>Rate</i>	0.5	0.4	0.5	0.4	0.4	0.5	0.4	0.4	0.4
Complications of internal prosthetic devices	<i>Rate</i>	1.2	1.3	1.3	1.1	1.2	1.2	1.4	0.8	1.2

TABLE 11A.54

Table 11A.54 **Separations with an adverse event, public hospitals (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Other diagnoses of complications of medical and surgical care</i>	<i>Rate</i>	0.7	1.1	0.8	0.8	0.8	1.1	0.7	0.6	0.8
Total (any of the above) (c)	<i>Rate</i>	6.3	6.1	6.0	6.0	6.7	7.7	6.3	3.2	6.1
2012-13										
Number of events										
External cause of injury and poisoning										
<i>Adverse effects of drugs, medicaments and biological substances</i>	<i>no.</i>	43 155	32 327	24 649	15 113	11 410	2 918	2 377	1 091	133 040
<i>Misadventures to patients during surgical and medical care</i>	<i>no.</i>	4 186	5 173	3 138	1 674	1 225	426	321	134	16 277
Procedures causing abnormal reactions/complications	<i>no.</i>	53 495	54 704	34 699	19 853	14 959	5 091	4 109	2 625	189 535
<i>Other external causes of adverse events</i>	<i>no.</i>	2 422	3 091	1 469	466	1 326	190	220	124	9 308
Place of occurrence of injury and poisoning										
Place of occurrence: Health service area	<i>no.</i>	106 563	94 097	64 065	37 828	28 319	8 630	6 836	3 921	350 259
Diagnoses										
Selected post-procedural disorders	<i>no.</i>	14 707	10 007	8 125	4 795	4 645	1 417	1 202	503	45 401
Haemorrhage and haematoma complicating a procedure	<i>no.</i>	7 820	7 639	4 668	2 927	1 773	572	535	315	26 249
Infection following a procedure	<i>no.</i>	8 079	5 068	4 499	2 443	1 511	520	410	464	22 994
Complications of internal prosthetic devices	<i>no.</i>	20 443	22 995	13 966	7 208	5 103	1 465	1 713	1 072	73 965
<i>Other diagnoses of complications of medical and surgical care</i>	<i>no.</i>	11 916	18 627	9 036	5 072	3 700	1 172	950	704	51 177
Total (any of the above) (c)	<i>no.</i>	108 860	96 776	65 637	38 642	29 689	8 752	6 996	4 038	359 390
Events per 100 separations (d)										
External cause of injury and poisoning										
<i>Adverse effects of drugs, medicaments and biological substances</i>	<i>Rate</i>	2.5	2.3	2.4	2.5	2.8	2.7	2.5	0.9	2.4

TABLE 11A.54

Table 11A.54 **Separations with an adverse event, public hospitals (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Misadventures to patients during surgical and medical care	<i>Rate</i>	0.2	0.4	0.3	0.3	0.3	0.4	0.3	0.1	0.3
<i>Procedures causing abnormal reactions/complications</i>	<i>Rate</i>	3.1	3.8	3.3	3.3	3.6	4.8	4.3	2.2	3.4
<i>Other external causes of adverse events</i>	<i>Rate</i>	0.1	0.2	0.1	0.1	0.3	0.2	0.2	0.1	0.2
Place of occurrence of injury and poisoning										
Place of occurrence: Health service area	<i>Rate</i>	6.2	6.6	6.1	6.2	6.8	8.1	7.2	3.3	6.3
Diagnoses										
Selected post-procedural disorders	<i>Rate</i>	0.9	0.7	0.8	0.8	1.1	1.3	1.3	0.4	0.8
Haemorrhage and haematoma complicating a procedure	<i>Rate</i>	0.5	0.5	0.4	0.5	0.4	0.5	0.6	0.3	0.5
Infection following a procedure	<i>Rate</i>	0.5	0.4	0.4	0.4	0.4	0.5	0.4	0.4	0.4
Complications of internal prosthetic devices	<i>Rate</i>	1.2	1.6	1.3	1.2	1.2	1.4	1.8	0.9	1.3
<i>Other diagnoses of complications of medical and surgical care</i>	<i>Rate</i>	0.7	1.3	0.9	0.8	0.9	1.1	1.0	0.6	0.9
Total (any of the above) (c)	<i>Rate</i>	6.3	6.8	6.3	6.4	7.2	8.2	7.4	3.4	6.5

(a) Public hospitals include public acute and public psychiatric hospitals.

(b) Separations that included ICD-10-AM diagnosis and/or external cause codes that indicated an adverse event was treated and/or occurred during the hospitalisation.

(c) Categories do not sum to the totals because multiple diagnoses and external causes can be recorded for each separation and external cause codes and diagnosis codes can be used together to describe an adverse event.

(d) Age standardised rate.

Source: AIHW (unpublished) National Hospital Morbidity Database.

TABLE 11A.55

Table 11A.55 Separations for falls resulting in patient harm in hospitals, per 1000 separations, 2012-13

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (a)	
									Rate	No.
Hospital sector										
Public	4.8	3.5	3.5	3.6	4.3	5.3	3.8	1.6	4.0	21 920
Private	1.5	1.4	1.7	1.3	1.4	np	np	np	1.5	5 776
Indigenous status (b)										
Aboriginal and Torres Strait Islander Australians	1.6	1.5	1.0	0.6	1.3	2.4	1.3	0.9	1.1	420
Other Australians	3.6	2.6	2.8	2.8	3.2	3.0	2.7	2.5	3.0	27 050
Remoteness area of residence (c)										
Major cities	3.7	2.4	2.8	2.7	3.3	3.1	3.5	0.8	3.0	19 197
Inner regional	3.2	3.3	2.7	2.6	2.5	3.9	1.3	2.9	3.1	5 526
Outer regional	2.8	3.6	2.3	3.0	2.9	3.2	6.5	2.3	2.8	2 486
Remote and Very remote	2.0	2.6	1.8	1.4	2.0	3.0	np	1.0	1.5	386
Socioeconomic status of area of residence (d)										
1—Lowest	3.7	2.8	2.9	3.0	3.3	3.9	2.3	1.0	3.2	6 349
2	3.4	3.0	2.9	2.8	3.4	4.2	4.8	2.1	3.2	5 965
3	3.7	2.7	2.9	2.6	3.0	3.3	3.6	2.0	3.0	5 791
4	3.7	2.4	2.4	2.5	3.0	3.3	3.5	2.0	2.8	4 951
5—Highest	3.1	2.2	2.0	2.5	2.3	2.3	3.2	2.0	2.6	4 348
Total (d)	3.5	2.6	2.7	2.6	3.1	np	np	np	3.0	27 696

(a) The total includes separations for which the place of usual residence was not reported.

(b) Other Australians includes separations for which the Indigenous status was not reported.

(c) Disaggregation by remoteness area of usual residence, not remoteness of hospital. However, state/territory data are reported by jurisdiction of the hospital, regardless of the jurisdiction of usual residence.

Table 11A.55 **Separations for falls resulting in patient harm in hospitals, per 1000 separations, 2012-13**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (a)</i>
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(d) Disaggregation by socioeconomic group is based on the usual residence of the patient, not the location of the hospital. The socioeconomic status of area of residence is based on the ABS Index of Relative Socio-economic Disadvantage (IRSD). These socioeconomic groups represent approximately 20 per cent of the national population, but do not necessarily represent 20 per cent of the population in each state or territory.

Source: AIHW 2014, *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145, AIHW, Canberra.

TABLE 11A.56

Table 11A.56 **Nursing workforce (includes midwives), by age group and remoteness area (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>
Nurses (registered and enrolled) in workforce											
Major cities	no.	159 662	159 880	na	174 214	176 797	176 286	na	213 669	220 210	225 614
Inner regional	no.	50 080	51 726	na	55 701	56 742	59 076	na	59 342	56 716	57 522
Outer regional	no.	22 287	23 699	na	24 479	25 342	26 404	na	26 115	26 657	26 896
Remote and very remote	no.	5 460	5 504	na	5 867	6 680	6 579	na	7 064	7 334	7 098
Total	no.	253 592	254 956	na	277 297	282 968	291 246	na	306 414	311 176	317 988
Proportion of Nurses aged under 30											
Major cities	%	13.4	10.2	na	15.0	15.0	14.7	na	16.5	16.6	17.4
Inner regional	%	8.6	6.7	na	10.2	9.9	10.6	na	10.9	10.9	11.7
Outer regional	%	8.4	6.4	na	10.2	10.5	11.0	na	11.7	12.2	12.9
Remote and very remote	%	10.2	8.6	na	11.3	12.5	12.0	na	13.4	13.7	14.2
Total	%	11.8	9.0	na	13.6	13.6	13.5	na	15.0	15.1	15.9
Proportion of Nurses aged 30 to 39											
Major cities	%	25.1	22.6	na	24.6	23.5	23.4	na	22.0	21.8	21.7
Inner regional	%	21.3	18.5	na	21.1	19.0	19.7	na	16.7	16.5	16.7
Outer regional	%	21.9	19.2	na	20.6	19.3	20.4	na	17.4	17.3	17.2
Remote and very remote	%	23.7	20.6	na	24.8	23.0	21.5	na	20.5	19.8	20.1
Total	%	24.0	21.4	na	23.6	22.3	22.1	na	20.5	20.4	20.4
Proportion of Nurses aged 40 to 49											
Major cities	%	33.1	32.9	na	29.3	28.6	28.0	na	26.5	25.8	25.3
Inner regional	%	39.3	37.4	na	33.6	32.6	30.6	na	28.4	27.1	25.9
Outer regional	%	38.2	37.4	na	33.5	32.8	31.0	na	27.3	26.5	25.6
Remote and very remote	%	34.4	34.9	na	30.6	29.2	29.8	na	24.5	24.4	23.5
Total	%	34.8	34.3	na	30.4	29.7	28.8	na	26.9	26.1	25.4
Proportion of Nurses aged 50 to 59											
Major cities	%	22.8	26.9	na	24.1	25.4	25.9	na	25.8	26.0	25.5
Inner regional	%	25.0	30.0	na	28.1	30.5	30.8	na	33.8	34.4	33.8
Outer regional	%	24.9	29.5	na	27.5	29.2	29.3	na	33.0	32.6	32.2

TABLE 11A.56

Table 11A.56 **Nursing workforce (includes midwives), by age group and remoteness area (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>
Remote and very remote	%	25.3	28.2	na	26.7	27.4	28.8	na	31.5	30.9	30.6
Total	%	23.5	27.8	na	25.2	26.8	27.3	na	28.1	28.2	27.7
Proportion of Nurses aged 60+											
Major cities	%	5.6	7.4	na	7.0	7.4	7.9	na	9.2	9.8	10.1
Inner regional	%	5.8	7.3	na	7.0	7.9	8.4	na	10.3	11.1	11.9
Outer regional	%	6.6	7.7	na	8.2	8.1	8.3	na	10.7	11.3	12.1
Remote and very remote	%	6.3	7.7	na	6.7	7.9	8.0	na	10.2	11.1	11.6
Total	%	5.9	7.5	na	7.2	7.7	8.2	na	9.5	10.2	10.6

(a) No data collected for 2010. The 2012 and 2013 data exclude provisional registrants.

(b) In 2008, 2009, 2011, 2012 and 2013 total include 'Not Stated' for ASGC Remoteness areas. Numbers of 'Not Stated' are significantly higher in 2008 and 2009 than in later years.

(c) Nurses are allocated to a region based on postcode of main job where available; otherwise, postcode of principal practice is used as a proxy. If principal practice details are unavailable, postcode of residence is used. Records with no information on all 3 locations are coded to 'not stated'. In 2009 and 2011, region is based on 2006 version Australian Standard Geographical Classification (ASGC) — Remoteness Areas. In 2012 and 2013, region is based on 2011 version Australian Statistical Geography Standard (ASGS) — Remoteness Areas. Previous versions of these data were supplied using a mix of 2001 and 2006 versions of the classification so these data may not match earlier supplies.

(d) In 2008, 2009, 2011, 2012 and 2013 data include registered and enrolled nurses in the workforce: those who are employed in nursing, on extended leave and looking for work in nursing.

(e) 2008 data has been revised due to the correction of an error in processing Victoria data.

na Not available.

Source: AIHW National Health Workforce Data Set (unpublished).

TABLE 11A.57

Table 11A.57 **Nursing workforce (includes midwives), by age group (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld (f)</i>	<i>WA (f)</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust</i>
2004										
Nurses (registered and enrolled) in workforce										
Nurses aged under 30	%	12.6	14.3	9.4	8.1	11.4	6.9	8.0	14.6	11.8
Nurses aged 30 to 39	%	24.0	25.5	24.1	21.2	23.7	19.5	20.2	27.5	24.0
Nurses aged 40 to 49	%	35.4	33.1	33.8	35.8	38.2	38.0	36.7	30.6	34.8
Nurses aged 50 to 59	%	22.4	22.1	25.0	27.0	22.5	28.4	28.9	23.6	23.5
Nurses aged 60+	%	5.6	5.0	7.7	7.9	4.2	7.3	6.2	3.7	5.9
Total nurses in workforce	no.	79 293	70 986	42 690	23 895	23 836	6 347	4 048	2 496	253 592
2005										
Nurses (registered and enrolled) in workforce										
Nurses aged under 30	%	12.7	7.4	5.9	6.1	10.1	8.7	8.5	na	9.0
Nurses aged 30 to 39	%	23.9	21.1	18.9	18.2	22.1	19.1	20.2	na	21.4
Nurses aged 40 to 49	%	33.9	33.2	35.1	34.5	37.0	36.1	34.6	na	34.3
Nurses aged 50 to 59	%	23.8	29.6	30.7	31.9	25.5	29.2	30.2	na	27.8
Nurses aged 60+	%	5.7	8.6	9.5	9.2	5.2	6.9	6.5	na	7.5
Total nurses in workforce	no.	77 075	72 153	42 973	23 839	24 279	6 823	4 284	na	254 956
2006										
Nurses (registered and enrolled) in workforce										
Nurses aged under 30	%	na	na	na	na	na	na	na	na	na
Nurses aged 30 to 39	%	na	na	na	na	na	na	na	na	na
Nurses aged 40 to 49	%	na	na	na	na	na	na	na	na	na
Nurses aged 50 to 59	%	na	na	na	na	na	na	na	na	na

TABLE 11A.57

Table 11A.57 **Nursing workforce (includes midwives), by age group (a), (b). (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld (f)</i>	<i>WA (f)</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust</i>
Nurses aged 60+	%	na	na	na	na	na	na	na	na	na
Total nurses in workforce	no.	na	na	na	na	na	na	na	na	na
2007										
Nurses (registered and enrolled) in workforce										
Nurses aged under 30	%	14.6	15.5	13.3	9.8	8.8	10.8	12.8	17.6	13.6
Nurses aged 30 to 39	%	25.5	24.0	23.6	21.0	20.6	17.5	23.5	23.5	23.6
Nurses aged 40 to 49	%	28.6	29.2	31.5	33.0	34.3	34.1	32.6	27.8	30.4
Nurses aged 50 to 59	%	24.5	24.2	24.2	27.8	28.9	29.1	26.1	25.0	25.2
Nurses aged 60+	%	6.8	7.1	7.4	8.5	7.4	8.4	4.9	6.2	7.2
Total nurses in workforce	no.	81 606	79 279	51 436	25 047	24 952	7 329	4 413	3 234	277 297
2008										
Nurses (registered and enrolled) in workforce										
Nurses aged under 30	%	14.1	14.6	13.4	12.4	11.8	10.2	11.7	16.9	13.6
Nurses aged 30 to 39	%	22.2	23.0	23.0	21.3	21.3	16.9	22.4	24.2	22.3
Nurses aged 40 to 49	%	28.5	28.5	31.3	30.4	32.4	32.8	30.1	28.0	29.7
Nurses aged 50 to 59	%	27.8	26.1	24.8	27.3	27.8	30.6	28.7	24.8	26.8
Nurses aged 60+	%	7.5	7.8	7.5	8.6	6.7	9.5	7.1	6.1	7.7
Total nurses in workforce	no.	82 450	77 839	51 249	27 858	27 017	7 570	4 632	4 353	282 968
2009										
Nurses (registered and enrolled) in workforce										
Nurses aged under 30	%	14.1	13.9	13.4	12.1	12.4	10.3	12.6	16.7	13.5
Nurses aged 30 to 39	%	21.4	23.3	23.0	21.2	21.7	16.0	21.2	26.7	22.1
Nurses aged 40 to 49	%	26.8	28.0	31.4	30.1	30.4	31.2	28.7	27.4	28.8

TABLE 11A.57

Table 11A.57 **Nursing workforce (includes midwives), by age group (a), (b). (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld (f)</i>	<i>WA (f)</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust</i>
Nurses aged 50 to 59	%	29.2	26.3	24.7	27.8	28.4	31.8	29.7	22.8	27.3
Nurses aged 60+	%	8.4	8.5	7.5	8.7	7.1	10.8	7.8	6.4	8.2
Total nurses in workforce	no.	83 516	79 844	54 180	28 092	28 889	7 650	4 720	4 355	291 246
2010										
Nurses (registered and enrolled) in workforce										
Nurses aged under 30	%	na	na	na	na	na	na	na	na	na
Nurses aged 30 to 39	%	na	na	na	na	na	na	na	na	na
Nurses aged 40 to 49	%	na	na	na	na	na	na	na	na	na
Nurses aged 50 to 59	%	na	na	na	na	na	na	na	na	na
Nurses aged 60+	%	na	na	na	na	na	na	na	na	na
Total nurses in workforce	no.	na	na	na	na	na	na	na	na	na
2011										
Nurses (registered and enrolled) in workforce										
Nurses aged under 30	%	13.3	17.0	14.7	15.9	13.8	12.7	14.0	16.9	15.0
Nurses aged 30 to 39	%	20.3	21.4	21.0	19.6	19.3	15.2	21.4	25.1	20.5
Nurses aged 40 to 49	%	25.4	26.6	28.6	27.6	27.8	28.2	26.1	23.6	26.9
Nurses aged 50 to 59	%	30.5	26.1	26.3	26.7	30.7	33.7	29.6	26.1	28.1
Nurses aged 60+	%	10.5	8.9	9.3	10.3	8.4	10.2	8.8	8.4	9.5
Total nurses in workforce	no.	85 196	84 715	59 851	30 842	29 056	7 837	5 004	3 773	306 414
2012										
Nurses (registered and enrolled) in workforce										
Nurses aged under 30	%	13.8	17.0	14.7	16.0	14.1	12.0	15.4	17.9	15.1
Nurses aged 30 to 39	%	20.1	21.3	20.7	20.1	18.9	15.5	21.7	25.6	20.4
Nurses aged 40 to 49	%	24.5	25.9	27.8	26.7	26.7	27.7	25.6	22.8	26.1
Nurses aged 50 to 59	%	30.3	26.3	26.7	26.8	31.0	34.2	28.3	25.3	28.2

TABLE 11A.57

Table 11A.57 **Nursing workforce (includes midwives), by age group (a), (b). (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld (f)</i>	<i>WA (f)</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust</i>
Nurses aged 60+	%	11.2	9.5	10.0	10.4	9.3	10.6	9.0	8.4	10.2
Total nurses in workforce	no.	86 451.9	85 472.1	60 995.4	32 109.0	29 327.0	7 630.9	5 073.6	4 036.0	311 175.8
2013										
Nurses (registered and enrolled) in workforce										
Nurses aged under 30	%	15.1	17.7	15.1	16.8	14.4	12.7	16.6	18.5	15.9
Nurses aged 30 to 39	%	20.1	21.0	20.7	20.6	19.2	15.2	21.8	25.7	20.4
Nurses aged 40 to 49	%	23.9	25.2	27.2	25.7	25.8	26.7	25.5	21.9	25.4
Nurses aged 50 to 59	%	29.1	26.0	26.8	26.4	30.7	34.4	26.2	24.4	27.7
Nurses aged 60+	%	11.7	10.1	10.3	10.5	9.9	11.0	9.8	9.5	10.6
Total nurses in workforce	no.	89 579.0	86 340.0	61 973.0	33 090.0	29 843.0	7 729.0	5 215.0	4 091.0	317 988.0

(a) In 2008, 2009, 2011, 2012 and 2013 data include registered and enrolled nurses in the workforce: those who are employed in nursing, on extended leave and looking for work in nursing.

(b) 2011, 2012 and 2013 data is by derived state, derived from state and territory of main job where available; otherwise, state and territory of principal practice is used as a proxy. If principal practice details unavailable, state and territory of residence is used. For records with no information on all three locations, they are coded to 'Not stated'.

(c) 2012 and 2013 data exclude provisional registrants

(d) No data collected for 2010

(e) In 2008 and 2009 Victorian data was affected by large numbers of online survey records not being able to be used for technical reasons. Estimates for Victoria for 2008 and 2009 should be treated with caution due to low response rate (39.9 per cent, 33.3 per cent and 31.6 per cent respectively). Estimates for Victoria for 2005 are derived from responses to the 2006 AIHW Nursing and Midwifery Labour Force Census, weighted to 2005 registration and enrolment benchmark figures. Nurse labour force data for 2008 has been revised due to the correction of an error in processing Victorian data.

(f) Estimates for Queensland for 2008 and 2009 should be treated with caution due to low response rate (32.9 per cent and 28.2 per cent respectively). Estimates for WA for 2008 and 2009 should be treated with caution due to low response rates (34.4 per cent and 35.4 per cent respectively). Estimates for Tasmania for 2009 should be treated with caution due to a low response rate 33.2 per cent.

Table 11A.57 **Nursing workforce (includes midwives), by age group (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld (f)</i>	<i>WA (f)</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust</i>
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(g) Estimates for the NT for 2008 and 2009 should be treated with caution due to low response rates (34.9 per cent and 32.8 per cent respectively). Data for the NT is affected by the transient nature of the nursing labour force in that jurisdiction. According to the Nursing Board Annual Report, approximately one-third of all nurses do not re-register each year, primarily because they no longer practise in the jurisdiction. There has been some variation across years in the degree to which nurses who are interstate have been removed from the renewal process and hence the survey.

na Not available.

Source: AIHW National Health Workforce Data Set (unpublished).

TABLE 11A.58

Table 11A.58 **Medical practitioner workforce, by age group and remoteness area (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>
Medical practitioners in workforce											
Major cities	no.	45 994	47 632	49 835	50 981	52 639	56 655	42 427	64 433	64 641	66 774
Inner regional	no.	7 471	7 577	7 816	8 141	8 686	9 258	7 621	11 098	11 029	11 388
Outer regional	no.	2 710	2 993	3 061	3 258	3 516	3 924	2 092	4 656	4 964	4 988
Remote and very remote	no.	582	711	886	1 001	867	1 095	514	1 218	1 197	1 219
Total	no.	59 004	61 165	63 688	68 812	70 193	74 260	55 424	81 751	81 910	84 613
Medical practitioners under 30											
Major cities	%	11.0	12.4	10.2	10.2	10.8	10.6	10.3	10.7	9.6	10.1
Inner regional	%	9.3	8.8	7.4	8.2	8.1	8.8	8.9	9.2	7.8	9.1
Outer regional	%	7.5	7.9	8.8	7.1	8.0	10.3	8.9	11.1	9.1	9.5
Remote and very remote	%	5.8	8.4	13.0	9.6	5.9	15.5	10.7	9.0	9.6	10.0
Total	%	10.6	11.6	9.8	9.7	10.2	10.6	10.1	10.5	9.3	10.0
Medical practitioners aged 30 to 39											
Major cities	%	26.3	26.4	25.7	27.1	27.2	27.1	27.7	29.1	28.2	27.9
Inner regional	%	21.0	21.1	21.1	22.3	22.2	22.7	24.7	25.8	26.1	25.8
Outer regional	%	24.1	24.6	22.6	24.7	26.8	24.4	27.2	27.7	28.2	28.1
Remote and very remote	%	29.7	29.7	30.1	29.9	30.0	30.5	26.1	29.1	26.3	27.2
Total	%	25.7	25.8	25.0	26.3	26.5	26.7	27.5	28.6	27.9	27.6
Medical practitioners aged 40 to 49											
Major cities	%	27.5	27.0	27.0	26.2	26.0	26.0	24.2	23.9	24.6	24.3
Inner regional	%	32.4	31.7	29.8	29.0	27.7	27.1	25.9	25.4	25.4	25.3
Outer regional	%	30.9	30.7	30.3	30.0	28.1	28.0	24.6	25.9	26.9	26.2
Remote and very remote	%	28.7	29.0	27.2	28.8	32.4	27.9	27.8	25.8	27.0	25.4
Total	%	28.0	27.6	27.4	26.7	26.3	26.1	24.4	24.3	24.9	24.6
Medical practitioners aged 50 to 59											

Table 11A.58 **Medical practitioner workforce, by age group and remoteness area (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>
Major cities	%	20.8	20.3	21.1	20.4	20.5	20.5	20.7	20.1	20.7	20.5
Inner regional	%	24.0	25.4	26.9	25.6	26.7	25.6	24.6	23.7	23.9	23.1
Outer regional	%	22.5	22.2	23.6	24.0	22.5	23.2	24.1	21.1	21.1	21.2
Remote and very remote	%	20.8	19.7	16.3	18.7	19.4	14.2	18.1	20.3	21.4	20.4
Total	%	21.1	20.9	21.7	21.0	21.3	21.0	21.1	20.6	21.1	20.9
Medical practitioners aged 60+											
Major cities	%	14.4	13.8	16.0	16.1	15.5	15.8	17.0	16.2	16.9	17.2
Inner regional	%	13.3	13.1	14.8	14.8	15.2	15.9	15.8	15.9	16.9	16.7
Outer regional	%	14.9	14.7	14.7	14.3	14.6	14.0	15.1	14.1	14.6	15.0
Remote and very remote	%	15.1	13.1	13.4	13.1	12.3	11.8	17.1	15.8	15.7	16.9
Total	%	14.7	14.0	16.0	16.2	15.8	15.7	16.8	16.0	16.8	17.0

(a) No 2010 data collected for Queensland and WA. 2012 and 2013 data excludes provisional registrants.

(b) In 2008, 2009, 2011, 2012 and 2013 total include 'Not Stated' for ASGC Remoteness areas. Numbers of 'Not Stated' are significantly higher in 2008 and 2009 than in later years.

(c) In 2008, 2009, 2010, 2011, 2012 and 2013 data include employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine.

(d) In 2008, 2009, 2010, 2011, 2012 and 2013 Remote and very remote areas include Migratory areas. Estimates for remote and very remote areas should be treated with caution due to the relatively small number of medical practitioners used to produce these estimates.

(e) Medical practitioners are allocated to a region based on postcode of main job where available; otherwise, postcode of principal practice is used as a proxy. If principal practice details are unavailable, postcode of residence is used. Records with no information on all 3 locations are coded to 'not stated'. In 2009, 2010 and 2011, region is based on 2006 version Australian Standard Geographical Classification (ASGC) — Remoteness Areas. In 2012 and 2013, region is based on 2011 version Australian Statistical Geography Standard (ASGS) — Remoteness Areas. Previous versions of these data were supplied using a mix of 2001 and 2006 versions of the classification so these data may not match earlier supplies.

Source: AIHW National Health Workforce Data Set (unpublished).

TABLE 11A.59

Table 11A.59 **Medical practitioner workforce, by age group (a), (b), (c)**

	<i>Unit</i>	<i>NSW (d)</i>	<i>Vic (e)</i>	<i>Qld (f), (g)</i>	<i>WA (g), (h)</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT</i>	<i>NT (j)</i>	<i>Aust</i>
2004										
Medical practitioners in workforce										
Medical practitioners under 30	%	11.3	13.1	7.8	8.0	9.2	5.6	6.8	13.1	10.6
Medical practitioners aged 30 to 39	%	26.7	25.9	24.4	23.5	27.6	17.6	21.7	32.8	25.7
Medical practitioners aged 40 to 49	%	26.3	27.5	30.7	29.2	28.5	32.1	33.3	27.5	28.0
Medical practitioners aged 50 to 59	%	20.3	20.2	22.3	21.8	21.6	27.6	25.5	17.8	21.1
Medical practitioners aged 60+	%	15.4	13.4	14.8	17.5	13.0	17.2	12.6	8.8	14.7
Total Medical practitioners in workforce	no.	21 406	15 757	8 718	4 895	5 011	1 416	1 302	497	59 004
2005										
Medical practitioners in workforce										
Medical practitioners under 30	%	13.6	14.4	6.5	8.8	8.7	4.5	6.7	19.9	11.6
Medical practitioners aged 30 to 39	%	26.7	26.5	24.4	23.2	27.8	17.4	21.1	34.0	25.8
Medical practitioners aged 40 to 49	%	26.0	27.3	30.5	28.4	27.6	32.6	33.2	22.6	27.6
Medical practitioners aged 50 to 59	%	19.9	19.4	22.8	22.3	21.8	28.5	26.1	15.6	20.9
Medical practitioners aged 60+	%	13.8	12.4	15.8	17.3	14.1	17.0	13.0	7.9	14.0
Total Medical practitioners in workforce	no.	22 015	16 085	9 474	4 990	5 006	1 481	1 381	732	61 165
2006										
Medical practitioners in workforce										
Medical practitioners under 30	%	9.1	13.3	7.1	9.5	8.3	4.2	6.7	18.5	9.8
Medical practitioners aged 30 to 39	%	25.1	26.0	23.5	23.6	26.7	18.9	25.1	33.1	25.0
Medical practitioners aged 40 to 49	%	26.4	26.1	29.9	28.3	28.3	30.4	28.8	26.9	27.4
Medical practitioners aged 50 to 59	%	22.0	20.2	23.6	21.3	21.4	28.4	23.6	14.7	21.7

TABLE 11A.59

Table 11A.59 **Medical practitioner workforce, by age group (a), (b), (c)**

	<i>Unit</i>	<i>NSW (d)</i>	<i>Vic (e)</i>	<i>Qld (f), (g)</i>	<i>WA (g), (h)</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT</i>	<i>NT (j)</i>	<i>Aust</i>
Medical practitioners aged 60+	%	17.4	14.3	15.8	17.3	15.3	18.0	15.8	6.9	16.0
Total Medical practitioners in workforce	no.	21 656	16 900	9 937	6 378	5 178	1 384	1 364	891	63 688
2007										
Medical practitioners in workforce										
Medical practitioners under 30	%	9.2	11.9	7.6	12.0	8.8	4.2	4.7	13.9	9.7
Medical practitioners aged 30 to 39	%	24.4	26.2	28.0	27.4	27.5	19.4	37.1	28.9	26.3
Medical practitioners aged 40 to 49	%	26.4	25.6	28.5	26.3	26.7	28.0	28.2	29.1	26.7
Medical practitioners aged 50 to 59	%	22.4	19.7	21.0	19.9	21.1	28.7	16.4	16.4	21.0
Medical practitioners aged 60+	%	17.5	16.6	14.9	14.3	16.1	19.7	13.6	11.7	16.2
Total Medical practitioners in workforce	no.	21 530	17 515	12 436	7 758	5 526	1 638	1 486	924	68 812
2008										
Medical practitioners in workforce										
Medical practitioners under 30	%	11.2	11.9	5.1	13.3	9.6	4.1	12.0	14.0	10.2
Medical practitioners aged 30 to 39	%	24.2	26.7	28.6	28.1	27.6	18.5	28.9	32.8	26.5
Medical practitioners aged 40 to 49	%	26.0	25.7	27.8	26.4	25.2	27.6	26.2	25.6	26.3
Medical practitioners aged 50 to 59	%	21.9	20.5	22.3	19.0	20.6	29.3	21.3	16.8	21.3
Medical practitioners aged 60+	%	16.6	15.1	16.2	13.2	17.1	20.6	11.6	10.8	15.8
Total Medical practitioners in workforce	no.	21 958	17 813	13 571	6 995	5 791	1 607	1 592	865	70 193
2009										
Medical practitioners in workforce										
Medical practitioners under 30	%	10.2	12.0	8.0	16.0	8.0	3.6	10.8	14.8	10.6

TABLE 11A.59

Table 11A.59 **Medical practitioner workforce, by age group (a), (b), (c)**

	<i>Unit</i>	<i>NSW (d)</i>	<i>Vic (e)</i>	<i>Qld (f), (g)</i>	<i>WA (g), (h)</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT</i>	<i>NT (j)</i>	<i>Aust</i>
Medical practitioners aged 30 to 39	%	24.4	27.2	28.8	27.8	28.4	17.9	31.4	29.4	26.7
Medical practitioners aged 40 to 49	%	25.1	25.2	28.8	24.9	25.9	30.7	24.4	27.7	26.1
Medical practitioners aged 50 to 59	%	22.3	20.2	20.2	18.9	21.2	27.9	21.5	17.2	21.0
Medical practitioners aged 60+	%	17.9	15.3	14.3	12.4	16.5	20.0	11.9	10.9	15.7
Total Medical practitioners in workforce	no.	22 442	18 620	15 026	7 708	5 827	1 884	1 708	1 045	74 260
2010										
Medical practitioners in workforce										
Medical practitioners under 30	%	8.6	11.8	na	na	11.1	9.3	9.3	11.9	10.1
Medical practitioners aged 30 to 39	%	26.8	28.3	na	na	27.8	25.9	25.4	32.8	27.5
Medical practitioners aged 40 to 49	%	24.5	24.0	na	na	24.4	25.5	26.5	27.1	24.4
Medical practitioners aged 50 to 59	%	21.6	20.5	na	na	20.5	23.7	24.1	18.0	21.1
Medical practitioners aged 60+	%	18.5	15.4	na	na	16.3	15.5	14.6	10.3	16.8
Total Medical practitioners in workforce	no.	25 134	19 528	na	na	6 361	1 849	1 566	836	55 424
2011										
Medical practitioners in workforce										
Medical practitioners under 30	%	8.9	11.9	10.4	12.3	11.6	9.0	8.0	12.1	10.5
Medical practitioners aged 30 to 39	%	27.3	28.4	30.6	29.0	27.7	26.4	28.3	37.2	28.6
Medical practitioners aged 40 to 49	%	24.0	23.6	25.3	24.8	23.7	24.8	26.0	22.8	24.3
Medical practitioners aged 50 to 59	%	21.1	20.6	20.0	19.9	20.3	23.8	23.4	15.9	20.6
Medical practitioners aged 60+	%	18.7	15.6	13.6	14.0	16.7	15.9	14.4	11.9	16.0
Total Medical practitioners in workforce	no.	26 286	20 116	16 177	7 914	6 524	1 884	1 607	1 022	81 751

TABLE 11A.59

Table 11A.59 **Medical practitioner workforce, by age group (a), (b), (c)**

	<i>Unit</i>	<i>NSW (d)</i>	<i>Vic (e)</i>	<i>Qld (f), (g)</i>	<i>WA (g), (h)</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT</i>	<i>NT (j)</i>	<i>Aust</i>
2012										
Medical practitioners in workforce										
Medical practitioners under 30	%	7.7	10.3	9.5	11.7	10.0	8.6	7.0	9.6	9.3
Medical practitioners aged 30 to 39	%	26.7	28.1	29.6	27.9	27.4	23.9	28.1	35.6	27.9
Medical practitioners aged 40 to 49	%	24.5	24.1	25.7	25.4	24.9	26.4	26.6	24.4	24.9
Medical practitioners aged 50 to 59	%	21.8	21.0	20.7	20.4	20.5	23.8	23.3	17.6	21.1
Medical practitioners aged 60+	%	19.3	16.4	14.4	14.6	17.2	17.3	14.9	12.7	16.8
Total Medical practitioners in workforce	no.	26 277	20 166	16 330	8 149	6 467	1 840	1 611	1 039	81 910
2013										
Medical practitioners in workforce										
Medical practitioners under 30	%	8.8	10.6	9.8	12.1	10.2	9.8	9.7	11.0	10.0
Medical practitioners aged 30 to 39	%	26.3	28.4	28.9	28.3	26.6	24.0	27.3	36.5	27.6
Medical practitioners aged 40 to 49	%	24.0	23.5	25.8	25.5	25.4	25.9	25.5	23.2	24.6
Medical practitioners aged 50 to 59	%	21.1	20.9	20.9	19.7	20.5	23.7	21.4	17.5	20.9
Medical practitioners aged 60+	%	19.8	16.6	14.5	14.3	17.3	16.6	16.2	11.9	17.0
Total Medical practitioners in workforce	no.	27 514	20 744	16 588	8 489	6 581	1 899	1 695	1 041	84 613

- (a) In 2008, 2009, 2010, 2011, 2012 and 2013 data include employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine.
- (b) 2011, 2012 and 2013 data is by derived state, derived from state and territory of main job where available; otherwise, state and territory of principal practice is used as a proxy. If principal practice details unavailable, state and territory of residence is used. For records with no information on all three locations, they are coded to 'Not stated'.
- (c) 2012 and 2013 data exclude provisional registrants.

Table 11A.59 **Medical practitioner workforce, by age group (a), (b), (c)**

	<i>Unit</i>	<i>NSW (d)</i>	<i>Vic (e)</i>	<i>Qld (f), (g)</i>	<i>WA (g), (h)</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT</i>	<i>NT (j)</i>	<i>Aust</i>	
(d)	In 2008 and 2009, NSW data are based on responses to the Medical Labour Force Survey weighted to financial registrants holding general, conditional specialist, limited prescribing and referring or non-practising registration.										
(e)	In 2008 and 2009, Victoria surveyed only general, specific and provisional registered medical practitioners in the Medical Labour Force Survey but responses are weighted to all registered medical practitioners.										
(f)	In 2008 and 2009, Queensland data are based on responses to the Medical Labour Force Survey weighted to all registrants excluding some conditional registration types. The Queensland benchmarks for 2009 were taken from the Queensland medical board annual report which included an age breakdown in 10 year increments whilst the estimates for previous years was done using 5 year increments. Given that the response rates have fallen between 2008 and 2009 and that the response rates for some age groups are particularly small, (notably the response rate for 25-34 year olds was only 7.8 per cent for males and 11.4 per cent for females), Queensland data should be treated with caution, particularly for the younger groups.										
(g)	In 2010 no data collected for Queensland and WA.										
(h)	In 2008 and 2009, for WA data, the scope has been consistent, that is, the survey population and the benchmark figures are based on general and conditional registrants. For 2005, survey was administered to both general and conditional registrants but benchmark figures were for general registrants only. For 2008 the benchmark used was the total number of registered practitioners in 2008 using 2007 age by sex proportions. For WA in 2007, 2008 and 2009, the benchmark data includes a significant number of registered medical practitioners that are no longer active in the workforce. This inflates the perception of the medical labour force in WA. It is also unknown how significantly past years have been affected. Care should be taken when interpreting these figures.										
(i)	In 2008 and 2009, Tasmania data are based on responses to the annual Medical Labour Force Survey weighted to general registrants, conditionally registered specialists and non-practising practitioners only.										
(j)	2010 data is by state of principal practice, while 2011, 2012 and 2013 data is by derived state, derived from state and territory of main job where available; otherwise, state and territory of principal practice is used as a proxy. If principal practice details unavailable, state and territory of residence is used. For records with no information on all three locations, they are coded to 'Not stated'.										

na Not available.

Source: AIHW National Health Workforce Data Set (unpublished).

TABLE 11A.60

Table 11A.60 Recurrent cost per casemix-adjusted separation, selected public acute hospitals 2011-12 (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (b)</i>	<i>Aust</i>
Total separations (c)	'000	1 593	1 511	977	565	384	98	97	113	5 339
Acute separations (d)	'000	1 559	1 473	937	552	372	96	93	112	5 193
Proportion of separations not acute	%	2.1	2.5	4.1	2.3	3.1	2.0	4.1	0.9	2.7
Average cost weight (e)	no.	1.04	0.96	1.15	0.91	1.07	1.06	1.00	0.67	0.99
Casemix-adjusted separations (f)	'000	1 657	1 451	1 124	514	411	104	97	76	5 286
Total admitted patient days (c)	'000	5 583	4 587	2 985	1 611	1 349	334	327	294	17 070
Admitted patient days for acute patients	'000	5 100	3 813	102	1 423	1 181	293	270	278	14 865
Proportion of bed days not acute	%	8.7	16.9	96.6	11.7	12.5	12.3	17.4	5.4	12.9
Total recurrent expenditure	\$m	12 906	9 746	7 706	4 381	3 230	916	933	568	40 384
Admitted patient cost proportion (g)		0.69	0.70	0.68	0.72	0.70	0.69	0.69	0.80	0.70
Total admitted patient recurrent expenditure	\$m	8 905	6 823	5 240	3 154	2 261	632	644	454	28 269
Relative stay index (h)		1.09	0.92	0.90	1.01	1.06	1.09	1.02	1.18	1.00
<i>Average cost data for selected included hospitals</i>										
<i>Non-medical labour costs per casemix-adjusted separation</i>										
Nursing	\$	1 320	1 271	1 338	1 323	1 396	1 460	1 857	1 788	1 336
Diagnostic/allied health (i)	\$	347	412	373	353	285	314	392	380	366
Administrative	\$	361	284	356	438	292	450	526	364	346
Other staff	\$	215	229	343	326	151	324	100	437	251
Superannuation	\$	247	247	296	289	249	443	453	na	265
Total non-medical labour costs	\$	2 490	2 443	2 707	2 729	2 373	2 990	3 328	2 969	2 564

TABLE 11A.60

Table 11A.60 Recurrent cost per casemix-adjusted separation, selected public acute hospitals 2011-12 (a)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (b)	Aust
<i>Other recurrent costs per casemix-adjusted separation</i>										
Domestic services	\$	117	100	108	139	93	99	224	158	113
Repairs/maintenance	\$	113	87	97	202	104	65	75	153	109
Medical supplies (i)	\$	574	400	572	380	349	746	518	435	491
Drug supplies	\$	235	243	243	286	244	326	156	247	245
Food supplies	\$	92	46	36	34	32	50	44	49	49
Administration	\$	360	278	286	233	150	281	452	199	294
Other	\$	113	121	21	323	671	180	170	507	168
Total other recurrent costs	\$	1 604	1 275	1 362	1 596	1 642	1 747	1 639	1 749	1 477
<i>Total excluding medical labour costs</i>	\$	4 094	3 718	4 068	4 326	4 015	4 738	4 967	4 718	4 041
<i>Medical labour costs per casemix-adjusted separation</i>										
Public patients										
Salaried/sessional staff	\$	630	731	961	1 054	856	1 006	902	1 150	797
Visiting medical officer payments	\$	248	70	63	172	185	2	301	97	147
Private patients (estimated) (j)	\$	307	174	153	181	195	288	214	51	218
Total medical labour costs	\$	1 185	975	1 177	1 407	1 237	1 295	1 417	1 299	1 163
<i>Total labour costs (medical + non-medical)</i>	\$	3 675	3 418	3 884	4 136	3 609	4 285	4 745	4 267	3 727
Total recurrent cost per casemix-adjusted separation	\$	5 280	4 693	5 246	5 733	5 251	6 033	6 384	6 017	5 204
Experimental estimates of recurrent cost per casemix-adjusted acute non-psychiatric separations (k)	\$	4 983	4 038	na	5 497	na	na	na	na	na

(a) Psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other, hospices, rehabilitation facilities, small non-acute hospitals and multi-purpose services are excluded from this table. The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included. Expenditure data exclude depreciation.

(b) These figures should be interpreted in conjunction with the consideration of cost disabilities associated with hospital service delivery in the NT.

Table 11A.60 **Recurrent cost per casemix-adjusted separation, selected public acute hospitals 2011-12 (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (b)</i>	<i>Aust</i>
(c)	Excludes separations for which the care type was reported as newborn with no qualified days, and records for hospital boarders and posthumous organ procurement.									
(d)	Separations for which the care type was reported as acute and unspecified and newborn episodes of care with qualified days.									
(e)	Average cost weight from the National Hospital Cost Data Collection, using the 2008–09 AR-DRG version 5.2 cost weights for separations for which the care type was reported as acute, newborn with at least one qualified day or was not reported.									
(f)	Casemix-adjusted separations are the product of total separations and average cost weight.									
(g)	Of the selected hospitals, three small hospitals had their admitted patient cost proportion estimated by the Health and Allied Services Advisory Council ratio. Admitted patient cost proportion was previously called the inpatient fraction.									
(h)	Relative stay index based on public hospitals using the indirect method. The indirectly standardised relative stay index is not technically comparable between cells but is a comparison of the hospital group with the national average of public hospitals based on the casemix of that group. Relative stay index based on AR-DRG version 5.2.									
(i)	Queensland pathology services are purchased from the statewide pathology service rather than being provided by each hospital's employees resulting in higher medical supplies costs and lower diagnostic staff costs.									
(j)	Estimated private patient medical costs calculated as the sum of salary/sessional and visiting medical officer payments divided by the number of public patient days multiplied by the number of private patient days. This is a notional estimate of the medical costs for all non-public patients, including those self funded and those funded by private health insurance, compensation and the Department of Veterans' Affairs.									
(k)	Estimates relate to a subset of the selected public hospitals only. This subset excludes hospitals where the inpatient fraction was equal to the acute inpatient fraction and more than 1000 non-acute patient days were recorded. Also excludes hospitals where the apparent cost of non-acute patients exceeded \$1000 per day and more than \$1 000 000 of apparent expenditure on non-acute patients days was reported. These data are provided by states and territories on a voluntary basis.									

na Not available.

Source: AIHW 2013, *Australian Hospital Statistics 2011-12*, Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra.

TABLE 11A.61

Table 11A.61 **Costs and utilisation by hospital peer group, public hospitals, 2011-12 (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Principal referral: major cities (>20 000 acute weighted separations) and regional (>16 000 acute weighted separations)										
Number of hospitals	no.	28	19	17	5	4	2	2	2	79
Separations per hospital (c)	no.	39 613	61 896	44 533	62 586	55 057	39 107	48 728	48 507	48 710
AR-DRGs (5+) per hospital (d)	no.	438	525	422	463	504	474	454	401	461
Average cost weight (e)		1.10	0.99	1.05	0.96	1.20	1.07	1.00	0.70	1.04
Relative stay index (f)		1.12	0.89	0.92	1.02	1.07	1.03	1.02	1.21	1.00
Cost per casemix adjusted separation	\$	5 291	4 586	5 285	5 659	5 223	5 777	6 384	5 967	5 158
Specialist women's and children's (>10 000 acute weighted separations)										
Number of hospitals	no.	3	2	3	2	1	–	–	–	11
Separations per hospital (c)	no.	19 877	30 046	16 046	21 096	31 472	..	..	..	21 956
AR-DRGs (5+) per hospital (d)	no.	237	247	202	202	321	..	..	..	231
Average cost weight (e)		1.22	1.30	1.20	1.26	1.15	..	..	..	1.24
Relative stay index (f)		1.08	0.99	0.96	1.10	1.13	..	..	..	1.05
Cost per casemix adjusted separation	\$	6 200	5 990	6 345	6 200	5 749	..	..	..	6 107
Total principal referral and specialist women's and children's										
Number of hospitals	no.	31	21	20	7	5	2	2	2	90
Separations per hospital (c)	no.	37 703	58 863	40 260	50 732	50 340	39 107	48 728	48 507	45 440
AR-DRGs (5+) per hospital (d)	no.	418	499	389	389	467	474	454	401	433
Average cost weight (e)		1.10	1.00	1.06	1.00	1.19	1.07	1.00	0.70	1.05
Relative stay index (f)		1.12	0.90	0.92	1.03	1.08	1.03	1.02	1.21	1.00
Cost per casemix adjusted separation	\$	5 337	4 670	5 355	5 738	5 287	5 777	6 384	5 967	5 222
Large major cities (>10 000 acute weighted separations)										
Number of hospitals	no.	10	2	2	3	2	–	–	–	19
Separations per hospital (c)	no.	16 001	17 446	22 138	23 381	18 172	..	..	..	18 193
AR-DRGs (5+) per hospital (d)	no.	259	125	280	284	275	..	..	..	253
Average cost weight (e)		1.00	1.00	1.00	1.00	1.00	..	..	..	1.00

TABLE 11A.61

Table 11A.61 **Costs and utilisation by hospital peer group, public hospitals, 2011-12 (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Relative stay index (f)		1.08	0.96	0.83	0.92	0.95	..	..	..	1.00
Cost per casemix adjusted separation	\$	4 839	5 347	3 965	4 851	5 051	..	..	..	4 832
Large regional (>8 000 acute weighted separations) and remote (>5 000 acute weighted separations)										
Number of hospitals	no.	3	8	1	4	–	1	–	–	17
Separations per hospital (c)	no.	11 613	17 491	6 857	15 803	..	7 736	..	..	14 857
AR-DRGs (5+) per hospital (d)	no.	236	322	206	240	..	243	..	..	276
Average cost weight (e)		1.00	1.00	1.00	1.00	..	1.00	..	..	1.00
Relative stay index (f)		1.02	0.95	0.97	0.97	..	1.11	..	..	0.97
Cost per casemix adjusted separation	\$	5 933	4 442	4 029	5 539	..	7 390	..	..	5 025
Total large hospitals										
Number of hospitals	no.	13	10	3	7	2	1	–	–	36
Separations per hospital (c)	no.	14 988	17 482	17 044	19 051	18 172	7 736	..	..	16 618
AR-DRGs (5+) per hospital (d)	no.	253	283	255	259	275	243	..	..	264
Average cost weight (e)		1.00	1.00	1.00	1.00	1.00	1.00	..	..	1.00
Relative stay index (f)		1.07	0.95	0.86	0.94	0.95	1.11	..	..	0.99
Cost per casemix adjusted separation	\$	5 003	4 593	3 973	5 149	5 051	7 390	..	..	4 912
Medium (5000 to 10 000 acute weighted separations)										
Number of hospitals	no.	11	3	4	3	4	1	–	–	26
Separations per hospital (c)	no.	8 567	8 329	10 617	10 624	10 253	8 872	..	..	9 363
AR-DRGs (5+) per hospital (d)	no.	175	194	190	113	195	195	..	..	176
Average cost weight (e)		0.87	0.73	0.64	0.87	0.72	0.77	..	..	0.79
Relative stay index (f)		1.02	0.97	0.56	0.99	0.96	1.10	..	..	0.93
Cost per casemix adjusted separation	\$	5 051	5 057	4 397	5 291	5 423	6 406	..	..	5 100
Medium (2000 to 5000 acute weighted separations)										
Number of hospitals	no.	20	10	9	2	8	–	–	–	49
Separations per hospital (c)	no.	4 185	4 623	4 103	4 072	4 353	..	..	..	4 282

TABLE 11A.61

Table 11A.61 **Costs and utilisation by hospital peer group, public hospitals, 2011-12 (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
AR-DRGs (5+) per hospital (d)	no.	116	125	124	119	128	..	..	..	122
Average cost weight (e)		0.75	0.70	0.73	0.74	0.77	..	..	..	0.74
Relative stay index (f)		1.01	1.04	0.80	0.90	0.92	..	..	..	0.96
Cost per casemix adjusted separation	\$	4 858	4 885	4 911	5 879	4 946	..	..	..	4 929
Total medium										
Number of hospitals	no.	31	13	13	5	12	1	–	–	75
Separations per hospital (c)	no.	5 740	5 478	6 107	8 003	6 319	8 872	..	..	6 043
AR-DRGs (5+) per hospital (d)	no.	137	141	144	115	150	195	..	..	141
Average cost weight (e)		0.81	0.71	0.68	0.84	0.74	0.77	..	..	0.76
Relative stay index (f)		1.01	1.02	0.68	0.97	0.94	1.10	..	..	0.94
Cost per casemix adjusted separation	\$	4 964	4 945	4 645	5 399	5 208	6 406	..	..	5 025
Small regional acute (<2000 acute weighted separations and less than 40 per cent not acute or outlier bed days)										
Number of hospitals	no.	40	22	26	3	14	5	–	–	110
Separations per hospital (c)	no.	1 186	1 311	1 108	1 348	1 018	518	..	..	1 145
AR-DRGs (5+) per hospital (d)	no.	49	44	49	61	47	25	..	..	47
Average cost weight (e)		0.76	0.68	0.76	0.78	0.79	0.87	..	..	0.75
Relative stay index (f)		1.02	1.32	0.90	1.12	1.03	1.71	..	..	1.07
Cost per casemix adjusted separation	\$	5 694	5 947	4 931	5 565	4 744	7 580	..	..	5 505
Remote acute (<5000 acute weighted separations)										
Number of hospitals	no.	5	–	16	12	4	1	–	3	41
Separations per hospital (c)	no.	803	..	785	2 679	1 557	303	..	5 448	1 746
AR-DRGs (5+) per hospital (d)	no.	32	..	36	87	47	14	..	110	56
Average cost weight (e)		0.60	..	0.74	0.74	0.75	0.70	..	0.52	0.68
Relative stay index (f)		0.91	..	1.00	0.85	1.00	1.06	..	0.93	0.91
Cost per casemix adjusted separation	\$	9 318	..	5 372	8 596	5 211	6 799	..	6 424	7 322
Total small acute										

TABLE 11A.61

Table 11A.61 **Costs and utilisation by hospital peer group, public hospitals, 2011-12 (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Number of hospitals	no.	45	22	42	15	18	6	–	3	151
Separations per hospital (c)	no.	1 143	1 311	985	2 413	1 138	482	..	5 448	1 308
AR-DRGs (5+) per hospital (d)	no.	47	44	44	82	47	24	..	110	49
Average cost weight (e)		0.75	0.68	0.75	0.75	0.78	0.85	..	0.52	0.72
Relative stay index (f)		1.01	1.32	0.93	0.88	1.02	1.65	..	0.93	1.02
Cost per casemix adjusted separation	\$	5 931	5 947	5 065	8 259	4 884	7 514	..	6 424	6 171
Total hospitals in cost per casemix adjusted separation analysis										
Number of hospitals	no.	120	66	78	34	37	10	2	5	352
Separations per hospital (c)	no.	13 275	22 894	12 527	16 608	10 388	9 772	48 728	22 671	15 167
AR-DRGs (5+) per hospital (d)	no.	188	244	157	186	150	153	454	226	189
Average cost weight (e)		1.04	0.96	1.01	0.91	1.07	1.06	1.00	0.67	0.99
Relative stay index (f)		1.10	0.91	0.91	1.00	1.04	1.07	1.02	1.18	1.00
Cost per casemix adjusted separation	\$	5 280	4 693	5 246	5 733	5 251	6 033	6 384	6 017	5 204
Small non-acute (<2000 acute weighted separations more than 40 per cent not acute or outlier bed days)										
Number of hospitals	no.	17	3	14	4	18	1	–	–	57
Separations per hospital (c)	no.	1 097	1 241	837	1 494	627	304	–	–	906
Total expenditure	\$'000	140 250	33 114	71 049	42 058	65 098	2 450	–	–	354 018
Cost per casemix adjusted separation	\$	7548.0	8222.0	6309.0	9094.0	6752.0	5227.0	0.0	0.0	7371.0
Multi-purpose service										
Number of hospitals	no.	18	9	9	40	2	–	–	–	78
Separations per hospital (c)	no.	235	689	663	221	973	–	–	–	349
Total expenditure	\$'000	69 399	58 697	46 054	92 322	9 786	–	–	–	276 259
Cost per casemix adjusted separation	\$	15952.0	10293.0	5756.0	6550.0	6404.0	0.0	0.0	0.0	8613.0
Rehabilitation										
Number of hospitals	no.	5	–	–	1	2	–	–	–	8
Separations per hospital (c)	no.	458	–	–	4 597	1 234	–	–	–	1 170

TABLE 11A.61

Table 11A.61 **Costs and utilisation by hospital peer group, public hospitals, 2011-12 (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total expenditure	\$'000	110 634	–	–	87 916	58 119	–	–	–	256 670
Cost per casemix adjusted separation	\$	21214.0	0.0	0.0	9617.0	21519.0	0.0	–	0.0	12734.0
Mothercraft										
Number of hospitals	no.	3	2	1	–	–	–	1	–	7
Separations per hospital (c)	no.	2 318	1 914	2 224	–	–	–	–	–	1 858
Total expenditure	\$'000	17 289	11 204	4 674	–	–	–	3 154	–	36 321
Cost per casemix adjusted separation	\$	1338.0	2200.0	2190.0	0.0	0.0	0.0	0.0	0.0	1694.0
Other non-acute										
Number of hospitals	no.	12	–	–	–	–	–	–	–	12
Separations per hospital (c)	no.	916	–	–	–	–	–	–	–	916
Total expenditure	\$'000	162 761	–	–	–	–	–	–	–	162 761
Cost per casemix adjusted separation	\$	7333.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7333.0
Total non-acute										
Number of hospitals	no.	105	38	92	62	43	13	1	–	354
Separations per hospital	no.	587	863	262	378	513	147	na	..	469
AR-DRGs (5+) per hospital	no.	10	12	9	10	15	5	na	..	11
Average cost weight		1	1	1	1	1	1	na	..	1
Relative stay index		1	1	1	1	1	2	na	..	1
Cost per casemix adjusted separation	\$	9 526	9 156	9 898	11 489	12 058	13 878	na	..	10 534
Psychiatric (g)										
Number of hospitals	no.	7	2	4	2	2	1	–	–	18
Separations per hospital (c)	no.	756	232	96	699	927	356	–	–	541
Total expenditure	\$'000	245 061	49 417	137 584	88 033	78 950	18 101	–	–	617 146
Cost per casemix adjusted separation	\$	11593.0	41040.0	53649.0	15863.0	19115.0	29609.0	0.0	0.0	17270.0
Unpeered and other acute (includes hospitals with fewer than 200 separations)										
Number of hospitals	no.	43	22	64	15	19	11	–	–	174

TABLE 11A.61

Table 11A.61 **Costs and utilisation by hospital peer group, public hospitals, 2011-12 (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Separations per hospital (c)	no.	307	844	60	176	237	114	–	–	253
Total expenditure	\$'000	274 457	247 556	97 636	93 092	40 394	27 421	–	–	780 556
Cost per casemix adjusted separation	\$	10 920	7 628	13 428	26 432	8 815	10 971	–	–	12 327
Total										
Number of hospitals used in this analysis	no.	225	104	170	96	80	23	3	5	706
Average beds per hospital (h)	no.	89	89	66	59	65	52	313	139	78
Number of hospitals	no.	225	151	170	96	80	23	3	5	753
Separations per hospital	no.	7 354	14 844	5 890	6 126	5 080	4 332	32 485	22 671	7 797
Total expenditure	\$'000	12 905 606	9 746 466	7 705 940	4 380 674	3 229 556	915 578	932 981	567 521	40 384 321
Teaching (excluding psychiatric)										
Number of hospitals	no.	20	16	22	6	7	3	2	2	78
Separations per hospital (c)	no.	43 876	49 937	35 600	50 107	41 149	28 650	48 728	48 507	42 677
AR-DRGs (5+) per hospital (d)	no.	425	402	349	349	412	397	454	401	391
Average cost weight (e)		1.14	1.15	1.08	1.03	1.18	1.10	1.00	0.70	1.10
Relative stay index (f)		1.14	0.92	0.93	1.05	1.06	1.04	1.02	1.21	1.02
Cost per casemix adjusted separation	\$	5 321	5 896	5 396	6 004	5 257	5 961	6 384	5 967	5 591

- (a) The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included.
- (b) Expenditure and cost per casemix adjusted separation data exclude depreciation.
- (c) Separations for which the care type was reported as newborn with no qualified days, and records for hospital boarders and posthumous organ procurement have been excluded.
- (d) The number of different version 5.2 AR-DRGs provided by a hospital for which there were at least five acute separations.
- (e) Average cost weight from the National Hospital Cost Data Collection, based on acute and unspecified separations and Newborn episodes of care with qualified days, using the 2008–09 AR-DRG version 5.2 cost weights.

Table 11A.61 **Costs and utilisation by hospital peer group, public hospitals, 2011-12 (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(f)	Relative stay index based on observed vs expected length of stay based on age and AR-DRG Version 5.2, public hospitals using the indirect method. The indirectly standardised relative stay index is not technically comparable between cells but is a comparison of the hospital group with the national average of public hospitals based on the casemix of that group.									
(g)	Psychiatric hospitals consist of a mix of short-term acute, long-term, psychogeriatric and forensic psychiatric hospitals.									
(h)	Calculated by dividing total number of available beds across all hospitals by total number of hospitals.									
	na Not available. .. Not applicable. np Not published. – Nil or rounded to zero.									

Source: AIHW 2013, *Australian Hospital Statistics 2011-12*, Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra.

TABLE 11A.62

Table 11A.62 **Capital cost per casemix-adjusted separation — indicative estimates for inpatient services at major public acute hospitals, 2011-12 (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA (d)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
Land										
Asset value at 30 June	\$m	1 664	na	685	428	229	38	28	20	3 093
User cost of capital	\$m	133	na	55	34	18	3	2	2	247
Casemix-adjusted separations	'000	1 657	1 451	1 124	514	411	104	97	76	5 286
Inpatient fraction		0.69	0.70	0.68	0.72	0.70	0.69	0.69	0.80	0.70
Cost per casemix-adj. separation	\$	55	na	33	67	31	20	16	17	33
Buildings										
Asset value at 30 June	\$m	7 682	5 197	4 886	2 270	1 520	403	580	534	23 072
User cost of capital	\$m	615	416	391	182	122	32	46	43	1846
Annual depreciation	\$m	329	398	147	55	73	15	15	17	1049
Casemix-adjusted separations	'000	1 657	1 451	1 124	514	411	104	97	76	5 286
Inpatient fraction		0.69	0.70	0.68	0.72	0.70	0.69	0.69	0.80	0.70
Cost per casemix-adj. separation	\$	393	561	326	459	332	316	434	633	383
Equipment										
Asset value at 30 June	\$m	870	1 862	975	181	118	110	58	17	4 191
User cost of capital	\$m	70	149	78	15	9	9	5	1	335
Annual depreciation	\$m	170	203	84	31	32	8	13	4	544
Casemix-adjusted separations	'000	1 657	1 451	1 124	514	411	104	97	76	5 286
Inpatient fraction		0.69	0.70	0.68	0.72	0.70	0.69	0.69	0.80	0.70
Cost per casemix-adj. separation	\$	100	243	98	88	70	111	124	60	116
Interest payments	\$m	41.6	—	—	2.8	4.5	—	0.2	—	49.1
Interest payments per separation	\$	17.3	—	—	5.4	7.7	—	1.2	—	6.5
Total capital cost (excl. land) per casemix-adj. separation	\$	475	804	424	542	395	427	556	693	493

Table 11A.62 Capital cost per casemix-adjusted separation — indicative estimates for inpatient services at major public acute hospitals, 2011-12 (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA (d)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
(a)	Capital cost is defined as the user cost of capital (calculated at 8 per cent of the current value of non-current physical assets) plus the depreciation amount. The capital cost per casemix-adjusted separation is equal to the capital cost adjusted by the inpatient fraction, divided by the number of casemix-adjusted separations.									
(b)	Where possible, data relate to inpatients in public acute hospitals, with the scope the same as that for recurrent cost per casemix adjusted separations calculated by the AIHW, that is - psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other, hospices, rehabilitation facilities and small non-acute and multi-purpose services are excluded.									
(c)	Inpatient fractions sourced from AIHW's Australian Hospital Statistics for all jurisdictions.									
(d)	The asset values and depreciation amounts for Victoria and WA relate to inpatients only and so have not been adjusted by the inpatient fraction.									
(e)	Interest payments are not reported.									
	na Not available. – Nil or rounded to zero.									

Source: State and Territory governments (unpublished); AIHW 2013, *Australian Hospital Statistics 2011-12*, Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra.

TABLE 11A.63

Table 11A.63 **Relative stay index for patients in public hospitals, by funding source, 2012-13 (a), (b)**

<i>Accommodation status</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Public patients (c)	1.03	0.93	0.85	0.96	1.02	1.00	1.01	1.13	0.96
Private health insurance	1.06	0.96	0.91	1.10	1.14	1.02	1.11	1.00	1.02
Self-funded	0.97	0.95	0.90	0.90	0.92	0.90	0.69	1.25	0.95
Workers compensation	1.06	1.02	0.98	1.24	1.22	0.99	1.06	1.41	1.06
Motor vehicle 3rd party personal claim	1.28	0.91	1.02	1.20	1.23	1.14	1.25	1.33	1.10
Department of Veterans' Affairs	0.96	0.94	0.77	0.87	1.06	1.08	0.90	1.19	0.94
Other (d)	1.75	0.96	0.91	1.07	1.03	1.04	0.99	1.04	1.21
Total	1.04	0.93	0.86	0.98	1.04	1.01	1.02	1.13	0.97

(a) Separations for which the care type was reported as acute or newborn with qualified days, or was not reported.

(b) Relative stay index based on all hospitals using the indirect method using AR-DRG version 6.0x. The indirectly standardised relative stay index is not technically comparable between cells but is a comparison of the hospital group with the national average based on the casemix of that group.

(c) Public patients includes separations with a funding source of Australian Health Care Agreements, Reciprocal health care agreements, Other hospital or public authority (with a public patient election status) and No charge raised (in public hospitals).

(d) Includes patients whose funding source was reported as other compensation, Department of Defence, Correctional facilities, other hospital or public authority, other and unknown.

– Nil or rounded to zero.

Source: AIHW 2014, *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145, AIHW, Canberra.

Table 11A.64 **Relative stay index, indirectly standardised, patients in public hospitals, by medical, surgical and other type of diagnosis related group 2012-13 (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Medical	1.02	0.93	0.82	0.94	1.02	1.02	1.00	1.06	0.95
Surgical	1.08	0.94	0.95	1.05	1.06	0.99	1.04	1.34	1.02
Other	1.14	0.95	0.94	1.01	1.08	0.97	1.08	1.24	1.04
All public hospitals	1.04	0.93	0.86	0.98	1.04	1.01	1.02	1.13	0.97

(a) Separations for which the care type was reported as acute or newborn with qualified days, or was not reported. Relative stay index based on all hospitals using AR-DRG version 6.0x.

(b) The indirectly standardised relative stay index is not technically comparable between cells but is a comparison of the hospital group with the national average based on the casemix of that group.

Source: AIHW 2014, *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145, AIHW, Canberra.

TABLE 11A.65

Table 11A.65 **NSW recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2008-09	2009-10	2010-11	2011-12	2012-13
Occasions of service						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	no.	882 510	906 689	916 314	952 499	984 949
Large hospitals	no.	689 374	683 249	693 313	718 201	735 485
Medium hospitals	no.	559 006	570 768	590 426	590 153	578 220
Small hospitals	no.	141 249	139 356	139 172	131 678	135 252
Unpeered and other acute hospitals	no.	26 353	26 662	27 044	25 519	25 108
Total public acute	no.	2 298 492	2 326 724	2 366 269	2 418 050	2 459 014
Outpatient						
Principal referral and Women's and children's hospitals	no.	8 428 689	8 024 141	8 057 030	9 159 883	8 388 222
Large hospitals	no.	2 694 304	2 646 680	2 692 358	3 014 713	2 739 848
Medium hospitals	no.	1 154 536	1 184 590	1 261 467	1 358 327	1 416 818
Small hospitals	no.	110 675	116 213	125 779	124 305	113 276
Unpeered and other acute hospitals	no.	3 621 901	3 504 152	3 476 754	3 685 381	3 898 020
Total public acute	no.	16 010 105	15 475 776	15 613 388	17 342 609	16 556 184
Other						
Principal referral and Women's and children's hospitals	no.	1 164 306	1 043 412	879 446	1 212 795	1 747 734
Large hospitals	no.	690 388	567 511	612 388	619 867	927 075
Medium hospitals	no.	440 748	421 894	386 468	554 453	643 935
Small hospitals	no.	108 954	106 655	116 928	164 585	168 957
Unpeered and other acute hospitals	no.	503 100	501 099	468 942	503 515	589 442
Total public acute	no.	2 907 496	2 640 571	2 464 172	3 055 215	4 077 143
Total						
Principal referral and Women's and children's hospitals	no.	10 475 505	9 974 242	9 852 790	11 325 177	11 120 905
Large hospitals	no.	4 074 066	3 897 440	3 998 059	4 352 781	4 402 408
Medium hospitals	no.	2 154 290	2 177 252	2 238 361	2 502 933	2 638 973
Small hospitals	no.	360 878	362 224	381 879	420 568	417 485

TABLE 11A.65

Table 11A.65 **NSW recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2008-09	2009-10	2010-11	2011-12	2012-13
Unpeered and other acute hospitals	no.	4 151 354	4 031 913	3 972 740	4 214 415	4 512 570
Total public acute	no.	21 216 093	20 443 071	20 443 829	22 815 874	23 092 341
Public psychiatric						
Emergency department	no.	na	na	na	na	na
Outpatient	no.	46 561	43 263	57 306	60 501	72 060
Other	no.	na	na	na	na	na
Total	no.	46 561	43 263	57 306	60 501	72 062
Cost per occasion						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	\$	216	226	281	277	268
Large hospitals	\$	151	204	252	267	257
Medium hospitals	\$	164	220	221	256	262
Small hospitals	\$	98	117	106	234	238
Unpeered and other acute hospitals	\$	96	105	116	129	151
Total public acute	\$	175	210	245	265	260
Outpatient						
Principal referral and Women's and children's hospitals	\$	139	154	164	124	152
Large hospitals	\$	103	114	119	104	128
Medium hospitals	\$	73	94	92	93	114
Small hospitals	\$	111	133	125	177	175
Unpeered and other acute hospitals	\$	9	38	40	47	33
Total public acute	\$	99	116	122	102	117
Other						
Principal referral and Women's and children's hospitals	\$	101	106	129	138	81
Large hospitals	\$	80	103	94	144	70
Medium hospitals	\$	124	122	141	90	84
Small hospitals	\$	103	120	113	98	123

Table 11A.65 **NSW recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2008-09	2009-10	2010-11	2011-12	2012-13
Unpeered and other acute hospitals	\$	84	85	101	12	104
Total public acute	\$	96	105	116	108	84
Total						
Principal referral and Women's and children's hospitals	\$	142	155	172	138	151
Large hospitals	\$	107	128	138	136	138
Medium hospitals	\$	107	133	135	131	139
Small hospitals	\$	103	123	115	164	174
Unpeered and other acute hospitals	\$	19	44	48	44	43
Total public acute	\$	107	125	136	120	127
Public psychiatric						
Emergency department	\$	na	na	na	na	na
Outpatient	\$	894	1 123	862	736	526
Other	\$	na	na	na	na	na
Total	\$	907	1 137	872	771	533

(a) These data are based on the hospitals that participated in the National Hospital Cost Data Collection.

na Not available.

Source: NSW Government (unpublished).

TABLE 11A.66

Table 11A.66 **WA recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2008-09	2009-10	2010-11	2011-12	2012-13
Occasions of service						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	no.	229 705	280 942	377 377	408 829	416 918
Large hospitals	no.	133 032	106 722	255 184	283 874	295 120
Medium hospitals	no.	105 399	110 235	24 967	26 855	28 411
Small hospitals	no.	131 683	147 031	160 324	173 961	173 803
Unpeered and other acute hospitals	no.	85 514	81 393	83 831	81 990	76 272
Total public acute	no.	685 333	726 323	901 683	975 509	990 524
Outpatient						
Principal referral and Women's and children's hospitals	no.	1 611 707	1 662 696	1 317 725	1 023 297	1 080 723
Large hospitals	no.	290 118	317 121	363 001	258 069	284 167
Medium hospitals	no.	515 736	565 286	128 633	89 716	92 169
Small hospitals	no.	367 379	388 176	180 793	120 151	158 165
Unpeered and other acute hospitals	no.	241 705	242 553	160 312	97 307	158 441
Total public acute	no.	3 026 645	3 175 832	2 150 464	1 588 540	1 773 665
Other						
Principal referral and Women's and children's hospitals	no.	10 857	136 365	na	na	na
Large hospitals	no.	30 934	15 201	na	na	na
Medium hospitals	no.	40 991	44 293	na	na	na
Small hospitals	no.	72 764	92 460	na	na	na
Unpeered and other acute hospitals	no.	80 629	30 249	na	na	na
Total public acute	no.	236 175	318 568	na	na	na
Total						
Principal referral and Women's and children's hospitals	no.	1 852 269	2 080 003	1 695 102	1 432 126	1 497 641
Large hospitals	no.	454 084	439 044	618 185	541 943	579 287
Medium hospitals	no.	662 126	719 814	153 600	116 571	120 580
Small hospitals	no.	440 143	480 636	341 117	294 112	331 968

TABLE 11A.66

Table 11A.66 **WA recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2008-09	2009-10	2010-11	2011-12	2012-13
Unpeered and other acute hospitals	no.	322 334	272 802	244 143	179 297	234 713
Total public acute	no.	3 730 956	3 992 299	3 052 147	2 564 049	2 764 189
Public psychiatric						
Emergency department	no.	na	na	na	na	na
Outpatient	no.	na	na	na	na	na
Other	no.	na	na	na	na	na
Total	no.	na	na	na	na	na
Cost per occasion						
Public acute						
Emergency department (b)						
Principal referral and Women's and children's hospitals	\$	530	505	465	603	635
Large hospitals	\$	411	635	585	534	567
Medium hospitals	\$	214	643	370	481	491
Small hospitals	\$	na	na	433	437	470
Unpeered and other acute hospitals	\$	na	na	311	424	462
Total public acute	\$	na	na	476	535	568
Outpatient						
Principal referral and Women's and children's hospitals	\$	244	267	246	306	311
Large hospitals	\$	119	157	87	248	268
Medium hospitals	\$	126	121	62	213	232
Small hospitals	\$	213	245	141	237	254
Unpeered and other acute hospitals	\$	180	201	125	254	241
Total public acute	\$	203	222	190	283	289
Other						
Principal referral and Women's and children's hospitals	\$	78	81	na	na	na
Large hospitals	\$	78	81	na	na	na
Medium hospitals	\$	78	81	na	na	na
Small hospitals	\$	78	81	na	na	na

Table 11A.66 **WA recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2008-09	2009-10	2010-11	2011-12	2012-13
Unpeered and other acute hospitals	\$	78	81	na	na	na
Total public acute	\$	78	81	na	na	na
Total						
Principal referral and Women's and children's hospitals	\$	278	287	295	391	401
Large hospitals	\$	152	271	292	398	420
Medium hospitals	\$	117	198	112	275	293
Small hospitals	\$	191	213	278	355	367
Unpeered and other acute hospitals	\$	154	188	189	332	313
Total public acute	\$	213	253	275	379	389
Public psychiatric						
Emergency department	\$	na	na	na	na	na
Outpatient	\$	na	na	na	na	na
Other	\$	na	na	na	na	na
Total	\$	na	na	na	na	na

(a) These data are based on the hospitals that participated in the National Hospital Cost Data Collection.

(b) Total cost per emergency department calculated using data for metropolitan hospitals only.

na Not available.

Source: WA Government (unpublished).

TABLE 11A.67

Table 11A.67 SA recurrent cost per non-admitted patient occasion of service, public hospitals (a)

		2008-09	2009-10	2010-11	2011-12	2012-13
Occasions of service						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	no.	257 999	272 164	280 184	286 285	302 207
Large hospitals	no.	38 518	39 971	42 569	40 564	38 193
Medium hospitals	no.	142 719	147 775	148 348	201 743	144 659
Small hospitals	no.	62 979	65 586	61 869	68 473	60 700
Unpeered and other acute hospitals	no.	9 055	8 760	11 018	10 817	6 905
Total public acute	no.	511 270	534 256	543 988	607 882	552 664
Outpatient						
Principal referral and Women's and children's hospitals	no.	990 999	1 012 893	1 026 225	1 109 261	1 070 995
Large hospitals	no.	139 747	170 186	170 025	164 271	155 822
Medium hospitals	no.	196 281	205 610	191 881	187 799	187 649
Small hospitals	no.	88 939	87 954	84 746	80 649	78 956
Unpeered and other acute hospitals	no.	21 995	21 542	17 542	20 651	19 820
Total public acute	no.	1 437 961	1 498 185	1 490 389	1 562 631	1 513 242
Other						
Principal referral and Women's and children's hospitals	no.	na	na	na	na	na
Large hospitals	no.	na	na	na	na	na
Medium hospitals	no.	na	na	na	na	na
Small hospitals	no.	na	na	na	na	na
Unpeered and other acute hospitals	no.	na	na	na	na	na
Total public acute	no.	na	na	na	na	na
Total						
Principal referral and Women's and children's hospitals	no.	1 248 998	1 285 057	1 306 409	1 395 546	1 373 202
Large hospitals	no.	178 265	210 157	212 594	204 835	194 015
Medium hospitals	no.	339 000	353 385	340 229	389 542	332 308
Small hospitals	no.	151 918	153 540	146 585	149 122	139 656

TABLE 11A.67

Table 11A.67 SA recurrent cost per non-admitted patient occasion of service, public hospitals (a)

		2008-09	2009-10	2010-11	2011-12	2012-13
Unpeered and other acute hospitals	no.	31 050	30 302	28 560	31 468	26 725
Total public acute	no.	1 949 231	2 032 441	2 034 377	2 170 513	2 065 906
Public psychiatric						
Emergency department	no.	na	na	na	na	na
Outpatient	no.	na	na	na	na	na
Other	no.	na	na	na	na	na
Total	no.	na	na	na	na	na
Cost per occasion						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	\$	529	556	658	691	561
Large hospitals	\$	333	244	402	502	717
Medium hospitals	\$	213	232	256	215	468
Small hospitals	\$	60	64	94	67	273
Unpeered and other acute hospitals	\$	—	—	—	—	—
Total public acute	\$	365	380	460	455	549
Outpatient						
Principal referral and Women's and children's hospitals	\$	355	370	410	365	395
Large hospitals	\$	287	216	220	267	260
Medium hospitals	\$	85	82	115	108	164
Small hospitals	\$	34	39	133	65	160
Unpeered and other acute hospitals	\$	—	—	—	—	—
Total public acute	\$	291	292	334	314	356
Other						
Principal referral and Women's and children's hospitals	\$	na	na	na	na	na
Large hospitals	\$	na	na	na	na	na
Medium hospitals	\$	na	na	na	na	na
Small hospitals	\$	na	na	na	na	na

TABLE 11A.67

Table 11A.67 SA recurrent cost per non-admitted patient occasion of service, public hospitals (a)

		2008-09	2009-10	2010-11	2011-12	2012-13
Unpeered and other acute hospitals	\$	na	na	na	na	na
Total public acute	\$	na	na	na	na	na
Total						
Principal referral and Women's and children's hospitals	\$	391	409	463	432	431
Large hospitals	\$	297	221	256	314	350
Medium hospitals	\$	139	145	178	164	296
Small hospitals	\$	45	50	117	66	209
Unpeered and other acute hospitals	\$	–	–	–	–	–
Total public acute	\$	310	315	368	353	408
Public psychiatric						
Emergency department	\$	na	na	na	na	na
Outpatient	\$	na	na	na	na	na
Other	\$	na	na	na	na	na
Total	\$	na	na	na	na	na

(a) These data are based on the hospitals that participated in the National Hospital Cost Data Collection.

na Not available. – Nil or rounded to zero.

Source: SA Government (unpublished).

TABLE 11A.68

Table 11A.68 **Tasmania recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2008-09	2009-10	2010-11	2011-12	2012-13
Occasions of service						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	no.	80 151	62 340	68 687	68 418	72 293
Large hospitals	no.	49 957	44 871	44 328	43 194	44 096
Medium hospitals	no.	..	..	..	..	..
Small hospitals	no.	..	..	..	..	..
Unpeered and other acute hospitals	no.	12 234	6 822	10 324	12 987	12 642
Total public acute	no.	142 342	114 033	123 339	124 599	129 031
Outpatient						
Principal referral and Women's and children's hospitals	no.	389 290	218 617	395 067	390 313	391 530
Large hospitals	no.	89 672	81 085	84 057	76 266	73 542
Medium hospitals	no.	..	..	..	..	..
Small hospitals	no.	..	..	..	..	..
Unpeered and other acute hospitals	no.	6 582	2 234	4 539	14 896	7 780
Total public acute	no.	485 544	301 936	483 663	481 475	472 852
Other						
Principal referral and Women's and children's hospitals	no.	na	60 464	na	na	na
Large hospitals	no.	na	1 460	na	na	na
Medium hospitals	no.	na	na	na	na	na
Small hospitals	no.	na	na	na	na	na
Unpeered and other acute hospitals	no.	na	na	na	na	na
Total public acute	no.	na	na	na	na	na
Total						
Principal referral and Women's and children's hospitals	no.	na	na	na	na	na
Large hospitals	no.	na	na	na	na	na
Medium hospitals	no.	na	na	na	na	na
Small hospitals	no.	na	na	na	na	na

TABLE 11A.68

Table 11A.68 **Tasmania recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2008-09	2009-10	2010-11	2011-12	2012-13
Unpeered and other acute hospitals	no.	na	na	na	na	na
Total public acute	no.	na	na	na	na	na
Public psychiatric						
Emergency department	no.	na	na	na	na	na
Outpatient	no.	na	na	na	na	na
Other	no.	na	na	na	na	na
Total	no.	na	na	na	na	na
Cost per occasion						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	\$	575	469	391	483	390
Large hospitals	\$	353	340	338	360	380
Medium hospitals	\$	..	..	..	..	..
Small hospitals	\$	..	..	..	..	..
Unpeered and other acute hospitals	\$	44	169	184	140	152
Total public acute	\$	451	400	355	451	363
Outpatient						
Principal referral and Women's and children's hospitals	\$	213	302	248	260	269
Large hospitals	\$	185	182	272	281	277
Medium hospitals	\$	..	..	..	..	..
Small hospitals	\$	..	..	..	..	..
Unpeered and other acute hospitals	\$	78	59	65	412	202
Total public acute	\$	206	268	250	268	272
Other						
Principal referral and Women's and children's hospitals	\$	na	133	na	na	na
Large hospitals	\$	na	166	na	na	na
Medium hospitals	\$	na	na	na	na	na
Small hospitals	\$	na	na	na	na	na

Table 11A.68 **Tasmania recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2008-09	2009-10	2010-11	2011-12	2012-13
Unpeered and other acute hospitals	\$	na	na	na	na	na
Total public acute	\$	na	na	na	na	na
Total						
Principal referral and Women's and children's hospitals	\$	na	na	na	na	na
Large hospitals	\$	na	na	na	na	na
Medium hospitals	\$	na	na	na	na	na
Small hospitals	\$	na	na	na	na	na
Unpeered and other acute hospitals	\$	na	na	na	na	na
Total public acute	\$	na	na	na	na	na
Public psychiatric						
Emergency department	\$	na	na	na	na	na
Outpatient	\$	na	na	na	na	na
Other	\$	na	na	na	na	na
Total	\$	na	na	na	na	na

(a) These data are based on the hospitals that participated in the National Hospital Cost Data Collection.

na Not available. .. Not applicable.

Source: Tasmania Government (unpublished).

TABLE 11A.69

Table 11A.69 **ACT recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2008-09	2009-10	2010-11	2011-12	2012-13
Occasions of service						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	no.	54 117	57 487	60 572	64 928	65 821
Large hospitals	no.	47 781	49 327	51 355	53 839	53 154
Medium hospitals	no.	na	na	na	na	na
Small hospitals	no.	na	na	na	na	na
Unpeered and other acute hospitals	no.	na	na	na	na	na
Total public acute	no.	101 898	106 814	112 197	118 767	118 975
Outpatient						
Principal referral and Women's and children's hospitals	no.	230 384	256 195	240 336	285 636	261 975
Large hospitals	no.	57 435	60 653	74 157	71 812	56 748
Medium hospitals	no.	na	na	na	na	na
Small hospitals	no.	na	na	na	na	na
Unpeered and other acute hospitals	no.	na	na	na	na	na
Total public acute	no.	287 819	316 848	314 493	340 455	318 723
Other						
Principal referral and Women's and children's hospitals	no.	na	na	na	na	379 798
Large hospitals	no.	na	na	na	na	9 588
Medium hospitals	no.	na	na	na	na	na
Small hospitals	no.	na	na	na	na	na
Unpeered and other acute hospitals	no.	na	na	na	na	na
Total public acute	no.	na	na	na	na	389 386
Total						
Principal referral and Women's and children's hospitals	no.	284 501	313 682	300 908	350 564	707 594
Large hospitals	no.	105 216	109 980	125 512	125 651	119 490
Medium hospitals	no.	na	na	na	na	na
Small hospitals	no.	na	na	na	na	na

TABLE 11A.69

Table 11A.69 **ACT recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2008-09	2009-10	2010-11	2011-12	2012-13
Unpeered and other acute hospitals	no.	na	na	na	na	na
Total public acute	no.	389 717	423 662	426 420	459 222	827 084
Public psychiatric						
Emergency department	no.	na	na	na	na	na
Outpatient	no.	na	na	na	na	na
Other	no.	na	na	na	na	na
Total	no.	na	na	na	na	na
Cost per occasion						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	\$	na	na	na	na	na
Large hospitals	\$	na	na	na	na	na
Medium hospitals	\$	na	na	na	na	na
Small hospitals	\$	na	na	na	na	na
Unpeered and other acute hospitals	\$	na	na	na	na	na
Total public acute	\$	637	665	723	839	832
Outpatient						
Principal referral and Women's and children's hospitals	\$	na	na	na	na	na
Large hospitals	\$	na	na	na	na	na
Medium hospitals	\$	na	na	na	na	na
Small hospitals	\$	na	na	na	na	na
Unpeered and other acute hospitals	\$	na	na	na	na	na
Total public acute	\$	268	330	255	338	358
Other						
Principal referral and Women's and children's hospitals	\$	na	na	na	na	na
Large hospitals	\$	na	na	na	na	na
Medium hospitals	\$	na	na	na	na	na
Small hospitals	\$	na	na	na	na	na

Table 11A.69 **ACT recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2008-09	2009-10	2010-11	2011-12	2012-13
Unpeered and other acute hospitals	\$	na	na	na	na	na
Total public acute	\$	na	na	na	na	212
Total						
Principal referral and Women's and children's hospitals	\$	na	na	na	na	na
Large hospitals	\$	na	na	na	na	na
Medium hospitals	\$	na	na	na	na	na
Small hospitals	\$	na	na	na	na	na
Unpeered and other acute hospitals	\$	na	na	na	na	na
Total public acute	\$	368	371	340	463	357
Public psychiatric						
Emergency department	\$	na	na	na	na	na
Outpatient	\$	na	na	na	na	na
Other	\$	na	na	na	na	na
Total	\$	na	na	na	na	na

(a) These data are based on the hospitals that participated in the National Hospital Cost Data Collection.

na Not available.

Source: ACT Government (unpublished).

Table 11A.70 Emergency department admitted and non-admitted cost per presentation, 2011-12 (a)

<i>Line item</i>	<i>Average cost/presentation</i>
	\$
Salary & Wages – Medical (non-VMO)	158
Salary & Wages VMO	16
Salary & Wages – Nursing	130
Salary & Wages – Allied health	23
Salary & Wages – other	56
On-costs	40
Medical supplies	20
Prostheses	1
Imaging	14
Pathology	25
Pharmaceuticals – non PBS	8
Pharmaceuticals – PBS	1
Blood	5
Hotel	11
Goods and services	48
Depreciation – building	7
Depreciation – equipment	5
Lease	3
Payroll tax	–
Capital	–
Corporate	14
Excluded costs	–
Total	585

(a) Emergency department urgency related grouping data reported by 247 hospitals in 2011-12.

– Nil or rounded to zero. VMO=Visiting Medical Officer.

Source: IHPA (2014), *National Hospital Cost Data Collection Australian Public Hospitals Cost Report 2011-12 Round 16*, Commonwealth of Australia.

TABLE 11A.71

Table 11A.71 **Emergency department presentations by Urgency Related Groupings (URG) codes - presentations and average cost per presentation (a), (b)**

<i>Urgency related grouping</i>	<i>2009-10</i>		<i>2010-11</i>		<i>2011-12</i>	
	<i>Presentations</i>	<i>Average cost</i>	<i>Presentations</i>	<i>Average cost</i>	<i>Presentations</i>	<i>Average cost</i>
	<i>no.</i>	<i>\$</i>	<i>no.</i>	<i>\$</i>	<i>no.</i>	<i>\$</i>
Admitted emergency department presentations						
3 Adm_T1_Injury	4 629	1 336	5 404	1 950	5 104	2 146
4 Adm_T1_Poisoning	1 287	1 204	1 265	1 396	1 348	1 576
5 Adm_T1_Respiratory system illness	2 946	1 286	3 668	1 461	3 778	1 530
6 Adm_T1_Circulatory system illness	4 625	981	6 021	1 217	6 045	1 367
7 Adm_T1_All other MDB groups	5 926	1 273	7 087	1 508	7 640	1 727
9 Adm_T2_Poisoning	712	1 101	4 545	1 060	5 917	1 170
10 Adm_T2_Injury	21 551	885	22 053	1 140	27 644	1 331
11 Adm_T2_Gastrointestinal system illness	13 635	978	15 295	1 136	19 273	1 334
12 Adm_T2_Respiratory system illness	29 297	909	35 081	1 014	41 263	1 175
14 Adm_T2_Neurological illness	14 589	997	16 770	1 138	19 762	1 397
15 Adm_T2_Toxic effects of drugs	5 672	977	1 242	1 057	2 048	1 129
16 Adm_T2_Circulatory system illness	86 085	890	95 704	953	112 312	1 131
17 Adm_T2_All other MDB groups	29 497	931	33 305	980	41 827	1 219
19 Adm_T3_Blood / Immune system illness	10 705	803	12 419	889	14 001	1 185
20 Adm_T3_Injury	54 725	736	57 266	819	68 459	1 009
21 Adm_T3_Neurological illness	45 891	868	48 898	934	60 922	1 145
22 Adm_T3_Obstetric/Gynaecological illness	16 242	545	16 881	538	18 803	616
23 Adm_T3_Gastrointestinal system illness	99 644	818	106 829	914	131 839	1 094
24 Adm_T3_Circulatory system illness	74 634	809	80 261	875	95 032	1 040
25 Adm_T3_Poisoning/Toxic effects of drugs	9 944	870	10 066	870	13 955	959
26 Adm_T3_Urological illness	29 502	815	30 212	905	36 708	1 076

TABLE 11A.71

Table 11A.71 **Emergency department presentations by Urgency Related Groupings (URG) codes - presentations and average cost per presentation (a), (b)**

<i>Urgency related grouping</i>	<i>2009-10</i>		<i>2010-11</i>		<i>2011-12</i>	
	<i>Presentations</i>	<i>Average cost</i>	<i>Presentations</i>	<i>Average cost</i>	<i>Presentations</i>	<i>Average cost</i>
27 Adm_T3_Respiratory system illness	66 371	799	75 864	863	83 508	1 039
29 Adm_T3_All other MDB groups	70 320	859	83 088	841	96 053	1 011
30 Adm_T4_Poisoning/Toxic effects of drugs	16 215	656	3 075	700	11 067	735
31 Adm_T4_Respiratory system illness	21 067	714	22 110	732	23 448	873
32 Adm_T4_Gastrointestinal system illness	61 238	716	59 537	775	73 009	917
33 Adm_T4_All other MDB groups	121 710	693	127 249	710	146 602	848
34 Adm_T4_Injury	29 020	601	42 858	643	44 058	781
35 Adm_T4_Psychiatric/Social problem/Other presentation	21 316	766	23 228	784	24 584	801
36 Adm_T5_Psychiatric/Social problem/Other presentation	3 230	518	3 988	528	3 692	545
37 Adm_T5_All other MDB groups	17 134	532	19 676	596	21 839	661
AE1 Error - Episode End Status not=1,2,3,4,5,6 or 7	..	..	..	..	5	1 378
AE2 Error - Triage not=1,2,3,4 or 5	61	529	33	543	50	686
AE3 Error - Blank Diagnosis Code	2 101	660	14 829	701	125 103	1 016
AE4 Error - Invalid Diagnosis Code	59 973	812	43 642	848	72 055	1 294
AE5 Error - Diagnosis Code – No MDB map	1 731	844	1 622	964	29 485	649
EDAdm1 Emergency admission Triage 1	7 632	1 683	..	..	..	..
EDAdm2 Emergency admission Triage 2	77 548	893	..	..	..	..
EDAdm3 Emergency admission Triage 3	184 658	764	..	..	..	..
EDAdm4 Emergency admission Triage 4	94 582	620	..	..	..	..
EDAdm5 Emergency admission Triage 5	9 488	463	..	..	..	..

TABLE 11A.71

Table 11A.71 **Emergency department presentations by Urgency Related Groupings (URG) codes - presentations and average cost per presentation (a), (b)**

<i>Urgency related grouping</i>	<i>2009-10</i>		<i>2010-11</i>		<i>2011-12</i>		
	<i>Presentations</i>	<i>Average cost</i>	<i>Presentations</i>	<i>Average cost</i>	<i>Presentations</i>	<i>Average cost</i>	
Total	1 427 133	791	1 131 071	865	1 488 238	1 037	
Non-admitted ED presentations							
38	Dead on Arrival w any Triage w any MDB	2 532	240	3 986	169	4 620	339
39	N-A_T1_All MDB groups	4 158	1 197	6 366	1 468	5 314	1 441
40	N-A_T2_Alcohol/drug abuse	1 818	836	2 866	879	2 799	887
42	N-A_T2_Musculoskeletal/connective tissue illness	2 352	665	3 078	707	4 857	646
43	N-A_T2_Circulatory system / Respiratory system illness	44 052	747	71 623	840	80 365	821
44	N-A_T2_Injury	21 817	786	29 432	834	27 875	855
45	N-A_T2_Poisoning	2 398	739	3 945	820	3 365	847
46	N-A_T2_All other MDB groups	37 976	676	55 693	751	63 656	713
48	N-A_T3_Circulatory system illness	52 077	602	82 193	649	82 488	645
50	N-A_T3_Injury	127 237	527	159 828	553	177 038	573
51	N-A_T3_Genitourinary illness	43 767	589	62 606	626	67 612	627
52	N-A_T3_Gastrointestinal system illness	90 575	565	128 172	607	135 027	618
53	N-A_T3_Neurological illness	45 628	594	66 256	629	69 073	647
55	N-A_T3_Respiratory system illness	75 478	462	100 247	510	112 337	495
56	N-A_T3_Musculoskeletal/connective tissue illness	10 825	511	15 026	543	22 360	523
57	N-A_T3_All other MDB groups	161 901	473	224 866	490	244 429	498
58	N-A_T4_Injury	366 551	322	434 911	343	502 035	366
60	N-A_T4_Genitourinary illness	74 566	361	90 982	407	104 355	405

TABLE 11A.71

Table 11A.71 **Emergency department presentations by Urgency Related Groupings (URG) codes - presentations and average cost per presentation (a), (b)**

<i>Urgency related grouping</i>	<i>2009-10</i>		<i>2010-11</i>		<i>2011-12</i>	
	<i>Presentations</i>	<i>Average cost</i>	<i>Presentations</i>	<i>Average cost</i>	<i>Presentations</i>	<i>Average cost</i>
61 N-A_T4_Circulatory system / Respiratory system illness	112 793	333	149 082	369	170 357	371
62 N-A_T4_Gastrointestinal system illness	117 673	381	160 501	422	171 180	428
63 N-A_T4_Musculoskeletal/connective tissue illness	37 657	358	53 036	382	74 004	393
65 N-A_T4_Illness of the ENT	49 809	269	68 375	286	86 744	307
66 N-A_T4_Illness of the eyes	34 115	248	51 543	250	60 797	276
67 N-A_T4_Other presentation block	94 256	300	109 494	338	110 627	351
68 N-A_T4_All other MDB groups	197 298	343	286 707	344	315 145	368
69 N-A_T5_Poisoning/Toxic effects of drugs	2 700	257	3 812	257	3 783	281
70 N-A_T5_Injury	83 738	227	110 355	236	122 662	262
71 N-A_T5_Other presentation block	89 279	183	102 520	206	87 073	217
72 N-A_T5_All other MDB groups	137 695	209	172 661	235	184 510	276
73 Did Not Wait	225 731	200	258 865	155	281 664	166
EDDC1 Emergency discharge Triage 1	1 592	641	..	..	..	..
EDDC2 Emergency discharge Triage 2	48 660	534	..	..	..	..
EDDC3 Emergency discharge Triage 3	273 115	453	..	..	..	..
EDDC4 Emergency discharge Triage 4	601 058	358	..	..	..	..
EDDC5 Emergency discharge Triage 5	180 719	216	..	..	..	..
EDDNW Emergency Did not wait	70 933	41	..	..	..	..
NE1 Error - Episode End Status not=1,2,3,4,5,6 or 7	25 728	419	22 356	346	893	547
NE2 Error - Triage not=1,2,3,4 or 5	182	376	156	699	420	271
NE3 Error - Blank Diagnosis Code	38 552	319	178 959	242	531 141	496

TABLE 11A.71

Table 11A.71 **Emergency department presentations by Urgency Related Groupings (URG) codes - presentations and average cost per presentation (a), (b)**

<i>Urgency related grouping</i>		<i>2009-10</i>		<i>2010-11</i>		<i>2011-12</i>	
		<i>Presentations</i>	<i>Average cost</i>	<i>Presentations</i>	<i>Average cost</i>	<i>Presentations</i>	<i>Average cost</i>
NE4	Error - Invalid	122 893	412	189 587	396	324 637	464
NE5	Error - Diagnosis Code – No MDB map	6 468	428	14 383	453	279 223	298
National non-admitted emergency department presentations		3 718 352	365	3 474 468	395	4 514 465	422
National emergency department presentations		5 145 485	484	4 605 539	511	6 002 703	574

(a) Costs include depreciation.

(b) Emergency department urgency related grouping data reported by 180 hospitals in 2009-10, 167 hospitals in 2010-11 and 247 hospitals in 2011-12.

.. Not applicable. Adm=Admitted. N-A=Non-admitted. T= triage category 1, 2, 3, 4, 5

Source: IHPA (2014), *National Hospital Cost Data Collection Australian Public Hospitals Cost Report 2011-12 Round 16*, Commonwealth of Australia.

Table 11A.72 Non-admitted service events and average cost per service event (a), (b), (c)

	<i>Service events</i>	<i>Average cost</i>
	no.	\$
2009-10	4 718 585	287
2010-11	5 268 539	322
2011-12	10 690 539	318

(a) Tier 2 NHCDC clinics.

(b) Costs include depreciation.

(c) 2010-11 data based on 164 hospitals, 2011-12 data based on 202 hospitals.

Source: IHPA (2014), *National Hospital Cost Data Collection Australian Public Hospitals Cost Report 2011-12 Round 16*, Commonwealth of Australia.

TABLE 11A.73

Table 11A.73 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2013-14 (a), (b), (c)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often <u>listened carefully</u> to them										
		<i>proportion</i>								
Major cities	%	88.6	85.1	84.0	87.7	89.7	..	74.3	..	86.2
Other (c)	%	84.3	82.4	83.2	85.7	82.0	76.9	-	90.6	83.8
Total	%	86.6	84.9	84.4	86.7	86.8	76.9	75.2	90.6	85.4
		<i>relative standard error</i>								
Major cities	%	2.1	1.6	1.9	2.5	2.0	..	5.1	..	1.3
Other (c)	%	4.5	3.6	3.4	4.6	3.8	2.9	-	4.4	1.0
Total	%	1.5	1.6	0.8	2.1	0.7	2.9	4.8	4.4	0.9
		<i>95 per cent confidence interval</i>								
Major cities	±	3.7	2.7	3.1	4.3	3.6	..	7.4	..	2.3
Other (c)	±	7.8	5.8	5.5	7.7	6.1	4.4	-	7.8	1.6
Total	±	2.5	2.7	1.3	3.6	1.2	4.4	7.1	7.8	1.5
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often <u>showed respect</u> to them										
		<i>proportion</i>								
Major cities	%	88.7	86.9	85.8	87.1	88.5	..	76.4	..	86.9
Other (c)	%	86.0	84.4	85.7	90.5	80.1	85.5	-	87.2	85.8
Total	%	87.2	86.2	86.1	87.4	86.3	85.5	77.3	87.2	86.5
		<i>relative standard error</i>								
Major cities	%	2.5	2.2	1.4	3.1	2.4	..	5.1	..	1.3
Other (c)	%	4.5	3.5	2.9	4.3	0.8	3.2	-	5.2	1.5

TABLE 11A.73

Table 11A.73 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2013-14 (a), (b), (c)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total	%	1.9	2.0	1.3	2.9	1.7	3.2	4.9	5.2	1.2
		<i>95 per cent confidence interval</i>								
Major cities	±	4.3	3.8	2.4	5.4	4.2	..	7.7	..	2.2
Other (c)	±	7.6	5.8	4.8	7.6	1.2	5.3	-	8.9	2.5
Total	±	3.2	3.4	2.2	5.0	2.8	5.3	7.4	8.9	2.1
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often <u>spent enough time with them</u>										
		<i>proportion</i>								
Major cities	%	82.3	80.5	81.9	82.3	86.5	..	74.5	..	81.7
Other (c)	%	80.7	78.5	81.0	80.0	70.3	77.9	-	85.0	79.9
Total	%	81.5	80.4	81.3	81.3	81.7	77.9	75.3	85.0	81.0
		<i>relative standard error</i>								
Major cities	%	2.6	2.2	4.2	3.3	1.4	..	5.9	..	1.4
Other (c)	%	2.0	4.0	2.9	3.6	3.6	2.9	-	4.2	1.2
Total	%	2.3	1.6	3.2	2.4	5.5	2.9	5.7	4.2	1.1
		<i>95 per cent confidence interval</i>								
Major cities	±	4.3	3.5	6.7	5.3	2.3	..	8.6	..	2.3
Other (c)	±	3.1	6.1	4.7	5.7	5.0	4.5	-	7.0	1.8
Total	±	3.6	2.5	5.1	3.8	8.8	4.5	8.4	7.0	1.8

(a) Persons 15 years and over who went to an emergency department for their own health in the last 12 months, excluding interviews by proxy.

(b) Cells in this table have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Table 11A.73 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2013-14 (a), (b), (c)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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(c) Includes inner and outer regional, remote and very remote areas.

.. Not applicable. – Nil or rounded to zero.

Source: ABS (unpublished) Patient Experience Survey 2013-14.

Table 11A.74 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2013-14 (a), (b), (c)**

	<i>Proportion (%)</i>	<i>relative standard error (%)</i>	<i>95 per cent confidence interval (±)</i>
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often <u>listened carefully</u> to them			
Major cities	86.2	1.3	2.3
Other (c)	83.8	1.0	1.6
Inner regional	84.1	1.2	2.0
Outer regional	83.0	2.3	3.7
Remote/very remote	84.3	14.3	23.6
Total	85.4	0.9	1.5
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often <u>showed respect</u> to them			
Major cities	86.9	1.3	2.2
Other (c)	85.8	1.5	2.5
Inner regional	85.7	1.6	2.7
Outer regional	85.4	1.3	2.2
Remote/very remote	88.3	3.3	5.7
Total	86.5	1.2	2.1
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often <u>spent enough time with</u> them			
Major cities	81.7	1.4	2.3
Other (c)	79.9	1.2	1.8
Inner regional	80.0	1.5	2.4
Outer regional	79.7	1.5	2.3
Remote/very remote	80.1	13.7	21.5
Total	81.0	1.1	1.8

(a) Persons 15 years and over who went to an emergency department for their own health in the last 12 months, excluding interviews by proxy.

(b) Cells in this table have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

(c) Includes inner and outer regional, remote and very remote areas.

Source: ABS (unpublished) Patient Experience Survey 2013-14.

TABLE 11A.75

Table 11A.75 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2013-14 (a), (b), (c)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often <u>listened carefully</u> to them										
<i>proportion</i>										
Major cities	%	89.0	90.0	89.8	86.1	89.3	..	82.1	..	89.2
Other (c)	%	89.9	87.0	91.3	89.7	91.0	85.3	-	90.6	89.2
Total	%	90.2	89.7	90.4	87.0	90.3	85.3	81.7	90.6	89.1
<i>relative standard error</i>										
Major cities	%	1.3	1.3	4.5	2.0	2.5	..	3.8	..	0.9
Other (c)	%	1.1	2.1	1.6	6.2	4.9	5.3	-	4.1	0.3
Total	%	1.3	1.7	0.7	2.2	2.3	5.3	3.7	4.1	0.7
<i>95 per cent confidence interval</i>										
Major cities	±	2.3	2.3	7.9	3.4	4.4	..	6.1	..	1.6
Other (c)	±	1.9	3.5	2.8	11.0	8.7	8.9	-	7.3	0.6
Total	±	2.2	3.0	1.3	3.8	4.1	8.9	5.9	7.3	1.2
Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often <u>showed respect</u> to them										
<i>proportion</i>										
Major cities	%	90.3	90.2	91.4	85.6	90.4	..	85.5	..	90.2
Other (c)	%	90.1	88.4	92.3	90.4	90.5	87.6	-	92.0	90.3
Total	%	90.7	90.1	91.7	88.7	90.4	87.6	85.1	92.0	90.2
<i>relative standard error</i>										
Major cities	%	2.0	1.7	4.7	1.6	2.0	..	3.8	..	0.6
Other (c)	%	0.8	2.1	1.4	4.8	5.0	2.9	-	3.4	3.0
Total	%	1.6	1.8	1.3	1.6	1.9	2.9	3.7	3.4	0.6

TABLE 11A.75

Table 11A.75 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2013-14 (a), (b), (c)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>95 per cent confidence interval</i>										
Major cities	±	3.5	2.9	8.4	2.7	3.6	..	6.4	..	1.1
Other (c)	±	1.4	3.6	2.5	8.5	8.8	5.0	-	6.1	5.3
Total	±	2.9	3.2	2.4	2.8	3.4	5.0	6.2	6.1	1.1
Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often <u>spent enough time with them</u>										
<i>proportion</i>										
Major cities	%	85.3	85.7	85.7	84.6	87.0	..	82.9	..	85.5
Other (c)	%	86.8	85.1	89.3	86.2	84.5	79.7	-	94.2	86.3
Total	%	85.9	86.0	86.7	85.5	84.9	79.7	82.5	94.2	85.8
<i>relative standard error</i>										
Major cities	%	1.5	2.2	4.5	1.7	2.2	..	4.9	..	0.5
Other (c)	%	1.6	1.9	1.6	3.0	4.0	3.5	-	4.2	3.0
Total	%	1.6	2.0	0.8	5.5	5.7	3.5	4.8	4.2	0.5
<i>95 per cent confidence interval</i>										
Major cities	±	2.5	3.6	7.6	2.9	3.8	..	7.9	..	0.8
Other (c)	±	2.8	3.1	2.9	5.1	6.6	5.5	-	7.7	5.1
Total	±	2.7	3.4	1.3	9.2	9.5	5.5	7.8	7.7	0.8

(a) Persons 15 years and over who went to an emergency department for their own health in the last 12 months, excluding interviews by proxy.

(b) Cells in this table have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

(c) Includes inner and outer regional, remote and very remote areas.

.. Not applicable. – Nil or rounded to zero.

Table 11A.75 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2013-14 (a), (b), (c)**

<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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Source: ABS (unpublished) Patient Experience Survey 2013-14.

Table 11A.76 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2013-14 (a), (b), (c)**

	<i>Proportion (%)</i>	<i>relative standard error (%)</i>	<i>95 per cent confidence interval (±)</i>
Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often <u>listened carefully</u> to them			
Major cities	89.2	0.9	1.6
Other (c)	89.2	0.3	0.6
Inner regional	88.8	4.0	7.0
Outer regional	89.6	4.5	7.9
Remote/very remote	88.7	7.5	13.0
Total	89.1	0.7	1.2
Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often <u>showed respect</u> to them			
Major cities	90.2	0.6	1.1
Other (c)	90.3	3.0	5.3
Inner regional	89.8	4.0	7.0
Outer regional	91.5	4.6	8.2
Remote/very remote	90.2	5.7	10.0
Total	90.2	0.6	1.1
Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often <u>spent enough time with</u> them			
Major cities	85.5	0.5	0.8
Other (c)	86.3	3.0	5.1
Inner regional	86.3	0.8	1.3
Outer regional	87.2	4.6	7.9
Remote/very remote	83.6	15.2	24.9
Total	85.8	0.5	0.8

(a) Persons 15 years and over who visited an emergency department for their own health in the last 12 months, excluding interviews by proxy.

(b) Cells in this table have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

(c) Includes inner and outer regional, remote and very remote areas.

Source: ABS (unpublished) Patient Experience Survey 2013-14.

TABLE 11A.77

Table 11A.77 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2013-14 (a), (b), (c)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often <u>listened carefully</u> to them										
		<i>proportion</i>								
Major cities	%	92.1	91.9	89.0	88.7	94.7	..	83.9	..	91.3
Other (c)	%	91.6	88.6	86.8	90.0	90.3	88.5	-	91.0	89.6
Total	%	91.3	90.5	88.4	90.0	93.6	88.5	83.9	91.0	90.6
		<i>relative standard error</i>								
Major cities	%	1.1	1.7	2.2	2.5	2.1	..	4.8	..	0.7
Other (c)	%	2.7	2.0	2.9	2.6	3.4	1.5	-	4.0	1.3
Total	%	1.2	1.3	1.7	1.4	4.2	1.5	4.8	4.0	0.5
		<i>95 per cent confidence interval</i>								
Major cities	±	2.0	3.1	3.8	4.4	4.0	..	8.0	..	1.3
Other (c)	±	4.8	3.4	5.0	4.5	6.1	2.6	-	7.2	2.2
Total	±	2.1	2.3	3.0	2.5	7.7	2.6	8.0	7.2	0.9

Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often showed respect to them

		<i>proportion</i>								
Major cities	%	93.2	93.2	92.1	90.3	97.1	..	84.8	..	92.7
Other (c)	%	91.8	92.3	88.8	95.6	93.0	89.5	-	91.8	91.3
Total	%	92.7	93.0	90.3	91.2	96.0	89.5	84.8	91.8	92.4
		<i>relative standard error</i>								
Major cities	%	1.5	1.7	6.8	2.7	1.8	..	4.3	..	0.8

TABLE 11A.77

Table 11A.77 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2013-14 (a), (b), (c)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Other (c)	%	2.8	2.5	2.5	0.3	2.8	1.6	-	4.6	1.0
Total	%	1.2	1.5	0.7	1.8	4.2	1.6	4.3	4.6	0.5
<i>95 per cent confidence interval</i>										
Major cities	±	2.7	3.2	12.3	4.7	3.4	..	7.2	..	1.4
Other (c)	±	5.1	4.6	4.3	0.6	5.1	2.8	-	8.2	1.9
Total	±	2.2	2.8	1.2	3.3	7.9	2.8	7.2	8.2	0.9
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often <u>spent enough time</u> with them										
<i>proportion</i>										
Major cities	%	88.5	89.3	87.0	86.1	93.2	..	79.1	..	88.0
Other (c)	%	87.4	85.8	86.2	86.8	87.4	84.7	-	92.3	86.9
Total	%	87.7	88.4	86.1	86.9	92.3	84.7	79.1	92.3	87.7
<i>relative standard error</i>										
Major cities	%	1.8	2.1	2.4	2.8	2.7	..	5.7	..	0.9
Other (c)	%	2.9	0.8	3.1	7.4	4.5	0.6	-	3.7	0.7
Total	%	1.3	1.6	1.9	2.4	1.3	0.6	5.7	3.7	1.7
<i>95 per cent confidence interval</i>										
Major cities	±	3.1	3.7	4.1	4.8	5.0	..	8.9	..	1.6
Other (c)	±	5.0	1.3	5.2	12.6	7.8	1.0	-	6.7	1.3
Total	±	2.3	2.8	3.2	4.1	2.3	1.0	8.9	6.7	2.9

(a) Persons 15 years and over who were admitted to hospital for their own health in the last 12 months, excluding interviews by proxy.

TABLE 11A.77

Table 11A.77 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2013-14 (a), (b), (c)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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(b) Cells in this table have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

(c) Includes inner and outer regional, remote and very remote areas.

.. Not applicable. – Nil or rounded to zero.

Source: ABS (unpublished) Patient Experience Survey 2013-14.

Table 11A.78 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2013-14 (a), (b), (c)**

	<i>Proportion (%)</i>	<i>relative standard error (%)</i>	<i>95 per cent confidence interval (±)</i>
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often <u>listened carefully</u> to them			
Major cities	91.3	0.7	1.3
Other (c)	89.6	1.3	2.2
Inner regional	90.2	5.0	8.8
Outer regional	88.3	2.1	3.6
Remote/very remote	92.0	3.6	6.4
Total	90.6	0.5	0.9
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often <u>showed respect</u> to them			
Major cities	92.7	0.8	1.4
Other (c)	91.3	1.0	1.9
Inner regional	91.4	4.9	8.8
Outer regional	91.0	1.6	2.9
Remote/very remote	95.7	1.9	3.5
Total	92.4	0.5	0.9
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often <u>spent enough time</u> with them			
Major cities	88.0	0.9	1.6
Other (c)	86.9	0.7	1.3
Inner regional	86.8	4.8	8.2
Outer regional	87.0	0.9	1.6
Remote/very remote	91.1	4.2	7.5
Total	87.7	1.7	2.9

(a) Persons 15 years and over who were admitted to hospital for their own health in the last 12 months, excluding interviews by proxy.

(b) Cells in this table have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

(c) Includes inner and outer regional, remote and very remote areas.

Source: ABS (unpublished) Patient Experience Survey 2013-14.

TABLE 11A.79

Table 11A.79 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2013-14 (a), (b), (c)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often <u>listened carefully</u> to them										
<i>proportion</i>										
Major cities	%	90.9	94.0	90.5	89.3	93.7	..	83.9	..	91.8
Other (c)	%	93.0	90.0	90.3	94.0	87.7	88.5	-	91.3	90.8
Total	%	92.3	92.5	90.1	91.3	91.4	88.5	83.9	91.3	91.5
<i>relative standard error</i>										
Major cities	%	1.2	2.4	1.1	2.9	2.8	..	4.9	..	0.9
Other (c)	%	1.5	2.5	1.9	7.7	3.7	3.0	-	8.4	1.1
Total	%	0.8	1.6	4.3	2.0	1.1	3.0	4.9	8.4	0.3
<i>95 per cent confidence interval</i>										
Major cities	±	2.1	4.3	2.0	5.0	5.1	..	8.1	..	1.5
Other (c)	±	2.7	4.5	3.3	14.2	6.4	5.2	-	15.0	1.9
Total	±	1.5	3.0	7.6	3.5	1.9	5.2	8.1	15.0	0.5
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often <u>showed respect</u> to them										
<i>proportion</i>										
Major cities	%	93.4	94.3	93.3	90.7	93.4	..	83.9	..	93.1
Other (c)	%	92.7	92.0	90.6	95.6	92.8	90.9	-	94.2	91.7
Total	%	94.0	93.3	91.4	91.5	92.9	90.9	83.9	94.2	92.6
<i>relative standard error</i>										
Major cities	%	1.4	1.9	0.1	2.8	2.8	..	4.9	..	0.7
Other (c)	%	7.4	2.5	2.2	7.4	3.2	2.6	-	8.4	1.1
Total	%	1.3	1.4	0.5	2.0	1.8	2.6	4.9	8.4	0.4

TABLE 11A.79

Table 11A.79 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2013-14 (a), (b), (c)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>95 per cent confidence interval</i>										
Major cities	±	2.5	3.5	0.3	4.9	5.1	..	8.1	..	1.3
Other (c)	±	13.4	4.5	3.9	13.9	5.8	4.6	-	15.5	2.1
Total	±	2.4	2.5	0.9	3.5	3.2	4.6	8.1	15.5	0.7
<i>proportion</i>										
Major cities	%	88.0	91.9	86.5	86.7	90.4	..	81.9	..	89.2
Other (c)	%	89.4	87.9	90.3	92.0	84.6	86.2	-	94.2	88.6
Total	%	88.6	91.2	87.2	88.4	88.9	86.2	81.9	94.2	89.0
<i>relative standard error</i>										
Major cities	%	0.8	1.7	0.2	3.2	1.8	..	5.7	..	0.6
Other (c)	%	7.3	3.4	2.2	0.8	4.7	2.4	-	8.2	0.9
Total	%	1.6	1.3	0.7	2.2	4.2	2.4	5.7	8.2	0.3
<i>95 per cent confidence interval</i>										
Major cities	±	1.4	3.0	0.4	5.4	3.3	..	9.2	..	1.1
Other (c)	±	12.8	5.8	3.9	1.4	7.8	4.0	-	15.1	1.6
Total	±	2.7	2.4	1.2	3.7	7.3	4.0	9.2	15.1	0.5

(a) Persons 15 years and over who were admitted to hospital for their own health in the last 12 months, excluding interviews by proxy.

(b) Cells in this table have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

(c) Includes inner and outer regional, remote and very remote areas.

.. Not applicable. – Nil or rounded to zero.

Table 11A.79 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2013-14 (a), (b), (c)**

<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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Source: ABS (unpublished) Patient Experience Survey 2013-14.

Table 11A.80 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2013-14 (a), (b), (c)**

	<i>Proportion (%)</i>	<i>relative standard error (%)</i>	<i>95 per cent confidence interval (±)</i>
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often <u>listened carefully</u> to them			
Major cities	91.8	0.9	1.5
Other (c)	90.8	1.1	1.9
Inner regional	90.2	0.6	1.1
Outer regional	91.9	5.4	9.7
Remote/very remote	95.9	4.2	7.8
Total	91.5	0.3	0.5
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often <u>showed respect</u> to them			
Major cities	93.1	0.7	1.3
Other (c)	91.7	1.1	2.1
Inner regional	92.0	0.9	1.6
Outer regional	91.2	5.5	9.8
Remote/very remote	95.3	3.9	7.3
Total	92.6	0.4	0.7
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often <u>spent enough time</u> with them			
Major cities	89.2	0.6	1.1
Other (c)	88.6	0.9	1.6
Inner regional	87.7	1.2	2.1
Outer regional	90.0	5.4	9.5
Remote/very remote	91.7	4.8	8.7
Total	89.0	0.3	0.5

(a) Persons 15 years and over who were admitted to hospital for their own health in the last 12 months, excluding interviews by proxy.

(b) Cells in this table have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

(c) Includes inner and outer regional, remote and very remote areas.

Source: ABS (unpublished) Patient Experience Survey 2013-14.

Table 11A.81 **NSW patient evaluation of hospital services**

When the survey was conducted*Year(s):*

2013

Time period (eg. July to Sept):

January to December - monthly

Survey method (eg. telephone, mailout etc):

The Adult Admitted Patient Survey is a paper survey mailed to more than 6000 patients each month. Depending on when the survey is returned, patients typically receive the initial questionnaire pack and up to two reminders. The survey can also be completed online, and in non-English languages, through an interpreter phone service.

Respondents (eg. Admitted patients in public acute care hospitals):

Adult Admitted patients (aged 18 and over) in public hospitals

Sample size:

More than 73 000

Response rate:

49 per cent

Size of underlying population:

900 000

Organisation conducting the survey:

Bureau of Health Information

Organisation funding the survey:

Table 11A.81 NSW patient evaluation of hospital services

NSW Ministry of Health & Local Health Districts/Specialty Health Networks

How was information from the survey used to help improve public hospital quality:

Detailed results are provided to the individual Local Health Districts and Specialty Health Networks to assist with assessment of responses from the survey.

Survey results:**Overall Experience of Care**

Most patients reported their overall experience of care in NSW public hospitals as 'good' (27 per cent) or 'very good' (64 per cent). More than three-quarters (77 per cent) said they would speak highly of their hospital experience if asked by family or friends. Full survey results are available through the BHI's interactive reporting tool, Healthcare Observer on the BHI website www.bhi.nsw.gov.au. Survey results for admitted patients aged less than 18 years and for patients attending Emergency Departments are to be published.

na Not available.

Source: NSW Government (unpublished).

Table 11A.82 Victorian patient evaluation of hospital services

When the survey was conducted

Year(s):

2014

Time period (eg. July to Sept):

April - June

Survey method (eg. telephone, mailout etc):

Email, if the patient has provided an email address. Postal mailout for other patients with the option of responding online.

Respondents (eg. Admitted patients in public acute care hospitals):

Admitted patients in public hospitals (acute and sub-acute). Non-admitted emergency department attendees.

Sample size:

Adult (16yrs and over) admitted patients - 16 075;

Adult Emergency Department attendees - 6927;

Paediatric admitted patients - 4158;

Paediatric Emergency Department attendees - 4699

Response rate:

Adult (16yrs and over) admitted patients - 37.7 per cent;

Adult Emergency Department attendees - 21.6 per cent ;

Paediatric admitted patients - 23.7 per cent;

Paediatric Emergency Department attendees - 21.7 per cent

Size of underlying population:

Eligible inpatients and emergency department attendees of Victorian public hospitals (adult and paediatric)

Table 11A.82 Victorian patient evaluation of hospital services

Organisation conducting the survey:

Ipsos Social Research Institute

Organisation funding the survey:

Department of Health, Victoria

How was information from the survey used to help improve public hospital quality:

It is anticipated that health services will use these results to determine where to direct improvement activity. The change from a largely satisfaction-based survey to an experience-based survey will provide health services with actionable results. At time of writing health services have not received their first results from the Victorian Healthcare Experience Survey.

Survey results:

Please note that this is the first quarter of results from a newly designed survey.

The score is derived from the percentage of positive responses (Very Good or Good) to the question 'Overall, how would you rate the care you/your child received in the hospital/emergency department?'

The overall score represents an aggregated score, unique to Victoria, from each patient category, based on the number of patients within each category.

The Overall Victorian Experience score is 88 per cent.

This was derived from

Adult Inpatient score of 92 per cent (representing 41 per cent of all stays)

Paediatric inpatient score of 93 per cent (representing 5 per cent of all stays)

Adult Emergency score of 84 per cent (representing 42 per cent of all stays)

Paediatric Emergency score of 82 per cent (representing 11 per cent of all stays).

Source: Victorian Government (unpublished).

Table 11A.83 Queensland patient evaluation of hospital services

When the survey was conducted

Year(s):

2013 Emergency Department Patient Experience Survey (EDPES)

Time period (eg. July to Sept):

August to September 2013

Survey method (eg. telephone, mailout etc):

Telephone (CATI - Computer Assisted Telephone Interviews)

Respondents (eg. Admitted patients in public acute care hospitals):

Patients who visited a public hospital emergency department between 1 May and 30 June 2013.

Patients were excluded if they:

- were deceased in the emergency department or subsequently;
- did not wait for treatment or left after treatment had commenced;
- presented for a mental health issue or were admitted to a mental health unit or ward;
- presented with self-harm;
- were in a known or suspected domestic violence situation;
- had a miscarriage, stillbirth, live birth where the neonate subsequently died before discharge, intrauterine death, hydatidiform mole, or complications following miscarriage or termination;
- were discharged to a correctional facility, nursing home or another healthcare facility other than a hospital;
- could not communicate effectively for a telephone interview in English (e.g.hearing problems / comprehension problems / poor English / requested an interpreter in hospital);
- had refused consent to be contacted to provide feedback;
- were usually resident outside Australia;
- had been contacted as part of the Press Ganey Survey conducted by the Mater Hospitals;
- were 16 years of age or older if they were a patient in one of the children's hospitals;
- were less than 16 years of age if they were a patient in any of the other hospitals.

Sample size:

10 626

Table 11A.83 Queensland patient evaluation of hospital services

Response rate:

Sixty per cent (60 per cent)

Size of underlying population:

232 320

Organisation conducting the survey:

Office of Economic and Statistical Research, Queensland Treasury (now Queensland Government Statistician's Office, Queensland Treasury and Trade)

Organisation funding the survey:

Queensland Health

How was information from the survey used to help improve public hospital quality:

Individualised hospital reports were produced, presenting the hospital's results against the results of other participating facilities. These were disseminated to Hospital and Health Service (HHS) Chief Executives, Executive Directors of Medical Services (EDMSs), Executive Directors of Nursing Services (EDONs), Directors of Safety and Quality and Directors of Clinical Governance. Hospitals were encouraged to review the results to identify areas in need of improvement and subsequently design and implement improvement initiatives. Results were presented to statewide groups such as the Statewide Emergency Strategic Advisory Panel, Directors of Medical Services Advisory Committee (DOMSAC), Directors of Nursing and Midwifery Advisory Committee (DONMAC), etc. and quality improvement initiatives were discussed and identified, and then promoted through these organisations.

Survey results:

Table 11A.83 Queensland patient evaluation of hospital services

Key results:

Overall, how would you rate the care you (child) received in the Emergency Department?

42 per cent Excellent

31 per cent Very good

17 per cent Good

6 per cent Fair

3 per cent Poor

1 per cent Very poor

Areas of most favourable patient experience

- 98 per cent rated the cleanliness of the Emergency Department as 'Very clean' or 'Fairly clean'
- 94 per cent had all or some of the staff introduce themselves
- 93 per cent rated the cleanliness of toilets as 'Very clean' or 'Fairly clean'
- 93 per cent were not bothered or threatened by other patients/visitors
- 90 per cent had confidence and trust in all or most of the doctors and nurses.

Areas of most unfavourable patient experience

- 85 per cent did not see or receive information in the Emergency Department about how to give feedback about the care they received
- 78 per cent were not told the expected wait time to be examined
- 72 per cent were not told why they had to wait
- 61 per cent were not given written information about their condition/treatment
- 50 per cent were not told, were only told to some extent, or did not need information, about side effects of new medications.

Table 11A.83 Queensland patient evaluation of hospital services

Areas of improved patient experience compared with 2011EDPES survey results

- Patient recall of triage process (70 per cent vs 67 per cent)
- Told expected wait time to be examined (22 per cent vs 15 per cent)
- Not ever worried about being forgotten (86 per cent vs 84 per cent)
- Sufficient information about condition or treatment provided (83 per cent vs 81 per cent)
- Sufficient privacy during examination or treatment (89 per cent vs 86 per cent)
- Assistance from staff when needed (73 per cent vs 69 per cent)
- All or some staff introduced themselves (94 per cent vs 92 per cent)
- Not bothered or threatened by patients/visitors (93 per cent vs 91 per cent)
- Given written/printed information about condition or treatment (39 per cent vs 35 per cent)
- Adequately advised when to resume usual activities (62 per cent vs 58 per cent)
- Danger signs of illness/treatment adequately explained (63 per cent vs 57 per cent)

Source: Queensland Government (unpublished).

Table 11A.84 **WA patient evaluation of hospital services****When the survey was conducted***Year(s):*

2013-2014

Time period (eg. July to Sept):

July 2013 to June 2014

Survey method (eg. telephone, mailout etc):

Computer Assisted Telephone Interview (CATI). Self report adults (16+ years) and parent/guardian reports on behalf of child (<16 years).

Respondents (eg. Admitted patients in public acute care hospitals):

Survey conducted on admitted patients (including the subsets long-stay and maternity) and emergency department patients. The scope was public patients in Western Australian hospitals. The groups reported on in this document include adult admitted, child admitted, adult long-stay and adult emergency department patients. Child emergency department patients and maternity patients are not reported as this would result in hospital level identification.

Sample size:

7157 adult and child standard admitted patients, 94 longstay admitted patients and 1491 adult and child ED patients.

Response rate:

The eligible contacted response rate for adult emergency department patients was 93.2 per cent, the eligible contacted response rate for child admitted patients was 94.0 per cent, the eligible contacted response rate for adult admitted patients was 91.6 per cent and the eligible contacted response rate for adult long stay patients was 93.0 per cent.

Size of underlying population:

For the admitted population the underlying population are those people aged between 0-74 years admitted to hospitals within scope for the PEHS program and who meet the same criteria as survey participants. For admitted patients this is ~300,000 admissions in 2013-2014. The criteria are public acute patients, residents of WA, not requiring an interpreter, discharged home, no psychiatric care days.

Table 11A.84 **WA patient evaluation of hospital services****Organisation conducting the survey:**

Edith Cowen University, Survey Research Centre

Organisation funding the survey:

WA Department of Health

How was information from the survey used to help improve public hospital quality:

Each participating hospital receives detailed information from the survey that is used to inform service improvement. Hospitals can also request a workshop to assist in the interpretation of the survey results so that the best use can be made of them. In WA, many hospitals use patient satisfaction as a performance indicator and the use made of the results is hospital-based. Some examples of how hospitals have used the survey to improve public hospital quality include the implementation of a process to record and cross reference for food allergies, employment of a Customer Liaison Officer to improve communication with patients on rights and services, storage of patient care plans in the wall desk of all rooms to increase patient involvement, improved discharge coordination procedures, and the introduction of brochures to inform patients on how the ED works.

Survey results:**Admitted Adults (0-34 Nights)**

Scales	Sample Size	Mean Scale Score	SE	Lower 95% CI	Upper 95% CI
Access Scale: Getting into hospital	4904	70.31	0.3	69.78	70.84
Consistency Scale: Continuity of care	4861	72.19	0.4	71.49	72.88
Informed Scale: Information and communication	4904	83.90	0.3	83.37	84.42
Involvement Scale: Involved in decisions about your care and treatment	4912	74.47	0.3	73.90	75.04
Needs Scale: Meeting personal needs	4907	90.54	0.2	90.09	91.00
Residential Scale: Residential aspects of the hospital	4896	63.38	0.3	62.81	63.95
Time and Care Scale: Time and attention paid to patient care	4909	87.92	0.2	87.51	88.33

TABLE 11A.84

Table 11A.84 **WA patient evaluation of hospital services**

Outcome Scale: Patient rated outcome of hospital stay	4914	86.69	0.3	86.19	87.19
Overall indicator of satisfaction weighted by ranked issues of importance	4912	79.60	0.2	79.19	80.00

Admitted Children (0-34 Nights)

Scales	Sample Size	Mean Scale Score	SE	Lower 95% CI	Upper 95% CI
Access Scale: Getting into hospital	2242	66.91	0.4	66.16	67.65
Consistency Scale: Continuity of care	2230	71.97	0.5	70.97	72.97
Informed Scale: Information and communication	2243	84.28	0.4	83.55	85.01
Involvement Scale: Involved in decisions about your care and treatment	2243	75.86	0.4	75.11	76.60
Needs Scale: Meeting personal needs	2241	90.87	0.3	90.23	91.52
Residential Scale: Residential aspects of the hospital	2238	61.79	0.4	60.94	62.65
Time and Care Scale: Time and attention paid to patient care	2243	87.09	0.3	86.47	87.70
Outcome Scale: Patient rated outcome of hospital stay	2243	89.34	0.3	88.67	90.02
Overall indicator of satisfaction weighted by ranked issues of importance	2243	79.58	0.3	79.00	80.15

Admitted Adults (Long Stay 35+ Nights)

Scales	Sample Size	Mean Scale Score	SE	Lower 95% CI	Upper 95% CI
Access Scale: Getting into hospital	94	73.19	2.4	68.52	77.86
Consistency Scale: Continuity of care	94	72.75	2.6	67.64	77.87
Informed Scale: Information and communication	94	82.13	2.1	77.98	86.27
Involvement Scale: Involved in decisions about your care and treatment	94	71.75	2.1	67.52	75.98
Needs Scale: Meeting personal needs	94	84.94	2.1	80.69	89.18
Residential Scale: Residential aspects of the hospital	93	59.19	2.3	54.63	63.74
Time and Care Scale: Time and attention paid to patient care	94	87.84	1.6	84.73	90.94

TABLE 11A.84

Table 11A.84 **WA patient evaluation of hospital services**

Outcome Scale: Patient rated outcome of hospital stay	94	78.85	2.3	74.24	83.47
Overall indicator of satisfaction weighted by ranked issues of importance	94	78.36	1.7	75.01	81.72

Emergency Department Adults

Scales	Sample Size	Mean Scale Score	SE	Lower 95% CI	Upper 95% CI
Access Scale: Getting into hospital	1374	69.83	0.5	68.91	70.75
Consistency Scale: Continuity of care	1369	77.79	0.6	76.60	78.98
Informed Scale: Information and communication	1374	83.75	0.5	82.67	84.83
Involvement Scale: Involved in decisions about your care and treatment	1373	61.27	0.8	59.75	62.79
Needs Scale: Meeting personal needs	1375	83.16	0.4	82.35	83.97
Residential Scale: Residential aspects of the hospital	1367	61.79	0.6	60.55	63.04
Time and Care Scale: Time and attention paid to patient care	1375	88.57	0.5	87.58	89.56
Outcome Scale: Patient rated outcome of hospital stay	1375	85.85	0.6	84.70	87.00
Overall indicator of satisfaction weighted by ranked issues of importance	1375	77.37	0.4	76.59	78.16

Source: WA Government (unpublished).

Table 11A.85 **SA patient evaluation of hospital services**

When the survey was conducted*Year(s):*

2013

Time period (eg. July to Sept):

January to December 2013

Survey method (eg. telephone, mailout etc):

Computer Assisted Telephone Interviewing (CATI) of a random sample.

Respondents (eg. Admitted patients in public acute care hospitals):

South Australian adults aged 16 years or more who have been in hospital care at least overnight in a metropolitan or country hospital.

Sample size:

2427 consumers were interviewed.

Response rate:

The response rate was 75 per cent

Size of underlying population:

A sample of 3630 was drawn from all consumers who met the South Australian Consumer Experience Surveillance System (SACESS) eligibility criteria.

Organisation conducting the survey:

Population Research and Outcomes Studies (PROS), The University of Adelaide

Organisation funding the survey:

SA Health

Table 11A.85 SA patient evaluation of hospital services

How was information from the survey used to help improve public hospital quality:

The first Measuring Consumer Experience SA Public Hospital Inpatient Annual Report for 2010-11 was released in 2012. The second Measuring Consumer Experience Report 2011-12 was released in 2013, with the third report for 2013, released in 2014. Six monthly reports have been established to report by Local Health Networks and Hospitals. Ongoing monitoring consumers' experiences requires the LHNs to review and implement strategies to improve their results to 85 by 2014-15. A statewide Measuring Consumer Experience Strategic Action Plan is to be developed in 2014-15.

Survey results:

Table 11A.85 SA patient evaluation of hospital services

Questions about each domain were coded to generate scores ranging from zero (a negative response) to 100 (a positive response). The average of the responses to items from domains was used to derive a mean score. The results show the average score for core domains of care relating to consumer experiences of overnight care at a South Australian metropolitan or country hospital.

- 74.2 for involvement in care and treatment (KPI)
- 78.7 for consistent and co-ordination of care
- 92.0 for treated with respect and dignity
- 79.8 for involved in decision making
- 88.2 for doctors
- 89.7 for nursing
- 90.5 for cleanliness
- 90.1 for pain control
- 94.7 for privacy
- 68.5 for food
- 68.0 for discharge information

The lowest mean score (68.0) was recorded for the domain discharge information and the highest (94.7) for the domain privacy.

A score of 85 or less is considered to represent an area where improvement is required. SA Health performed above the benchmark score of 85 for six of these domains. Scores for the four domains 'privacy', 'treated with respect and dignity', 'cleanliness' and pain control' were above 90.

Four domains of care are below the SA Health benchmark of 85. These were consistent and coordination of care, involvement in decision making, food and discharge information. Patients generally gave hospital food a low rating, and felt that there was not enough help from staff when they needed assistance to eat their meals. Lack of written information about what they should or should not do after leaving hospital was a major concern among the surveyed patients. When compared to the 2012 (July to December) mean scores, only privacy scored significantly higher ($p < 0.05$).

The domain 'involvement in care and treatment' is a key performance indicator (KPI) for health services. Results from 2013 have been compared with the previous reporting period in 2011-12 to allow monitoring of performance over time. The results from questions in one domain 'involvement in care and treatment' were able to be compared with results from previous survey in 2008 as a KPI.

Source: SA Government (unpublished).

Table 11A.86 Tasmanian patient evaluation of hospital services

When the survey was conducted*Year(s):*

na

Time period (eg. July to Sept):

na

Survey method (eg. telephone, mailout etc):

na

Respondents (eg. Admitted patients in public acute care hospitals):

na

Sample size:

na

Response rate:

na

Size of underlying population:

na

Organisation conducting the survey:

na

Organisation funding the survey:

na

Table 11A.86 **Tasmanian patient evaluation of hospital services**

How was information from the survey used to help improve public hospital quality:

na

Survey results:

na

na Not available.

Source: Tasmanian Government (unpublished).

Table 11A.87 ACT patient evaluation of hospital services

When the survey was conducted

Year(s):

First hospital, 2013; Second hospital, 2014

Time period (eg. July to Sept):

First hospital, January to June; Second hospital, May/June

Survey method (eg. telephone, mailout etc):

Mailout survey in both hospitals

Respondents (eg. Admitted patients in public acute care hospitals):

Cross section of consumers; in second hospital, admitted inpatients in acute and sub-acute care.

Sample size:

3270 in first hospital; 526 in second hospital.

Response rate:

1370 received equating to a 36.8 per cent response rate in first hospital; 32.1 per cent response rate in second hospital (169 responses)

Size of underlying population:

617 071 (this is the ACT Capital Region population as of June 2012; includes ACT and surrounding areas of NSW).

Organisation conducting the survey:

Ultrafeedback and Press Ganey respectively.

Organisation funding the survey:

Calvary Health Care ACT and ACT Health

Table 11A.87 ACT patient evaluation of hospital services

How was information from the survey used to help improve public hospital quality:

In the first hospital, this is currently under consideration by the Executives; In second hospital, the survey provided patient feedback against 90 survey questions.

Survey results:

Overall satisfaction with first hospital was high; 4.36 out of a possible 5. 84.7 per cent were 'satisfied' or 'very satisfied' with 'all aspects of their experience with the hospital/health service'. 82.9 per cent indicated that they were helped 'quite a bit' or 'great deal' by their stay. Top 10 performing items were: courtesy of staff (4.21 out of 5), being treated with respect (4.19), respect for privacy (4.14), helpfulness of staff (4.13), personal safety at the hospital (4.09), how well cultural, social or religious needs were respected (4.09), helpfulness of staff in general (4.08), confidence in treatment staff (4.05), compassion shown by staff in general (4.04) and cleanliness of facilities (3.97). Top five priorities to improve were identified as: level of involvement in planning care in hospital (3.33 out of 5), way hospital routines were explained e.g. meal times, doctor visits, visiting hours (3.06), level of involvement in planning care after leaving hospital (3.49), restfulness (peace and quite) of the hospital (2.97) and time given to plan your return home (3.37).

At the second hospital, the overall mean score was 80.6, which was in the 50th percentile group of public hospitals of similar bed capacity. The survey identified a number of priority issues for attention with each clinical area devising a formal plan to address the priority issues.

Source: ACT Government (unpublished).

Table 11A.88 NT patient evaluation of hospital services

When the survey was conducted*Year(s):*

No valid survey results available

Time period (eg. July to Sept):

na

Survey method (eg. telephone, mailout etc):

na

Respondents (eg. Admitted patients in public acute care hospitals):

na

Sample size:

na

Response rate:

na

Size of underlying population:

na

Organisation conducting the survey:

na

Organisation funding the survey:

na

Table 11A.88 **NT patient evaluation of hospital services**

How was information from the survey used to help improve public hospital quality:

na

Survey results:

na

na Not available.

Source: NT Government (unpublished).

TABLE 11A.89

Table 11A.89 **NSW selected sentinel events (number) (a)**

	2008-09	2009-10	2010-11	2011-12	2012-13
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	6	3	1	1	–
Suicide of a patient in an inpatient unit.	2	18	12	20	15
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	16	16	10	14	13
Intravascular gas embolism resulting in death or neurological damage.	2	–	1	–	2
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	1	1	–	1	1
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	1	4	2	1	2
Maternal death associated with pregnancy, birth or the puerperium. (b)	4	7	6	8	5
Infant discharged to the wrong family.	–	–	–	–	–
Total	32	49	32	45	38

(a) Sentinel events definitions can vary across jurisdictions.

(b) Data are for calander years 2008, 2009, 2010, 2011 and 2012 rather than financial years.

– Nil or rounded to zero.

TABLE 11A.90

Table 11A.90 **Victoria selected sentinel events (number) (a)**

	2008-09	2009-10	2010-11	2011-12	2012-13
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	–	–	1	1	–
Suicide of a patient in an inpatient unit.	7	6	9	8	9
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	3	9	5	7	6
Intravascular gas embolism resulting in death or neurological damage.	–	1	1	–	–
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	1	2	1	–	–
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	1	1	2	4	1
Maternal death or serious morbidity associated with labour or delivery (b).	3	2	2	–	1
Infant discharged to the wrong family.	–	–	–	–	–
Total	15	21	21	20	17

(a) Sentinel events definitions can vary across jurisdictions.

(b) Victoria has supplied data using the sentinel event definition applicable to the data collection period. Most other jurisdictions have retrospectively applied the amended definition to 2012-13 data.

– Nil or rounded to zero.

Source: Victorian government (unpublished).

TABLE 11A.91

Table 11A.91 **Queensland selected sentinel events (number) (a)**

	2008-09	2009-10	2010-11	2011-12	2012-13
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	2	1	–	1	–
Suicide of a patient in an inpatient unit.	2	4	1	1	2
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	1	1	5	5	4
Intravascular gas embolism resulting in death or neurological damage.	–	–	–	–	–
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	–	–	–	–	–
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	6	2	4	–	–
Maternal death associated with pregnancy, birth or the puerperium.	–	1	–	1	1
Infant discharged to the wrong family.	–	–	–	–	–
Total	11	9	10	8	7

(a) Sentinel events definitions can vary across jurisdictions.

– Nil or rounded to zero.

Source: Queensland government (unpublished).

TABLE 11A.92

Table 11A.92 **WA selected sentinel events (number) (a)**

	2008-09	2009-10	2010-11	2011-12	2012-13
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	–	1	1	1	1
Suicide of a patient in an inpatient unit.	3	3	5	5	7
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	3	1	1	3	3
Intravascular gas embolism resulting in death or neurological damage.	–	–	–	–	–
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	2	–	–	–	–
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	2	1	2	–	3
Maternal death or serious morbidity associated with labour or delivery (b).	1	1	3	2	1
Infant discharged to the wrong family.	–	–	–	–	–
Total	11	7	12	11	15

(a) Sentinel events definitions can vary across jurisdictions.

(b) WA has supplied data using the sentinel event definition applicable to the data collection period. Most other jurisdictions have retrospectively applied the amended definition to 2012-13 data.

– Nil or rounded to zero.

Table 11A.93 **SA selected sentinel events (number) (a)**

	2008-09	2009-10	2010-11	2011-12	2012-13
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	–	–	–	–	–
Suicide of a patient in an inpatient unit.	5	5	2	1	1
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	7	3	3	5	5
Intravascular gas embolism resulting in death or neurological damage.	–	–	–	–	–
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	–	–	–	–	1
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	–	1	1	1	–
Maternal death associated with pregnancy, birth or the puerperium.	1	2	–	2	2
Infant discharged to the wrong family.	–	–	–	–	–
Total	13	11	6	9	9

(a) Sentinel events definitions can vary across jurisdictions.

– Nil or rounded to zero.

Source: SA government (unpublished).

Table 11A.94 **Tasmania selected sentinel events (number) (a)**

	2008-09	2009-10	2010-11	2011-12	2012-13
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	–	–	–	–	–
Suicide of a patient in an inpatient unit.	–	–	–	–	–
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	–	–	–	1	–
Intravascular gas embolism resulting in death or neurological damage.	–	–	–	–	–
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	–	–	–	–	–
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	–	–	–	–	–
Maternal death associated with pregnancy, birth or the puerperium.	–	–	–	–	–
Infant discharged to the wrong family.	–	–	–	–	–
Total	–	–	–	1	–

(a) Sentinel events definitions can vary across jurisdictions.

– Nil or rounded to zero.

Source: Tasmanian government (unpublished).

TABLE 11A.95

Table 11A.95 **ACT selected sentinel events (number) (a)**

	2008-09	2009-10	2010-11	2011-12	2012-13
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	–	np	np	np	np
Suicide of a patient in an inpatient unit.	–	np	np	np	np
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	–	np	np	np	np
Intravascular gas embolism resulting in death or neurological damage.	–	np	np	np	np
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	–	np	np	np	np
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	–	np	np	np	np
Maternal death associated with pregnancy, birth or the puerperium.	–	np	np	np	np
Infant discharged to the wrong family.	–	np	np	np	np
Total	–	7	2	3	3

(a) Sentinel events definitions can vary across jurisdictions.

– Nil or rounded to zero. **np** Not published.

Source: ACT government (unpublished).

Table 11A.96 **NT selected sentinel events (number) (a)**

	2008-09	2009-10	2010-11	2011-12	2012-13
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	–	–	–	–	–
Suicide of a patient in an inpatient unit.	–	–	–	–	1
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	–	–	2	–	–
Intravascular gas embolism resulting in death or neurological damage.	–	–	–	–	–
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	–	–	–	–	–
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	–	–	–	–	–
Maternal death or serious morbidity associated with labour or delivery (b).	–	1	–	–	–
Infant discharged to the wrong family.	–	–	–	–	–
Total	–	1	2	–	1

(a) Sentinel events definitions can vary across jurisdictions.

(b) The NT has supplied data using the sentinel event definition applicable to the data collection period. Most other jurisdictions have retrospectively applied the amended definition to 2012-13 data.

– Nil or rounded to zero.

Source: NT government (unpublished).

TABLE 11A.97

Table 11A.97 **Australia selected sentinel events (number) (a)**

	2008-09	2009-10	2010-11	2011-12	2012-13
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	8	5	3	4	1
Suicide of a patient in an inpatient unit.	19	36	29	35	35
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	30	30	26	35	31
Intravascular gas embolism resulting in death or neurological damage.	2	1	2	–	2
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	4	3	1	1	2
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	10	9	11	6	6
Maternal death associated with pregnancy, birth or the puerperium.	9	14	11	13	10
Infant discharged to the wrong family.	–	–	–	–	–
Total (b)	82	105	85	97	90

(a) Sentinel events definitions can vary across jurisdictions.

(b) The total includes sentinel events for the ACT which are not reported in the 8 sub categories of sentinel events due to confidentiality issues.

– Nil or rounded to zero.

Source: State and Territory governments (unpublished).

TABLE 11A.98

Table 11A.98 **Separations, same day separations, patient days, average length of stay and costs for MDC 14 and MDC 15, public hospitals, Australia, 2012-13**

	Unit	AR-DRG		Total (all acute separations in public hospitals) (a)
		Pregnancy, childbirth and the puerperium (MDC14)	Newborns and other neonates (MDC15)	
Separations	no.	365 184	85 850	5 334 793
Separations per 10 000 population (b)	no.	159.4	37.5	2 329.3
Same day separations	no.	87 852	5 956	2 751 061
Patient days	no.	898 667	574 766	15 418 908
Patient days per 10 000 population	no.	392.4	251.0	6 732.2
Average length of stay (ALOS)	days	2.5	6.7	2.9
ALOS (days) excluding same day	days	2.9	7.1	4.9
Cost by volume (c)	\$'000	1 758 450	825 819	24 312 817
Cost by proportion	%	7.2	3.4	100.0

(a) Includes separations for which the type of episode of care was reported as 'acute', or 'newborn with qualified patient days', or was not reported.

(b) Crude rate based on the Australian population as at 31 December 2012.

(c) Based on AR-DRG version 6.0x estimated public cost estimates.

ALOS—average length of stay, MDC—Major Diagnostic Category, DRG—Diagnosis Related Group.

Source: AIHW (unpublished), National Hospital Morbidity Database.

TABLE 11A.99

Table 11A.99 Separations by major diagnostic category (AR-DRGs) version 6.0x, public hospitals, 2012-13

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Separations										
Pregnancy, childbirth and puerperium	no.	116 954	83 684	81 527	35 631	27 170	5 904	6 704	7 610	365 184
Newborns and other neonates	no.	40 220	15 549	13 406	7 254	5 157	1 724	1 519	1 021	85 850
Total acute (a) separations	no.	1 651 230	1 388 457	996 021	589 559	398 239	103 642	90 238	117 407	5 334 793
Proportion of all separations										
Pregnancy, childbirth and puerperium	%	7.1	6.0	8.2	6.0	6.8	5.7	7.4	6.5	6.8
Newborns and other neonates	%	2.4	1.1	1.3	1.2	1.3	1.7	1.7	0.9	1.6
Separations per 1000 population										
Pregnancy, childbirth and puerperium	no.	15.9	14.7	17.7	14.4	16.3	11.5	17.7	32.1	15.9
Newborns and other neonates	no.	5.5	2.7	2.9	2.9	3.1	3.4	4.0	4.3	3.7

(a) Includes separations for which the type of episode of care was reported as 'acute', or 'newborn with qualified patient days', or was not reported.

Source: AIHW (unpublished), National Hospital Morbidity Database; ABS (unpublished), Australian Demographic Statistics, December Quarter 2012, Cat. no. 3101.0; table AA.2.

TABLE 11A.100

Table 11A.100 **10 Diagnosis related groups with highest cost, by volume, public hospitals, Australia, 2012-13 (a)**

<i>AR-DRG</i>	<i>Separations</i>	<i>Same day separations</i>	<i>Same day separations</i>	<i>Separations per 10 000 population (b)</i>	<i>Patient days</i>	<i>Patient days per 10 000 population (b)</i>	<i>ALOS (days)</i>	<i>ALOS (days), excluding same day</i>	<i>Cost by volume</i>
	no.	no.	%	per 10 000	no.	per 10 000	no.	no.	\$'000
O60A Vaginal Delivery W Catastrophic or Severe CC	18 688	209	1.1	8.2	74 242	32.7	4.0	4.0	140 384
O60B Vaginal Delivery W/O Catastrophic or Severe CC	107 604	4 550	4.2	47.4	257 714	113.5	2.0	2.5	524 247
O60C Vaginal Delivery Single uncomplicated	26 637	3 809	14.3	11.7	45 677	20.1	2.0	1.8	110 970
A06B Trach W Vent >95 hours W/O Cat CC or Trach/Vent >95 hours W Cat CC	7 019	9	0.1	3.1	176 677	77.8	25.0	25.2	611 186
L61Z Haemodialysis	1 033 444	1 030 272	99.7	455.1	1 033 784	455.2	1.0	1.1	609 732
U61A Schizophrenia Disorders W MHLS	15 470	–	0.0	6.8	438 675	193.2	28.0	28.4	345 894
U61B Schizophrenia Disorders W/O MHLS	12 561	–	0.0	5.5	229 982	101.3	18.0	18.3	173 292
A06A Tracheostomy W Ventilation >95 hours W Catastrophic CC	2 067	–	0.0	0.9	103 558	45.6	50.0	50.1	393 269
O01A Caesarean Delivery W Catastrophic CC	4 805	48	1.0	2.1	43 285	19.1	9.0	9.1	83 434
O01B Caesarean Delivery W Severe CC	12 454	51	0.4	5.5	62 110	27.3	5.0	5.0	142 935
O01C Caesarean Delivery W/O Catastrophic or Severe CC	46 667	115	0.2	20.5	171 283	75.4	4.0	3.7	437 456
U63A Major Affective Disorders, Age >69 or W Catastrophic or Severe CC	3 164	0	0.0	1.4	94 928	41.8	30.0	30.0	79 524
U63B Major Affective Disorders, Age<70 or W/O Catastrophic or Severe CC	18 326	0	0.0	8.1	264 741	116.6	14.0	14.4	249 857

Table 11A.100 **10 Diagnosis related groups with highest cost, by volume, public hospitals, Australia, 2012-13 (a)**

<i>AR-DRG</i>	<i>Separations</i>	<i>Same day separations</i>	<i>Same day separations</i>	<i>Separations per 10 000 population (b)</i>	<i>Patient days</i>	<i>Patient days per 10 000 population (b)</i>	<i>ALOS (days)</i>	<i>ALOS (days), excluding same day</i>	<i>Cost by volume</i>
E65B Chronic Obstructive Airways Disease W/O Catastrophic CC	41 462	4 110	9.9	18.3	178 694	78.7	4.0	4.7	218 546
R63Z Chemotherapy	136 638	136 622	100.0	60.2	136 647	60.2	1.0	1.6	201 268
I03B Hip Replacement W/O Catastrophic CC	10 588	15	0.1	4.7	62 503	27.5	6.0	5.9	207 091

(a) Based on AR-DRG version 6.0x estimated public cost estimates.

(b) Crude rate based on Australian population as at 31 December 2012.

ALOS = Average Length of Stay. CC = complication or comorbidity. W = with. W/O = without.

– Nil or rounded to zero.

Source: AIHW (unpublished), National Hospital Morbidity Database.

TABLE 11A.101

Table 11A.101 **Mean age of mothers at time of giving birth, public hospitals**

	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA (a)</i>	<i>SA (a)</i>	<i>Tas</i>	<i>ACT (a,b)</i>	<i>NT</i>
2004								
First birth	27.7	28.1	25.3	25.9	26.8	25.2	27.6	23.9
Second birth	29.9	30.3	27.9	28.4	29.2	27.5	30.4	26.3
Third birth	31.3	31.8	29.6	29.7	30.8	28.8	31.2	27.7
All births	29.5	29.9	27.7	28.0	28.8	27.8	29.5	26.4
2005								
First birth	27.8	27.7	25.5	25.9	26.6	25.1	27.6	24.2
Second birth	29.9	29.9	28.0	28.6	29.4	27.3	29.7	26.3
Third birth	31.4	31.4	29.5	29.9	31.1	29.4	31.0	28.0
All births	29.6	29.5	27.8	28.1	28.9	27.2	29.3	26.5
2006								
First birth	27.1	27.7	25.5	26.0	26.8	24.8	27.7	23.8
Second birth	30.4	29.9	28.1	28.5	29.4	27.7	30.1	26.3
Third birth	31.6	31.5	29.6	29.8	31.0	29.6	31.5	28.2
All births	29.3	29.5	27.9	28.1	29.0	27.2	29.6	26.5
2007								
First birth	28.1	27.8	25.6	26.0	26.9	26.0	27.7	24.1
Second birth	30.2	30.0	28.0	28.5	29.4	28.5	30.2	26.4
Third birth	31.4	31.5	29.7	30.0	31.1	29.9	31.4	27.8
All births	29.1	29.6	27.9	28.1	29.0	28.1	29.6	26.6
2008								
First birth	27.9	27.7	25.5	26.0	26.9	27.0	28.0	24.5
Second birth	30.2	30.0	28.1	28.6	29.5	29.6	30.2	26.4
Third birth	31.5	31.5	29.7	30.1	31.0	31.7	31.9	28.5
All births	29.8	29.6	27.9	28.2	29.1	29.2	29.8	26.8
2009								
First birth	27.9	28.2	25.6	26.2	27.0	27.9	28.0	24.2
Second birth	30.4	30.6	28.3	28.6	29.6	30.4	30.5	26.8
Third birth	31.6	32.0	29.8	30.1	31.1	31.6	31.4	28.6
All births	29.9	30.1	28.0	28.3	29.1	29.9	29.8	26.9
2010								
First birth	28.2	28.4	25.6	26.3	27.1	28.2	28.0	24.6
Second birth	30.3	30.8	28.2	28.8	29.6	30.3	30.4	27.1
Third birth	31.6	32.1	29.8	30.3	31.3	31.6	31.9	28.9
All births	29.9	30.2	28.0	28.4	29.2	29.9	29.9	27.0
2011								
First birth	28.2	28.4	25.9	26.5	27.3	28.2	28.4	24.7
Second birth	30.4	30.7	28.2	28.8	29.8	30.4	30.6	27.2
Third birth	31.6	32.2	30.1	30.4	31.3	31.6	32.2	28.7
All births	29.9	30.2	28.1	28.5	29.3	29.9	30.0	27.1
2012								

Table 11A.101 **Mean age of mothers at time of giving birth, public hospitals**

	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA (a)</i>	<i>SA (a)</i>	<i>Tas</i>	<i>ACT (a,b)</i>	<i>NT</i>
First birth	28.3	28.6	26.0	26.6	27.3	27.8	28.3	24.8
Second birth	30.4	30.9	28.4	28.9	29.8	30.3	30.7	27.4
Third birth	31.8	32.2	29.9	30.3	31.3	31.5	31.8	28.8
All births	30.0	30.3	28.2	28.5	29.3	29.5	29.9	27.2
2013								
First birth	28.6	28.8	26.1	26.9	27.6	na	28.7	25.2
Second birth	30.5	30.9	28.4	29.1	30.0	na	30.8	27.9
Third birth	31.7	32.2	29.9	30.4	31.2	na	32.4	29.7
All births	30.1	30.4	28.2	28.5	29.4	na	30.3	27.6

(a) Data for 2013 are preliminary.

(b) Between 12 and 15 per cent of births each year in the ACT are to non-residents of the ACT.

na Not available.

Source: State and Territory governments (unpublished).

TABLE 11A.102

Table 11A.102 **Intervention rates for selected primiparae, 2013 (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA (b)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (c)</i>	<i>NT</i>	<i>Aust (d)</i>
Proportion of inductions for selected primiparae										
Public hospitals										
Selected primiparae who gave birth	no.	21 300	17 681	11 965	5 728	4 511	na	1 554	846	63 585
Selected primiparae inductions	no.	8 389	6 125	3 579	2 057	1 878	na	460	302	22 790
Rate	%	39.4	34.6	29.9	35.9	41.6	na	29.6	35.7	35.8
Private hospitals										
Selected primiparae who gave birth	no.	6 832	na	5 608	3 928	1 413	na	313	na	18 094
Selected primiparae inductions	no.	2 399	na	1 907	1 622	604	na	123	na	6 655
Rate	%	35.1	na	34.0	41.3	42.7	na	39.3	na	36.8
Proportion of caesareans for selected primiparae										
Public hospitals										
Selected primiparae who gave birth	no.	21 300	17 681	11 965	5 728	4 511	na	1 554	846	63 585
Selected primiparae caesareans	no.	4 945	4 394	2 732	1 418	1 233	na	378	257	15 357
Rate	%	23.2	24.9	22.8	24.8	27.3	na	24.3	30.4	24.2
Private hospitals										
Selected primiparae who gave birth	no.	6 832	na	5 608	3 928	1 413	na	313	na	18 094
Selected primiparae caesareans	no.	2 478	na	2 253	1 360	480	na	109	na	6 680
Rate	%	36.3	na	40.2	34.6	34.0	na	34.8	na	36.9

(a) Selected primiparae: mothers with no previous deliveries, 20–34 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

(b) Data for Victoria and WA are preliminary.

(c) Between 12 and 15 per cent of births each year in the ACT are to non-residents of the ACT.

(d) Totals for Australia include only jurisdictions for which data are available.

na Not available.

Source: State and Territory governments.

Table 11A.103 Intervention rates for selected primiparae, NSW (a)

	<i>Unit</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	na	na	na	19 547	19 600	20 106	20 574	21 374	22 045	21 300
Selected primiparae inductions	no.	na	na	na	6 320	6 398	6 757	7 013	7 502	7 983	8 389
Rate	%	na	na	na	32.3	32.6	33.6	34.1	35.1	36.2	39.4
Private hospitals											
Selected primiparae who gave birth	no.	na	na	na	6 976	6 986	7 290	7 115	7 153	7 745	6 832
Selected primiparae inductions	no.	na	na	na	2 384	2 377	2 500	2 459	2 473	2 617	2 399
Rate	%	na	na	na	34.2	34.0	34.3	34.6	34.6	33.8	35.1
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	na	na	na	19 547	19 600	20 106	20 574	21 374	22 045	21 300
Selected primiparae caesareans	no.	na	na	na	4 304	4 359	4 544	4 658	4 903	4 801	4 945
Rate	%	na	na	na	22.0	22.2	22.6	22.6	22.9	21.8	23.2
Private hospitals											
Selected primiparae who gave birth	no.	na	na	na	6 976	6 986	7 290	7 115	7 153	7 745	6 832
Selected primiparae caesareans	no.	na	na	na	2 275	2 276	2 483	2 431	2 525	2 883	2 478
Rate	%	na	na	na	32.6	32.6	34.1	34.2	35.3	37.2	36.3

(a) Selected primiparae: mothers with no previous deliveries, 20–34 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

Source: NSW Government (unpublished).

TABLE 11A.104

Table 11A.104 **Intervention rates for selected primiparae, Victoria (a)**

	<i>Unit</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	12 419	13 041	13 833	14 571	14 309	14 748	15 671	16 192	17 327	17 681
Selected primiparae inductions	no.	4 023	4 002	4 243	4 427	4 261	4 258	4 692	5 078	5 606	6 125
Rate	%	32.4	30.7	30.7	30.4	29.8	28.9	29.9	31.4	32.4	34.6
Private hospitals											
Selected primiparae who gave birth	no.	5 709	5 706	5 793	5 772	5 989	5 845	5 757	5 832	6 208	na
Selected primiparae inductions	no.	1 984	2 021	2 047	2 060	2 052	1 891	1 935	2 017	2 098	na
Rate	%	34.8	35.4	35.3	35.7	34.3	32.4	33.6	34.6	33.8	na
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	12 419	13 041	13 833	14 571	14 309	14 748	15 671	16 192	17 327	17 681
Selected primiparae caesareans	no.	2 815	3 009	3 186	3 267	3 230	3 400	3 669	3 925	4 172	4 394
Rate	%	22.7	23.1	23.0	22.4	22.6	23.1	23.4	24.2	24.1	24.9
Private hospitals											
Selected primiparae who gave birth	no.	5 709	5 706	5 793	5 772	5 989	5 845	5 757	5 832	6 208	na
Selected primiparae caesareans	no.	1 676	1 719	1 691	1 786	1 790	1 830	1 895	1 940	2 091	na
Rate	%	29.4	30.1	29.2	30.9	29.9	31.3	32.9	33.3	33.7	na

(a) Selected primiparae: mothers with no previous deliveries, 20–34 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

Source: Victorian Government (unpublished).

TABLE 11A.105

Table 11A.105 **Intervention rates for selected primiparae, Queensland (a)**

	<i>Unit</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	8 735	9 405	9 620	10 316	10 524	10 834	11 187	11 443	11 815	11 965
Selected primiparae inductions	no.	2 512	2 631	2 839	2 954	2 964	2 943	3 026	3 236	3 401	3 579
Rate	%	28.8	28.0	29.5	28.6	28.2	27.2	27.0	28.3	28.8	29.9
Private hospitals											
Selected primiparae who gave birth	no.	4 752	5 050	5 066	5 248	5 394	5 397	5 367	5 317	5 405	5 608
Selected primiparae inductions	no.	1 557	1 710	1 636	1 648	1 830	1 734	1 712	1 804	1 775	1 907
Rate	%	32.8	33.9	32.3	31.4	33.9	32.1	31.9	33.9	32.8	34.0
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	8 735	9 405	9 620	10 316	10 524	10 834	11 187	11 443	11 815	11 965
Selected primiparae caesareans	no.	1 882	2 153	2 289	2 405	2 548	2 587	2 476	2 737	2 796	2 732
Rate	%	21.5	22.9	23.8	23.3	24.2	23.9	22.1	23.9	23.7	22.8
Private hospitals											
Selected primiparae who gave birth	no.	4 752	5 050	5 066	5 248	5 394	5 397	5 367	5 317	5 405	5 608
Selected primiparae caesareans	no.	1 795	2 023	2 083	2 172	2 116	2 100	2 096	2 085	2 175	2 253
Rate	%	37.8	40.1	41.1	41.4	39.2	38.9	39.1	39.2	40.2	40.2

(a) Selected primiparae: mothers with no previous deliveries, 20–34 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

Source: Queensland Government (unpublished).

Table 11A.106 Intervention rates for selected primiparae, WA (a)

	<i>Unit</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013 (b)</i>
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	3 887	3 986	4 470	4 664	4 578	4 759	4 894	5 181	5 571	5 728
Selected primiparae inductions	no.	1 239	1 371	1 434	1 505	1 379	1 539	1 599	1 768	2 000	2 057
Rate	%	31.9	34.4	32.1	32.3	30.1	32.3	32.7	34.1	35.9	35.9
Private hospitals											
Selected primiparae who gave birth	no.	3 121	3 263	3 248	3 562	3 630	3 883	3 889	3 868	4 246	3 928
Selected primiparae inductions	no.	1 211	1 255	1 215	1 387	1 378	1 494	1 496	1 532	1 689	1 622
Rate	%	38.8	38.5	37.4	38.9	38.0	38.5	38.5	39.6	39.8	41.3
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	3 887	3 986	4 470	4 664	4 578	4 759	4 894	5 181	5 571	5 728
Selected primiparae caesareans	no.	880	938	990	1 067	1 067	1 190	1 217	1 351	1 424	1 418
Rate	%	22.6	23.5	22.1	22.9	23.3	25.0	24.9	26.1	25.6	24.8
Private hospitals											
Selected primiparae who gave birth	no.	3 121	3 263	3 248	3 562	3 630	3 883	3 889	3 868	4 246	3 928
Selected primiparae caesareans	no.	1 209	1 289	1 192	1 202	1 201	1 389	1 376	1 350	1 484	1 360
Rate	%	38.7	39.5	36.7	33.7	33.1	35.8	35.4	34.9	35.0	34.6

(a) Selected primiparae: mothers with no previous deliveries, 20–34 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

(b) Data for 2012 are preliminary.

TABLE 11A.107

Table 11A.107 **Intervention rates for selected primiparae, SA (a), (b)**

	<i>Unit</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	3 433	3 544	3 536	3 855	3 930	3 963	4 133	4 365	4 519	4 511
Selected primiparae inductions	no.	1 123	1 221	1 280	1 401	1 366	1 448	1 583	1 751	1 778	1 878
Rate	%	32.7	34.5	36.2	36.3	34.8	36.5	38.3	40.1	39.3	41.6
Private hospitals											
Selected primiparae who gave birth	no.	1 581	1 514	1 588	1 647	1 580	1 579	1 555	1 511	1 448	1 413
Selected primiparae inductions	no.	588	607	605	692	603	653	631	633	603	604
Rate	%	37.2	40.1	38.1	42.0	38.2	41.4	40.6	41.9	41.6	42.7
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	3 433	3 544	3 536	3 855	3 930	3 963	4 133	4 365	4 519	4 511
Selected primiparae caesareans	no.	837	928	917	1 026	964	1 018	1 091	1 170	1 215	1 233
Rate	%	24.4	26.2	25.9	26.6	24.5	25.7	26.4	26.8	26.9	27.3
Private hospitals											
Selected primiparae who gave birth	no.	1 581	1 514	1 588	1 647	1 580	1 579	1 555	1 511	1 448	1 413
Selected primiparae caesareans	no.	604	592	601	600	532	498	508	529	476	480
Rate	%	38.2	39.1	37.8	36.4	33.7	31.5	32.7	35.0	32.9	34.0

(a) Selected primiparae: mothers with no previous deliveries, 20–34 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

(b) Data for 2012 are preliminary.

Source: SA Government (unpublished).

Table 11A.108 **Intervention rates for selected primiparae, Tasmania (a)**

	<i>Unit</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	na									
Selected primiparae inductions	no.	na									
Rate	%	na									
Private hospitals											
Selected primiparae who gave birth	no.	na									
Selected primiparae inductions	no.	na									
Rate	%	na									
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	na									
Selected primiparae caesareans	no.	na									
Rate	%	na									
Private hospitals											
Selected primiparae who gave birth	no.	na									
Selected primiparae caesareans	no.	na									
Rate	%	na									

(a) Selected primiparae: mothers with no previous deliveries, 20–34 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

na Not available.

Source: Tasmanian Government (unpublished).

Table 11A.109 Intervention rates for selected primiparae, ACT (a), (b), (c)

	Unit	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013 (c)
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	887	865	948	1 085	1 076	1 135	1 215	1 257	1 431	1 554
Selected primiparae inductions	no.	162	193	190	215	222	278	291	339	405	460
Rate	%	18.3	22.3	20.0	19.8	20.6	24.5	24.0	27.0	28.3	29.6
Private hospitals											
Selected primiparae who gave birth	no.	550	582	613	521	564	574	471	435	367	313
Selected primiparae inductions	no.	141	169	185	160	195	160	137	139	115	123
Rate	%	25.6	29.0	30.2	30.7	34.6	27.9	29.1	32.0	31.3	39.3
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	887	865	948	1 085	1 076	1 135	1 215	1 257	1 431	1 554
Selected primiparae caesareans	no.	164	157	187	195	176	198	278	307	339	378
Rate	%	18.5	18.2	19.7	18.0	16.4	17.4	22.9	24.4	23.7	24.3
Private hospitals											
Selected primiparae who gave birth	no.	550	582	613	521	564	574	471	435	367	313
Selected primiparae caesareans	no.	148	162	174	173	181	184	154	159	128	109
Rate	%	26.9	27.8	28.4	33.2	32.1	32.1	32.7	36.6	34.9	34.8

(a) Data are calculated according to ACHS Obstetric Clinical Indicator 1 denominator, Clinical Indicator 1.2 and Clinical Indicator 1.4. Selected primiparae: mothers with no previous deliveries, 20–34 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

(b) Between 12 and 15 per cent of births each year in the ACT are to non-residents of the ACT.

(c) Data are preliminary.

Source: ACT Government (unpublished).

TABLE 11A.110

Table 11A.110 **Intervention rates for selected primiparae, NT (a)**

	<i>Unit</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	549	560	596	628	633	638	669	756	822	846
Selected primiparae inductions	no.	148	145	181	152	170	189	221	255	268	302
Rate	%	27.0	25.9	30.4	24.2	26.9	29.6	33.0	33.7	32.6	35.7
Private hospitals											
Selected primiparae who gave birth	no.	na	na	na	na	na	na	na	na	na	na
Selected primiparae inductions	no.	na	na	na	na	na	na	na	na	na	na
Rate	%	na									
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	549	560	596	628	633	638	669	756	822	846
Selected primiparae caesareans	no.	130	143	158	156	145	156	154	230	203	257
Rate	%	23.7	25.5	26.5	24.8	22.9	24.5	23.0	30.4	24.7	30.4
Private hospitals											
Selected primiparae who gave birth	no.	na	na	na	na	na	na	na	na	na	na
Selected primiparae caesareans	no.	na	na	na	na	na	na	na	na	na	na
Rate	%	na									

(a) Selected primiparae: mothers with no previous deliveries, 20–34 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

na Not available. np Not published.

Source: NT Government (unpublished).

TABLE 11A.111

Table 11A.111 **Method of birth for selected women giving birth for the first time, 2012 (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Number										
Non-instrument vaginal	no.	15 363	10 061	8 495	3 972	2 821	743	847	516	42 818
Instrumental vaginal	no.	6 748	6 235	3 736	2 982	1 468	367	500	182	22 218
Caesarean section	no.	7 662	5 820	4 951	2 908	1 691	294	475	293	24 094
Not stated	no.	6	1	–	–	–	–	–	–	7
Total	no.	29 779	22 117	17 182	9 862	5 980	1 404	1 822	991	89 137
Per cent										
Non-instrument vaginal	%	51.6	45.5	49.4	40.3	47.2	52.9	46.5	52.1	48.0
Instrumental vaginal	%	22.7	28.2	21.7	30.2	24.5	26.1	27.4	18.4	24.9
Caesarean section	%	25.7	26.3	28.8	29.5	28.3	20.9	26.1	29.6	27.0
Not stated	%	0.0	0.0	–	–	–	–	–	–	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Selection criteria: women aged 20 to 34 years, with a singleton baby positioned with head towards the cervix at the onset of labour born between 37 and 41 weeks gestation.

(b) This indicator is not for women who gave birth in public hospital only. Data includes women who met the selection criteria and gave birth in private hospitals and outside of hospital.

(c) Provisional data were provided by Victoria for this table.

– Nil or rounded to zero.

Source: AIHW (unpublished) National Perinatal Data Collection.

TABLE 11A.112

Table 11A.112 **Multiparous mothers who have had a previous caesarean section by current method of birth (a), (b)**

	<i>Unit</i>	<i>NSW (c)</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA (c)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT (c)</i>	<i>Aust</i>
2008										
Number										
Non-instrumental vaginal	no.	2 053	1 395	1 441	483	497	134	140	136	6 279
Instrumental vaginal (e)	no.	506	447	275	172	141	23	31	15	1 610
Caesarean section	no.	11 539	9 371	9 014	4 635	2 800	767	614	450	39 190
Not stated	no.	1	–	–	–	–	–	–	–	1
Total	no.	14 099	11 213	10 730	5 290	3 438	924	785	601	47 080
Per cent										
Non-instrumental vaginal	%	14.6	12.4	13.4	9.1	14.5	14.5	17.8	22.6	13.3
Instrumental vaginal (e)	%	3.6	4.0	2.6	3.3	4.1	2.5	3.9	2.5	3.4
Caesarean section	%	81.8	83.6	84.0	87.6	81.4	83.0	78.2	74.9	83.2
Not stated	%	–	–	–	–	–	–	–	–	–
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2009										
Number										
Non-instrumental vaginal	no.	2 001	1 380	1 405	498	476	142	116	164	6 182
Instrumental vaginal (e)	no.	510	488	249	159	144	19	30	19	1 618
Caesarean section	no.	11 956	9 477	9 174	4 438	2 850	766	528	467	39 656
Not stated	no.	–	23	–	–	–	–	–	–	23
Total	no.	14 467	11 363	10 828	5 095	3 470	927	674	650	47 474
Per cent										
Non-instrumental vaginal	%	13.8	12.1	13.0	9.8	13.7	15.3	17.2	25.2	13.0
Instrumental vaginal (e)	%	3.5	4.3	2.3	3.1	4.1	2.0	4.5	2.9	3.4
Caesarean section	%	82.6	83.4	84.7	87.1	82.1	82.6	78.3	71.8	83.5
Not stated	%	–	0.2	–	–	–	–	–	–	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

TABLE 11A.112

Table 11A.112 **Multiparous mothers who have had a previous caesarean section by current method of birth (a), (b)**

	<i>Unit</i>	<i>NSW (c)</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA (c)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT (c)</i>	<i>Aust</i>
2010										
Number										
Non-instrumental vaginal	no.	1 925	1 470	1 443	507	477	135	122	135	6 214
Instrumental vaginal (e)	no.	537	454	261	180	149	25	28	21	1 655
Caesarean section	no.	11 851	9 512	9 225	4 481	2 809	761	627	499	39 765
Not stated	no.	3	3	–	–	–	–	–	–	6
Total	no.	14 316	11 439	10 929	5 168	3 435	921	777	655	47 640
Per cent										
Non-instrumental vaginal	%	13.4	12.9	13.2	9.8	13.9	14.7	15.7	20.6	13.0
Instrumental vaginal (e)	%	3.8	4.0	2.4	3.5	4.3	2.7	3.6	3.2	3.5
Caesarean section	%	82.8	83.2	84.4	86.7	81.8	82.6	80.7	76.2	83.5
Not stated	%	–	–	–	–	–	–	–	–	–
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2011										
Number										
Non-instrumental vaginal	no.	1 952	1 429	1 306	508	458	136	91	124	6 004
Instrumental vaginal (e)	no.	546	456	277	196	145	39	38	20	1 717
Caesarean section	no.	12 617	9 703	9 128	4 645	2 880	802	664	532	40 971
Not stated	no.	1	1	–	–	–	–	–	–	2
Total	no.	15 116	11 589	10 711	5 349	3 483	977	793	676	48 694
Per cent										
Non-instrumental vaginal	%	12.9	12.3	12.2	9.5	13.1	13.9	11.5	18.3	12.3
Instrumental vaginal (e)	%	3.6	3.9	2.6	3.7	4.2	4.0	4.8	3.0	3.5
Caesarean section	%	83.5	83.7	85.2	86.8	82.7	82.1	83.7	78.7	84.1
Not stated	%	0.0	0.0	–	–	–	–	–	–	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

TABLE 11A.112

Table 11A.112 **Multiparous mothers who have had a previous caesarean section by current method of birth (a), (b)**

	<i>Unit</i>	<i>NSW (c)</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA (c)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT (c)</i>	<i>Aust</i>
2012										
Number										
Non-instrumental vaginal	no.	1 924	1 303	1 350	514	455	112	110	119	5 887
Instrumental vaginal (e)	no.	589	482	320	171	136	31	53	22	1 804
Caesarean section	no.	12 858	9 438	9 266	4 968	3 080	777	737	494	41 618
Not stated	no.	1	1	–	–	–	1	–	–	3
Total	no.	15 372	11 224	10 936	5 653	3 671	921	900	635	49 312
Per cent										
Non-instrumental vaginal	%	12.5	11.6	12.3	9.1	12.4	12.2	12.2	18.7	11.9
Instrumental vaginal (e)	%	3.8	4.3	2.9	3.0	3.7	3.4	5.9	3.5	3.7
Caesarean section	%	83.7	84.1	84.7	87.9	83.9	84.4	81.9	77.8	84.4
Not stated	%	0.0	0.0	–	–	–	0.1	–	–	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

- (a) For multiple births, the method of birth of the first born baby was used.
- (b) Data include all women who gave birth vaginally, including births in public hospitals, private hospitals and outside of hospital, such as homebirths.
- (c) In 2010 and 2011, for NSW and WA, 'Non-instrumental vaginal' includes all women who had a vaginal breech birth, whether or not instruments were used. For the remaining jurisdictions, vaginal breech births are only included where instruments were not used. In 2006 to 2009, for NSW, Victoria, WA and the NT, 'Non-instrumental vaginal' includes all women who had a vaginal breech birth, whether or not instruments were used. For the remaining jurisdictions, vaginal breech births are only included where instruments were not used.
- (d) Between 12 and 15 per cent of births each year in the ACT are to non-residents of the ACT.
- (e) Instrumental vaginal birth includes forceps and vacuum extraction.

– Nil or rounded to zero.

Source: AIHW (various years), *Australia's mothers and babies*, Perinatal statistics series, Sydney, AIHW National Perinatal Epidemiology and Statistics Unit.

TABLE 11A.113

Table 11A.113 Perineal status after vaginal births (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
2003										
Number										
Intact	no.	17 657	18 688	13 368	6 779	3 761	na	1 176	1 455	62 956
1st degree laceration	no.	17 923	6 993	6 955	2 808	1 924	na	613	370	37 594
2nd degree laceration	no.	14 404	8 718	6 855	3 350	3 950	na	1 103	466	38 772
3rd/4th degree laceration	no.	958	343	340	172	176	na	33	42	2 065
Episiotomy	no.	9 284	9 425	4 032	3 181	2 227	na	551	272	28 976
Combined laceration and episiotomy	no.	616	878	767	390	299	na	96	94	3 132
Other (g)	no.	2 659	–	1 724	550	2	na	np	35	4 970
Not stated	no.	12	–	1	–	–	na	5	2	15
Total	no.	63 513	45 045	34 042	17 230	12 339	na	3 578	2 736	178 480
Proportion of perineal										
Intact	%	27.8	41.5	39.3	39.3	30.5	na	32.9	53.2	35.3
1st degree laceration	%	28.2	15.5	20.4	16.3	15.6	na	17.1	13.5	21.1
2nd degree laceration	%	22.7	19.4	20.1	19.4	32.0	na	30.8	17.0	21.7
3rd/4th degree laceration	%	1.5	0.8	1.0	1.0	1.4	na	0.9	1.5	1.2
Episiotomy	%	14.6	20.9	11.8	18.5	18.0	na	15.4	9.9	16.2
Combined laceration and episiotomy	%	1.0	1.9	2.3	2.3	2.4	na	2.7	3.4	1.8
Other (g)	%	4.2	–	5.1	3.2	0.0	na	np	1.3	2.8
Not stated	%	0.0	–	0.0	–	–	na	0.1	0.1	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	na	100.0	100.0	100.0
2004										
Number										
Intact	no.	16 840	18 426	13 352	6 530	3 753	na	1 153	1 223	61 301
1st degree laceration	no.	17 838	6 486	7 173	2 840	1 842	na	577	543	37 335
2nd degree laceration	no.	14 263	9 013	7 148	3 502	4 194	na	1 161	475	39 698

TABLE 11A.113

Table 11A.113 Perineal status after vaginal births (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
3rd/4th degree laceration	no.	1 053	368	346	202	113	na	66	42	2 157
Episiotomy	no.	9 082	9 459	4 191	2 744	2 064	na	438	246	28 337
Combined laceration and episiotomy	no.	537	790	385	340	286	na	108	28	2 462
Other (g)	no.	2 837	–	1 703	616	–	na	–	35	5 191
Not stated	no.	8	–	1	–	2	na	1	21	37
Total	no.	62 458	44 542	34 299	16 774	12 254	na	3 504	2 613	176 518
Proportion of perineal										
Intact	%	27.0	41.4	38.9	38.9	30.6	na	32.9	46.8	34.7
1st degree laceration	%	28.6	14.6	20.9	16.9	15.0	na	16.5	20.8	21.2
2nd degree laceration	%	22.8	20.2	20.8	20.9	34.2	na	33.1	18.2	22.5
3rd/4th degree laceration	%	1.7	0.8	1.0	1.2	0.9	na	1.9	1.6	1.2
Episiotomy	%	14.5	21.2	12.2	16.4	16.8	na	12.5	9.4	16.1
Combined laceration and episiotomy	%	0.9	1.8	1.1	2.0	2.3	na	3.1	1.1	1.4
Other (g)	%	4.5	–	5.0	3.7	–	na	–	1.3	2.9
Not stated	%	–	–	–	–	–	na	–	0.8	–
Total	%	100.0	100.0	100.0	100.0	100.0	na	100.0	100.0	100.0
2005										
Number										
Intact	no.	16 172	18 231	13 137	6 570	3 594	na	1 223	1 095	59 952
1st degree laceration	no.	17 427	6 116	7 044	2 815	1 733	na	593	593	36 305
2nd degree laceration	no.	14 952	9 241	7 309	3 636	4 000	na	1 146	491	40 791
3rd/4th degree laceration	no.	1 027	472	378	206	147	na	65	31	2 327
Episiotomy	no.	8 487	9 174	4 248	2 739	2 024	na	441	213	27 323
Combined laceration and episiotomy	no.	515	883	356	430	294	na	85	26	2 612
Other (g)	no.	2 786	–	1 862	587	–	na	–	–	5 235
Not stated	no.	12	4	–	–	1	na	–	–	18

TABLE 11A.113

Table 11A.113 Perineal status after vaginal births (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
Total	no.	61 378	44 121	34 334	16 983	11 793	na	3 553	2 449	174 563
Proportion of perineal										
Intact	%	26.3	41.3	38.3	38.7	30.5	na	34.4	44.7	34.3
1st degree laceration	%	28.4	13.9	20.5	16.6	14.7	na	16.7	24.2	20.8
2nd degree laceration	%	24.4	20.9	21.3	21.4	33.9	na	32.3	20.0	23.4
3rd/4th degree laceration	%	1.7	1.1	1.1	1.2	1.2	na	1.8	1.3	1.3
Episiotomy	%	13.8	20.8	12.4	16.1	17.2	na	12.4	8.7	15.7
Combined laceration and episiotomy	%	0.8	2.0	1.0	2.5	2.5	na	2.4	1.1	1.5
Other (g)	%	4.5	–	5.4	3.5	–	na	–	–	3.0
Not stated	%	–	–	–	–	–	na	–	–	–
Total	%	100.0	100.0	100.0	100.0	100.0	na	100.0	100.0	100.0
2006										
Number										
Intact	no.	17 100	19 017	14 623	6 819	3 753	2 221	1 238	1 161	65 917
1st degree laceration	no.	17 154	6 059	7 416	2 848	2 936	646	643	682	38 334
2nd degree laceration	no.	16 020	9 945	7 761	3 900	2 975	779	1 258	449	42 975
3rd/4th degree laceration	no.	1 190	483	395	207	159	58	82	38	2 595
Episiotomy	no.	8 482	9 361	4 273	2 775	1 950	578	429	226	28 086
Combined laceration and episiotomy	no.	582	756	444	343	330	–	96	32	2 572
Other (g)	no.	3 516	–	1 982	649	18	–	–	–	6 165
Not stated	no.	19	1	–	–	1	–	–	–	21
Total	no.	64 063	45 622	36 894	17 541	12 122	4 282	3 746	2 588	186 665
Proportion of perineal										
Intact	%	26.7	41.7	39.6	38.9	31.0	51.9	33.0	44.9	35.3
1st degree laceration	%	26.8	13.3	20.1	16.2	24.2	15.1	17.2	26.4	20.5
2nd degree laceration	%	25.0	21.8	21.0	22.2	24.5	18.2	33.6	17.3	23.0

TABLE 11A.113

Table 11A.113 Perineal status after vaginal births (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
3rd/4th degree laceration	%	1.9	1.1	1.1	1.2	1.3	1.4	2.2	1.5	1.4
Episiotomy	%	13.2	20.5	11.6	15.8	16.1	13.5	11.5	8.7	15.0
Combined laceration and episiotomy	%	0.9	1.7	1.2	2.0	2.7	–	2.6	1.2	1.4
Other (g)	%	5.5	–	5.4	3.7	0.1	–	–	–	3.3
Not stated	%	0.0	0.0	–	–	0.0	–	–	–	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2007										
Number										
Intact	no.	17 326	19 664	14 361	7 543	3 836	2 224	1 358	1 190	67 383
1st degree laceration	no.	16 622	6 124	7 440	3 102	3 010	688	636	644	38 273
2nd degree laceration	no.	16 428	10 693	8 208	4 139	3 227	856	1 282	487	45 296
3rd/4th degree laceration	no.	1 125	647	401	277	153	62	80	56	2 803
Episiotomy	no.	8 539	9 752	4 351	2 938	1 805	593	396	218	28 625
Combined laceration and episiotomy	no.	1 058	760	474	367	370	–	97	14	3 139
Other (g)	no.	3 526	–	1 966	651	19	–	–	13	6 175
Not stated	no.	127	1	2	–	1	–	3	4	135
Total	no.	64 751	47 641	37 203	19 017	12 421	4 423	3 852	2 626	191 829
Proportion of perineal										
Intact	%	26.8	41.3	38.6	39.7	30.9	50.3	35.3	45.3	35.1
1st degree laceration	%	25.7	12.9	20.0	16.3	24.2	15.6	16.5	24.5	20.0
2nd degree laceration	%	25.4	22.4	22.1	21.8	26.0	19.4	33.3	18.5	23.6
3rd/4th degree laceration	%	1.7	1.4	1.1	1.5	1.2	1.4	2.1	2.1	1.5
Episiotomy	%	13.2	20.5	11.7	15.4	14.5	13.4	10.3	8.3	14.9
Combined laceration and episiotomy	%	1.6	1.6	1.3	1.9	3.0	–	2.5	0.5	1.6
Other (g)	%	5.4	–	5.3	3.4	0.2	–	–	0.5	3.2
Not stated	%	0.2	–	–	–	–	–	0.1	0.2	0.1

TABLE 11A.113

Table 11A.113 Perineal status after vaginal births (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2008										
Number										
Intact	no.	16 994	20 209	12 876	7 863	3 809	2 246	1 276	1 401	66 672
1st degree laceration	no.	19 072	6 019	6 811	3 175	3 400	726	628	426	40 257
2nd degree laceration	no.	17 382	11 714	9 461	4 599	3 603	921	1 509	566	49 755
3rd/4th degree laceration	no.	1 056	778	623	317	250	71	92	60	3 247
Episiotomy	no.	9 063	10 103	4 685	2 470	1 609	560	363	235	29 088
Combined laceration and episiotomy	no.	1 855	743	587	979	620	–	68	41	4 893
Other (g)	no.	1 433	–	5 173	767	44	–	np	23	7 443
Not stated	no.	14	–	3	–	2	–	–	2	21
Total	no.	66 869	49 566	40 219	20 170	13 337	4 524	3 939	2 754	201 376
Proportion of perineal										
Intact	%	25.4	40.8	32.0	39.0	28.6	49.6	32.4	50.9	33.1
1st degree laceration	%	28.5	12.1	16.9	15.7	25.5	16.0	15.9	15.5	20.0
2nd degree laceration	%	26.0	23.6	23.5	22.8	27.0	20.4	38.3	20.6	24.7
3rd/4th degree laceration	%	1.6	1.6	1.5	1.6	1.9	1.6	2.3	2.2	1.6
Episiotomy	%	13.6	20.4	11.6	12.2	12.1	12.4	9.2	8.5	14.4
Combined laceration and episiotomy	%	2.8	1.5	1.5	4.9	4.6	–	1.7	1.5	2.4
Other (g)	%	2.1	–	12.9	3.8	0.3	–	np	0.8	3.7
Not stated	%	–	–	–	–	–	–	–	0.1	–
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2009										
Number										
Intact	no.	16 297	14 541	12 325	7 799	3 723	2 216	1 352	1 191	59 442
1st degree laceration	no.	18 857	8 663	6 907	3 242	3 318	700	685	620	42 992

TABLE 11A.113

Table 11A.113 Perineal status after vaginal births (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
2nd degree laceration	no.	17 528	11 536	10 014	4 759	3 665	940	1 546	520	50 508
3rd/4th degree laceration	no.	1 074	754	666	413	269	49	125	53	3 403
Episiotomy	no.	9 134	9 382	4 778	2 595	1 608	566	380	297	28 740
Combined laceration and episiotomy	no.	2 040	904	563	1 060	631	–	47	38	5 283
Other (g)	no.	1 391	3 543	5 431	651	31	–	–	34	11 081
Not stated	no.	3	152	1	–	–	–	–	1	157
Total	no.	66 324	49 475	40 685	20 519	13 245	4 471	4 135	2 754	201 606
Proportion of perineal										
Intact	%	24.6	29.4	30.3	38.0	28.1	49.6	32.7	43.2	29.5
1st degree laceration	%	28.4	17.5	17.0	15.8	25.1	15.7	16.6	22.5	21.3
2nd degree laceration	%	26.4	23.3	24.6	23.2	27.7	21.0	37.4	18.9	25.1
3rd/4th degree laceration	%	1.6	1.5	1.6	2.0	2.0	1.1	3.0	1.9	1.7
Episiotomy	%	13.8	19.0	11.7	12.6	12.1	12.7	9.2	10.8	14.3
Combined laceration and episiotomy	%	3.1	1.8	1.4	5.2	4.8	–	1.1	1.4	2.6
Other (g)	%	2.1	7.2	13.3	3.2	0.2	–	–	1.2	5.5
Not stated	%	–	0.3	–	–	–	–	–	–	0.1
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2010										
Number										
Intact	no.	15 340	16 124	11 998	7 768	3 551	1 831	1 391	1 082	59 085
1st degree laceration	no.	18 909	8 904	7 580	3 146	3 377	781	614	567	43 878
2nd degree laceration	no.	17 874	12 025	10 465	4 980	3 645	912	1 395	619	51 915
3rd/4th degree laceration	no.	1 129	908	693	382	282	46	120	61	3 621
Episiotomy	no.	9 488	10 283	5 047	2 626	1 816	549	436	326	30 571
Combined laceration and episiotomy	no.	2 065	1 441	433	1 133	659	27	47	44	5 849
Other (g)	no.	1 205	–	4 747	448	13	97	–	22	4 879

TABLE 11A.113

Table 11A.113 Perineal status after vaginal births (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
Not stated	no.	10	439	–	–	–	–	–	–	449
Total	no.	66 020	50 124	40 963	20 483	13 343	4 243	4 003	2 721	201 900
Proportion of perineal										
Intact	%	23.2	32.2	29.3	37.9	26.6	43.2	34.7	39.8	29.3
1st degree laceration	%	28.6	17.8	18.5	15.4	25.3	18.4	15.3	20.8	21.7
2nd degree laceration	%	27.1	24.0	25.5	24.3	27.3	21.5	34.8	22.7	25.7
3rd/4th degree laceration	%	1.7	1.8	1.7	1.9	2.1	1.1	3.0	2.2	1.8
Episiotomy	%	14.4	20.5	12.3	12.8	13.6	12.9	10.9	12.0	15.1
Combined laceration and episiotomy	%	3.1	2.9	1.1	5.5	4.9	0.6	1.2	1.6	2.9
Other (g)	%	1.8	–	11.6	2.2	0.1	2.3	–	0.8	2.4
Not stated	%	–	0.9	–	–	–	–	–	–	0.2
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2011										
Number										
Intact	no.	14 789	12 182	11 997	7 643	3 628	1 363	1 228	1 003	53 986
1st degree laceration	no.	19 065	8 405	8 119	3 274	3 313	1 098	531	557	44 362
2nd degree laceration	no.	17 584	12 198	10 331	5 016	3 702	985	1 368	608	51 812
3rd/4th degree laceration	no.	1 304	928	720	439	290	73	134	77	3 980
Episiotomy	no.	9 603	10 405	5 047	2 947	2 085	442	426	332	31 134
Combined laceration and episiotomy	no.	2 269	1 490	410	1 267	370	97	56	30	5 954
Other (g), (h), (i)	no.	1 120	3 529	4 190	393	6	227	–	31	9 496
Not stated	no.	25	428	4	–	1	–	–	–	458
Total	no.	65 759	49 565	40 818	20 979	13 395	4 285	3 743	2 638	201 182
Proportion of perineal										
Intact	%	22.5	24.6	29.4	36.4	27.1	31.8	32.8	38.0	26.8
1st degree laceration	%	29.0	17.0	19.9	15.6	24.7	25.6	14.2	21.1	22.1

TABLE 11A.113

Table 11A.113 Perineal status after vaginal births (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
2nd degree laceration	%	26.7	24.6	25.3	23.9	27.6	23.0	36.5	23.0	25.8
3rd/4th degree laceration	%	2.0	1.9	1.8	2.1	2.2	1.7	3.6	2.9	2.0
Episiotomy	%	14.6	21.0	12.4	14.0	15.6	10.3	11.4	12.6	15.5
Combined laceration and episiotomy	%	3.5	3.0	1.0	6.0	2.8	2.3	1.5	1.1	3.0
Other (g), (h), (i)	%	1.7	7.1	10.3	1.9	0.0	5.3	–	1.2	4.7
Not stated	%	0.0	0.9	0.0	–	0.0	–	–	–	0.2
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2012										
Number										
Intact	no.	14 766	12 168	12 455	7 844	3 610	1 185	1 294	895	54 217
1st degree laceration	no.	19 689	7 987	7 758	3 229	3 423	1 074	526	740	44 426
2nd degree laceration	no.	18 214	12 406	11 090	5 321	3 554	924	1 524	680	53 713
3rd/4th degree laceration	no.	1 347	1 020	836	500	307	67	166	79	4 322
Episiotomy	no.	10 177	10 953	5 597	3 619	2 174	431	464	313	33 728
Combined laceration and episiotomy	no.	2 229	2 055	363	886	391	117	57	50	6 148
Other (g), (h), (i)	no.	1 132	5 656	3 768	435	4	274	–	11	11 280
Not stated	no.	8	116	–	18	–	–	–	6	148
Total	no.	67 562	52 361	41 867	21 852	13 463	4 072	4 031	2 774	207 982
Proportion of perineal										
Intact	%	21.9	23.2	29.7	35.9	26.8	29.1	32.1	32.3	26.1
1st degree laceration	%	29.1	15.3	18.5	14.8	25.4	26.4	13.0	26.7	21.4
2nd degree laceration	%	27.0	23.7	26.5	24.4	26.4	22.7	37.8	24.5	25.8
3rd/4th degree laceration	%	2.0	1.9	2.0	2.3	2.3	1.6	4.1	2.8	2.1
Episiotomy	%	15.1	20.9	13.4	16.6	16.1	10.6	11.5	11.3	16.2
Combined laceration and episiotomy	%	3.3	3.9	0.9	4.1	2.9	2.9	1.4	1.8	3.0
Other (g), (h), (i)	%	1.7	10.8	9.0	2.0	0.0	6.7	–	0.4	5.4

Table 11A.113 **Perineal status after vaginal births (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
Not stated	%	0.0	0.2	–	0.1	–	–	–	0.2	0.1
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) 1st degree laceration: perineal laceration, rupture or tear during delivery involving fourchette, labia, skin, slight, vagina, vulva; 2nd degree laceration: perineal laceration, rupture or tear during delivery as with 1st degree also involving pelvic floor, perineal muscles, vaginal muscles; 3rd degree laceration: perineal laceration, rupture or tear during delivery as with 2nd degree also involving anal sphincter, rectovaginal septum, sphincter NOS; 4th degree laceration: perineal laceration, rupture or tear during delivery as with 3rd degree also involving anal mucosa, rectal mucosa. Because of differences in definitions and methods used for data collection, care must be taken when comparing across jurisdictions.

(b) For multiple births, the perineal status after delivery of the first born was used.

(c) Data include all women who gave birth vaginally, including births in public hospitals, private hospitals and outside of hospital, such as homebirths.

(d) Include mothers reported with a labial, clitoral, vaginal and/or cervical laceration.

(e) In 2010 and 2011, for Tasmania, cases where both a laceration and episiotomy occurred were coded as 'Combined laceration and episiotomy' in the electronic systems. In the paper-based form they were recorded as 'Episiotomy'. Care must be taken when interpreting these numbers. Before 2010, for Tasmania, cases where both a laceration and episiotomy occurred were coded as episiotomy. Care must be taken when interpreting these numbers.

(f) Between 12 and 15 per cent of births each year in the ACT are to non-residents of the ACT.

(g) For NSW, includes unspecified perineal tear and vulval or perineal haematoma.

(h) In 2010 and 2011, for Queensland, other includes genital grazes such as clitoral or labial.

(i) In 2010 and 2011, for WA, 'other' includes unspecified perineal tear and vulval or perineal haematoma.

– Nil or rounded to zero. **np** Not published.

Source:

AIHW (various years), *Australia's mothers and babies*, Perinatal statistics series, Sydney, AIHW National Perinatal Epidemiology and Statistics Unit.

TABLE 11A.114

Table 11A.114 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c), (d)</i>	<i>ACT (c)</i>	<i>NT (c),(e)</i>	<i>Aust</i>
2010-11										
O01A - Caesarean Delivery +Ccc										
Separations	no.	1 227	910	774	442	310	67	76	71	3 877
Patient days	no.	11 558	9 522	6 191	4 288	3 121	581	486	806	36 554
ALOS	days	9.42	10.46	8.00	9.71	10.05	8.66	6.39	11.35	9.43
Sample size (f)	no. hospitals	42	28	24	19	12	3	2	4	134
Average cost (g)	\$/DRG	15 639	19 089	15 760	20 571	17 615	20 871	21 464	24 365	17 558
Direct	\$/DRG	11 405	14 230	13 207	17 789	13 970	16 557	12 314	15 838	13 548
Overhead	\$/DRG	4 234	4 859	2 553	2 782	3 645	4 315	9 150	8 527	4 009
O01B - Caesarean Delivery +Scc										
Separations	no.	3 403	2 949	1 844	1 236	826	193	226	163	10 839
Patient days	no.	19 468	15 538	9 100	6 480	4 861	1 030	1 061	1 280	58 818
ALOS	days	5.72	5.27	4.93	5.24	5.89	5.35	4.69	7.85	5.43
Sample size (f)	no. hospitals	56	33	27	23	21	3	2	4	169
Average cost (g)	\$/DRG	10 911	11 365	11 729	14 715	11 940	15 134	15 663	16 012	11 937
Direct	\$/DRG	7 982	8 623	9 756	11 744	9 247	12 038	8 960	10 045	9 107
Overhead	\$/DRG	2 929	2 741	1 973	2 971	2 692	3 096	6 703	5 967	2 829
O01C - Caesarean Delivery -Csc										
Separations	no.	15 100	10 770	–	4 838	3 295	877	798	614	36 292
Patient days	no.	58 120	42 121	–	18 790	13 720	3 475	2 976	2 959	142 160
ALOS	days	3.85	3.91	–	3.88	4.16	3.96	3.73	4.82	3.92
Sample size (f)	no. hospitals	57	34	–	24	25	3	2	4	149
Average cost (g)	\$/DRG	8 689	8 947	–	13 196	9 917	12 010	12 328	11 257	9 681
Direct	\$/DRG	6 408	6 841	–	9 955	7 581	9 611	7 404	6 664	7 220
Overhead	\$/DRG	2 280	2 106	–	3 240	2 337	2 399	4 923	4 593	2 462

TABLE 11A.114

Table 11A.114 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c), (d)</i>	<i>ACT (c)</i>	<i>NT (c),(e)</i>	<i>Aust</i>
O02A - Vaginal Delivery +Or Pr +Csc										
Separations	no.	451	371	301	240	130	20	36	39	1 589
Patient days	no.	2 082	1 506	1 217	1 001	691	72	137	243	6 948
ALOS	days	4.61	4.06	4.05	4.17	5.29	3.54	3.81	6.23	4.37
Sample size (f)	no. hospitals	46	26	25	22	15	3	2	4	143
Average cost (g)	\$/DRG	10 544	9 373	10 980	13 854	10 200	11 385	15 355	14 047	11 030
Direct	\$/DRG	7 888	7 200	9 177	10 650	7 874	9 039	9 231	8 910	8 457
Overhead	\$/DRG	2 656	2 173	1 803	3 204	2 327	2 346	6 124	5 137	2 573
O02B - Vaginal Delivery +Or Pr -Csc										
Separations	no.	1 707	1 124	934	438	359	75	135	76	4 849
Patient days	no.	5 754	3 302	2 807	1 572	1 248	235	427	259	15 604
ALOS	days	3.37	2.94	3.00	3.58	3.47	3.15	3.16	3.41	3.22
Sample size (f)	no. hospitals	54	29	31	23	18	3	2	4	164
Average cost (g)	\$/DRG	6 974	6 546	7 767	9 078	6 487	8 300	8 733	6 734	7 247
Direct	\$/DRG	5 163	5 020	6 477	7 132	5 043	6 605	5 249	3 969	5 558
Overhead	\$/DRG	1 811	1 526	1 290	1 946	1 444	1 695	3 484	2 765	1 689
O03A - Ectopic Pregnancy (h)										
Separations	no.	134	136	76	66	38	11	12	14	487
Patient days	no.	412	386	237	164	96	35	28	46	1 404
ALOS	days	3.07	2.85	3.13	2.49	2.50	3.14	2.33	3.29	2.89
Sample size (f)	no. hospitals	38	23	19	13	9	3	2	3	110
Average cost (g)	\$/DRG	7 911	6 543	10 358	9 708	8 491	8 955	14 054	9 339	8 416
Direct	\$/DRG	6 295	5 267	8 806	7 201	6 616	7 198	7 660	6 074	6 595
Overhead	\$/DRG	1 616	1 276	1 552	2 507	1 874	1 757	6 393	3 265	1 821
O03B - Ectopic Pregnancy (h)										

Table 11A.114 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c), (d)</i>	<i>ACT (c)</i>	<i>NT (c),(e)</i>	<i>Aust</i>
Separations	no.	797	633	520	229	160	41	46	42	2 469
Patient days	no.	1 461	1 068	819	369	282	71	89	81	4 239
ALOS	days	2	2	2	2	2	2	2	2	2
Sample size (f)	no. hospitals	47	29	22	14	12	3	2	3	132
Average cost (g)	\$/DRG	4 587	4 086	6 231	6 185	5 748	7 454	7 978	6 507	5 172
Direct	\$/DRG	3 613	3 259	5 267	4 837	4 598	6 073	4 877	4 279	4 124
Overhead	\$/DRG	974	827	963	1 348	1 150	1 381	3 102	2 228	1 048
O04A - Postpartum & Post Abortn+Or Pr (h)										
Separations	no.	65	64	63	36	14	6	9	4	260
Patient days	no.	328	383	248	185	124	15	33	27	1 344
ALOS	days	5.05	5.98	3.96	5.21	8.80	2.45	3.67	6.75	5.16
Sample size (f)	no. hospitals	29	23	16	10	7	3	2	1	91
Average cost (g)	\$/DRG	9 721	11 787	9 912	13 567	13 351	4 710	15 897	19 483	11 240
Direct	\$/DRG	7 560	9 537	8 322	10 818	10 833	3 831	10 646	13 427	8 959
Overhead	\$/DRG	2 162	2 249	1 590	2 749	2 518	880	5 251	6 055	2 281
O04B - Postpartum & Post Abortn+Or Pr (h)										
Separations	no.	396	369	260	158	99	56	24	17	1,381
Patient days	no.	741	664	487	268	327	74	54	79	2,694
ALOS	days	2	2	2	2	3	1	2	5	2
Sample size (f)	no. hospitals	52	34	25	22	19	3	2	4	161
Average cost (g)	\$/DRG	3,770	3,239	4,500	5,085	4,834	3,664	7,493	10,356	4,135
Direct	\$/DRG	2,934	2,512	3,823	3,853	3,536	2,935	4,556	5,569	3,198
Overhead	\$/DRG	837	726	677	1,232	1,298	730	2,937	4,787	936
O05Z - Abortion+ Or Proc										
Separations	no.	6 565	7 473	2 884	2 102	5 431	489	274	1 099	26 318

TABLE 11A.114

Table 11A.114 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c), (d)</i>	<i>ACT (c)</i>	<i>NT (c),(e)</i>	<i>Aust</i>
Patient days	no.	7 170	7 780	23 213	2 298	5 572	534	313	1 167	48 047
ALOS	days	1.09	1.04	8.05	1.09	1.03	1.09	1.14	1.06	1.83
Sample size (f)	no. hospitals	65	38	32	21	29	3	2	4	194
Average cost (g)	\$/DRG	1 879	1 850	2 977	3 330	1 686	2 465	4 768	1 709	2 101
Direct	\$/DRG	1 407	1 410	2 546	2 417	1 355	1 989	2 968	1 122	1 618
Overhead	\$/DRG	472	440	432	913	331	476	1 800	587	483
O60A - Vaginal Delivery +Csc										
Separations	no.	4 432	3 652	2 628	1 596	1 367	283	127	279	14 364
Patient days	no.	20 436	13 953	19 771	6 795	6 064	1 132	513	1 443	70 109
ALOS	days	4.61	3.82	7.52	4.26	4.44	4.01	4.04	5.17	4.88
Sample size (f)	no. hospitals	60	36	33	23	24	3	2	5	186
Average cost (g)	\$/DRG	8 233	6 739	7 867	9 243	7 597	9 525	10 167	9 508	7 905
Direct	\$/DRG	6 053	5 119	6 532	7 893	5 799	7 426	6 353	5 854	6 109
Overhead	\$/DRG	2 180	1 620	1 335	1 350	1 797	2 099	3 814	3 653	1 796
O60B - Vaginal Delivery -Csc										
Separations	no.	31 013	26 184	19 741	9 156	6 934	1 833	485	1 277	96 623
Patient days	no.	84 279	64 685	56 022	23 785	18 823	5 126	1 366	3 807	257 894
ALOS	days	2.72	2.47	2.84	2.60	2.71	2.80	2.82	2.98	2.67
Sample size (f)	no. hospitals	61	37	48	25	26	3	2	5	207
Average cost (g)	\$/DRG	5 304	4 359	5 096	5 669	4 495	5 829	6 919	5 137	4 998
Direct	\$/DRG	3 863	3 307	4 223	4 660	3 408	4 584	4 347	2 975	3 834
Overhead	\$/DRG	1 440	1 051	872	1 009	1 087	1 245	2 571	2 162	1 164
O60C - Vaginal Delivery + Mod Comp Dx										
Separations	no.	16 085	5 854	6 824	4 901	1 664	706	2 213	481	38 729
Patient days	no.	34 429	11 474	10 948	11 874	3 021	1 428	4 538	1 040	78 752

TABLE 11A.114

Table 11A.114 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c), (d)</i>	<i>ACT (c)</i>	<i>NT (c),(e)</i>	<i>Aust</i>
ALOS	days	2.14	1.96	1.60	2.42	1.82	2.02	2.05	2.16	2.03
Sample size (f)	no. hospitals	61	34	48	26	25	3	2	4	203
Average cost (g)	\$/DRG	4 278	3 484	3 838	7 356	2 977	4 541	4 296	3 737	4 413
Direct	\$/DRG	3 167	2 646	3 215	5 103	2 213	3 599	2 764	2 094	3 272
Overhead	\$/DRG	1 111	838	622	2 252	764	942	1 532	1 642	1 141
2011-12										
O01A - Caesarean Delivery +Ccc										
Separations	no.	1 307	921	803	477	337	73	109	83	4 108
Patient days	no.	12 689	8 536	6 036	4 566	3 568	804	816	901	37 903
ALOS	days	9.71	9.27	7.52	9.57	10.59	11.01	7.49	10.86	9.23
Sample size (f)	no. hospitals	46	28	24	18	9	3	2	3	132
Average cost (g)	\$/DRG	16 593	14 526	16 642	21 573	18 979	17 921	21 501	30 607	17 352
Direct	\$/DRG	11 985	10 785	12 650	17 506	15 284	14 188	12 403	22 361	13 018
Overhead	\$/DRG	4 608	3 741	3 992	4 067	3 696	3 733	9 097	8 246	4 334
O01B - Caesarean Delivery +Scc										
Separations	no.	3 417	2736	2060	1102	909	219	257	195	10 884
Patient days	no.	18 652	14 380	9 633	5 732	5 257	1 165	1 370	1 264	57 409
ALOS	days	5.46	5.26	4.68	5.20	5.78	5.32	5.33	6.48	5.28
Sample size (f)	no. hospitals	59	34	33	22	21	3	2	4	174
Average cost (g)	\$/DRG	10 671	10 096	11 978	15 727	12 551	10 146	16 324	19 583	11 727
Direct	\$/DRG	7 721	7 579	9 088	12 264	10 028	8 158	9 332	13 913	8 755
Overhead	\$/DRG	2 950	2 518	2 890	3 463	2 523	1 988	6 992	5 670	2 972
O01C - Caesarean Delivery -Csc										
Separations	no.	14 845	9536	8902	3855	3476	796	896	663	42 813

TABLE 11A.114

Table 11A.114 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c), (d)</i>	<i>ACT (c)</i>	<i>NT (c),(e)</i>	<i>Aust</i>
Patient days	no.	56 984	36 067	30 273	14 503	14 319	3 042	3 438	3 019	161 052
ALOS	days	3.84	3.78	3.40	3.76	4.12	3.82	3.84	4.55	3.76
Sample size (f)	no. hospitals	62	32	36	24	25	3	2	4	182
Average cost (g)	\$/DRG	8 848	7 889	9 651	13 675	10 712	7 746	12 936	15 333	9 546
Direct	\$/DRG	6 426	5 980	7 292	10 166	8 409	6 249	7 442	10 706	7 082
Overhead	\$/DRG	2 422	1 909	2 358	3 510	2 302	1 497	5 494	4 627	2 464
O02A - Vaginal Delivery +Or Pr +Csc										
Separations	no.	485	328	337	198	102	25	37	26	1 534
Patient days	no.	2 249	1 321	1 239	815	423	122	164	129	6 437
ALOS	days	4.64	4.03	3.68	4.12	4.15	4.88	4.43	4.96	4.20
Sample size (f)	no. hospitals	49	28	27	18	13	3	2	4	141
Average cost (g)	\$/DRG	10 752	7 891	10 672	12 013	9 660	10 196	14 191	15 224	10 325
Direct	\$/DRG	7 848	6 025	8 006	9 460	7 818	8 457	8 468	10 662	7 746
Overhead	\$/DRG	2 904	1 866	2 666	2 553	1 842	1 740	5 722	4 561	2 579
O02B - Vaginal Delivery +Or Pr -Csc										
Separations	no.	1 783	944	897	390	391	83	141	63	4 683
Patient days	no.	5 734	2 750	2 621	1 306	1 300	276	393	236	14 588
ALOS	days	3.22	2.91	2.92	3.35	3.32	3.33	2.79	3.75	3.12
Sample size (f)	no. hospitals	59	32	34	18	18	3	2	4	166
Average cost (g)	\$/DRG	6 991	5 644	8 049	9 154	7 029	5 720	8 779	10 905	7 188
Direct	\$/DRG	5 054	4 250	6 011	6 961	5 612	4 658	5 286	7 716	5 314
Overhead	\$/DRG	1 937	1 393	2 038	2 193	1 417	1 063	3 493	3 189	1 873
O03A - Ectopic Pregnancy (h)										
Separations	no.	163	159	111	69	45	6	6	11	570
Patient days	no.	425	410	274	140	104	18	17	35	1 423

TABLE 11A.114

Table 11A.114 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c), (d)</i>	<i>ACT (c)</i>	<i>NT (c),(e)</i>	<i>Aust</i>
ALOS	days	2.61	2.58	2.47	2.03	2.31	3.00	2.83	3.18	2.50
Sample size (f)	no. hospitals	42	22	19	10	9	3	2	3	110
Average cost (g)	\$/DRG	7 046	6 856	9 687	7 440	7 655	9 021	14 792	9 554	7 754
Direct	\$/DRG	5 336	5 486	7 499	5 782	6 360	7 051	8 661	7 052	6 020
Overhead	\$/DRG	1 710	1 370	2 187	1 658	1 295	1 970	6 131	2 502	1 734
O03B - Ectopic Pregnancy (h)										
Separations	no.	796	712	561	220	142	59	44	30	2 564
Patient days	no.	1 434	1 128	914	335	265	129	72	68	4 345
ALOS	days	1.80	1.58	1.63	1.52	1.87	2.19	1.64	2.27	1.70
Sample size (f)	no. hospitals	47	26	25	11	14	3	2	3	131
Average cost (g)	\$/DRG	4 664	3 820	7 042	6 171	5 299	6 979	8 139	7 605	5 262
Direct	\$/DRG	3 521	3 005	5 477	4 819	4 260	5 551	4 612	5 766	4 050
Overhead	\$/DRG	1 143	815	1 565	1 352	1 038	1 428	3 527	1 838	1 212
O04A - Postpartum & Post Abortn+Or Pr (h)										
Separations	no.	77	77	67	41	19	6	5	3	295
Patient days	no.	386	388	287	220	112	36	24	24	1 477
ALOS	days	5.01	5.04	4.28	5.37	5.89	6.00	4.80	8.00	5.01
Sample size (f)	no. hospitals	31	23	17	10	8	2	2	2	95
Average cost (g)	\$/DRG	10 473	10 187	11 403	14 818	8 438	19 406	16 890	10 918	11 377
Direct	\$/DRG	7 920	8 158	8 708	11 938	6 760	16 227	11 237	8 583	8 877
Overhead	\$/DRG	2 553	2 030	2 695	2 879	1 678	3 179	5 652	2 336	2 501
O04B - Postpartum & Post Abortn+Or Pr (h)										
Separations	no.	365	310	254	145	98	51	31	19	1 273
Patient days	no.	771	513	488	337	200	77	63	59	2 508
ALOS	days	2.11	1.65	1.92	2.32	2.04	1.51	2.03	3.11	1.97

TABLE 11A.114

Table 11A.114 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c), (d)</i>	<i>ACT (c)</i>	<i>NT (c),(e)</i>	<i>Aust</i>
Sample size (f)	no. hospitals	59	36	29	18	19	3	2	2	168
Average cost (g)	\$/DRG	3 760	3 245	5 021	5 741	5 097	4 070	8 121	5 972	4 366
Direct	\$/DRG	2 813	2 467	3 870	4 459	3 776	3 209	4 855	4 595	3 294
Overhead	\$/DRG	947	777	1 151	1 282	1 321	861	3 266	1 376	1 073
O05Z - Abortion+ Or Proc										
Separations	no.	6 050	7003	2823	2041	4711	370	322	995	24 276
Patient days	no.	6 673	7 428	3 164	2 241	4 854	394	347	1 069	26 118
ALOS	days	1.10	1.06	1.12	1.10	1.03	1.06	1.08	1.07	1.08
Sample size (f)	no. hospitals	71	41	40	22	29	3	2	4	205
Average cost (g)	\$/DRG	1 986	2 112	3 318	3 042	1 731	2 824	4 600	1 930	2 257
Direct	\$/DRG	1 470	1 613	2 636	2 251	1 416	2 233	2 737	1 502	1 729
Overhead	\$/DRG	516	499	682	791	315	592	1 863	428	529
O60A - Vaginal Delivery +Csc										
Separations	no.	5 053	3687	2821	1720	1314	292	297	291	15 441
Patient days	no.	21 961	14 393	9 833	7 488	5 703	1 255	1 153	1 344	63 022
ALOS	days	4.35	3.90	3.49	4.35	4.34	4.30	3.88	4.62	4.08
Sample size (f)	no. hospitals	63	34	37	23	25	4	2	4	186
Average cost (g)	\$/DRG	7 672	5 893	7 533	9 929	7 978	7 026	9 657	11 009	7 590
Direct	\$/DRG	5 468	4 398	5 601	7 805	6 270	5 585	6 010	7 935	5 625
Overhead	\$/DRG	2 203	1 495	1 932	2 125	1 708	1 441	3 647	3 074	1 965
O60B - Vaginal Delivery -Csc										
Separations	no.	34 515	21598	20042	8915	6587	1638	2069	1374	96 392
Patient days	no.	88 474	53 440	44 233	22 887	17 423	4 585	4 636	3 922	238 598
ALOS	days	2.56	2.47	2.21	2.57	2.65	2.80	2.24	2.85	2.48
Sample size (f)	no. hospitals	67	35	61	25	26	4	2	5	210

Table 11A.114 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c), (d)</i>	<i>ACT (c)</i>	<i>NT (c),(e)</i>	<i>Aust</i>
Average cost (g)	\$/DRG	4 975	3 634	4 900	6 499	4 911	4 050	5 706	7 503	4 826
Direct	\$/DRG	3 560	2 734	3 559	4 884	3 774	3 224	3 620	5 208	3 526
Overhead	\$/DRG	1 414	900	1 340	1 615	1 137	826	2 086	2 295	1 300
O60C - Vaginal Delivery + Mod Comp Dx										
Separations	no.	9 354	4836	6750	1992	1888	690	565	447	26 240
Patient days	no.	17 042	9 039	10 671	3 730	3 358	1 364	808	896	46 181
ALOS	days	1.82	1.87	1.58	1.87	1.78	1.98	1.43	2.00	1.76
Sample size (f)	no. hospitals	67	36	66	27	25	6	2	5	221
Average cost (g)	\$/DRG	3 755	2 648	3 882	4 781	3 177	3 369	3 907	5 779	3 588
Direct	\$/DRG	2 681	2 004	2 776	3 528	2 410	2 699	2 499	3 866	2 597
Overhead	\$/DRG	1 074	644	1 106	1 254	767	670	1 408	1 913	991

(a) Cells with fewer than five separations have been marked 'np' for privacy concerns.

(b) Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population.

(c) DRGs with few separations depict an average cost per patients that is significantly different to that reported nationally. Results for smaller jurisdictions such as Tasmania, NT and the ACT are affected by diseconomies of scale and the requirement to provide comprehensive health care to their populations. Caution should be used when interpreting this information. Due to the relatively few observations within these DRGs, smaller State/Territories (Tasmania, NT and ACT) average cost per patient is not a suitable measure if intended for comparative purposes.

(d) The effects of the interaction and relation between Public and Private sectors in the provision of Tasmanian health service should be considered when interpreting the data. An example of this is the Public Sector is the only provider of Intensive Care Services to the North and North West of the State.

(e) The admitted patient results from the NT will be affected by many factors distinguishing them from the average for the nation. Including, issues of remoteness, poor health status of the population, measurable high instance of chronic disease not reflected in DRG assignment, low numbers of primary care facilities and lack of community based opportunities to aid in discharge planning strategies. NT ALOS is consistently greater or equal to the national average. The reasons for this will vary from DRG to DRG, but typically it is a function of large distances travelled by the patient and there may be language issues and additional supervision prior to surgery (many Indigenous Australians do not speak English as a first language), interruption of the process due to emergency procedures, (only having a single hospital in each location), and few opportunities for those individuals suffering from chronic poverty, and a lack or responsiveness of the DRGs to the high levels of chronic illness many of the Indigenous patients suffer.

Table 11A.114 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c), (d)</i>	<i>ACT (c)</i>	<i>NT (c),(e)</i>	<i>Aust</i>
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(f) The sample size is the number of hospitals contributing to the cost and activity data for each AR-DRG.

(g) Average cost is affected by a number of factors, some of which are admission practices, sample size, remoteness and the type of hospitals contributing to the collection. Direct comparison between jurisdictions is difficult as there are differences in hospital costing systems. In accordance with NHCDC methodology, depreciation and some capital costs are included in these figures, except for Victoria, which did not include depreciation cost in 2009-10 but did in 2010-11 (Round 15).

(h) Instead of O03Z, O04Z (which are DRGs in ARDRG version 5.2), figures are according to DRGs (O03A, O03B, O04A, O04B) in AR-DRG version 6.0x)

ALOS = patient's Average Length of Stay. c = catastrophic. cc = complications and co-morbidities. Or Pr = operating room procedure. s = severe. w/o = without. w = with.

np Not published. – Nil or rounded to zero.

source: IHPA, NHCDC Round 14 (2009-10) v6.0x and Round 15 (2010-11) v6.0x.

Table 11A.115 **Average length of stay for selected maternity AR-DRG (version 6.0x) 2012-13 (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
O01C Caesarean delivery without catastrophic or severe CC									
ALOS (days)									
Public	3.8	3.7	3.3	3.7	4.0	3.8	3.8	4.4	3.7
Private	5.2	5.0	4.6	5.0	5.2	np	np	np	5.0
Total	4.3	4.2	3.9	4.3	4.4	np	np	np	4.2
Separations									
Public	15 170	11 944	8 954	4 737	3 573	775	953	561	46 667
Private	8 508	7 157	6 992	4 156	1 543	np	np	np	29 680
Total	23 678	19 101	15 946	8 893	5 116	np	np	np	76 347
O60C Vaginal delivery single uncomplicated									
ALOS (days)									
Public	1.8	1.8	1.5	1.7	1.7	1.8	1.4	2.1	1.7
Private	3.8	3.9	3.4	3.3	3.9	np	np	np	3.6
Total	2.1	2.2	1.8	2.0	2.0	np	np	np	2.0
Separations									
Public	9 115	4 863	6 623	2 456	1 975	619	584	402	26 637
Private	1 468	1 282	1 260	599	246	np	np	np	5 328
Total	10 583	6 145	7 883	3 055	2 221	np	np	np	31 965

(a) Separations for which the care type was reported as Acute, Newborn (with qualified days) or was not reported. Excludes separations where the length of stay was greater than 120 days. Average length of stay suppressed for private hospitals in Tasmania, the ACT and the NT, or if fewer than 50 separations were reported.

np Not published.

CC=complications and comorbidities

Source: AIHW 2014, *Australian Hospital Statistics 2012-13*, Health Services Series No. 54, Cat no. HSE 145, AIHW, Canberra.

TABLE 11A.116

Table 11A.116 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA (b)</i>	<i>SA (c)</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT (e)</i>	<i>Aust</i>
2004										
Birthweight less than 1500g	no. of live births	813	544	483	270	190	49	60	51	2 460
Apgar score 0	% of live births	1.6	2.0	5.0	2.2	2.1	–	–	3.9	2.4
Apgar score 1-3	% of live births	12.2	13.6	12.4	5.6	13.7	4.1	10.0	17.7	11.8
Apgar score 4-6	% of live births	12.9	7.4	9.3	10.4	6.3	8.2	13.3	11.8	10.1
Apgar score 7-10	% of live births	72.1	75.7	72.7	81.1	77.9	87.8	76.7	66.7	74.7
Birthweight 1500-1999g	no. of live births	910	575	512	280	213	50	89	34	2 663
Apgar score 0	% of live births	0.1	–	–	–	–	–	–	–	–
Apgar score 1-3	% of live births	0.9	0.9	0.8	0.7	–	–	1.1	–	0.8
Apgar score 4-6	% of live births	5.0	2.6	2.9	1.4	2.8	6.0	5.6	–	3.5
Apgar score 7-10	% of live births	93.9	96.3	96.3	97.1	97.2	94.0	93.3	100.0	95.5
Birthweight 2000-2499g	no. of live births	2 593	1 926	1 488	690	558	159	166	175	7 755
Apgar score 0	% of live births	–	0.1	0.1	–	–	–	–	–	0.1
Apgar score 1-3	% of live births	0.5	0.3	0.5	0.1	0.5	–	0.6	0.6	0.4
Apgar score 4-6	% of live births	1.9	2.2	2.0	2.5	3.4	1.3	1.2	4.0	2.2
Apgar score 7-10	% of live births	97.1	97.1	97.2	97.1	96.1	98.8	98.2	95.4	97.1
Birthweight 2500g and over	no. of live births	60 011	40 353	31 948	13 662	11 601	2 949	2 777	2 451	165 752
Apgar score 0	% of live births	–	–	–	–	–	–	0.1	–	–
Apgar score 1-3	% of live births	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.3	0.1
Apgar score 4-6	% of live births	1.0	0.9	0.9	0.7	0.8	1.4	1.0	1.9	0.9
Apgar score 7-10	% of live births	98.6	98.8	98.9	99.1	99.1	98.5	98.7	97.8	98.8
2005										
Birthweight less than 1500g	no. of live births	767	620	484	267	240	44	69	46	2 537
Apgar score 0	% of live births	3.3	2.3	3.7	1.5	2.1	2.3	2.9	4.4	2.8
Apgar score 1-3	% of live births	15.1	16.9	11.4	8.6	13.3	6.8	7.3	19.6	13.7
Apgar score 4-6	% of live births	12.8	10.8	8.1	10.9	7.9	11.4	11.6	10.9	10.6

TABLE 11A.116

Table 11A.116 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA (b)</i>	<i>SA (c)</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT (e)</i>	<i>Aust</i>
Apgar score 7-10	% of live births	67.4	68.9	76.5	78.3	76.7	79.5	78.3	65.2	72.0
Birthweight 1500-1999g	no. of live births	910	586	565	282	224	52	66	59	2 744
Apgar score 0	% of live births	–	0.2	–	0.4	–	–	–	–	0.1
Apgar score 1-3	% of live births	1.4	0.7	0.7	1.1	–	–	1.5	–	0.9
Apgar score 4-6	% of live births	4.2	3.9	2.8	3.9	4.5	1.9	3.0	3.4	3.7
Apgar score 7-10	% of live births	93.5	94.7	96.5	94.7	95.5	98.1	95.5	96.6	94.9
Birthweight 2000-2499g	no. of live births	2 701	1 953	1 650	741	621	174	159	169	8 168
Apgar score 0	% of live births	0.1	0.1	–	–	–	0.5	–	–	0.1
Apgar score 1-3	% of live births	0.4	0.5	0.4	0.3	0.3	–	1.3	1.2	0.4
Apgar score 4-6	% of live births	2.5	2.4	1.6	1.6	2.1	1.7	0.6	2.4	2.1
Apgar score 7-10	% of live births	96.4	96.9	97.7	97.8	97.6	97.1	98.1	96.5	97.0
Birthweight 2500g and over	no. of live births	62 819	42 376	34 917	14 659	12 078	3 652	2 811	2 607	175 919
Apgar score 0	% of live births	–	–	–	–	–	–	–	0.1	–
Apgar score 1-3	% of live births	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1
Apgar score 4-6	% of live births	1.0	0.9	0.7	0.8	1.3	1.0	0.6	2.1	0.9
Apgar score 7-10	% of live births	98.7	98.9	99.1	99.1	98.6	98.9	99.3	97.6	98.8
2006										
Birthweight less than 1500g	no. of live births	1 014	455	585	299	196	40	75	52	2 716
Apgar score 0	% of live births	3.7	2.4	3.2	2.3	2.0	2.5	–	–	2.9
Apgar score 1-3	% of live births	10.6	12.6	13.2	7.4	4.6	7.5	18.7	17.3	11.0
Apgar score 4-6	% of live births	12.5	12.6	9.2	13.0	9.7	20.0	5.3	7.7	11.5
Apgar score 7-10	% of live births	71.4	71.4	73.7	76.3	83.7	70.0	76.0	75.0	73.5
Birthweight 1500-1999g	no. of live births	1 012	641	590	308	193	54	73	56	2 927
Apgar score 0	% of live births	0.2	0.1	–	–	–	1.9	–	5.4	0.2
Apgar score 1-3	% of live births	1.1	1.2	1.0	0.3	–	1.9	–	–	0.9
Apgar score 4-6	% of live births	5.1	4.7	3.7	4.9	3.1	3.7	5.5	–	4.5

TABLE 11A.116

Table 11A.116 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA (b)</i>	<i>SA (c)</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT (e)</i>	<i>Aust</i>
Apgar score 7-10	% of live births	93.2	93.7	95.1	94.8	96.9	92.6	94.5	94.6	94.1
Birthweight 2000-2499g	no. of live births	2 872	2 042	1 673	798	616	194	172	187	8 554
Apgar score 0	% of live births	–	0.1	0.1	–	–	–	–	–	0.1
Apgar score 1-3	% of live births	0.5	0.4	0.3	0.6	0.5	0.5	1.7	–	0.4
Apgar score 4-6	% of live births	1.9	2.1	1.4	2.8	2.1	1.0	3.5	1.6	2.0
Apgar score 7-10	% of live births	97.0	97.1	97.5	96.6	97.4	98.5	94.8	98.4	97.2
Birthweight 2500g and over	no. of live births	64 305	44 192	35 847	15 735	12 538	3 845	3 145	2 637	182 244
Apgar score 0	% of live births	–	–	–	–	–	0.1	–	0.1	–
Apgar score 1-3	% of live births	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1
Apgar score 4-6	% of live births	1.0	0.9	0.7	0.8	1.0	0.9	1.1	1.7	0.9
Apgar score 7-10	% of live births	98.6	98.8	99.1	99.0	98.9	99.0	98.7	98.1	98.8
2007										
Birthweight less than 1500g	no. of live births	774	658	543	289	215	71	64	57	2 671
Apgar score 0	% of live births	2.1	3.0	2.6	1.4	1.4	9.9	1.6	–	2.4
Apgar score 1-3	% of live births	13.8	14.3	10.3	8.0	11.2	5.6	21.9	14.0	12.4
Apgar score 4-6	% of live births	14.3	15.5	12.0	15.9	9.3	9.9	18.8	22.8	14.1
Apgar score 7-10	% of live births	69.8	66.1	74.4	74.7	78.1	74.7	57.8	59.6	70.6
Birthweight 1500-1999g	no. of live births	942	712	610	344	195	88	89	45	3 025
Apgar score 0	% of live births	0.1	0.1	–	–	–	–	–	–	0.1
Apgar score 1-3	% of live births	1.7	1.1	1.1	1.2	0.5	1.1	–	–	1.2
Apgar score 4-6	% of live births	5.4	5.1	5.2	5.2	7.2	–	6.7	8.8	5.3
Apgar score 7-10	% of live births	92.8	93.4	93.1	93.0	92.3	98.9	93.3	88.9	93.1
Birthweight 2000-2499g	no. of live births	2 827	2 067	1 667	858	653	261	165	166	8 664
Apgar score 0	% of live births	0.1	–	0.1	0.1	0.2	–	–	–	0.1
Apgar score 1-3	% of live births	0.6	0.5	0.5	0.2	0.5	–	–	1.8	0.5
Apgar score 4-6	% of live births	2.9	3.1	1.6	2.2	1.5	1.2	–	3.0	2.4

TABLE 11A.116

Table 11A.116 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA (b)</i>	<i>SA (c)</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT (e)</i>	<i>Aust</i>
Apgar score 7-10	% of live births	96.4	96.1	97.7	97.2	97.9	98.9	97.6	95.8	96.9
Birthweight 2500g and over	no. of live births	66 970	46 496	38 689	16 110	13 194	5 849	3 304	2 721	193 333
Apgar score 0	% of live births	–	–	–	–	–	0.2	–	–	–
Apgar score 1-3	% of live births	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.3	0.1
Apgar score 4-6	% of live births	1.0	1.2	0.7	1.0	1.1	0.9	1.2	1.8	1.0
Apgar score 7-10	% of live births	98.9	98.6	99.0	98.8	98.7	98.9	98.5	97.8	98.8
2008										
Birthweight less than 1500g	no. of live births	849	628	564	298	204	53	65	47	2 708
Apgar score 0	% of live births	3.1	3.0	2.1	1.3	1.5	9.4	–	6.4	3
Apgar score 1-3	% of live births	17.1	13.5	14.2	7.4	14.2	9.4	15.4	14.9	14
Apgar score 4-6	% of live births	14.6	19.9	12.8	17.8	9.3	7.6	30.8	23.4	16
Apgar score 7-10	% of live births	64.2	63.5	70.4	73.5	75.0	73.6	53.9	53.2	67
Birthweight 1500-1999g	no. of live births	1 052	628	602	332	240	98	74	43	3 069
Apgar score 0	% of live births	0.3	3.0	–	0.3	–	–	1.4	–	1
Apgar score 1-3	% of live births	0.8	13.5	1.5	0.6	0.8	2.0	4.1	2.3	4
Apgar score 4-6	% of live births	5.6	19.9	5.3	6.6	3.3	4.1	16.2	4.7	9
Apgar score 7-10	% of live births	93.3	63.5	92.9	92.5	95.8	93.9	78.4	93.0	87
Birthweight 2000-2499g	no. of live births	2 880	1 985	1 706	817	605	290	159	185	8 627
Apgar score 0	% of live births	–	0.1	0.1	–	–	0.3	–	–	0
Apgar score 1-3	% of live births	0.6	0.4	0.5	0.6	0.3	0.3	–	–	0
Apgar score 4-6	% of live births	2.4	3.2	1.8	1.7	2.8	1.7	1.3	1.1	2
Apgar score 7-10	% of live births	96.2	96.3	97.5	97.4	96.9	97.6	98.7	98.4	97
Birthweight 2500g and over	no. of live births	67 810	46 453	39 344	16 439	13 402	5 959	3 367	2 742	195 516
Apgar score 0	% of live births	–	–	–	–	–	0.2	–	0.1	0
Apgar score 1-3	% of live births	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.1	0
Apgar score 4-6	% of live births	1.0	1.3	0.8	1.0	0.9	0.8	1.6	1.6	1

TABLE 11A.116

Table 11A.116 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA (b)</i>	<i>SA (c)</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT (e)</i>	<i>Aust</i>
Apgar score 7-10	% of live births	98.5	98.6	99.0	98.9	99.0	99.0	98.0	98.1	98.7
2009										
Birthweight less than 1500g	no. of live births	829	659	537	327	222	829	68	52	3 523
Apgar score 0	% of live births	2.1	1.5	3.7	2.1	2.3	2.1	1.5	1.9	2.2
Apgar score 1-3	% of live births	17.0	15.5	12.7	7.3	7.2	17.0	8.8	21.2	14.4
Apgar score 4-6	% of live births	11.8	14.1	14.3	17.1	8.6	11.8	27.9	9.6	13.2
Apgar score 7-10	% of live births	67.4	64.8	66.7	72.8	82.0	67.4	61.8	67.3	68.1
Birthweight 1500-1999g	no. of live births	933	793	618	325	260	933	67	61	3 990
Apgar score 0	% of live births	0.3	0.4	–	0.6	–	0.3	–	–	0.3
Apgar score 1-3	% of live births	0.9	1.1	0.8	1.2	1.5	0.9	4.5	1.6	1.1
Apgar score 4-6	% of live births	4.5	7.2	4.5	9.2	5.0	4.5	10.5	13.1	5.7
Apgar score 7-10	% of live births	93.9	90.7	94.3	88.6	93.5	93.9	85.1	83.4	92.6
Birthweight 2000-2499g	no. of live births	2 847	2 050	1 843	837	669	2 847	184	204	11 481
Apgar score 0	% of live births	–	–	–	–	–	0.0	–	–	0.0
Apgar score 1-3	% of live births	0.6	0.5	0.8	0.4	0.1	0.6	1.1	–	0.6
Apgar score 4-6	% of live births	2.9	3.1	2.3	3.1	4.2	2.9	3.8	3.4	3.0
Apgar score 7-10	% of live births	96.0	96.3	96.7	96.3	98.8	96.0	95.1	96.6	96.3
Birthweight 2500g and over	no. of live births	67 545	47 025	39 765	16 581	13 345	67 545	3 540	2 749	258 095
Apgar score 0	% of live births	–	–	–	–	–	0.0	0.1	–	–
Apgar score 1-3	% of live births	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1
Apgar score 4-6	% of live births	1.1	1.3	1.0	1.1	1.1	1.1	1.8	1.7	1.1
Apgar score 7-10	% of live births	98.4	98.4	98.7	98.7	98.8	98.4	98.1	98.2	98.5
2010										
Birthweight less than 1500g	no. of live births	841	686	585	277	214	841	74	54	3 572
Apgar score 0	% of live births	2.0	1.5	3.2	1.4	0.9	2.0	1.4	–	2.0

TABLE 11A.116

Table 11A.116 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA (b)</i>	<i>SA (c)</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT (e)</i>	<i>Aust</i>
Apgar score 1-3	% of live births	14.9	15.6	15.7	6.9	10.3	14.9	16.2	18.5	14.3
Apgar score 4-6	% of live births	15.1	18.8	16.1	16.3	9.3	15.1	12.2	24.1	15.8
Apgar score 7-10	% of live births	67.3	62.8	63.9	75.5	79.4	67.3	70.3	57.4	67.2
Birthweight 1500-1999g	no. of live births	964	714	603	300	261	964	73	55	3 934
Apgar score 0	% of live births	–	0.3	0.2	–	0.4	–	1.4	–	0.1
Apgar score 1-3	% of live births	1.5	1.0	1.5	1.3	0.8	1.5	–	1.8	1.3
Apgar score 4-6	% of live births	5.0	8.0	5.6	8.3	5.0	5.0	5.5	9.1	5.9
Apgar score 7-10	% of live births	93.0	90.5	92.2	90.3	93.9	93.0	93.2	89.1	92.2
Birthweight 2000-2499g	no. of live births	2 852	2 153	1 796	800	659	2 852	179	163	11 454
Apgar score 0	% of live births	–	0.0	0.1	0.1	–	–	0.6	–	0.0
Apgar score 1-3	% of live births	0.6	0.5	0.5	0.1	0.2	0.6	0.6	1.2	0.5
Apgar score 4-6	% of live births	2.9	3.7	3.2	3.8	2.0	2.9	2.2	3.7	3.1
Apgar score 7-10	% of live births	96.1	95.5	96.0	95.6	97.9	96.1	96.7	95.1	96.1
Birthweight 2500g and over	no. of live births	66 894	48 599	39 878	16 723	13 462	66 894	3 726	2 758	258 934
Apgar score 0	% of live births	–	0.0	–	–	–	–	0.1	–	–
Apgar score 1-3	% of live births	0.2	0.2	0.2	0.1	0.1	0.2	0.3	0.2	0.2
Apgar score 4-6	% of live births	1.1	1.3	1.0	1.3	1.2	1.1	1.1	1.7	1.2
Apgar score 7-10	% of live births	98.4	98.3	98.8	98.6	98.7	98.4	98.6	98.1	98.4
2011										
Birthweight less than 1500g	no. of live births	884	620	563	283	204	884	81	55	3 574
Apgar score 0	% of live births	3.5	0.3	2.7	1.8	2.9	3.5	–	np	na
Apgar score 1-3	% of live births	14.5	12.9	13.5	6.0	3.9	14.5	17.3	9.1	12.8
Apgar score 4-6	% of live births	13.1	17.9	16.7	17.7	14.2	13.1	17.3	9.1	15.0
Apgar score 7-10	% of live births	68.0	63.5	66.1	74.2	78.9	68.0	65.4	78.2	68.1

TABLE 11A.116

Table 11A.116 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA (b)</i>	<i>SA (c)</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT (e)</i>	<i>Aust</i>
Birthweight 1500-1999g	no. of live births	941	745	635	290	242	941	104	64	3 962
Apgar score 0	% of live births	0.4	–	0.2	–	–	0.4	–	–	0.2
Apgar score 1-3	% of live births	1.1	1.2	0.9	0.3	0.8	1.1	2.9	np	na
Apgar score 4-6	% of live births	7.0	9.1	5.8	5.9	4.5	7.0	7.7	7.8	7.0
Apgar score 7-10	% of live births	91.0	89.0	92.9	93.5	94.6	91.0	89.4	90.6	91.3
Birthweight 2000-2499g	no. of live births	2 955	2 212	1 730	849	752	2 955	204	196	11 853
Apgar score 0	% of live births	0.1	–	–	–	–	0.1	–	np	na
Apgar score 1-3	% of live births	0.8	0.7	1.1	0.5	0.1	0.8	–	–	0.7
Apgar score 4-6	% of live births	2.4	3.2	3.0	4.1	3.6	2.4	6.4	3.1	2.9
Apgar score 7-10	% of live births	96.2	95.4	95.7	95.5	96.3	96.2	93.6	96.4	95.9
Birthweight 2500g and over	no. of live births	68 594	49 166	40 505	17 391	13 958	68 594	3 675	2 748	264 631
Apgar score 0	% of live births	–	–	–	–	–	–	–	–	–
Apgar score 1-3	% of live births	0.2	0.2	0.2	0.1	0.1	0.2	0.2	np	na
Apgar score 4-6	% of live births	1.2	1.4	1.0	1.2	1.4	1.2	1.6	1.6	1.2
Apgar score 7-10	% of live births	98.3	98.2	98.7	98.6	98.5	98.3	98.1	98.3	98.4
2012										
Birthweight less than 1500g	no. of live births	842	670	591	296	227	913	83	44	3 666
Apgar score 0	% of live births	2.1	2.1	2.5	1.0	2.6	3.1	–	np	na
Apgar score 1-3	% of live births	12.9	14.9	14.4	3.0	10.1	14.6	12.1	np	na
Apgar score 4-6	% of live births	14.4	17.3	14.4	16.6	10.6	14.1	15.7	20.5	14.9
Apgar score 7-10	% of live births	69.0	64.5	67.2	79.1	76.7	67.5	72.3	70.5	68.9
Birthweight 1500-1999g	no. of live births	1 000	758	647	311	281	1 364	81	47	4 489
Apgar score 0	% of live births	–	0.1	–	–	0.4	0.3	–	–	0.1
Apgar score 1-3	% of live births	1.3	0.9	2.2	1.3	0.4	1.0	–	np	na
Apgar score 4-6	% of live births	4.3	6.9	5.0	6.8	3.9	5.5	9.9	np	na
Apgar score 7-10	% of live births	94.3	91.7	92.9	92.0	95.4	92.6	90.1	95.7	93.0

TABLE 11A.116

Table 11A.116 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA (b)</i>	<i>SA (c)</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT (e)</i>	<i>Aust</i>
Birthweight 2000-2499g	no. of live births	2 959	2 258	1 907	873	742	3 630	208	188	12 765
Apgar score 0	% of live births	0.1	0.1	–	–	–	0.1	–	–	–
Apgar score 1-3	% of live births	0.4	0.5	0.6	0.5	0.1	0.6	0.5	np	na
Apgar score 4-6	% of live births	3.3	3.3	3.0	4.2	3.0	2.6	3.4	3.2	3.1
Apgar score 7-10	% of live births	95.7	95.9	96.4	95.2	96.9	96.3	96.2	96.3	96.1
Birthweight 2500g and over	no. of live births	69 208	52 578	41 784	18 096	14 239	73 524	4 116	2 896	276 441
Apgar score 0	% of live births	–	–	–	–	–	–	–	np	na
Apgar score 1-3	% of live births	0.1	0.2	0.2	0.1	0.1	0.2	0.2	0.3	0.2
Apgar score 4-6	% of live births	1.3	1.5	1.2	1.4	1.4	1.1	2.2	1.5	1.3
Apgar score 7-10	% of live births	98.3	98.2	98.5	98.4	98.5	98.3	97.6	98.1	98.3
2013										
Birthweight less than 1500g	no. of live births	846	726	544	294	225	na	80	50	2 765
Apgar score 0	% of live births	2.5	2.8	2.9	0.3	1.8	na	1.3	14.0	na
Apgar score 1-3	% of live births	12.6	16.0	15.6	5.1	6.2	na	12.5	12.0	na
Apgar score 4-6	% of live births	14.4	14.6	15.1	19.1	15.6	na	17.5	22.0	na
Apgar score 7-10	% of live births	69.3	65.4	64.5	75.5	76.4	na	68.8	48.0	na
Birthweight 1500-1999g	no. of live births	965	757	648	374	297	na	70	64	3 175
Apgar score 0	% of live births	0.1	0.1	–	0.3	0.3	na	–	np	na
Apgar score 1-3	% of live births	1.6	1.2	1.5	0.8	0.3	na	1.4	np	na
Apgar score 4-6	% of live births	6.5	6.6	7.3	7.5	5.4	na	8.6	9.4	na
Apgar score 7-10	% of live births	91.0	90.9	90.6	90.9	93.9	na	90.0	87.5	na
Birthweight 2000-2499g	no. of live births	3 021	2 407	1 815	904	708	na	210	172	9 237
Apgar score 0	% of live births	–	–	0.1	0.1	–	na	0.5	np	na
Apgar score 1-3	% of live births	0.6	0.3	0.4	0.4	0.6	na	0.5	np	na
Apgar score 4-6	% of live births	2.6	3.9	4.2	4.2	2.8	na	3.3	2.9	na
Apgar score 7-10	% of live births	96.1	95.3	95.0	95.1	96.6	na	95.7	95.9	na

Table 11A.116 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA (b)</i>	<i>SA (c)</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT (e)</i>	<i>Aust</i>
Birthweight 2500g and over	no. of live births	67 065	53 069	41 458	18 485	14 046	na	4 444	2 960	201 527
Apgar score 0	% of live births	0.1	–	–	–	–	na	–	np	na
Apgar score 1-3	% of live births	0.2	0.2	0.2	0.2	0.1	na	0.3	0.4	na
Apgar score 4-6	% of live births	1.4	1.5	1.4	1.4	1.3	na	1.5	2.2	na
Apgar score 7-10	% of live births	98.0	98.1	98.3	98.4	98.5	na	98.2	97.6	na

(a) Data for 2013 for Victoria are preliminary.

(b) Data for WA for 2013 are preliminary. The low Apgar rate for 2012 would seem to indicate that babies belonging in the numerator were not available for reporting at the time of extract.

(c) SA data exclude live births if Apgar scores are not recorded. Data for 2013 are preliminary.

(d) Between 12 and 15 per cent of births each year in the ACT are to non-residents of the ACT.

(e) 2005 data exclude one baby with birthweight 0–1499g with unknown Apgar score.

na Not available. – Nil or rounded to zero.

Source: State and Territory governments (unpublished).

TABLE 11A.117

Table 11A.117

Fetal deaths (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (b)</i>	<i>NT</i>	<i>Aust (b) (c)</i>
2003										
Total all births (d)	no.	86 772	61 498	48 644	24 465	17 584	5 808	4 159	3 838	252 799
Fetal deaths (e), (f)	no.	428	440	302	192	141	56	31	48	1 638
Fetal death rate	per 1000 total relevant births	4.9	7.2	6.2	7.8	8.0	9.6	7.5	12.5	6.5
2004										
Total all births (d)	no.	86 367	62 919	50 275	25 492	17 263	5 853	4 199	3 577	255 971
Fetal deaths (e), (f)	no.	473	502	335	197	123	44	25	26	1 725
Fetal death rate	per 1000 total relevant births	5.5	8.0	6.7	7.7	7.1	7.5	6.0	7.3	6.7
2005										
Total all births (d)	no.	91 718	63 821	52 094	26 444	17 911	6 363	4 246	3 702	266 330
Fetal deaths (e), (f)	no.	494	524	387	191	110	53	36	42	1 837
Fetal death rate	per 1000 total relevant births	5.4	8.2	7.4	7.2	6.1	8.3	8.5	11.3	6.9
2006										
Total all births (d)	no.	92 708	65 592	53 054	27 941	18 342	6 518	4 525	3 735	272 444
Fetal deaths (e), (f)	no.	520	347	359	164	82	43	41	39	1 595
Fetal death rate	per 1000 total relevant births	5.6	5.3	6.8	5.9	4.5	6.6	9.1	10.4	5.9
2007										
Total all births (d)	no.	96 847	70 732	61 740	29 326	19 744	6 704	4 787	3 925	293 828
Fetal deaths (e), (f)	no.	496	407	434	161	78	41	30	29	1 676
Fetal death rate	per 1000 total relevant births	5.1	5.8	7.0	5.5	4.0	6.1	6.3	7.4	5.7
2008										
Total all births (d)	no.	100 744	71 564	63 590	32 052	20 324	6 822	4 822	3 965	303 920
Fetal deaths (e), (f)	no.	468	380	422	201	95	47	14	21	1 648
Fetal death rate	per 1000 total relevant births	4.6	5.3	6.6	6.3	4.7	6.9	2.9	5.3	5.4
2009										
Total all births (d)	no.	98 726	71 360	66 590	31 094	19 810	6 684	4 885	3 859	303 033

TABLE 11A.117

Table 11A.117

Fetal deaths (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (b)</i>	<i>NT</i>	<i>Aust (b) (c)</i>
Fetal deaths (e), (f)	no.	495	432	441	215	75	57	25	39	1 780
Fetal death rate	per 1000 total relevant births	5.0	6.1	6.6	6.9	3.8	8.5	5.1	10.1	5.9
2010										
Total all births (d)	no.	101 765	70 979	64 964	31 609	20 156	6 439	5 224	3 930	305 085
Fetal deaths (e), (f)	no.	499	407	441	185	78	54	72	31	1 767
Fetal death rate	per 1000 total relevant births	4.9	5.7	6.8	5.9	3.9	8.4	13.8	7.9	5.8
2011										
Total all births (d)	no.	99 567	71 844	63 630	32 513	19 981	6 657	5 149	3 988	303 365
Fetal deaths (e), (f)	no.	513	400	377	254	89	49	28	34	1 748
Fetal death rate	per 1000 total relevant births	5.2	5.6	5.9	7.8	4.5	7.4	5.4	8.5	5.8
2012										
Total all births (d)	no.	99 025	77 840	64 289	33 866	20 504	6 213	5 502	4 127	311 414
Fetal deaths (e), (f)	no.	517	435	452	239	71	45	41	23	1 832
Fetal death rate	per 1000 total relevant births	5.2	5.6	7.0	7.1	3.5	7.2	7.5	5.6	5.9

(a) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table is 2010 (preliminary). See ABS Causes of Death (cat. no. 3303.0) 2010 Explanatory Notes 35-39 and Technical Notes, Causes of Death Revisions, 2006 and Causes of Death Revisions, 2008 and 2009.

(b) Data may exclude stillbirth data which were not received or processed by the ABS in time for the finalisation of the 2008 reference year. According to scope rules, these 2008 data will be included in the 2010 reference year.

(c) All states and territories, including other territories

(d) All births is the number of live births and fetal deaths combined. Fetal deaths by definition include only infants of a gestational age of at least 20 weeks or weighing at least 400 grams.

(e) Perinatal deaths (including fetal deaths) for years 2003-2007 have been subject to a revision of scope rules. See ABS Perinatal Deaths, Australia, 2007 (cat.no. 3304.0) Explanatory Notes 18-20 for further information.

(f) Fetal death (stillbirth) is the birth of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Fetal deaths by definition include only infants of a gestational age of at least 20 weeks or weighing at least 400 grams.

Source: ABS Perinatal deaths, Australia, Cat. no. 3304.0, Canberra (unpublished).

TABLE 11A.118

Table 11A.118 Neonatal deaths (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (b)</i>
2003										
Total live births (c)	no.	86 344	61 058	48 342	24 273	17 443	5 752	4 128	3 790	251 161
Neonatal deaths (d), (e)	no.	272	250	153	62	40	27	16	21	841
Neonatal death rate	per 1000 live births	3.2	4.1	3.2	2.6	2.3	4.7	3.9	5.5	3.3
2004										
Total live births (c)	no.	85 894	62 417	49 940	25 295	17 140	5 809	4 174	3 551	254 246
Neonatal deaths (d), (e)	no.	272	206	186	55	36	15	25	21	816
Neonatal death rate	per 1000 live births	3.2	3.3	3.7	2.2	2.1	2.6	6.0	5.9	3.2
2005										
Total live births (c)	no.	91 224	63 297	51 707	26 253	17 801	6 310	4 210	3 660	264 493
Neonatal deaths (d), (e)	no.	309	242	192	76	59	13	20	21	932
Neonatal death rate	per 1000 live births	3.4	3.8	3.7	2.9	3.3	2.1	4.8	5.7	3.5
2006										
Total live births (c)	no.	92 188	65 245	52 695	27 777	18 260	6 475	4 484	3 696	270 849
Neonatal deaths (d), (e)	no.	301	201	185	93	33	16	15	20	864
Neonatal death rate	per 1000 live births	3.3	3.1	3.5	3.3	1.8	2.5	3.3	5.4	3.2
2007										
Total live births (c)	no.	96 351	70 325	61 306	29 165	19 666	6 663	4 757	3 896	292 152
Neonatal deaths (d), (e)	no.	286	200	218	40	55	21	15	21	856
Neonatal death rate	per 1000 live births	3.0	2.8	3.6	1.4	2.8	3.2	3.2	5.4	2.9
2008										
Total live births (c)	no.	100 276	71 184	63 168	31 851	20 229	6 775	4 808	3 944	302 272
Neonatal deaths (d), (e)	no.	317	187	209	60	37	15	17	10	853
Neonatal death rate	per 1000 live births	3.2	2.6	3.3	1.9	1.8	2.2	3.5	2.5	2.8
2009										
Total live births (c)	no.	98 231	70 928	66 149	30 879	19 735	6 627	4 860	3 820	301 253

Table 11A.118 Neonatal deaths (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (b)</i>
Neonatal deaths (d), (e)	no.	287	204	253	58	48	14	9	18	891
Neonatal death rate	per 1000 live births	2.9	2.9	3.8	1.9	2.4	2.1	1.9	4.7	3.0
2010										
Total live births (c)	no.	101 266	70 572	64 523	31 424	20 078	6 385	5 152	3 899	303 318
Neonatal deaths (d), (e)	no.	279	159	243	68	44	16	15	18	842
Neonatal death rate	per 1000 live births	2.8	2.3	3.8	2.2	2.2	2.5	2.9	4.6	2.8
2011										
Total live births (c)	no.	99 054	71 444	63 253	32 259	19 892	6 608	5 121	3 954	301 617
Neonatal deaths (d), (e)	no.	284	185	199	63	30	18	9	17	805
Neonatal death rate	per 1000 live births	2.9	2.6	3.1	2.0	1.5	2.7	1.8	4.3	2.7
2012										
Total live births (c)	no.	98 508	77 405	63 837	33 627	20 433	6 168	5 461	4 104	309 582
Neonatal deaths (d), (e)	no.	229	164	190	46	49	18	14	16	726
Neonatal death rate	per 1000 live births	2.3	2.1	3.0	1.4	2.4	2.9	2.6	3.9	2.3

(a) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table is 2010 (preliminary). See ABS Causes of Death (cat. no. 3303.0) 2010 Explanatory Notes 35-39 and Technical Notes, Causes of Death Revisions, 2006 and Causes of Death Revisions, 2008 and 2009.

(b) All states and territories, including other territories

(c) Total live births are all live births registered in the calendar year.

(d) Perinatal deaths (including neonatal deaths) for years 2003-2007 have been subject to a revision of scope rules. See ABS Perinatal Deaths, Australia, 2007 (cat.no. 3304.0) Explanatory Notes 18-20 for further information.

(e) A neonatal death is the death within 28 days of birth of a child who after delivery, breathes or shows any evidence of life such as a heartbeat.

Source: ABS Perinatal deaths, Australia, Cat. no. 3304.0, Canberra (unpublished).

Table 11A.119 **Neonatal, fetal and perinatal death rates, Australia (a)**

	<i>Fetal death rate (b)</i>	<i>Neonatal death rate (c)</i>	<i>Perinatal death rate (d)</i>
2003	6.5	3.3	9.8
2004	6.7	3.2	9.9
2005	6.9	3.5	10.4
2006	5.9	3.2	9.0
2007	5.7	2.9	8.6
2008	5.4	2.8	8.2
2009	5.9	3.0	8.8
2010	5.8	2.8	8.6
2011	5.8	2.7	8.4
2012	5.9	2.3	8.2

(a) Perinatal deaths (including fetal and neonatal deaths) for years 2003-2007 have been subject to a revision of scope rules. See ABS Perinatal Deaths, Australia, 2007 (cat.no. 3304.0) Explanatory Notes 18-20 for further information.

(b) Fetal death (stillbirth) is the birth of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Fetal deaths by definition include only infants of a gestational age of at least 20 weeks or weighing at least 400 grams.

(c) A neonatal death is the death within 28 days of birth of a child who after delivery, breathes or shows any evidence of life such as a heartbeat.

(d) Perinatal deaths are fetal and neonatal deaths combined. Fetal deaths exclude those records where gestational age was less than 20 weeks or birthweight was known to be less than 400 grams.

Source: ABS Perinatal deaths, Australia, Cat. no. 3304.0, Canberra (unpublished).

TABLE 11A.120

Table 11A.120 Perinatal deaths (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (b)</i>	<i>NT</i>	<i>Aust (b) (c)</i>
2003										
Total all births (d)	no.	86 772	61 498	48 644	24 465	17 584	5 808	4 159	3 838	252 799
Perinatal deaths (e), (f)	no.	700	690	455	254	181	83	47	69	2 479
Perinatal death rate	per 1000 total births	8.1	11.2	9.4	10.4	10.3	14.3	11.3	18.0	9.8
2004										
Total all births (d)	no.	86 367	62 919	50 275	25 492	17 263	5 853	4 199	3 577	255 971
Perinatal deaths (e), (f)	no.	745	708	521	252	159	59	50	47	2 541
Perinatal death rate	per 1000 total births	8.6	11.3	10.4	9.9	9.2	10.1	11.9	13.1	9.9
2005										
Total all births (d)	no.	91 718	63 821	52 094	26 444	17 911	6 363	4 246	3 702	266 330
Perinatal deaths (e), (f)	no.	803	766	579	267	169	66	56	63	2 769
Perinatal death rate	per 1000 total births	8.8	12.0	11.1	10.1	9.4	10.4	13.2	17.0	10.4
2006										
Total all births (d)	no.	92 708	65 592	53 054	27 941	18 342	6 518	4 525	3 735	272 444
Perinatal deaths (e), (f)	no.	821	548	544	257	115	59	56	59	2 459
Perinatal death rate	per 1000 total births	8.9	8.4	10.3	9.2	6.3	9.1	12.4	15.8	9.0
2007										
Total all births (d)	no.	96 847	70 732	61 740	29 326	19 744	6 704	4 787	3 925	293 828
Perinatal deaths (e), (f)	no.	782	607	652	201	133	62	45	50	2 532
Perinatal death rate	per 1000 total births	8.1	8.6	10.6	6.9	6.7	9.2	9.4	12.7	8.6
2008										
Total all births (d)	no.	100 744	71 564	63 590	32 052	20 324	6 822	4 822	3 965	303 920
Perinatal deaths (e), (f)	no.	785	567	631	261	132	62	31	31	2 501
Perinatal death rate	per 1000 total births	7.8	7.9	9.9	8.1	6.5	9.1	6.4	7.8	8.2
2009										
Total all births (d)	no.	98 726	71 360	66 590	31 094	19 810	6 684	4 885	3 859	303 033

TABLE 11A.120

Table 11A.120 **Perinatal deaths (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (b)</i>	<i>NT</i>	<i>Aust (b) (c)</i>
Perinatal deaths (e), (f)	no.	782	636	694	273	123	71	34	57	2 671
Perinatal death rate	per 1000 total births	7.9	8.9	10.4	8.8	6.2	10.6	7.0	14.8	8.8
2010										
Total all births (d)	no.	101 765	70 979	64 964	31 609	20 156	6 439	5 224	3 930	305 085
Perinatal deaths (e), (f)	no.	778	566	684	253	122	70	87	49	2 609
Perinatal death rate	per 1000 total births	7.6	8.0	10.5	8.0	6.1	10.9	16.7	12.5	8.6
2011										
Total all births (d)	no.	99 567	71 844	63 630	32 513	19 981	6 657	5 149	3 988	303 365
Perinatal deaths (e), (f)	no.	797	585	576	317	119	67	37	51	2 553
Perinatal death rate	per 1000 total births	8.0	8.1	9.1	9.7	6.0	10.1	7.2	12.8	8.4
2012										
Total all births (d)	no.	99 025	77 840	64 289	33 866	20 504	6 213	5 502	4 127	311 414
Perinatal deaths (e), (f)	no.	746	599	642	285	120	63	55	39	2 558
Perinatal death rate	per 1000 total births	7.5	7.7	10.0	8.4	5.9	10.1	10.0	9.4	8.2

- (a) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table is 2010 (preliminary). See ABS Causes of Death (cat. no. 3303.0) 2010 Explanatory Notes 35-39 and Technical Notes, Causes of Death Revisions, 2006 and Causes of Death Revisions, 2008 and 2009.
- (b) Data may exclude stillbirth data which were not received or processed by the ABS in time for the finalisation of the 2008 reference year. According to scope rules, these 2008 data will be included in the 2010 reference year.
- (c) All states and territories, including other territories
- (d) Total all births is the number live births and fetal deaths combined. Fetal deaths by definition include only infants of a gestational age of at least 20 weeks or weighing at least 400 grams.
- (e) Perinatal deaths for years 2003-2007 have been subject to a revision of scope rules. See ABS Perinatal Deaths, Australia, 2007 (cat.no. 3304.0) Explanatory Notes 18-20 for further information.
- (f) Perinatal deaths are fetal and neonatal deaths combined. Fetal deaths exclude those records where gestational age was less than 20 weeks or birthweight was known to be less than 400 grams.

Table 11A.120 Perinatal deaths (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (b)</i>	<i>NT</i>	<i>Aust (b) (c)</i>
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Source: ABS Perinatal deaths, Australia, Cat. no. 3304.0, Canberra (unpublished).

TABLE 11A.121

Table 11A.121 **Perinatal, neonatal and fetal deaths (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (d)</i>
2004–2008										
Fetal deaths (e)										
Aboriginal and Torres Strait Islander Australians										
Total all births (f)	no.	18 000	na	19 592	10 065	3 911	na	na	7 811	59 379
Fetal deaths	no.	89	na	160	79	23	na	na	97	448
Fetal death rate	per 1000 total births	4.9	na	8.2	7.8	5.9	na	na	12.4	7.5
Other Australians (g)										
Total all births (f)	no.	428 449	na	260 992	131 187	89 668	na	na	11 088	921 384
Fetal deaths	no.	2 362	na	1 777	835	465	na	na	60	5 499
Fetal death rate	per 1000 total births	5.5	na	6.8	6.4	5.2	na	na	5.4	6.0
Neonatal deaths (h)										
Aboriginal and Torres Strait Islander Australians										
Total live births (i)	no.	17 911	na	19 432	9 986	3 888	na	na	7 714	58 931
Neonatal deaths	no.	84	na	116	49	15	na	na	65	329
Neonatal death rate	per 1000 live births	4.7	na	6.0	4.9	3.9	na	na	8.4	5.6
Other Australians (g)										
Total live births (i)	no.	426 087	na	259 215	130 352	89 203	na	na	11 028	915 885
Neonatal deaths	no.	1 401	na	874	275	205	na	na	28	2 783
Neonatal death rate	per 1000 live births	3.3	na	3.4	2.1	2.3	na	na	2.5	3.0
Perinatal deaths (j)										
Aboriginal and Torres Strait Islander Australians										
Total all births (f)	no.	18 000	na	19 592	10 065	3 911	na	na	7 811	59 379
Perinatal deaths	no.	173	na	276	128	38	na	na	162	777
Perinatal death rate	per 1000 total births	9.6	na	14.1	12.7	9.7	na	na	20.7	13.1
Other Australians (g)										
Total all births (f)	no.	428 449	na	260 992	131 187	89 668	na	na	11 088	921 384

TABLE 11A.121

Table 11A.121 **Perinatal, neonatal and fetal deaths (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (d)</i>
Perinatal deaths	no.	3 763	na	2 651	1 110	670	na	na	88	8 282
Perinatal death rate	per 1000 total births	8.8	na	10.2	8.5	7.5	na	na	7.9	9.0
2005–2009										
Fetal deaths (e)										
Aboriginal and Torres Strait Islander Australians										
Total all births (f)	no.	18 595	na	21 389	10 700	4 211	na	na	7 835	62 730
Fetal deaths	no.	89	na	176	17	87	na	na	107	476
Fetal death rate	per 1000 total births	4.8	na	8.2	4.1	8.1	na	na	13.7	7.6
Other Australians (g)										
Total all births (f)	no.	434 765	na	275 458	135 661	92 406	na	na	11 345	949 635
Fetal deaths	no.	2 384	na	1 867	423	845	na	na	63	5 582
Fetal death rate	per 1000 total births	5.5	na	6.8	4.6	6.2	na	na	5.6	5.9
Neonatal deaths (h)										
Aboriginal and Torres Strait Islander Australians										
Total live births (i)	no.	18 506	na	21 213	10 683	4 124	na	na	7 728	62 254
Neonatal deaths	no.	80	na	128	15	47	na	na	62	332
Neonatal death rate	per 1000 live births	4.3	na	6.0	3.6	4.4	na	na	8.0	5.3
Other Australians (g)										
Total live births (i)	no.	432 381	na	273 591	135 238	91 561	na	na	11 282	944 053
Neonatal deaths	no.	1 420	na	929	217	280	na	na	28	2 874
Neonatal death rate	per 1000 live births	3.3	na	3.4	2.4	2.1	na	na	2.5	3.0
Perinatal deaths (j)										
Aboriginal and Torres Strait Islander Australians										
Total all births (f)	no.	18 595	na	21 389	10 700	4 211	na	na	7 835	62 730
Perinatal deaths	no.	169	na	304	32	134	na	na	169	808
Perinatal death rate	per 1000 total births	9.1	na	14.2	7.7	12.4	na	na	21.6	12.9

TABLE 11A.121

Table 11A.121 **Perinatal, neonatal and fetal deaths (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (d)</i>
Other Australians (g)										
Total all births (f)	no.	434 765	na	275 458	135 661	92 406	na	na	11 345	949 635
Perinatal deaths	no.	3 804	na	2 796	640	1 125	na	na	91	8 456
Perinatal death rate	per 1000 total births	8.7	na	10.2	7.0	8.3	na	na	8.0	8.9
2006–2010										
Fetal deaths (e)										
Aboriginal and Torres Strait Islander Australians										
Total all births (f)	no.	19 870	na	23 042	11 336	4 358	na	na	7 906	66 512
Fetal deaths	no.	88	na	195	75	9	na	na	105	472
Fetal death rate	per 1000 total births	4.4	na	8.5	6.6	2.1	na	na	13.3	7.1
Other Australians (g)										
Total all births (f)	no.	442 824	na	286 640	140 682	94 011	na	na	11 503	975 660
Fetal deaths	no.	2 390	na	1 877	851	399	na	na	54	5 571
Fetal death rate	per 1000 total births	5.4	na	6.6	6.1	4.3	na	na	4.7	5.7
Neonatal deaths (h)										
Aboriginal and Torres Strait Islander Australians										
Total live births (i)	no.	19 782	na	22 847	11 261	4 349	na	na	7 801	66 040
Neonatal deaths	no.	86	na	129	47	14	na	na	62	338
Neonatal death rate	per 1000 live births	4.3	na	5.6	4.2	3.2	na	na	7.9	5.1
Other Australians (g)										
Total live births (i)	no.	440 434	na	284 763	139 831	93 612	na	na	11 449	970 089
Neonatal deaths	no.	1 384	na	979	272	202	na	na	25	2 862
Neonatal death rate	per 1000 live births	3.1	na	3.4	1.9	2.2	na	na	2.2	3.0
Perinatal deaths (j)										
Aboriginal and Torres Strait Islander Australians										
Total all births (f)	no.	19 870	na	23 042	11 336	4 358	na	na	7 906	66 512

TABLE 11A.121

Table 11A.121 **Perinatal, neonatal and fetal deaths (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (d)</i>
Perinatal deaths	no.	174	na	324	122	23	na	na	167	810
Perinatal death rate	per 1000 total births	8.8	na	14.1	10.8	5.3	na	na	21.1	12.2
Other Australians (g)										
Total all births (f)	no.	442 824	na	286 640	140 682	94 011	na	na	11 503	975 660
Perinatal deaths	no.	3 774	na	2 856	1 123	601	na	na	79	8 433
Perinatal death rate	per 1000 total births	8.6	na	10.0	8.0	6.4	na	na	6.9	8.6
2007–2011										
Fetal deaths (e)										
Aboriginal and Torres Strait Islander Australians										
Total all births (f)	no.	21 964	na	24 830	11 944	4 567	na	na	7 881	71 186
Fetal deaths	no.	84	na	190	87	7	na	na	101	469
Fetal death rate	per 1000 total births	3.8	na	7.7	7.3	1.5	na	na	12.8	6.6
Other Australians (g)										
Total all births (f)	no.	452 441	na	295 458	144 647	95 441	na	na	11 781	999 768
Fetal deaths	no.	2 387	na	1 900	929	408	na	na	53	5 677
Fetal death rate	per 1000 total births	5.3	na	6.4	6.4	4.3	na	na	4.5	5.7
Neonatal deaths (h)										
Aboriginal and Torres Strait Islander Australians										
Total live births (i)	no.	21 880	na	24 640	11 857	4 560	na	na	7 780	70 717
Neonatal deaths	no.	91	na	131	42	16	na	na	55	335
Neonatal death rate	per 1000 live births	4.2	na	5.3	3.5	3.5	na	na	7.1	4.7
Other Australians (g)										
Total live births (i)	no.	450 054	na	293 558	143 718	95 033	na	na	11 728	994 091
Neonatal deaths	no.	1 371	na	991	247	198	na	na	29	2 836
Neonatal death rate	per 1000 live births	3.0	na	3.4	1.7	2.1	na	na	2.5	2.9
Perinatal deaths (j)										

TABLE 11A.121

Table 11A.121 **Perinatal, neonatal and fetal deaths (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (d)</i>
Aboriginal and Torres Strait Islander Australians										
Total all births (f)	no.	21 964	na	24 830	11 944	4 567	na	na	7 881	71 186
Perinatal deaths	no.	175	na	321	129	23	na	na	156	804
Perinatal death rate	per 1000 total births	8.0	na	12.9	10.8	5.0	na	na	19.8	11.3
Other Australians (g)										
Total all births (f)	no.	452 441	na	295 458	144 647	95 441	na	na	11 781	999 768
Perinatal deaths	no.	3 758	na	2 891	1 176	606	na	na	82	8 513
Perinatal death rate	per 1000 total births	8.3	na	9.8	8.1	6.3	na	na	7.0	8.5
2008–2012										
Fetal deaths (e)										
Aboriginal and Torres Strait Islander Australians										
Total all births (f)	no.	27 161	na	25 958	12 494	4 642	na	na	7 858	78 113
Fetal deaths	no.	86	na	166	100	6	na	na	91	449
Fetal death rate	per 1000 total births	3.2	na	6.4	8.0	1.3	na	na	11.6	5.7
Other Australians (g)										
Total all births (f)	no.	472 666	na	297 080	148 640	96 133	na	na	12 011	1 026 530
Fetal deaths	no.	2 406	na	1 942	994	402	na	na	57	5 801
Fetal death rate	per 1000 total births	5.1	na	6.5	6.7	4.2	na	na	4.7	5.7
Neonatal deaths (h)										
Aboriginal and Torres Strait Islander Australians										
Total live births (i)	no.	27 075	na	25 792	12 394	4 636	na	na	7 767	77 664
Neonatal deaths	no.	72	na	122	43	11	na	na	52	300
Neonatal death rate	per 1000 live births	2.7	na	4.7	3.5	2.4	na	na	6.7	3.9
Other Australians (g)										
Total live births (i)	no.	470 260	na	295 138	147 646	95 731	na	na	11 954	1 020 729
Neonatal deaths	no.	1 324	na	972	252	197	na	na	27	2 772

TABLE 11A.121

Table 11A.121 **Perinatal, neonatal and fetal deaths (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (d)</i>
Neonatal death rate	per 1000 live births	2.8	na	3.3	1.7	2.1	na	na	2.3	2.7
Perinatal deaths (j)										
Aboriginal and Torres Strait Islander Australians										
Total all births (f)	no.	27 161	na	25 958	12 494	4 642	na	na	7 858	78 113
Perinatal deaths	no.	158	na	288	143	17	na	na	143	749
Perinatal death rate	per 1000 total births	5.8	na	11.1	11.4	3.7	na	na	18.2	9.6
Other Australians (g)										
Total all births (f)	no.	472 666	na	297 080	148 640	96 133	na	na	12 011	1 026 530
Perinatal deaths	no.	3 730	na	2 914	1 246	599	na	na	84	8 573
Perinatal death rate	per 1000 total births	7.9	na	9.8	8.4	6.2	na	na	7.0	8.4

- (a) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2006 (final) 2007 (final), 2008 (final), 2009 (revised), 2010 (preliminary). See Explanatory Notes 35-39 and Technical Notes, Causes of Death Revisions, 2006 and Causes of Death Revisions, 2008 and 2009.
- (b) Perinatal deaths (including fetal and neonatal deaths) for years 1999-2007 have been subject to a revision of scope rules. See ABS Perinatal Deaths, Australia, 2007 (cat.no. 3304.0) Explanatory Notes 18-20 for further information.
- (c) Data are reported individually by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. These 5 states have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths.
- (d) Total includes data for NSW, Queensland, WA, SA and the NT only.
- (e) Fetal death (stillbirth) is the birth of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Fetal deaths by definition include only infants of a gestational age of at least 20 weeks or weighing at least 400 grams.
- (f) Total all births is the number of live births and fetal deaths combined. Fetal deaths by definition include only infants of a gestational age of at least 20 weeks or weighing at least 400 grams
- (g) Other Australians includes Indigenous status not stated.
- (h) A neonatal death is the death within 28 days of birth of a child who after delivery, breathes or shows any evidence of life such as a heartbeat.
- (i) Total live births are all live births registered in the calendar year.
- (j) Perinatal deaths are fetal and neonatal deaths combined. Fetal deaths exclude those records where gestational age was less than 20 weeks or birthweight was known to be less than 400 grams.

Table 11A.121 **Perinatal, neonatal and fetal deaths (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (d)</i>
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na Not available.

Source: ABS Perinatal deaths, Australia, Cat. no. 3304.0, Canberra (unpublished).

Data quality information — Public hospitals, chapter 11

Data quality information

Data quality information (DQI) provides information against the seven Australian Bureau of Statistics (ABS) data quality framework dimensions, for a selection of performance indicators and/or measures in the Public hospitals chapter. DQI for additional indicators will be progressively introduced in future reports.

Technical DQI has been supplied or agreed by relevant data providers. Additional Steering Committee commentary does not necessarily reflect the views of data providers.

DQI are available for the following performance indicators:

Emergency department waiting times	2
Waiting times for admitted patient services	8
Separation rates for selected procedures	19
Unplanned hospital readmission rates	22
Accreditation	26
Adverse events in public hospitals	28
Workforce sustainability	37
Cost per casemix-adjusted separation	41
Relative stay index	46
Recurrent cost per non-admitted occasion of service	49
Patient satisfaction	50
Caesareans and inductions for selected primiparae	54
Instrument vaginal births	55
Vaginal birth after caesarean section	57
Perineal status after vaginal birth	58
Mother's average length of stay	60
Apgar score at five minutes	62
Fetal, neonatal and perinatal deaths	63

Emergency department waiting times

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Emergency department waiting times by triage category

Indicator definition and description

Element	Effectiveness — access
Indicator	Emergency department waiting times — Emergency department waiting times by triage category
Measure (computation)	<p>Percentage of patients who are treated within national benchmarks for waiting times for each triage category in public hospital emergency departments.</p> <p>The national benchmark waiting times are:</p> <ul style="list-style-type: none">• Triage category 1: seen within seconds, calculated as less than or equal to 2 minutes• Triage category 2: seen within 10 minutes• Triage category 3: seen within 30 minutes• Triage category 4: seen within 60 minutes• Triage category 5: seen within 120 minutes <p>The proportion of patients seen on time is calculated as:</p> <p><i>Numerator</i>—Number of patients seen within the cut-off point, by triage category.</p> <p><i>Denominator</i>—Number of patients by triage category.</p> <p>Inclusions: records with a type of visit of <i>Emergency presentation</i>.</p> <p>Restricted to hospitals that were classified as either peer group A (Principal referral and Specialist women's and children's hospital) or peer group B (Large hospitals).</p> <p>Exclusions: records with an episode end status of <i>Did not wait to be attended by a health care professional</i> or <i>Dead on arrival, not treated in emergency department</i>. Records are also excluded if the waiting time was missing or otherwise invalid.</p>
Data source/s	<p>This indicator is calculated using data from the AIHW's NNAPEDCD, based on the National Minimum Data Set (NMDS) for Non-admitted patient emergency department care (NAPEDC).</p> <p><u>For data by socioeconomic status:</u> calculated by AIHW using the Australian Bureau of Statistics (ABS) Socio-Economic Indexes For Areas (SEIFA), Index of Relative Socio-Economic Disadvantage (IRSD) 2011 and Estimated Resident Population (ERP) by Statistical Area level 2 (SA2) as at 30 June 2012 (2012–13) or 30 June 2013 (2013–14). Each SA2 in Australia is ranked and divided into quintiles and deciles in a population-based manner, such that each quintile has approximately 20 per cent of the population and each decile has approximately 10 per cent of the population.</p> <p><u>For data by remoteness:</u> ABS ERP as at 30 June 2011 (2011–12) or 30 June 2012 (2012–13), by remoteness areas, as specified in the Australian Statistical Geography Standard.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the <i>Australian Institute of Health and Welfare Act 1987</i> to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.</p> <p>The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.</p> <p>The Institute also plays a role in developing and maintaining national metadata</p>
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standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance to the *Privacy Act 1988 (Commonwealth)*, ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au.

Data for the NNAPEDCD were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

<http://www.aihw.gov.au/nhissc/>

<http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

The purpose of the NNAPEDCD is to collect information on the characteristics of emergency department care (including waiting times for care) for non-admitted patients registered for care in emergency departments in selected public hospitals classified as either *Principal referral and Specialist women's and children's hospitals* (peer group A) or *Large hospitals* (peer group B).

In 2013–14, hospitals in peer groups A and B provided about 80 per cent of all public hospital emergency presentations.

The data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Hospitals not included do not necessarily have emergency departments that are equivalent to those in hospitals in peer groups A and B.

The analyses by remoteness and socioeconomic status are based on the Statistical Area level 2 (SA2) of usual residence of the patient. However, data are reported by jurisdiction of presentation, regardless of the jurisdiction of usual residence. Hence, data represent the proportion of patients living in each remoteness area or Socio-Economic Indexes for Areas (SEIFA) population group (regardless of their jurisdiction of residence) seen within the benchmark time in the reporting jurisdiction. This is relevant if significant numbers of one jurisdiction's residents are treated in another jurisdiction.

The SEIFA categories for socioeconomic status represent approximately the same proportion of the national population, but do not necessarily represent that proportion of the population in each state or territory (each SEIFA decile or quintile represents 10 per cent and 20 per cent respectively of the national population). For 2012–13 and 2013–14, the SEIFA scores for each SA2 are derived from 2011 Census data and represent the attributes of the population in that SA2 in 2011.

Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated.

Timeliness

The reference period for these data is 2012–13 and 2013–14.

Accuracy

For 2012–13, the coverage of the NNAPEDCD was 100 per cent in all jurisdictions for public hospitals in peer groups A and B. For 2013–14, the preliminary estimate of the proportion of emergency occasions of service reported to the NNAPEDCD was 100 per cent for public hospitals in peer groups A and B.

In the baseline year (2007–08), the Tasmanian North West Regional Hospital comprised the combined activity of its Burnie Campus and its Mersey Campus. This hospital was a Peer Group B hospital. There was then a change in administrative arrangements for Mersey and it became the only hospital in the country owned and funded by the Australian Government and, by arrangement, operated by the Tasmanian Government. This administrative change necessitated reporting of these campuses as separate hospitals from 2008–09 onwards. On its own the North West Regional Hospital (Burnie Campus only) is a Peer Group B hospital, whilst, on its own the Mersey Community Hospital is a Peer Group C hospital. Burnie and Mersey did not substantially change their activity, rather, it is simply a case that activity is now spread

across two hospitals. For National Healthcare Agreement purposes, although it is a Peer Group C hospital, the Mersey Community Hospital continues to be included in reporting for Peer Group B hospitals to ensure comparability over time for Tasmania.

From 2009–10, the data for the Albury Base Hospital (previously reported in NSW hospital statistics) was reported in Victorian hospital statistics. This change in reporting arrangements should be factored into any analysis of data for NSW and Victoria.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors (including waiting time outliers) are queried with jurisdictions, and corrections and resubmissions may be made in response to these queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

The quality of Indigenous status data in the NNAPEDCD has not been formally assessed for completeness; therefore caution should be exercised when interpreting these data.

As this indicator is limited to public hospitals classified in peer groups A and B, most of the data relates to hospitals within major cities. Consequently, the data may not cover areas where the proportion of Aboriginal and Torres Strait Islander Australians (compared with other Australians) is higher than average. Similarly, disaggregation by socioeconomic status and remoteness should be interpreted with caution.

Comparability across jurisdictions may be impacted by variation in the assignment of triage categories.

Coherence

The data reported for 2012–13 and 2013–14 are consistent with data reported for the NNAPEDCD for previous years for individual hospitals.

In addition, the data reported to the NNAPEDCD in previous years has been consistent with the numbers of emergency occasions of services reported to the National Hospital Establishments Database (NPHED) for each hospital for the same reference year.

Time series presentations may be affected by changes in the number of hospitals reported to the collection and changes in coverage.

The information presented for this indicator are calculated using the same methodology as data published in *Australian hospital statistics: emergency department care* (report series) and the *National Healthcare Agreement: performance report 2012–13*.

However, 2012–13 data reported previously in these publications are different from the equivalent data published here because the hospitals classified as peer groups A and B were based on 2011–12, rather than 2012–13 peer groups.

Caution should be used in comparing data across reference years, as the number of hospitals classified as peer group A or B, or the peer group of a hospital, may vary over time.

Methodological variations also exist in the application of SEIFA to various data sets and performance indicators. Any comparisons of the SEIFA analysis for this indicator with other related SEIFA analysis should be undertaken with careful consideration of the methods used, in particular the SEIFA Census year, the SEIFA index used and the approach taken to derive quintiles and deciles.

National level data disaggregated by Indigenous status for 2007–08 included data from NSW, Qld, WA, SA and NT. National level data disaggregated by Indigenous status for 2008–09, 2009–10 and 2010–11 included data from NSW, Victoria, Qld, WA, SA and NT. National level data disaggregated by Indigenous status for 2011–12 and subsequent years includes data from all eight states and territories. Therefore, data disaggregated by Indigenous status from 2007–08 is not comparable to 2008–09, 2009–10 and 2010–11, and data for 2011–12 and subsequent years are not comparable with data for 2010–11 and prior years.

In 2011, the ABS updated the standard geography used in Australia for most data collections from the Australian Standard Geographical Classification (ASGC) to the Australian Statistical Geography Standard (ASGS). Also updated at this time were remoteness areas and the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing. The new remoteness areas will be referred to as RA 2011, and the previous remoteness areas as RA 2006. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006.

Data for 2007–08 through to 2011–12 reported by remoteness are reported for RA 2006. Data for 2012–13 and 2013–14 are reported for RA 2011. The AIHW considers the change from RA 2006 to RA 2011 to be a series break when applied to data supplied for this indicator, therefore remoteness data for 2011–12 and previous years are not directly comparable to remoteness data for 2012–13 and subsequent years.

Data for 2007–08 through to 2010–11 reported for SEIFA quintiles and deciles are

reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011–12 are reported using SEIFA 2011 at the SLA level. Data for 2012–13 and 2013–14 are reported using SEIFA 2011 at the Statistical Area level 2 (SA2). The AIHW considers the change from SEIFA 2006 to SEIFA 2011, and the change from SLA to SA2 to be series breaks when applied to data supplied for this indicator. Therefore, SEIFA data for 2010–11 and previous years are not directly comparable with SEIFA data for 2011–12, and SEIFA data for 2011–12 and previous years are not directly comparable with SEIFA data for 2012–13 and subsequent years.

Accessibility	The AIHW provides a variety of products that draw upon the NNAPEDCD. Published products available on the AIHW website are: <i>Australian hospital statistics</i> suite of products with associated Excel tables. These products may be accessed on the AIHW website at: http://www.aihw.gov.au/hospitals/ .
Interpretability	Metadata information for the Non-Admitted Patient Emergency Department Care (NAPEDC) National Minimum Data Set (NMDS) is published in the AIHW's online metadata repository, METeOR, and the <i>National health data dictionary</i> . The <i>National health data dictionary</i> can be accessed online at: http://www.aihw.gov.au/publication-detail/?id=10737422826 The Data Quality Statement for the 2012–13 NNAPEDCD can be accessed on the AIHW website at: http://meteor.aihw.gov.au/content/index.phtml/itemId/546749

Data Gaps/Issues Analysis

Key data gaps/issues	<p>The Steering Committee notes the following key data gaps/issues:</p> <ul style="list-style-type: none"> • The comparability of emergency department waiting times data across jurisdictions can be influenced by differences in data coverage and clinical practices — in particular, the allocation of cases to urgency categories. The proportion of patients in each triage category who were subsequently admitted can indicate the comparability of triage categorisations across jurisdictions and thus the comparability of the waiting times data. • The scope of the data used to produce this indicator is non-admitted patients registered for care in emergency departments in public hospitals classified as either <i>Principal referral and Specialist women's and children's hospitals</i> (peer group A) or <i>Large hospitals</i> (peer group B). Most of the hospitals in peer groups A and B are in major cities. Therefore, disaggregation by remoteness, socioeconomic status and Indigenous status should be interpreted with caution. • For 2012–13, the coverage of the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD) collection is complete for public hospitals in peer groups A and B. It is estimated that 2013–14 has similar coverage, although final coverage cannot be calculated until the 2013–14 National Public Hospital Establishments Database (NPHEd) data are available. • The quality of Indigenous status data in the NNAPEDCD has not been formally assessed for completeness; therefore caution should be exercised when interpreting these data. • Caution should be used in comparing these data with earlier years as the number of hospitals classified as peer groups A or B, and the peer group for a hospital, may vary over time. • Remoteness data for 2011–12 and previous years are not directly comparable to remoteness data for 2012–13 and subsequent years. • SEIFA data for 2010–11 and previous years are not directly comparable with SEIFA data for 2011–12, and SEIFA data for 2011–12 and previous years are not directly comparable with SEIFA data for 2012–13 and subsequent years.
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Proportion of emergency department presentations with length of stay of 4 hours or less

Indicator definition and description

Element	Effectiveness — access
Indicator	Emergency department waiting times — Proportion of emergency department

**Measure
(computation)**

presentations with length of stay of 4 hours or less

Percentage of presentations to public hospital emergency departments where the time from presentation to physical departure (ED Stay length) is less than or equal to four hours.

Calculation includes presentations with any type of visit to emergency department.

ED stay length is calculated by subtracting presentation time/date from physical departure time/date, which is recorded as per the business rules included in the NAPEDC NMDS 2013–14:

<http://meteor.aihw.gov.au/content/index.phtml/itemId/509116>

The percentage of presentations to public hospital emergency departments completed within four hours is calculated as:

Numerator—Number of ED presentations where ED stay is less than or equal to four hours.

Denominator—Number of ED presentations.

Calculation includes all presentations with an ED stay completed in the reporting period, including records where the presentation date/time is prior to the reporting period. Invalid records are excluded from the numerator and denominator. Invalid records are records for which:

- Length of stay < 0.
- Presentation date or time missing.
- Physical departure date or time missing.

Data source/s

This indicator is calculated using data from the Australian Institute of Health and Welfare's (AIHW's) NNAPEDCD, based on the National Minimum Data Set (NMDS) for Non-admitted patient emergency department care (NAPEDC).

Data Quality Framework Dimensions

**Institutional
environment**

The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the *Australian Institute of Health and Welfare Act 1987* to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance to the *Privacy Act 1988 (Commonwealth)*, ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au.

Data for the NNAPEDCD were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

<http://www.aihw.gov.au/nhissc/>

<http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance	<p>The purpose of the NNAPEDCD is to collect information on the characteristics of emergency department care for non-admitted patients registered for care in emergency departments in selected public hospitals classified as either <i>Principal referral and Specialist women's and children's hospitals</i> (peer group A) or <i>Large hospitals</i> (peer group B). In 2012–13, hospitals in peer groups A and B provided over 86 per cent of all public hospital emergency presentations. In 2013–14, hospitals in peer groups A and B provided about 80 per cent of all public hospital emergency presentations.</p> <p>The data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Hospitals not included do not necessarily have emergency departments that are equivalent to those in hospitals in peer groups A and B.</p> <p>Data are reported by jurisdiction of presentation, regardless of the jurisdiction of usual residence.</p>
Timeliness	<p>The reference period for these data is 2012–13 and 2013–14.</p> <p>The financial year of 2011–12 is the first reporting period that these data are available according to the agreed specification.</p>
Accuracy	<p>For 2012–13, the coverage of the NNAPEDCD was 100 per cent in all jurisdictions for public hospitals in peer groups A and B and is estimated at about 85 per cent for all hospitals.</p> <p>For 2013–14, the preliminary estimate of the proportion of emergency occasions of service reported to the NNAPEDCD was 100 per cent for public hospitals in peer groups A and B and is estimated at about 88 per cent for all hospitals.</p> <p>In the baseline year (2007–08) for this indicator, the Tasmanian North West Regional Hospital comprised the combined activity of its Burnie Campus and its Mersey Campus. This hospital was a Peer Group B hospital. There was then a change in administrative arrangements for Mersey and it became the only hospital in the country owned and funded by the Australian Government and, by arrangement, operated by the Tasmanian Government. This administrative change necessitated reporting of these campuses as separate hospitals from 2008–09 onwards. On its own the North West Regional Hospital (Burnie Campus only) is a Peer Group B hospital, whilst, on its own the Mersey Community Hospital is a Peer Group C hospital. Burnie and Mersey did not substantially change their activity, rather, it is simply a case that activity is now spread across two hospitals. For National Healthcare Agreement purposes, although it is a Peer Group C hospital, the Mersey Community Hospital continues to be included in reporting for Peer Group B hospitals to ensure comparability over time for Tasmania.</p> <p>From 2009–10, data for the Albury Base Hospital (previously reported in NSW hospital statistics) were reported in Victorian hospital statistics. This reporting arrangement should be factored into any analysis of data for NSW and Victoria.</p> <p>States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on data. Data are checked for valid values, logical consistency and historical consistency. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.</p>
Coherence	<p>The scope of the NNAPEDCD NMDS changed between the 2012–13 and 2013–14 reporting periods. These changes may affect comparability of the data reported for 2013–14 with data reported for previous years.</p> <p>For 2012–13, the scope of the Non-admitted patient emergency department care national minimum data set was non-admitted patients registered for care in emergency departments in selected public hospitals that are classified as either Peer Group A or B in the Australian Institute of Health and Welfare's <i>Australian Hospital Statistics</i> publication from the preceding financial year.</p> <p>For 2013–14, the scope of the Non-admitted patient emergency department care national minimum data set specification (NNAPEDCD NMDS) is patients registered for care in emergency departments in public hospitals where the emergency department meets the following criteria:</p> <ul style="list-style-type: none"> • Purposely designed and equipped area with designated assessment, treatment and resuscitation areas. • Ability to provide resuscitation, stabilisation and initial management of all emergencies. • Availability of medical staff in the hospital 24 hours a day. • Designated emergency department nursing staff and nursing unit manager 24 hours per day 7 days per week. <p>The data reported for 2012–13 are consistent with data reported for the NNAPEDCD for</p>

previous years for individual hospitals. In addition, the data reported to the NNAPEDCD in previous years has been consistent with the numbers of emergency occasions of services reported to the NPHEd for each hospital for the same reference year. Time series presentations may be affected by changes in the number of hospitals reported to the collection and changes in coverage. The information presented for this indicator are calculated using the same methodology as data published in *Australian hospital statistics: emergency department care* (report series) and the *National Healthcare Agreement: performance report 2012–13*.

- Accessibility** The AIHW provides a variety of products that draw upon the NNAPEDCD. Published products available on the AIHW website are: Australian hospital statistics suite of products with associated Excel tables. These products may be accessed on the AIHW website at: <http://www.aihw.gov.au/hospitals/>.
- Interpretability** Metadata information for the NAPEDC NMDS and the NAPEDC Data Set Specification (DSS) are published in the AIHW's online metadata repository, METeOR, and the *National health data dictionary*. The *National health data dictionary* can be accessed online at: <http://www.aihw.gov.au/publication-detail/?id=10737422826>
The Data Quality Statement for the 2012–13 NNAPEDCD can be accessed on the AIHW website at: <http://meteor.aihw.gov.au/content/index.phtml/itemId/546749>

Data Gaps/Issues Analysis

- Key data gaps/issues** The Steering Committee notes the following key data gaps/issues:
- The scope of the data used to produce this indicator is non-admitted patients registered for care in emergency departments in public hospitals reporting to the Non-admitted Patient Emergency Department Care (NAPEDC) National Minimum Data Set (NMDS) (Peer Groups A, B and other) as at August 2011 (when the National Health Reform Agreement National Partnership Agreement on Improving Public Hospital Services was signed).
 - The scope of the NAPEDC NMDS changed between the 2012–13 and 2013–14 reporting periods. These changes may affect comparability of the data reported for 2013–14 with data reported for previous years.
 - For 2012–13, the coverage of the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD) collection is complete for public hospitals in peer groups A and B (*Principal referral and Specialist women's and children's hospitals and Large hospitals*) and is estimated at about 85 per cent for all hospitals.
 - It is estimated that 2013–14 has similar coverage for public hospitals in peer groups A and B, and is estimated at about 88 per cent for all hospitals, although final coverage cannot be calculated until the 2013–14 National Public Hospital Establishments Database (NPHEd) data are available.
 - Caution should be used in comparing these data with earlier years as the number of reporting hospitals and the peer group for a hospital, may vary over time.

Waiting times for admitted patient services

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Overall elective surgery waiting times

Indicator definition and description

- Element** Effectiveness — access
- Indicator** Waiting times for admitted patient services — Overall elective surgery waiting times

Measure (computation)	<p>The number of days' waiting time is calculated by subtracting the listing date for care from the removal date, minus any days when the patient was not ready for care and minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at removal.</p> <p>The 50th percentile (median) represents the number of days within which 50 per cent of patients were admitted; half the waiting times will be shorter than the median and half the waiting times longer. The 90th percentile data represent the number of days within which 90 per cent of patients were admitted.</p>
Data source/s	<p>For 2012–13 and 2013–14, this indicator is calculated using data from the NESWTDC, based on the National Minimum Data Set (NMDS) for Elective surgery waiting times (removals data).</p> <p>For 2012–13, the NESWTDC was linked to the NHMD, based on the NMDS for Admitted patient care, to allow disaggregation by remoteness of area of usual residence and SEIFA of usual residence (all jurisdictions).</p> <p><u>For data by socioeconomic status:</u> calculated by AIHW using the Australian Bureau of Statistics (ABS) Socio-Economic Indexes For Areas (SEIFA), Index of Relative Socio-Economic Disadvantage (IRSD) 2011 and Estimated Resident Population (ERP) by Statistical Area 2 (SA2) as at 30 June 2012 (2012–13). Each SA2 in Australia is ranked and divided into quintiles and deciles in a population-based manner, such that each quintile has approximately 20 per cent of the population and each decile has approximately 10 per cent of the population.</p> <p><u>For data by remoteness:</u> ABS ERP as at 30 June 2012 (2012–13), by remoteness areas, as specified in the Australian Statistical Geography Standard.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the <i>Australian Institute of Health and Welfare Act 1987</i> to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.</p> <p>The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.</p> <p>The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.</p> <p>One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.</p> <p>The <i>Australian Institute of Health and Welfare Act 1987</i>, in conjunction with compliance to the <i>Privacy Act 1988 (Commonwealth)</i>, ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.</p> <p>For further information see the AIHW website www.aihw.gov.au.</p> <p>Data for the NESWTDC were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):</p> <p>http://www.aihw.gov.au/nhissc/ http://meteor.aihw.gov.au/content/index.phtml/itemId/182135</p> <p>The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p>
Relevance	<p>The purpose of the NMDS for Elective surgery waiting times (removals data) is to collect information about patients waiting for elective surgery in public hospitals. The</p>

scope of this NMDS is patients removed from waiting lists for elective surgery (as either an elective or emergency case) which are managed by public acute hospitals. This includes private patients treated in public hospitals and may include public patients treated in private hospitals.

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.

Analyses by remoteness and socioeconomic status are based on the Statistical Area level 2 of usual residence of the patient.

The SEIFA categories for socioeconomic status represent approximately the same proportion of the national population, but do not necessarily represent that proportion of the population in each state or territory (each SEIFA decile or quintile represents 10 per cent and 20 per cent respectively of the national population). The SEIFA scores for each SA2 are derived from 2011 Census data and represent the attributes of the population in that SLA in 2011.

Separations are reported by jurisdiction of hospitalisation, regardless of the jurisdiction of usual residence. Hence, data represent the waiting time for patients living in each remoteness area or SEIFA population group (regardless of their jurisdiction of residence) for the reporting jurisdiction. This is relevant if significant numbers of one jurisdiction's residents are treated in another jurisdiction.

Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated.

The reference period for these data is 2012–13 and 2013–14.

**Timeliness
Accuracy**

For 2012–13 and 2013–14:

- Coverage of the NESWTDC was over 90 per cent. Coverage was 100 per cent for *Principal referral and Specialist women's and children's hospitals* (peer group A) and was progressively lower for *Large hospitals* (peer group B) and *Medium hospitals* (peer group C). In 2012–13, coverage also varied by jurisdiction, ranging from 100 per cent in NSW, WA, Tasmania, the ACT and the NT, to 80 per cent in Victoria. For 2013–14, the preliminary estimate of the proportion of public elective surgery that was also reported to the NESWTDC was 93 per cent.
- Almost all public hospitals provided data for the NHMD in 2012–13, with the exception of all separations for a mothercraft hospital in the ACT.
- Records from the NESWTDC and the NHMD were linked to assign remoteness areas and SEIFA categories from the admitted patient record to the corresponding elective surgery waiting times record. In 2012–13 approximately 96 per cent of NESWTDC records for removals were linked to the NHMD.
- There is apparent variation in the assignment of clinical urgency categories, both among and within jurisdictions, and for individual surgical specialties and indicator procedures, as well as overall. Interpretation of waiting times for jurisdictions should take into consideration these differences.
- The Indigenous status data were sourced from the NESWTDC for all jurisdictions.
- For 2009–10, the data for Albury Base Hospital (previously reported in NSW hospital statistics) was reported by the Victorian Department of Health as part of the Albury Wodonga Health Service. From 2010–11, the data for Albury Base Hospital have not been available.
- From 2011–12, SA and WA provided data for a large number of smaller hospitals (32 and 22 respectively) that were not included in the data for previous years.
- For 2011–12, Queensland was not able to provide data for 3 hospitals that had reported almost 10,000 admissions in 2010–11.
- The increase in admissions for the NT between 2010–11 and 2011–12 was, in part, due to the inclusion of certain surgical procedures from 2011–12 that had previously been incorrectly excluded from the NESWTDC by the NT.

Interpretation of waiting times for jurisdictions should take into consideration cross-border flows, particularly for the ACT.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on data. Data are checked for

valid values, logical consistency and historical consistency. Where possible, data in individual datasets are checked against data from other datasets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

Cells have been suppressed to protect confidentiality where the presentation could identify a patient or a service provider or where rates are likely to be highly volatile, for example, where the denominator is very small. The following rules were applied:

- Cells based on fewer than 10 elective surgery admissions were suppressed.
- Cells based on data from one public hospital only were suppressed.

Coherence

Caution should be exercised when comparing waiting times data between jurisdictions due to differences in the assignment of clinical urgency categories (see *Australian hospital statistics 2012–13: elective surgery waiting times*, Appendix A p 40 <http://www.aihw.gov.au/publication-detail/?id=60129544692>).

The data can be meaningfully compared across reference periods, except for the Indigenous disaggregation. Caution should be used in comparing data by peer groups across reference years, as the number of hospitals classified as peer group A or B, or the peer group of a hospital, may vary over time.

Methodological variations also exist in the application of SEIFA to various data sets and performance indicators. Any comparisons of the SEIFA analysis for this indicator with other related SEIFA analysis should be undertaken with careful consideration of the methods used, in particular the SEIFA Census year, the SEIFA index used and the approach taken to derive quintiles and deciles.

The information presented for this indicator is based on the same data as published in, *Australian hospital statistics 2012–13*, *Australian hospital statistics: elective surgery waiting times* (report series) and the *National Healthcare Agreement: performance report 2012–13*.

The data reported for the 2012–13 and 2013–14 NEWSTDC are consistent with data reported for previous years for individual hospitals.

In addition, some 2012–13 data reported previously in these publications are different from the equivalent data published here because the hospitals peer groups were based on 2011–12, rather than 2012–13 peer groups.

Caution should be exercised when interpreting the 2013–14 data as potential revisions to the 2013–14 NESWTDC data could occur following linking to the 2013–14 NHMD.

Analyses presented in *Australian hospital statistics* and previous *National Healthcare Agreement performance* reports may also differ slightly depending on whether the NESWTDC or linked NESWTDC/NHMD was used.

National level data disaggregated by Indigenous status for 2007–08 included data from NSW, Qld, WA, SA and NT. National level data disaggregated by Indigenous status for 2008–09, 2009–10 and 2010–11 included data from NSW, Victoria, Qld, WA, SA and NT. National level data disaggregated by Indigenous status for 2011–12 and subsequent years includes data from all eight states and territories. Therefore, data disaggregated by Indigenous status from 2007–08 is not comparable to 2008–09, 2009–10 and 2010–11, and data for 2011–12 and subsequent years are not comparable with data for 2010–11 and prior years.

When comparing data over time, linked data should not be compared with unlinked data. For example, the 2012–13 linked data supplied cannot be directly compared to the 2013–14 unlinked data supplied in this reporting cycle.

In 2011, the ABS updated the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006. Data for 2007–08 through to 2010–11 reported for SEIFA quintiles and deciles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011–12 are reported using SEIFA 2011 at the SLA level and data for 2012–13 are reported using SEIFA 2011 at the SA2 level. The AIHW considers the change from SEIFA 2006 to SEIFA 2011, and the change from SLA to SA2 to be series breaks when applied to data supplied for this indicator. Therefore, SEIFA data for 2010–11 and previous years are not directly comparable with SEIFA data for 2011–12, and SEIFA data for 2011–12 and previous years are not directly comparable with SEIFA data for 2012–13 and subsequent years.

Accessibility

The AIHW provides a variety of products that draw upon the NESWTDC. Published products available on the AIHW website are the *Australian hospital statistics* suite of products with associated Excel tables.

These products may be accessed on the AIHW website

Interpretability	<p>http://www.aihw.gov.au/hospitals/.</p> <p>Metadata information for the Elective Surgery Waiting Times (ESWT) NMDS and the Admitted patient care NMDS is published in the AIHW's online metadata repository, METeOR, and the <i>National health data dictionary</i>. The <i>National health data dictionary</i> can be accessed online at: http://www.aihw.gov.au/publication-detail/?id=10737422826</p> <p>The Data Quality Statement for the 2012–13 NESWTDC can be accessed on the AIHW website at: http://meteor.aihw.gov.au/content/index.phtml/itemId/543809</p> <p>The Data Quality Statement for the 2012–13 NHMD can be accessed on the AIHW website at: http://meteor.aihw.gov.au/content/index.phtml/itemId/568730</p>
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Data Gaps/Issues Analysis

Key data gaps/issues	<p>The Steering Committee notes the following key data gaps/issues:</p> <ul style="list-style-type: none"> Analyses for remoteness and socioeconomic status are based on the reported area of usual residence of the patient, regardless of the jurisdiction of the hospital. This is relevant if significant numbers of one jurisdiction's residents are treated in another jurisdiction. The quality of Indigenous status data in the NESWTDC has not been formally assessed for completeness: caution should be exercised when interpreting these data. Interpretation of waiting times for jurisdictions should take into consideration cross-border flows, particularly for the ACT. Remoteness data for 2011–12 and previous years are not directly comparable to remoteness data for 2012–13 and subsequent years. SEIFA data for 2010–11 and previous years are not directly comparable with SEIFA data for 2011–12, and SEIFA data for 2011–12 and previous years are not directly comparable with SEIFA data for 2012–13 and subsequent years.
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Elective surgery waiting times by clinical urgency category

Indicator definition and description

Element	Effectiveness — access
Indicator	Waiting times for admitted patient services — Elective surgery waiting times by clinical urgency category
Measure (computation)	<p>Elective surgery waiting times by clinical urgency category reports the proportion of patients who were admitted from waiting lists after an extended wait. The three generally accepted clinical urgency categories for elective surgery are:</p> <ul style="list-style-type: none"> category 1 — admission is desirable within 30 days for a condition that has the potential to deteriorate quickly to the point that it may become an emergency. category 2 — admission is desirable within 90 days for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency. category 3 — admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency. Desirable timeframe for this category is admission within 365 days.
Data source/s	<p>For 2012–13 and 2013–14, this indicator is calculated using data from the NESWTDC, based on the National Minimum Data Set (NMDS) for Elective surgery waiting times (removals data).</p> <p>For 2012–13, the NESWTDC was linked to the NHMD, based on the NMDS for Admitted patient care, to allow disaggregation by remoteness of area of usual residence and SEIFA of usual residence (all jurisdictions).</p>

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the <i>Australian Institute of Health and Welfare Act</i>
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1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance to the *Privacy Act 1988 (Commonwealth)*, ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au.

Data for the NESWTDC were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

<http://www.aihw.gov.au/nhissc/>

<http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

The purpose of the NMDS for Elective surgery waiting times (removals data) is to collect information about patients waiting for elective surgery in public hospitals. The scope of this NMDS is patients removed from waiting lists for elective surgery (as either an elective or emergency case) which are managed by public acute hospitals. This includes private patients treated in public hospitals and may include public patients treated in private hospitals.

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.

'Elective surgery waiting times by urgency category' data provide an indication of the extent to which patients are seen within a clinically desirable time and also draw attention to the variation in the way in which patients are classified across jurisdictions.

The system of urgency categorisation for elective surgery in public hospitals is important to ensure that priority is given to patients according to their needs. While elective surgery waiting times by urgency category are not comparable across jurisdictions, this measure has the advantage over other measures in that it provides an indication of the extent to which patients are seen within a clinically desirable time period according to the urgency category to which they have been assigned.

Timeliness

The reference period for these data is 2012–13 and 2013–14.

Accuracy

For 2012–13 and 2013–14:

- Coverage of the NESWTDC was over 90 per cent. Coverage was 100 per cent for *Principal referral and Specialist women's and children's hospitals* (peer group A) and was progressively lower for *Large hospitals* (peer group B) and *Medium hospitals* (peer group C). In 2012–13, coverage also varied by jurisdiction, ranging

from 100 per cent in New South Wales, Western Australia, Tasmania, the ACT and the NT, to 80 per cent in Victoria. For 2013–14, the preliminary estimate of the proportion of public elective surgery that was also reported to the NESWTDC was 93 per cent.

- Almost all public hospitals provided data for the NHMD in 2012–13, with the exception of all separations for a mothercraft hospital in the ACT.
- Records from the NESWTDC and the NHMD were linked to assign remoteness areas and SEIFA categories from the admitted patient record to the corresponding elective surgery waiting times record. In 2012–13 approximately 96 per cent of NESWTDC records for removals were linked to the NHMD.
- There is apparent variation in the assignment of clinical urgency categories, both among and within jurisdictions, and for individual surgical specialties and indicator procedures, as well as overall. Interpretation of waiting times for jurisdictions should take into consideration these differences.
- The Indigenous status data were sourced from the NESWTDC for all jurisdictions.
- For 2009–10, the data for Albury Base Hospital (previously reported in NSW hospital statistics) was reported by the Victorian Department of Health as part of the Albury Wodonga Health Service. From 2010–11, the data for Albury Base Hospital have not been available.
- From 2011–12, SA and WA provided data for a large number of smaller hospitals (32 and 22 respectively) that were not included in the data for previous years.
- For 2011–12, Queensland was not able to provide data for 3 hospitals that had reported almost 10 000 admissions in 2010–11.
- The increase in admissions for the NT between 2010–11 and 2011–12 was, in part, due to the inclusion of certain surgical procedures from 2011–12 that had previously been incorrectly excluded from the NESWTDC by the NT.

Interpretation of waiting times for jurisdictions should take into consideration cross-border flows, particularly for the ACT.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual datasets are checked against data from other datasets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

Cells have been suppressed to protect confidentiality where the presentation could identify a patient or a service provider or where rates are likely to be highly volatile, for example, where the denominator is very small. The following rules were applied:

- Cells based on fewer than 10 elective surgery admissions were suppressed.
- Cells based on data from one public hospital only were suppressed.

Coherence

Caution should be exercised when comparing waiting times data between jurisdictions due to differences in the assignment of clinical urgency categories (see Australian hospital statistics 2012–13: elective surgery waiting times, Appendix A p 40 <http://www.aihw.gov.au/publication-detail/?id=60129544692>

The data can be meaningfully compared across reference periods.

The data reported for the 2011–12 and 2012–13 NESWTDC are consistent with data reported for previous years for individual hospitals.

In addition, some 2011–12 data reported previously in these publications are different from the equivalent data published here because the hospitals classified as peer groups A and B were based on 2010–11, rather than 2011–12 peer groups. Caution should be exercised when interpreting the 2012–13 data as potential revisions to the 2012–13 NESWTDC data could occur following linking to the 2012–13 NHMD.

Analyses presented in Australian hospital statistics and previous National Healthcare Agreement performance reports may also differ slightly depending on whether the NESWTDC or linked NESWTDC/NHMD was used.

When comparing data over time, linked data should not be compared with unlinked data. For example, the 2011–12 linked data supplied cannot be directly compared to the 2012–13 unlinked data supplied in this reporting cycle.

Accessibility

The AIHW provides a variety of products that draw upon the NESWTDC. Published products available on the AIHW website are the Australian hospital statistics suite of

Interpretability

products with associated Excel tables.

These products may be accessed on the AIHW website <http://www.aihw.gov.au/hospitals/>

Metadata information for the Elective Surgery Waiting Times (ESWT) National Minimum Data Set (NMDS) and ESWT Data Set Specification (DSS) are published in the AIHW's online metadata repository, METeOR, and the National health data dictionary.

The National health data dictionary can be accessed online at:

<http://www.aihw.gov.au/publication-detail/?id=10737422826>

The Data Quality Statement for the NNAPEDCD can be accessed on the AIHW website at:

<http://meteor.aihw.gov.au/content/index.phtml/itemId/543809>

Variation in the way patients are classified to urgency categories should be taken into account. Rather than comparing jurisdictions, the results for individual jurisdictions should be viewed in the context of the proportions of patients assigned to each of the three urgency categories.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- Comparisons across jurisdictions should be made with caution, due to differences in clinical practices and classification of patients across Australia. The measures are also affected by variations across jurisdictions in the method used to calculate waiting times for patients who transferred from a waiting list managed by one hospital to a waiting list managed by another hospital. For patients who were transferred from a waiting list managed by one hospital to that managed by another, the time waited on the first list is included in the waiting time reported in NSW, SA and the NT. This approach can have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions.
- There is apparent variation in the assignment of clinical urgency categories, both among and within jurisdictions, for individual surgical specialties and indicator procedures, influencing the overall total. For example, for 2012–13, the proportion of patients admitted from waiting lists who were assigned to Category 3 treatment clinically recommended within 365 days) was 44 per cent for NSW and 16 per cent for Queensland (Table A.1 from *Australian hospital statistics 2012–13: elective surgery waiting times*, Appendix A p 40 <http://www.aihw.gov.au/publication-detail/?id=60129544692>

Table A.1: Admissions from waiting lists for elective surgery, by clinical urgency category, states and territories, 2012–13 (per cent).

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
				Per	cent				
Category 1	24	31	40	25	26	40	31	29	29
Category 2	32	47	44	35	36	41	45	49	39
Category 3	44	22	16	40	38	20	24	22	32
Total	100	100	100	100	100	100	100	100	100

Source: AIHW 2013. *Australian hospital Statistics 2012–13: elective surgery waiting times*. Health service series No.51. Cat. no. HSE 140. pp 40.

- Interpretation of waiting times for jurisdictions should take into consideration these differences. For example, a state could report relatively long median waiting times in association with a relatively high proportion of patients assessed by clinicians in the state as being in Category 3. Conversely, a state in which a relatively high proportion of patients are assessed by clinicians as being in Category 1 or 2 (treatment clinically recommended within 30 days and 90 days, respectively) could have relatively short median waiting times.
- Interpretation of waiting times for jurisdictions should take into consideration cross-border flows, particularly for the ACT.

Waiting times for admission following emergency department care

Indicator definition and description

Element	Effectiveness — access
Indicator	Waiting times for admitted patient services — Waiting times for admission following emergency department care
Measure (computation)	<p>'Presentations to emergency departments with a length of stay of 4 hours or less ending in admission' is defined as the percentage of presentations to public hospital emergency departments where the time from presentation to admission to hospital is less than or equal to four hours.</p> <p>Calculation includes presentations with any type of visit to emergency department. ED stay length is calculated by subtracting presentation time/date from physical departure time/date, which is recorded as per the business rules included in the NAPEDC NMDS 2013–14: http://meteor.aihw.gov.au/content/index.phtml/itemId/509116</p> <p>'Presentations to emergency departments with a length of stay of 4 hours or less ending in admission' is calculated as:</p> <p><i>Numerator:</i> Number of ED presentations where ED stay is less than or equal to four hours ending in hospital admission.</p> <p><i>Denominator:</i> Number of ED presentations.</p> <p>Calculation includes all presentations with an ED stay completed in the reporting period, including records where the presentation date/time is prior to the reporting period. Invalid records are excluded from the numerator and denominator. Invalid records are records for which:</p> <ul style="list-style-type: none">• Length of stay < 0.• Presentation date or time missing.• Physical departure date or time missing.
Data source/s	This indicator is calculated using data from the Australian Institute of Health and Welfare's (AIHW's) NNAPEDCD, based on the National Minimum Data Set (NMDS) for Non-admitted patient emergency department care (NAPEDC).

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the <i>Australian Institute of Health and Welfare Act 1987</i> to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.</p> <p>The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.</p> <p>The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.</p> <p>One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.</p> <p>The <i>Australian Institute of Health and Welfare Act 1987</i>, in conjunction with compliance to the <i>Privacy Act 1988 (Commonwealth)</i>, ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.</p> <p>For further information see the AIHW website www.aihw.gov.au.</p> <p>Data for the NNAPEDCD were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):</p>
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	<p>http://www.aihw.gov.au/nhissc/ http://meteor.aihw.gov.au/content/index.phtml/itemId/182135</p> <p>The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p>
Relevance	<p>The purpose of the NNAPEDCD is to collect information on the characteristics of emergency department care for non-admitted patients registered for care in emergency departments in selected public hospitals classified as either <i>Principal referral and Specialist women's and children's hospitals</i> (peer group A) or <i>Large hospitals</i> (peer group B). In 2012–13, hospitals in peer groups A and B provided over 86 per cent of all public hospital emergency presentations. In 2013–14, hospitals in peer groups A and B provided about 80 per cent of all public hospital emergency presentations. The data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Hospitals not included do not necessarily have emergency departments that are equivalent to those in hospitals in peer groups A and B. Data are reported by jurisdiction of presentation, regardless of the jurisdiction of usual residence.</p>
Timeliness	<p>The reference period for these data is 2012–13 and 2013–14. The financial year of 2011–12 is the first reporting period that these data are available according the agreed specification.</p>
Accuracy	<p>For 2012–13, the coverage of the NNAPEDCD was 100 per cent in all jurisdictions for public hospitals in peer groups A and B and is estimated at about 85 per cent for all hospitals.</p> <p>For 2013–14, the preliminary estimate of the proportion of emergency occasions of service reported to the NNAPEDCD was 100 per cent for public hospitals in peer groups A and B and is estimated at about 88 per cent for all hospitals.</p> <p>In the baseline year (2007–08) for this indicator, the Tasmanian North West Regional Hospital comprised the combined activity of its Burnie Campus and its Mersey Campus. This hospital was a Peer Group B hospital. There was then a change in administrative arrangements for Mersey and it became the only hospital in the country owned and funded by the Australian Government and, by arrangement, operated by the Tasmanian Government. This administrative change necessitated reporting of these campuses as separate hospitals from 2008–09 onwards. On its own the North West Regional Hospital (Burnie Campus only) is a Peer Group B hospital, whilst, on its own the Mersey Community Hospital is a Peer Group C hospital. Burnie and Mersey did not substantially change their activity, rather, it is simply a case that activity is now spread across two hospitals. For National Healthcare Agreement purposes, although it is a Peer Group C hospital, the Mersey Community Hospital continues to be included in reporting for Peer Group B hospitals to ensure comparability over time for Tasmania. From 2009–10, data for the Albury Base Hospital (previously reported in NSW hospital statistics) were reported in Victorian hospital statistics. This reporting arrangement should be factored into any analysis of data for NSW and Victoria.</p> <p>States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on data. Data are checked for valid values, logical consistency and historical consistency. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.</p>
Coherence	<p>The scope of the NAPEDC NMDS changed between the 2012–13 and 2013–14 reporting periods. These changes may affect comparability of the data reported for 2013–14 with data reported for previous years.</p> <p>For 2012–13, the scope of the Non-admitted patient emergency department care national minimum data set was non-admitted patients registered for care in emergency departments in selected public hospitals that are classified as either Peer Group A or B in the Australian Institute of Health and Welfare's <i>Australian Hospital Statistics</i> publication from the preceding financial year.</p> <p>For 2013–14, the scope of the Non-admitted patient emergency department care national minimum data set specification (NAPEDC NMDS) is patients registered for care in emergency departments in public hospitals where the emergency department meets the following criteria:</p> <ul style="list-style-type: none"> • Purposely designed and equipped area with designated assessment, treatment and resuscitation areas.

- Ability to provide resuscitation, stabilisation and initial management of all emergencies.
- Availability of medical staff in the hospital 24 hours a day.
- Designated emergency department nursing staff and nursing unit manager 24 hours per day 7 days per week.

The data reported for 2012–13 are consistent with data reported for the NNAPEDCD for previous years for individual hospitals.

In addition, the data reported to the NNAPEDCD in previous years has been consistent with the numbers of emergency occasions of services reported to the NPHEd for each hospital for the same reference year.

Time series presentations may be affected by changes in the number of hospitals reported to the collection and changes in coverage.

The information presented for this indicator are calculated using the same methodology as data published in *Australian hospital statistics: emergency department care* (report series) and the *National Healthcare Agreement: performance report 2012–13*.

Accessibility The AIHW provides a variety of products that draw upon the NNAPEDCD. Published products available on the AIHW website are: Australian hospital statistics suite of products with associated Excel tables. These products may be accessed on the AIHW website at: <http://www.aihw.gov.au/hospitals/>.

Interpretability Metadata information for the NAPEDC NMDS and the NAPEDC Data Set Specification (DSS) are published in the AIHW's online metadata repository, METeOR, and the *National health data dictionary*.

The *National health data dictionary* can be accessed online at: <http://www.aihw.gov.au/publication-detail?id=10737422826>

The Data Quality Statement for the 2012–13 NNAPEDCD can be accessed on the AIHW website at:

<http://meteor.aihw.gov.au/content/index.phtml/itemId/546749>

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- The scope of the data used to produce this indicator is non-admitted patients registered for care in emergency departments in public hospitals reporting to the Non-admitted Patient Emergency Department Care (NAPEDC) National Minimum Data Set (NMDS) (Peer Groups A, B and other) as at August 2011 (when the National Health Reform Agreement National Partnership Agreement on Improving Public Hospital Services was signed).
- The scope of the NAPEDC NMDS changed between the 2012–13 and 2013–14 reporting periods. These changes may affect comparability of the data reported for 2013–14 with data reported for previous years.
- For 2012–13, the coverage of the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD) collection is complete for public hospitals in peer groups A and B (*Principal referral and Specialist women's and children's hospitals* and *Large hospitals*) and is estimated at about 85 per cent for all hospitals.
- It is estimated that 2013–14 has similar coverage for public hospitals in peer groups A and B, and is estimated at about 88 per cent for all hospitals, although final coverage cannot be calculated until the 2013–14 National Public Hospital Establishments Database (NPHEd) data are available.
- Caution should be used in comparing these data with earlier years as the number of reporting hospitals and the peer group for a hospital, may vary over time.

Separation rates for selected procedures

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness—appropriateness
Indicator	Separation rates for selected procedures
Measure (computation)	<p>The <i>numerator</i> is the number of hospital separations involving the procedures: cataract extraction, cholecystectomy, coronary artery bypass graft, coronary angioplasty, cystoscopy, haemorrhoidectomy, hip replacement, inguinal herniorrhaphy, knee replacement, myringotomy, tonsillectomy, varicose veins stripping and ligation, septoplasty, prostatectomy and hysterectomy.</p> <p>The <i>denominator</i> is the Estimated Resident Population (ERP), with the exception of prostatectomy, where only the male ERP is used, and hysterectomy, where only the female ERP aged 15–69 years is used.</p> <p>A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).</p> <p><i>Calculation</i> is $1000 \times (\text{numerator} \div \text{denominator})$, presented as a number per 1000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 combined. Aboriginal and Torres Strait Islander population data are not available for all states and territories for 5-year age groups beyond 64 years, so the Indigenous disaggregation was standardised to 64 years, with ages over 64 combined.</p> <p>For hysterectomy only: Total population data were age-standardised using 5 year age groups between 15–69 years. Indigenous disaggregation for the ACT and Tasmania was age-standardised using 5-year age groups from 15–64, with ages over 64 combined. Indigenous disaggregation for all other jurisdictions was standardised using 5-year age groups between 15–69 years as data on the Aboriginal and Torres Strait Islander population aged 65–69 years were available for these jurisdictions.</p>
Data source/s	<p><i>Numerator:</i></p> <p>This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted patient care.</p> <p><i>Denominator:</i></p> <p><u>For total population:</u> Australian Bureau of Statistics (ABS) ERP as at 30 June 2011.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.</p> <p>The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.</p> <p>The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.</p> <p>One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.</p>
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The Australian Institute of Health and Welfare Act 1987, in conjunction with compliance to the Privacy Act 1988 (Cwth), ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au

Data for the NESWTDC were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

<http://www.aihw.gov.au/nhissc/>

<http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

Separations are reported by jurisdiction of hospitalisation, regardless of the jurisdiction of usual residence. This is relevant if significant numbers of one jurisdiction's residents are treated in another jurisdiction.

Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated.

Aboriginal and Torres Strait Islander and Other Australians' rates of hysterectomy in Tasmania and the ACT may underestimate rates of hysterectomy for women aged 15–69 years due to the age-standardisation method used (see above).

Timeliness

The reference period for these data is 2012–13.

Accuracy

For 2012–13 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT.

The majority of private hospitals provided data, with the exception of the private free-standing day hospitals in the ACT and the NT.

Coronary artery bypass graft and coronary angioplasty are not performed in NT hospitals. Residents of the NT requiring these procedures receive treatment interstate. States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

Data on procedures are recorded uniformly using the Australian Classification of Health Interventions.

Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

Cells have been suppressed to protect confidentiality where the presentation could identify a patient or a service provider or where rates are likely to be highly volatile, for example, where the denominator is very small. The following rules were applied:

- Rates were suppressed where the numerator was less than 5 and/or the denominator was less than 1000.
- Data for private hospitals in Tasmania, the ACT and the NT were suppressed.
- Rates which appear misleading (for example, because of cross border flows) were also suppressed.

Coherence

The information presented for this indicator is calculated using the same methodology

as data published in *Australian hospital statistics 2012–13*.

The data can be meaningfully compared across reference periods for all jurisdictions except Tasmania. 2008–09 data for Tasmania does not include two private hospitals that were included in 2007–08 and 2009–10 data reported in National Healthcare Agreement performance reports. In 2009–10, WA was missing 2400 separations for one public hospital and was not able to provide about 10 600 separations for one private hospital.

Caution is required when analysing SEIFA over time for the reasons outlined above (see Relevance section). Methodological variations also exist in the application of SEIFA to various data sets and performance indicators. Any comparisons of the SEIFA analysis for this indicator with other related SEIFA analysis should be undertaken with careful consideration of the methods used, in particular the SEIFA Census year, the SEIFA index used and the approach taken to derive quintiles and deciles.

National level data disaggregated by Indigenous status for 2007–08 included data from NSW, Queensland, WA, SA and NT. National level data disaggregated by Indigenous status for 2008–09, 2009–10 and 2010–11 included data from NSW, Victoria, Queensland, WA, SA and NT. National level data disaggregated by Indigenous status for 2011–12 and subsequent years includes data from all eight states and territories. Therefore, data disaggregated by Indigenous status from 2007–08 is not comparable to 2008–09, 2009–10 and 2010–11, and data for 2011–12 and subsequent years are not comparable with data for 2010–11 and prior years.

In 2011, the ABS updated the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006. Data for 2007–08 through to 2010–11 reported for SEIFA quintiles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011–12 are reported using SEIFA 2011 at the SLA level. The AIHW consider the change from SEIFA 2006 to SEIFA 2011 to be a series break when applied to data supplied for this indicator, therefore SEIFA data for 2011–12 are not directly comparable with SEIFA data from previous reporting cycles.

Accessibility The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:

- *Australian hospital statistics* with associated Excel tables
- interactive data cubes for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).
- Data are also included on the MyHospitals website.

Interpretability Supporting information on the quality and use of the NHMD are published annually in *Australian hospital statistics* (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to note caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Aboriginal and Torres Strait Islander data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care is published in the AIHW's online metadata repository METeOR and the *National health data dictionary*.

Data Gaps/Issues Analysis

Key data The Steering Committee notes the following key data gaps/issues:

gaps/issues Higher/lower rates are not necessarily associated with inappropriate care. However, large jurisdictional variations in rates for particular procedures can require investigation to determine whether service levels are appropriate.

Care needs to be taken when interpreting the differences in the separation rates for the selected procedures. Variations in rates can be attributable to variations in the prevalence of the conditions being treated, or to differences in clinical practice across states and territories. Higher rates can be acceptable for certain conditions and not for others. Higher rates of angioplasties, for example, can represent appropriate levels of care, whereas higher rates of hysterectomies or tonsillectomies can represent an over-reliance on procedures. Some of the selected procedures, such as angioplasty and coronary artery bypass graft, are alternative treatment options for people diagnosed with similar conditions.

Unplanned hospital readmission rates

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — quality/safety
Indicator	<p>Unplanned/unexpected readmissions within 28 days of selected surgical admissions.</p> <p>For the 2013 report, the National Health Information Standards and Statistics Committee (NHISSC), on behalf of Australian Health Ministers' Conference, amended the title of this indicator in the NHISSC specifications to: <i>Unplanned hospital readmission rates</i> to better reflect how the indicator is calculated. Readmissions for this indicator are defined within 28 days from the end of the patient's surgical episode of care.</p>
Measure (computation)	<p><i>Numerator:</i> the number of separations for public hospitals which meet all of the following criteria:</p> <ul style="list-style-type: none">• the separation is a readmission to the same hospital following a separation in which one of the following procedures was performed: knee replacement; hip replacement; tonsillectomy and adenoidectomy; hysterectomy; prostatectomy; cataract surgery; appendicectomy• the readmission occurs within 28 days of the previous date of separation• the principal diagnosis for the readmission is a post-operative complication. <p><i>Denominator:</i> the number of separations in which one of the following surgical procedures was undertaken: knee replacement; hip replacement; tonsillectomy and adenoidectomy; hysterectomy; prostatectomy; cataract surgery; appendicectomy.</p> <p>The denominator is limited to separations with a separation date between 1 July and 19 May in the reference year.</p>
Data source/s	<p>For all jurisdictions except WA, this indicator is calculated by the Australian Institute of Health and Welfare (AIHW) using data from the NHMD, based on the Admitted patient care national minimum data set (NMDS).</p> <p>For WA, the indicator was calculated and supplied by WA Health and was not independently verified by the AIHW.</p> <p><u>For data by socioeconomic status:</u> calculated by AIHW using the Australian Bureau of Statistics (ABS) Socio-Economic Indexes For Areas (SEIFA), Index of Relative Socio-Economic Disadvantage (IRSD) 2011 and Estimated Resident Population (ERP) by Statistical Area level 2 (SA2) as at 30 June 2012. Each SA2 in Australia is ranked and divided into quintiles and deciles in a population-based manner, such that each quintile has approximately 20 per cent of the population and each decile has approximately 10 per cent of the population.</p> <p><u>For data by remoteness:</u> each separation is allocated an ABS remoteness area, as specified in the Australian Standard Geographical Classification, based on the SA2 of usual residence of the patient.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the <i>Australian Institute of Health and Welfare Act 1987</i> to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.</p> <p>The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.</p> <p>The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of</p>
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data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance to the *Privacy Act 1988 (Commonwealth)*, ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au.

Data for the NNAPEDCD were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

<http://www.aihw.gov.au/nhissc/>

<http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

The analyses by remoteness and socioeconomic status are based on the Statistical Area level 2 (SA2) of usual residence of the patient. The Socio-Economic Indexes for Areas (SEIFA) categories for socioeconomic status represent approximately the same proportion of the national population, but do not necessarily represent that proportion of the population in each state or territory (each SEIFA decile or quintile represents 10 per cent and 20 per cent respectively of the national population). The SEIFA scores for each SA2 are derived from 2011 Census data and represent the attributes of the population in that SA2 in 2011.

Separations are reported by jurisdiction of hospitalisation, regardless of the jurisdiction of usual residence. Hence, rates represent the number of separations for patients living in each remoteness area or SEIFA population group (regardless of their jurisdiction of residence) divided by the total number of separations for people living in that remoteness area or SEIFA population group and hospitalised in the reporting jurisdiction. This is relevant if significant numbers of one jurisdiction's residents are treated in another jurisdiction.

The unplanned and/or unexpected readmissions counted in the computation for this indicator have been limited to those having a principal diagnosis of a post-operative adverse event for which a specified ICD-10-AM diagnosis code has been assigned. Unplanned and/or unexpected readmissions attributable to other causes have not been included.

With regard to hysterectomy, there are three related procedures that are not defined for the indicator, and therefore have not been included in any *National Healthcare Agreement* (NHA) reporting (all years). These are (in ICD-10-AM 7th edition), 35750-00—Laparoscopically assisted vaginal hysterectomy; 35753-02—Laparoscopically assisted vaginal hysterectomy with removal of adnexa; and 35653-00—Subtotal abdominal hysterectomy. For public hospitals, there were 1,692 separations in 2012–13 that involved one of these procedures.

The calculation of the indicator is limited to public hospitals and to readmissions to the same hospital.

Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated.

Timeliness

The reference period for this data set is 2012–13.

Accuracy

For 2012–13, almost all public hospitals provided data for the NHMD. The exception was a mothercraft hospital in the ACT.

The majority of private hospitals provided data, with the exception of the private day hospital facilities in the ACT and the NT.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

The AIHW report *Indigenous identification in hospital separations data: quality report* (AIHW 2013) found that nationally, about 88 per cent of Aboriginal and Torres Strait Islander Australians were identified correctly in hospital admissions data in the 2011–12 study period, and the 'true' number of separations for Aboriginal and Torres Strait Islander Australians was about 9 per cent higher than reported. The report recommended that the data for all jurisdictions are used in analysis of Aboriginal and Torres Strait Islander hospitalisation rates, for hospitalisations in total in national analyses of Aboriginal and Torres Strait Islander admitted patient care. However, these data should be interpreted with caution as there is variation among jurisdictions in the quality of the Indigenous status data.

For this indicator, the linkage of separations records is based on the patient identifiers which are reported for public hospitals. As a consequence, only readmissions to the same public hospital are in scope; and readmissions to different public hospitals and readmissions involving private hospitals are not included.

For WA the indicator was calculated and supplied by WA Health.

To calculate this indicator, readmissions within the 2012–13 financial year had to be linked to an initial separation (which involved the specified surgery) that occurred within the 2012–13 financial year. The 19 May was specified as the cut-off date for the initial separation to exclude initial separations from the denominator for which a readmission may occur in the following financial year. The use of the cut-off date ensures that the numerator and denominator for this indicator are consistent.

Data on procedures are recorded uniformly using the Australian Classification of Health Interventions. Data on diagnoses are recorded uniformly using the ICD-10-AM.

Cells have been suppressed to protect confidentiality where the presentation could identify a patient or a service provider or where rates are likely to be highly volatile, for example where the denominator is very small. The following rules were applied:

- Rates were suppressed where the numerator was less than 5 and/or the denominator was less than 200.
- Rates were suppressed where the numerator was zero and the denominator was less than 200.
- Counts were suppressed when the number was less than 5.

Data for private hospitals in Tasmania, ACT and the NT were suppressed.

Coherence

The information presented for this indicator is calculated using the same methodology as data published in *Australian hospital statistics 2012–13* and the *National healthcare agreement: performance report 2012–13*.

The data can be meaningfully compared across reference periods for all jurisdictions. However, caution is required when analysing SEIFA over time for the reasons outlined above (see Relevance section). Methodological variations also exist in the application of SEIFA to various data sets and performance indicators. Any comparisons of the SEIFA analysis for this indicator with other related SEIFA analysis should be undertaken with careful consideration of the methods used, in particular the SEIFA Census year, the SEIFA index used and the approach taken to derive quintiles and deciles.

National level data disaggregated by Indigenous status for 2007–08 included data from NSW, Qld, WA, SA and NT. National level data disaggregated by Indigenous status for 2008–09, 2009–10 and 2010–11 included data from NSW, Victoria, Qld, WA, SA and NT. National level data disaggregated by Indigenous status for 2011–12 and subsequent years includes data from all eight states and territories. Therefore, data disaggregated by Indigenous status from 2007–08 is not comparable to 2008–09, 2009–10 and 2010–11, and data for 2011–12 and subsequent years are not comparable with data for 2010–11 and prior years.

In 2011, the ABS updated the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006. Data for 2007–08 through to 2010–11 reported for SEIFA quintiles are reported using SEIFA 2006 at the Statistical

Local Area (SLA) level. Data for 2011–12 are reported using SEIFA 2011 at the SLA level. Data for 2012–13 are reported using SEIFA 2011 at the Statistical Area level 2 (SA2). The AIHW considers the change from SEIFA 2006 to SEIFA 2011, and the change from SLA to SA2 to be series breaks when applied to data supplied for this indicator. Therefore, SEIFA data for 2010–11 and previous years are not directly comparable with SEIFA data for 2011–12, and SEIFA data for 2011–12 and previous years are not directly comparable with SEIFA data for 2012–13 and subsequent years.

Accessibility The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:

- *Australian hospital statistics* with associated Excel tables
- interactive data cubes for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).

These products may be accessed on the AIHW website at:
<http://www.aihw.gov.au/hospitals/>.

Interpretability Supporting information on the quality and use of the NHMD are published annually in *Australian hospital statistics* (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to note caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Aboriginal and Torres Strait Islander data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the National Minimum Data Set (NMDS) for Admitted patient care is published in the AIHW's online metadata repository, METeOR, and the *National health data dictionary*.

The *National health data dictionary* can be accessed online at:

<http://www.aihw.gov.au/publication-detail/?id=10737422826>

The Data Quality Statement for the 2012–13 NHMD can be accessed on the AIHW website at:

<http://meteor.aihw.gov.au/content/index.phtml/itemId/546749>

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following issues:

- The National Hospital Morbidity Database (NHMD) is a comprehensive data set that has records for all separations of admitted patients from essentially all public and private hospitals in Australia.
- The indicator is an underestimate of all possible unplanned/unexpected readmissions because:
 - it could only be calculated for public hospitals and for readmissions to the same hospital.
 - episodes of non-admitted patient care provided in outpatient clinics or emergency departments which may have been related to a previous admission are not included.
 - the unplanned and/or unexpected readmissions are limited to those having a principal diagnosis of a post-operative adverse event for which a specified International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) diagnosis code has been assigned. This does not include all possible unplanned/unexpected readmissions.
- Calculation of the indicator for WA was not possible using data from the NHMD. Data for WA were supplied by WA Health and Australian rates and numbers do not include WA.
- Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.
- Remoteness data for 2011–12 and previous years are not directly comparable to remoteness data for 2012–13 and subsequent years.
- SEIFA data for 2010–11 and previous years are not directly comparable with SEIFA data for 2011–12, and SEIFA data for 2011–12 and previous years are not directly comparable with SEIFA data for 2012–13 and subsequent years.

Accreditation

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — quality/safety
Indicator	Accreditation
Measure (computation)	Accreditation' is defined as the number of beds in accredited hospitals as a percentage of total beds. Accreditation is awarded to a hospital based on meeting a defined set of standards. Public hospitals can seek accreditation through a number of agencies. These agencies are accredited through the Joint Accreditation System of Australia and New Zealand or the International Society for Quality in Healthcare. Jurisdictions apply specific criteria to determine which accreditation programs are suitable. Quality programs require hospitals to demonstrate continual adherence to quality improvement standards to gain and retain accreditation.
Data source/s	This indicator is calculated using data from the NPHEd. The NPHEd contains information on public hospital expenditure and estimates of the proportion of recurrent expenditure attributed to admitted patient care. The NPHEd is based on the National Minimum Data Set (NMDS) for Public hospital establishments.

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.</p> <p>The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.</p> <p>The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.</p> <p>One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.</p> <p>The Australian Institute of Health and Welfare Act 1987, in conjunction with compliance to the Privacy Act 1988 (Cwlth), ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.</p> <p>For further information see the AIHW website www.aihw.gov.au</p> <p>Data for the NESWTDC were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):</p> <p>http://www.aihw.gov.au/nhissc/</p> <p>http://meteor.aihw.gov.au/content/index.phtml/itemId/182135</p> <p>The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p>
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Relevance	The purpose of the NMDS for Public hospital establishments is to collect information on the characteristics of public hospitals and summary information on non-admitted services provided by them. The scope is public hospitals in Australia, including public acute and psychiatric hospitals, including hospitals operated for or by the Department of Veterans Affairs, and drug and alcohol treatment centres. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included. The collection covers hospitals within the jurisdiction of the State and Territory health authorities. Hence, public hospitals not administered by the State and Territory health authorities (hospitals operated by correctional authorities or the Australian Defence Force for example, and hospitals located in offshore territories) are not included. The collection does not include data for private hospitals.
Timeliness	The reference period for this data set is 2012-13.
Accuracy	<p>For 2012-13, coverage of the NPHEd was essentially complete.</p> <p>States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validation on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked with data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.</p> <p>Although there are national standards for public hospital establishments data, differences in financial accounting, counting and classification practices across jurisdictions may affect the comparability of these data.</p> <p>The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospital buildings or campuses.</p> <p>There was variation between states and territories in the reporting of expenditure, depreciation, available beds, staffing categories and outpatient occasions of service.</p> <p>Comparability of bed numbers can be affected by the range and types of patients treated by a hospital (casemix), with, for example, different proportions of beds being available for special and more general purposes.</p> <p>States and territories may differ in the extent to which non-admitted services are provided in non-hospital settings that are beyond the scope of the NPHEd.</p> <p>The comparability of accreditation data among states and territories is limited because of the voluntary nature of participation in award schemes for hospitals in some jurisdictions. As accreditation for public hospitals was counted as at 30 June 2011, hospitals that were accredited for the majority of the financial year, but had their accreditation status lapse shortly before this date, would have been counted as non-accredited.</p>
Coherence	<p>The NPHEd includes data for each year from 1993–94 to 2012–13.</p> <p>The data reported for 2011–12 are consistent with data reported for the NPHEd for previous years for individual hospitals.</p> <p>Time series presentations may be affected by changes in the number of hospitals reported to the collection and changes in admission practices.</p> <p>Changes in administrative and/or reporting practices for hospitals, changes in accounting practices for financial data, and changes in counting practices can affect comparisons over time.</p>
Accessibility	<p>The AIHW provides a variety of products that draw upon the NHMD and the NPHEd. Published products available on the AIHW website include:</p> <ul style="list-style-type: none"> • Australian hospital statistics with associated Excel tables • Interactive data cubes for Public hospital establishments.
Interpretability	Supporting information on the quality and use of the NPHEd are published annually in <i>Australian hospital statistics</i> (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, changes in accounting methods and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Public hospital establishments and Admitted patient care are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues	<p>The Steering Committee notes the following key data gaps/issues:</p> <p>The comparability of accreditation data among states and territories is limited because of the voluntary nature of participation in award schemes for hospitals in some jurisdictions. As accreditation for public hospitals was counted as at 30 June 2011, hospitals that were accredited for the majority of the financial year, but had their accreditation status lapse shortly before this date, would have been counted as non-accredited.</p> <p>It is not possible to draw conclusions about the quality of care in those hospitals that do not have 'accreditation'. Until 1 January 2013 public hospital accreditation was voluntary in all jurisdictions except Victoria and Queensland, where it was mandatory for all public hospitals (excluding those in Victoria that provide only dental or mothercraft services and those in Queensland that do not routinely admit patients).</p>
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Adverse events in public hospitals

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Healthcare-associated infections

Indicator definition and description

Element	Effectiveness — quality/safety
Indicator	Adverse events in public hospitals — Healthcare-associated <i>infections</i> .
Measure (computation)	<p>SAB patient episodes (as defined below) associated with acute care public hospitals. Patient episodes associated with care provided by private hospitals and non-hospital healthcare are excluded.</p> <p>The definition of an acute public hospital is 'all public hospitals including those hospitals defined as public psychiatric hospitals in the Public Hospital Establishments NMDS'.</p> <p>All types of public hospitals are included, both those focusing on acute care, and those focusing on non-acute or sub-acute care, including psychiatric, rehabilitation and palliative care.</p> <p>Unqualified newborns are included in the indicator. Hospital boarders and posthumous organ procurement are excluded from the indicator.</p> <p>A patient episode of SAB is defined as a positive blood culture for <i>Staphylococcus aureus</i>. For surveillance purposes, only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded.</p> <p>A <i>Staphylococcus aureus</i> bacteraemia will be considered to be healthcare-associated if: the first positive blood culture is collected more than 48 hours after hospital admission or less than 48 hours after discharge, OR, if the first positive blood culture is collected 48 hours or less after admission and one or more of the following key clinical criteria was met for the patient-episode of SAB:</p> <ol style="list-style-type: none">1. SAB is a complication of the presence of an indwelling medical device (e.g. intravascular line, haemodialysis vascular access, CSF shunt, urinary catheter)2. SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site3. An invasive instrumentation or incision related to the SAB was performed within 48 hours4. SAB is associated with neutropenia ($<1 \times 10^9$) contributed to by cytotoxic therapy <p>This definition of a patient episode of SAB was agreed by all states and territories and used by all states and territories for reporting for 2010-11 and subsequent years.</p> <p>The <i>denominator</i> is number of patient days for public acute care hospitals (only for hospitals included in the surveillance arrangements).</p> <p><i>Calculation</i> is $10\,000 \times (\text{Numerator} \div \text{Denominator})$, presented as a number per</p>

10 000 and number only.

Coverage: Denominator ÷ Number of patient days for all public hospitals in the State or Territory.

Data source/s *Numerator:* State and Territory healthcare-associated infection surveillance data.
Denominator: State and Territory admitted patient data.

Data Quality Framework Dimensions

Institutional environment The Australian Institute of Health and Welfare (AIHW) calculated the indicator from data provided by states and territories.

The AIHW is an independent statutory authority within the Health portfolio, which is accountable to the Parliament of Australia through the Minister. For further information see the AIHW website.

The data supplied by the states and territories were collected from hospitals through the healthcare associated infection surveillance programs run by the states and territories. The arrangements for the collection of data by hospitals and the reporting to State and Territory health authorities vary among the jurisdictions.

Relevance This indicator is for patient episodes of SAB acquired, diagnosed and treated in public acute care hospitals. The definition of a public acute care hospital is 'all public hospitals including those hospitals defined as public psychiatric hospitals in the Public Hospital Establishments NMDS'. All types of public hospitals are included, both those focusing on acute care, and those focusing on non-acute or sub-acute care, including psychiatric, rehabilitation and palliative care. The provision of 'acute' services varies among jurisdictions, so it is not possible to exclude 'non-acute' hospitals from the indicator in a way that would be uniform among the states and territories. Therefore all public hospitals have been included in the scope of the indicator so that the same approach is taken for each State and Territory.

The SAB patient episodes reported were associated with both admitted patient care and with non-admitted patient care (including emergency departments and outpatient clinics). No denominator is available to describe the total admitted and non-admitted patient activity of public hospitals. However, the number of patient days for admitted patient activity is used as the denominator to take into account the large differences between the sizes of the public hospital sectors among the jurisdictions. The accuracy and comparability of the SAB rates among jurisdictions and over time is limited because the count of patient days reflects the amount of admitted patient activity, but does not reflect the amount of non-admitted patient activity. The amount of hospital activity that patient days reflect varies among jurisdictions and over time because of variation in admission practices.

In 2012, the scope of the indicator was revised to include unqualified newborns. Data reported for 2010-11 and subsequent years include unqualified newborns. It is not possible to backcast the data for earlier years.

Only patient episodes associated with public acute care hospitals in each jurisdiction are counted. If a case is associated with care provided in another jurisdiction then it may be reported (where known) by the jurisdiction where the care associated with the SAB occurred.

Almost all patient episodes of SAB will be diagnosed when the patient is an admitted patient. However, the intention is that patient episodes are reported whether they were determined to be associated with admitted patient care or non-admitted patient care in public acute care hospitals.

The data presented have not been adjusted for any differences in case-mix between the states and territories.

Analysis by state/territory is based on the location of the hospital.

No denominator is available to describe the total admitted and non-admitted patient activity of public hospitals. However, the number of patient days for admitted patient activity is used as the denominator to take into account the large differences between the sizes of the public hospital sectors among the jurisdictions. Patient days are used rather than occupied bed days because occupied bed day data were not available for all states and territories and there is no nationally agreed definition for occupied bed days.

Timeliness The reference period for this data is 2013-14, with revised data provided for 2012-13, 2011-12 and 2010-11.

Accuracy For some states and territories there is less than 100 percent coverage of public hospitals. For those jurisdictions with incomplete coverage of public hospitals (in the numerator), only patient days for those hospitals (or parts of hospitals) that contribute

data are included (in the denominator). Differences in the types of hospitals not included may impact on the accuracy and comparability of rates.

For 2010-11 and previous years, data for Queensland include only patients aged 14 years and over.

Sometimes it is difficult to determine if a case of SAB is associated with care provided by a particular hospital. Counts therefore may not be precise where cases are incorrectly included or excluded. However, it is likely that the number of cases incorrectly included or excluded would be small.

It is possible that there will be less risk of SAB in hospitals not included in the SAB surveillance arrangements, especially if such hospitals undertake fewer invasive procedures than those hospitals which are included.

There may be imprecise exclusion of private hospital and non-hospital patient episodes due to the inherent difficulties in determining the origins of SAB episodes.

For 2010-11 and subsequent years, all states and territories used the definition of SAB patient episodes associated with acute care public hospitals as defined above.

The patient day data may be preliminary for some hospitals/jurisdictions.

NSW does not provide patient day data, but rather occupied bed days. There may be some difference between patient days and occupied bed days.

Some states and territories have provided revised data for 2012-13, 2011-12 and 2010-11, thus revised tables for these years provided.

Coherence

National data for this indicator were first presented in the 2010 COAG Reform Council report. Since that report further work has been undertaken on data development for this indicator, including the definition of an episode of SAB and a suitable denominator, as well as the coverage of public hospitals. The most recent work in 2012 was to revise the scope of the indicator to include unqualified newborns. Data reported for 2010-11 and subsequent years include unqualified newborns. It is not possible to backcast the data for earlier years. Data for 2013-14, 2012-13, 2011-12 and 2010-11 are therefore not comparable with data for previous years.

Data for 2010-11 and 2011-12 are comparable, except for Queensland, where the 2010-11 data do not include patients aged 13 years and under, whereas the 2011-12 data include patients of all ages.

Data for 2011-12, 2012-13 and 2013-14 are comparable.

NSW data for 2010-11, 2011-12, 2012-13 and 2013-14 are not comparable with data from other jurisdictions because NSW uses occupied bed days, rather than patient days, for calculation of the denominator.

NSW data are included in Australian totals for 2010-11, 2011-12, 2012-13 and 2013-14 because it is expected that at the national level the use of occupied bed days, rather than patient days, for NSW is unlikely to create a marked difference in the Australian data.

As 2008-09 data were provided prior to the development of agreed national definitions, by only five jurisdictions, and was limited to principal referral and large hospitals, these data are not comparable with 2009-10 data, except for Tasmania.

Some jurisdictions have previously published related data (see Accessibility above).

Accessibility

The following states and territories publish data relating to healthcare-associated SAB in various report formats on their websites:

New South Wales: *Your Health Service* public website reports SAB by individual hospital.

<http://www.health.nsw.gov.au/hospitals/search.asp>

New South Wales: *Healthcare associated infections reporting* for 8 infection indicators by state.

<http://www.health.nsw.gov.au/professionals/hai/Documents/HAI-data-collection-report-2014.pdf>

Queensland: Queensland Health Hospital Performance website:

<http://www.health.qld.gov.au/performance/default.asp>

WA: *Healthcare Associated Infection Unit - Annual Report and aggregate reports.*

http://www.public.health.wa.gov.au/3/455/3/reports__healthcare_associated_infection_unit.pm

SA: *Healthcare Associated Bloodstream Infection Report.*

<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/abo>

ut+us/health+statistics/healthcare+infection+statistics/healthcare+infection+statistics?contentIDR=bef94b0042d707bfa38ca3693c255719&useDefaultText=0&useDefaultDesc=1

Tasmania: Acute public hospitals healthcare associated infection surveillance report. http://www.dhhs.tas.gov.au/peh/tasmanian_infection_prevention_and_control_unit/publications_and_guidelines

Interpretability Jurisdictional manuals should be referred to for full details of the definitions used in healthcare-associated infection surveillance. Definitions for this indicator are published in the performance indicator specifications.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following issues:

- There may be imprecise exclusion of private hospital and non-hospital patient episodes due to the inherent difficulties in determining the origins of SAB episodes.
- For some states and territories there is less than 100 per cent coverage of public hospitals. For those jurisdictions with incomplete coverage of public hospitals (in the numerator), only patient days for those hospitals that contribute data are included (in the denominator). Differences in the types of hospitals not included may impact on the accuracy and comparability of rates.
- The accuracy and comparability of the rates of SAB among jurisdictions and over time is also limited because the count of patient days (denominator) reflects the amount of admitted patient activity, but does not reflect the amount of non-admitted patient activity.
- The data for 2013-14, 2012-13 and 2011-12 are comparable.
- The data for 2011-12 are comparable with those from 2010-11 except for Queensland.
- NSW data for 2010-11, 2011-12, 2012-13 and 2013-14 are not comparable with other jurisdictions.
- The patient day data may be preliminary for some hospitals/jurisdictions.

Adverse events treated in hospitals

Indicator definition and description

Element	Effectiveness — quality/safety
Indicator	Adverse events in public hospitals — Adverse events treated in hospitals
Measure (computation)	Adverse events treated in hospitals are measured by separations that had an adverse event including infections, falls resulting in injuries and problems with medication and medical devices that occurred during a hospitalisation. Hospitalisation is identified by diagnoses, places of occurrence and external causes of injury and poisoning that can indicate that an adverse event was treated and/or occurred during the hospitalisation.
Data source/s	This indicator is calculated using data from the National Hospital Morbidity Database (NHMD), based on the national minimum data set (NMDS) for Admitted patient care.

Data Quality Framework Dimensions

Institutional environment The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-

government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The Australian Institute of Health and Welfare Act 1987, in conjunction with compliance to the Privacy Act 1988 (CwIth), ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au

Data for the NESWTDC were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

<http://www.aihw.gov.au/nhissc/>

<http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

Timeliness

The reference period for this data set is 2012–13.

Accuracy

For 2012–13, almost all public hospitals provided data for the NHMD. The exception was a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private free-standing day hospital facilities in the ACT, the single private free-standing day hospital in the NT, and a private free-standing day hospital in Victoria.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors.

Hospital separations data include information on diagnoses, places of occurrence and external causes of injury and poisoning that can indicate that an adverse event was treated and/or occurred during the hospitalisation. However, other diagnosis codes may also suggest that an adverse event has occurred, and some adverse events are not identifiable using these codes. A separation may be recorded against more than one category as some adverse events are reported as diagnoses and others as external causes or places of occurrence (of the injury or poisoning).

The data can be interpreted as representing selected adverse events in health care that have resulted in, or have affected, hospital admissions, rather than all adverse events that occurred in hospitals. Some of the adverse events included in these tables may represent events that occurred before admission. Condition onset flag (COF) information (see *Australian hospital statistics 2012–13*, Chapter 6 and Appendix B) can be used to provide other information about adverse events occurring, and treated within, single episodes of care.

Coherence

The information presented for this indicator is calculated using the same methodology as data published in *Australian hospital statistics 2012–13*.

The data can be meaningfully compared across reference periods for all jurisdictions.

Accessibility	<p>The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:</p> <ul style="list-style-type: none"> • Australian hospital statistics with associated Excel tables • interactive data cubes for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups). <p>These products may be accessed on the AIHW website at: http://www.aihw.gov.au/hospitals/</p>
Interpretability	<p>Supporting information on the quality and use of the NHMD are published annually in Australian hospital statistics (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to note caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Aboriginal and Torres Strait Islander data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the National Minimum Data Set (NMDS) for Admitted patient care is published in the AIHW's online metadata repository, METeOR, and the National health data dictionary.</p> <p>The National health data dictionary can be accessed online at: http://www.aihw.gov.au/publication-detail/?id=10737422826</p> <p>The Data Quality Statement for the National Hospital Morbidity Database can be accessed on the AIHW website at: http://meteor.aihw.gov.au/content/index.phtml/itemId/529483</p>

Data Gaps/Issues Analysis

Key data gaps/issues	<p>The Steering Committee notes the following issues:</p> <p>A separation may be recorded against more than one category as some adverse events are reported as diagnoses and others as external causes or places of occurrence (of the injury or poisoning).</p> <p>These data can be interpreted as representing selected adverse events in health care that have resulted in, or have affected, hospital admissions, rather than all adverse events that occurred in hospitals. Some of the adverse events included may represent events that occurred before admission.</p> <p>Some adverse events are not identifiable using the codes for an adverse event or a place of occurrence of hospital. Some other diagnosis codes may suggest that an adverse event has occurred when it has not.</p>
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Falls resulting in patient harm in hospitals

Indicator definition and description

Element	Effectiveness — quality/safety
Indicator	Adverse events in public hospitals — Falls resulting in patient harm in hospitals
Measure (computation)	<p><i>Numerator:</i> Number of hospital separations with an external cause code for a fall and a place of occurrence of <i>health service area</i>.</p> <p><i>Denominator:</i> Total number of hospital separations.</p> <p>A fall is identified by ICD-10-AM external cause codes W00, W01, W03–W11, W13, W14, W16–W19. Excluded from the numerator are those separations where the ICD-10-AM code for the principal diagnosis is in the range of S00 to T14 (inclusive). Also excluded from the numerator are separations where the principal diagnosis has the ICD-10-AM code Z50.9 (<i>Care involving use of rehabilitation procedure, unspecified</i>) and the second diagnosis is in the range of S00 to T14 (inclusive).</p> <p>A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).</p> <p><i>Calculation:</i> Numerator only; and $1000 \times (\text{numerator} \div \text{denominator})$</p>
Data source/s	This indicator is calculated using data from the National Hospital Morbidity Database (NHMD), based on the national minimum data set (NMDS) for Admitted patient care.

For data by socioeconomic status: calculated by AIHW using the Australian Bureau of Statistics (ABS) Socio-Economic Indexes For Areas (SEIFA), Index of Relative Socio-Economic Disadvantage (IRSD) 2011 and Estimated Resident Population (ERP) by Statistical Local Area (SLA) as at 30 June 2011. Each SLA in Australia is ranked and divided into quintiles and deciles in a population-based manner, such that each quintile has approximately 20 per cent of the population and each decile has approximately 10 per cent of the population.

For data by remoteness: each separation is allocated an ABS remoteness area, as specified in the Australian Standard Geographical Classification, based on the SLA of usual residence of the patient.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The Australian Institute of Health and Welfare Act 1987, in conjunction with compliance to the Privacy Act 1988 (Cwth), ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au

Data for the NESWTDC were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

<http://www.aihw.gov.au/nhissc/>

<http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

The analyses by remoteness and socioeconomic status are based on the Statistical Local Area (SLA) of usual residence of the patient. The Socio-Economic Indexes for

Timeliness
Accuracy

Areas (SEIFA) categories for socioeconomic status represent approximately the same proportion of the national population, but do not necessarily represent that proportion of the population in each state or territory (each SEIFA decile or quintile represents 10 per cent and 20 per cent respectively of the national population). The SEIFA scores for each SLA are derived from 2011 Census data and represent the attributes of the population in that SLA in 2011.

Separations are reported by jurisdiction of hospitalisation, regardless of the jurisdiction of usual residence. Hence, rates represent the number of separations for patients living in each remoteness area or SEIFA population group (regardless of their jurisdiction of residence) divided by the total number of separations for people living in that remoteness area or SEIFA population group and hospitalised in the reporting jurisdiction. This is relevant if significant numbers of one jurisdiction's residents are treated in another jurisdiction.

Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated.

The reference period for this data set is 2012–13.

For 2012–13, almost all public hospitals provided data for the NHMD. The exception was a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private free-standing day hospital facilities in the ACT, the single private free-standing day hospital in the NT, and a private free-standing day hospital in Victoria.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors.

The AIHW report Indigenous identification in hospital separations data: quality report (AIHW 2013) found that nationally, about 88 per cent of Aboriginal and Torres Strait Islander Australians were identified correctly in hospital admissions data in the 2011–12 study period, and the 'true' number of separations for Aboriginal and Torres Strait Islander Australians was about 9 per cent higher than reported. The report recommended that the data for all jurisdictions are used in analysis of Aboriginal and Torres Strait Islander hospitalisation rates, for hospitalisations in total in national analyses of Aboriginal and Torres Strait Islander admitted patient care. However, these data should be interpreted with caution as there is variation among jurisdictions in the quality of the Indigenous status data.

The specification for the indicator defines a fall in hospital as being one for which the place of occurrence is coded as *Health service area*. The *Health service area* as a place of occurrence is broader in scope than hospitals—it includes other health service settings such as day surgery centres and hospices. Hence the numbers presented could be an overestimate as they include falls in health care settings other than hospitals.

Around 26 per cent of the records of separations involving falls did not have a code assigned for the place of occurrence. Consequently, the recorded number of falls occurring in hospitals may be an underestimate.

For separations having multiple external causes, it is not possible to establish (from the NHMD) whether the nominated place of occurrence is associated with the fall or with some other external cause. As a consequence, the count of separations may also be overestimated.

To minimise the chance of overestimation, separations where a person was admitted to hospital with a principal diagnosis of an injury were excluded on the basis that if the injury was the principal diagnosis it was associated with an external cause relating to an event occurring prior to admission. However, these exclusions may result in an underestimation of the indicator as the indicator does not count separations where a person is injured and admitted to hospital and then subsequently experiences a fall in hospital.

Data on falls are recorded uniformly using the ICD-10-AM.

The indicator provides a count of separations involving one or more falls. It does not provide a count of falls.

Comparability is affected by data not being adjusted for differences in casemix (for

example, patient age).

Cells have been suppressed to protect confidentiality where the presentation could identify a patient or a service provider or where rates are likely to be highly volatile, for example, where the denominator is very small. The following rules were applied:

- Rates were suppressed where the numerator was less than 5.
- Data for private hospitals in Tasmania, ACT and the NT were suppressed.

Coherence

The information presented for this indicator is calculated using the same methodology as data published in *Australian hospital statistics 2012–13*.

The data can be meaningfully compared across reference periods for all jurisdictions except Tasmania. 2008–09 data for Tasmania does not include two private hospitals that were included in 2007–08 and 2009–10 data reported in the National Healthcare Agreement performance reports.

Caution is required when analysing SEIFA over time for the reasons outlined above (see Relevance section). Methodological variations also exist in the application of SEIFA to various data sets and performance indicators. Any comparisons of the SEIFA analysis for this indicator with other related SEIFA analysis should be undertaken with careful consideration of the methods used, in particular the SEIFA Census year, the SEIFA index used and the approach taken to derive quintiles and deciles.

National level data disaggregated by Indigenous status for 2007–08 included data from NSW, Queensland, WA, SA and NT. National level data disaggregated by Indigenous status for 2008–09, 2009–10 and 2010–11 included data from NSW, Victoria, Queensland, WA, SA and NT. National level data disaggregated by Indigenous status for 2011–12 and subsequent years includes data from all eight states and territories. Therefore, data disaggregated by Indigenous status from 2007–08 is not comparable to 2008–09, 2009–10 and 2010–11, and data for 2011–12 and subsequent years are not comparable with data for 2010–11 and prior years.

In 2011, the ABS updated the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006. Data for 2007–08 through to 2010–11 reported for SEIFA quintiles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011–12 are reported using SEIFA 2011 at the SLA level. The AIHW consider the change from SEIFA 2006 to SEIFA 2011 to be a series break when applied to data supplied for this indicator, therefore SEIFA data for 2011–12 are not directly comparable with SEIFA data from previous reporting cycles.

Accessibility

The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:

- Australian hospital statistics with associated Excel tables
- interactive data cubes for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).

These products may be accessed on the AIHW website at: <http://www.aihw.gov.au/hospitals/>

Interpretability

Supporting information on the quality and use of the NHMD are published annually in Australian hospital statistics (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to note caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Aboriginal and Torres Strait Islander data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the National Minimum Data Set (NMDS) for Admitted patient care is published in the AIHW's online metadata repository, METeOR, and the National health data dictionary.

The National health data dictionary can be accessed online at:

<http://www.aihw.gov.au/publication-detail/?id=10737422826>

The Data Quality Statement for the National Hospital Morbidity Database can be accessed on the AIHW website at:

<http://meteor.aihw.gov.au/content/index.phtml/itemId/529483>

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following issues:

The recorded number of falls occurring in hospitals may be an underestimate as

around 26 per cent of the records of separations involving falls did not have a code assigned for the place of occurrence.

Underestimation and overestimation may also have occurred due to other limitations of the data.

The indicator provides a count of separations involving one or more falls. It does not provide a count of falls.

Comparability is affected by data not being adjusted for differences in casemix (for example, patient age).

Data on Indigenous status reported for Tasmania and the ACT should be interpreted with caution until an assessment of Indigenous identification is completed.

Workforce sustainability

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency — sustainability
Indicator	Workforce sustainability
Measure (computation)	Workforce sustainability reports age profiles for nurse and midwife, medical practitioner, dental practitioner and allied health practitioner workforces. It shows the numbers of each of these registered professions in ten year age brackets, both by jurisdiction and by region.
Data source/s	National Health Workforce Data Set: medical practitioners 2013 National Health Workforce Data Set: nurses and midwives 2013 National Health Workforce Data Set: dental practitioners 2013 National Health Workforce Data Set: allied health practitioners 2013

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) has calculated this indicator using estimates derived from the National Health Workforce Data Set (NHWDS). The NHWDS is developed through the collaboration of three agencies.</p> <p>The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the National Registration and Accreditation Scheme (NRAS) across Australia, including collecting registration data and administering the workforce surveys.</p> <p>Health Workforce Australia was responsible for the development of the health workforce surveys until its closure by the Australian Government on 6 August 2014.</p> <p>The AIHW receives registration and survey data from the AHPRA. The registration and workforce survey data are combined, cleansed and adjusted for non-response to form NHWDS, and the findings reported by profession. AIHW is the data custodian of the NHWDS. These data are used for workforce planning, monitoring and reporting.</p> <p>The AIHW is an independent statutory authority within the Health portfolio, which is accountable to the Parliament of Australia through the Minister. For further information, see the AIHW website.</p>
Relevance	<p>Medical practitioners, dental practitioners, nurses/midwives and allied health practitioners are required by law to be registered with their relevant national board to practise in Australia. All medical practitioners, dental practitioners, nurses/midwives and nominated allied health practitioners must complete the formal registration renewal form(s) to practise in Australia. This is the compulsory component of the renewal process. The exception is Aboriginal and Torres Strait Islander health practitioners in the allied health workforce; where those who are not required by their employer to use the title 'Aboriginal and Torres Strait Islander health practitioner', 'Aboriginal health practitioner' or 'Torres Strait Islander health practitioner' are not required to be registered, and can continue to work using their current titles (e.g. 'Aboriginal health worker', 'drug and alcohol worker' and 'mental health worker').</p> <p>The health workforce surveys for each of these professions is voluntary and only practitioners who renew their registration receive a questionnaire for completion. New registrants will not receive a survey form until they renew their registration the following</p>

year, during the registration renewal period. Practitioners with limited registration are due for renewal on the anniversary of their first registration and can thus renew and complete a survey at any time through the year.

National Health Workforce Data Set: medical practitioners 2013

The NHWDS: medical practitioners 2013 contain registration details of all registered medical practitioners in Australia, at 30 September on the annual renewal date. Data were extracted from the AHPRA database at the end of November of the same year. The NHWDS also contains workforce data of respondents obtained from the Medical Workforce Survey 2013.

National Health Workforce Data Set: dental practitioners 2013

The NHWDS: dental practitioners 2013 contain registration details of all registered dental practitioners in Australia, at 30 November on the annual renewal date. Data were extracted from the AHPRA database at the end of January the following year. The NHWDS also contains workforce data obtained from the Dental Workforce Survey 2013.

National Health Workforce Data Set: nurses and midwives 2013

The NHWDS: nurses and midwives 2013 contain registration details of all registered nurses/midwives in Australia at 31 May on the annual renewal date. Data were extracted from the AHPRA database at the end of November of the same year. The NHWDS also contains workforce data obtained from the Nursing and Midwifery Workforce Survey 2013.

National Health Workforce Data Set: allied health practitioners 2013

The NHWDS: allied health practitioners 2013 contain registration details of all registered allied health practitioners in Australia, at 30 November on the annual renewal date. Data were extracted from the AHPRA database at the end of January the following year. The NHWDS also contains workforce data obtained from each profession-specific health workforce survey.

Indicator data for allied health practitioners are not comparable between 2012 and 2013. Due to transitional arrangements with the migration of data from state and territory-based systems to NRAS, in 2012, many medical radiation practitioners in Queensland, WA and Tasmania were not required to renew their registrations and, as a result did not complete a workforce survey. As a consequence, data for Queensland, WA and Tasmania for this profession are excluded from the indicator data for allied health practitioners.

For the same reason, occupational therapists in Queensland, WA and SA are excluded from the indicator data for allied health practitioners in 2012.

Timeliness

National Health Workforce Data Set:

The NHWDS for each of the registered professions will be produced annually during the national registration renewal process. Each profession will also be administered a Workforce Survey as part of the registration renewal process.

—Medical practitioners 2013

The NHWDS: medical practitioners is produced annually from information collected by the national registration renewal process, conducted between 1 July and 30 September each year, including the collection of the Medical Workforce Survey.

—Nurses and midwives 2013

The NHWDS: nurses and midwives is produced annually from information collected by the national registration renewal process, conducted between 1 April and 31 May each year, including the collection of the Nursing and Midwifery Workforce Survey.

—Dental practitioners 2013

The NHWDS: dental practitioners is produced annually from information collected by the national registration renewal process, conducted between 1 September and 30 November each year, including the collection of the Dental Workforce Survey. Practitioners with limited registration are due for renewal on the anniversary of their first registration and can thus renew and complete a survey at any time through the year.

—Allied health practitioners 2013

The NHWDS: allied health practitioners is produced annually from information collected by the national registration renewal process, conducted between 1 September and 30 November each year, including the collection of the profession-specific workforce surveys. Practitioners with limited registration are due for renewal on the anniversary of their first registration and can thus renew and complete a survey at any time through the year.

Accuracy

Data manipulation and estimation processes

The registration and workforce survey data for each health profession are combined, cleansed and adjusted for non-response to form the National Health Workforce Data

Set (NHWDS). The cleaning and editing procedures included range and logic checks, clerical scrutiny at unit record level, and validation of unit record and aggregate data. Imputation methods are used to account for item non-response and survey non-response. In 2013, the methodology for survey non-response was changed from a weighting-based methodology to a randomised sequential hot deck-based imputation. It should be noted that both of these kinds of non-response is likely to introduce some bias in the estimates and any bias is likely to become more pronounced when response rates are low or when estimates are based on a small number of records. Care should be taken when drawing conclusions about the size of the differences between estimates.

As a result of the estimation method to adjust for non-response, numbers of medical practitioners, dental practitioners, nurses/midwives or allied health practitioners may have been in fractions, but have been rounded to whole numbers for this indicator. The full-time equivalent (FTE) rate calculations are based on rounded numbers.

Registration data from the National Registration and Accreditation Scheme (NRAS)

Registration details were migrated from the respective state and territory professional board (or council) for practitioners with registrations expiring after the official AHPRA closing date for their profession.

Some data items previously collected by the AIHW Labour Force Surveys are now collected by the NRAS. However, some data quality issues due to migrated data items from the respective state and territory health profession boards may have affected the weighting method.

Medical practitioners, dental practitioners, nurses/midwives and allied health practitioners who reside overseas have been included with practitioners whose state or territory of principal practice and state or territory of main job, respectively, could not be determined.

Health Workforce Survey

In 2013, the online survey questionnaire include for the first time electronic sequencing of questions to automatically guide the respondent to the next appropriate question based on previous responses to questions.

The online survey questionnaire prior to 2013 and in the paper version of the questionnaire, respondents may have made inconsistent responses by not correctly following the sequencing instructions.

The order of the response categories for some questions may have also impacted on the accuracy of the information captured. In addition, there was variation in some responses between the online and paper surveys.

NHWDS data by profession

The following should be noted when comparing state and territory indicator data:

- The data include employed professionals who did not state or adequately describe their state of principal practice and employed professionals who reside overseas. The national estimates include this group.
- *National Health Workforce Data Set: medical practitioners 2013:* The overall response rate of medical practitioners for 2013 was 88.6 per cent.
- *National Health Workforce Data Set: nurses and midwives 2013:* The overall response rate of nurses and midwives for 2013 was 87.6 per cent.
- *National Health Workforce Data Set: dental practitioners 2013:* The overall response rate of dentists for 2013 was 90.0 per cent.
- *National Health Workforce Data Set: allied health practitioners 2013:* The overall response rate of allied health practitioners for 2013 was 87.9 per cent.

Coherence

Health Workforce Survey—coherence with previous surveys

Labour force data published by the AIHW before the NRAS was established in July 2010 were the result of collated jurisdiction-level occupation-specific surveys. The current Health Workforce Survey gathers similar information from each professional group through a separate questionnaire, tailored slightly to take account of profession-specific responses to certain questions, e.g. work setting of main job.

For this indicator, the workforce surveys for medical practitioners, dental practitioners, nurses/midwives and allied health practitioners collect similar data items, but the methodology differs from previous years. The AHPRA is now the single source of registered practitioner data instead of eight state and territories bodies for each profession, and there is greater consistency between jurisdictions and years in the scope of registration information.

The scope and coverage of the Health Workforce Survey is also different from that of the previous series of AIHW Labour Force Surveys as not all jurisdictions surveyed all

types of registered health practitioners.

If the location of principal practice recorded in the registration data was different from the corresponding details of their main job self-reported by practitioners in the survey, the location was derived hierarchically based on main job information and then on principal practice location then place of residence.

Date of birth is one of many data items previously collected by the AIHW Labour Force Surveys, which is now collected by the NRAS.

The three employment-related questions in the new survey are now nationally consistent, but vary from the previous AIHW Labour Force Survey. Due to the differences in data collection (including survey design and questionnaire), processing and estimation methods, it is recommended that comparisons between workforce data from the NHWDS and the previous AIHW Labour Force Survey be made with caution.

AIHW Published Numbers

For this indicator, the rates are based on practitioners employed in the medical, dental, allied health and nursing and midwifery workforces, which is consistent with data published in AIHW's workforce output products available online..

Accessibility Published products available on the AIHW website include workforce online webpages, survey questionnaires and supplementary detailed tables. User guides to the data sets are available on request from the AIHW.

Interpretability Explanatory information for the Medical Workforce Survey, Dental Workforce Survey and the Nursing and Midwifery Workforce Survey is contained in the published online webpages, supplementary detailed tables and data quality statements to the data set for each. For the allied health professions, information about their workforce surveys is available in the National Health Workforce Data Set: allied health practitioners data quality statement. This includes collection method, scope and coverage, survey response, imputation and weighting procedures, and assessment of data quality (including comparison with other data sources).
These are available via the AIHW website and readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following issues:

- These measures are not a substitute for a full workforce analysis that allows for migration, trends in full-time work and expected demand increases. The indicator does not provide information on those currently in training and the intentions of those in the medical workforce to leave the workforce in the near future.
- The rates have been calculated per 100 000 population for this indicator to assist with interpretation.
- Due to the differences in data collection, processing and estimation methods, including survey design and questionnaire, it is recommended that comparisons between workforce data from the National Health Workforce Data Set (NHWDS) and the previous Australian Institute of Health and Welfare (AIHW) Labour Force Survey be made with caution and noted in any analyses.
- Results for the indicator are estimates because the survey data have undergone imputation to adjust for non-response. It should be noted that any of these adjustments may have introduced some bias in the estimates and any bias is likely to become more pronounced when response rates are low or when estimates are based on a small number of survey records. Care should be taken when drawing conclusions about the size of the differences between estimates.
- The 2013 allied health workforce indicator data exclude provisional registrants.
- The 2013 dental and medical workforce indicator data exclude provisional registrants.
- There is no provisional registration type for nurses and midwives.

Cost per casemix-adjusted separation

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Recurrent cost per casemix adjusted separation

Indicator definition and description

Element	Efficiency
Indicator	Cost per casemix-adjusted separation — Recurrent cost per casemix adjusted separation
Measure (computation)	<p>The average cost per case mix-adjusted separation in public hospitals. The formula used to calculate the cost per casemix-adjusted separation is:</p> $(\text{Recurrent expenditure} \times \text{IFRAC}) \div (\text{Total separations} \times \text{Average cost weight})$ <p>Where:</p> <ul style="list-style-type: none">• Recurrent expenditure is as defined by the recurrent expenditure data elements in the National Minimum Data Set for Public Hospital Establishments.• IFRAC (admitted patient cost proportion) is the estimated proportion of total hospital expenditure that relates to admitted patient care.• Average cost weight is calculated from the National Hospital Morbidity Database, using the 2009-10 Australian Refined Diagnosis Related Group (AR-DRG) version 6.0x cost weights published by the Department of Health.
Data source/s	<p>This indicator is calculated using data from the NPHEd and the NHMD. The NPHEd contains information on public hospital expenditure and estimates of the proportion of recurrent expenditure attributed to admitted patient care. The NPHEd is based on the National Minimum Data Set (NMDS) for Public hospital establishments.</p> <p>The NHMD is the source of data on casemix-adjusted separations for public hospitals. The NHMD is based on the NMDS for Admitted patient care.</p> <p>Casemix-adjusted separations are calculated by the application of cost weights sourced from the Independent Hospital Pricing Authority's National Hospital Cost Data Collection for each separation's recorded AR-DRG.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.</p> <p>The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.</p> <p>The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.</p> <p>One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.</p> <p>The Australian Institute of Health and Welfare Act 1987, in conjunction with compliance to the Privacy Act 1988 (Cwth), ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with</p>
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respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au

Data for the NESWTDC were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

<http://www.aihw.gov.au/nhissc/>

<http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

The purpose of the NMDS for Public hospital establishments is to collect information on the characteristics of public hospitals and summary information on non-admitted services provided by them. The scope is public hospitals in Australia, including public acute and psychiatric hospitals, including hospitals operated for or by the Department of Veterans Affairs, and drug and alcohol treatment centres. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included. The collection covers hospitals within the jurisdiction of the State and Territory health authorities. Hence, public hospitals not administered by the State and Territory health authorities (hospitals operated by correctional authorities or the Australian Defence Force for example, and hospitals located in offshore territories) are not included. The collection does not include data for private hospitals.

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in all public and private acute and psychiatric hospitals, free-standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories may also be included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

The scope of the analysis includes public hospitals that provide mainly acute care. These are the hospitals in the public hospital peer groups of Principal referral and specialist women's and children's hospitals, Large hospitals, Medium hospitals, and Small acute hospitals. Excluded are Small non-acute hospitals, Multi-purpose services, Hospices, Rehabilitation hospitals, Mothercraft hospitals, Other non-acute hospitals, Psychiatric hospitals, and hospitals in the Unpeered and other hospitals peer group. Also excluded are hospitals for which expenditure or admitted patient care data were incomplete, although most of these were excluded for other reasons (for example they are small non-acute hospitals).

This indicator is an efficiency indicator, in which the numerator represents the amount of resources used (expenditure) to generate outputs (measured in a standardised way, that is, as cost-weighted separations).

Timeliness

The reference period for this data set is 2011-12.

Accuracy

For 2011-12, coverage of the NPHEd was essentially complete. Almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT.

States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validation on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked with data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

The data are defined in the NMDSs detailed above.

However, the comparability of the cost per casemix-adjusted separation in any one year is sensitive to a number of deficiencies in available data:

- the proportion of recurrent expenditure that relates to admitted patient care is estimated in different ways in different hospitals and is not always comparable

- capital costs are not included in the numerator. While depreciation information is provided by most jurisdictions, this may vary across states and territories
- only cost weights applicable to acute care separations are available, so these have been applied to all separations, including the 3 per cent that were not acute. The proportions of separations that are not acute vary across states and territories.
- the proportions of patients other than public patients vary across states and territories, and the estimation of medical costs for these patients (undertaken to adjust expenditure to resemble what it would be if all patients had been public patients) is subject to error.

Cells have been suppressed to protect confidentiality (where the numerator would identify a single service provider).

Coherence The information presented for this indicator is calculated using the same methodology as data published in *Australian hospital statistics 2011-12*.

The denominator for the indicator is based on the reported admitted patient activity, adjusted using cost-weights to derive a 'standard' unit of output as an artificial construct. The estimated number of cost-weighted separations (particularly using constant AR-DRGs and AR-DRG cost weights over time) is for comparison purposes only.

Time series analysis of this indicator is not recommended.

Accessibility The AIHW provides a variety of products that draw upon the NHMD and the NPHEd. Published products available on the AIHW website include:

- *Australian hospital statistics* with associated Excel tables
- Interactive data cubes for Public hospital establishments.

Interpretability Supporting information on the quality and use of the NPHEd and NHMD are published annually in *Australian hospital statistics* (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, changes in accounting methods and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Public hospital establishments and Admitted patient care are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- the proportion of recurrent expenditure that relates to admitted patient care is estimated in different ways in different hospitals and is not always comparable
- only cost weights applicable to acute care separations are available, so these have been applied to all separations, including the 3 per cent that were not acute.
- the proportion of patients other than public patients can vary, and the estimation of medical costs for these patients (undertaken to adjust expenditure to resemble what it would be if all patients had been public patients) is subject to error.
- Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

Total cost per casemix adjusted separation

Indicator definition and description

Element	Efficiency
Indicator	Cost per casemix-adjusted separation — Total cost per casemix adjusted separation
Measure (computation)	The average cost per case mix-adjusted separation in public hospitals. The formula used to calculate the cost per casemix-adjusted separation is: $(\text{Recurrent expenditure} \times \text{IFRAC}) \div (\text{Total separations} \times \text{Average cost weight})$ Where: <ul style="list-style-type: none"> • Recurrent expenditure is as defined by the recurrent expenditure data elements in the National Minimum Data Set for Public Hospital Establishments. • IFRAC (admitted patient cost proportion) is the estimated proportion of total hospital

expenditure that relates to admitted patient care.

- Average cost weight is calculated from the National Hospital Morbidity Database, using the 2009-10 Australian Refined Diagnosis Related Group (AR-DRG) version 6.0x cost weights published by the Department of Health.

'Total cost per casemix-adjusted separation' is defined as the recurrent cost per casemix-adjusted separation plus the capital costs per casemix-adjusted separation. Recurrent costs include labour and material costs, and capital costs include depreciation and the user cost of capital for buildings and equipment. The indicator is included because it allows the full cost of hospital services to be considered in a single measure. The hospitals included in this measure are the same as for recurrent cost per casemix-adjusted separation.

Depreciation is defined as the cost of consuming an asset's services. It is measured by the reduction in value of an asset over the financial year. The user cost of capital is the opportunity cost of the capital invested in an asset, and is equivalent to the return foregone from not using the funds to deliver other government services or to retire debt. Interest payments represent a user cost of capital, so are deducted from capital costs in all jurisdictions to avoid double counting.

Data source/s

This indicator is calculated using data from the NPHEd and the NHMD. The NPHEd contains information on public hospital expenditure and estimates of the proportion of recurrent expenditure attributed to admitted patient care. The NPHEd is based on the National Minimum Data Set (NMDS) for Public hospital establishments.

The NHMD is the source of data on casemix-adjusted separations for public hospitals. The NHMD is based on the NMDS for Admitted patient care.

Casemix-adjusted separations are calculated by the application of cost weights sourced from the Independent Hospital Pricing Authority's National Hospital Cost Data Collection for each separation's recorded AR-DRG.

Capital costs are sourced from state and territory health departments as part of the annual Report on Government Services data collection.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The Australian Institute of Health and Welfare Act 1987, in conjunction with compliance to the Privacy Act 1988 (Cwlth), ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au

Data for the NESWTDC were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

<http://www.aihw.gov.au/nhissc/>

<http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

Relevance

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

The purpose of the NMDS for Public hospital establishments is to collect information on the characteristics of public hospitals and summary information on non-admitted services provided by them. The scope is public hospitals in Australia, including public acute and psychiatric hospitals, including hospitals operated for or by the Department of Veterans Affairs, and drug and alcohol treatment centres. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included. The collection covers hospitals within the jurisdiction of the State and Territory health authorities. Hence, public hospitals not administered by the State and Territory health authorities (hospitals operated by correctional authorities or the Australian Defence Force for example, and hospitals located in offshore territories) are not included. The collection does not include data for private hospitals.

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in all public and private acute and psychiatric hospitals, free-standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories may also be included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

The scope of the analysis includes public hospitals that provide mainly acute care. These are the hospitals in the public hospital peer groups of Principal referral and specialist women's and children's hospitals, Large hospitals, Medium hospitals, and Small acute hospitals. Excluded are Small non-acute hospitals, Multi-purpose services, Hospices, Rehabilitation hospitals, Mothercraft hospitals, Other non-acute hospitals, Psychiatric hospitals, and hospitals in the Unpeered and other hospitals peer group. Also excluded are hospitals for which expenditure or admitted patient care data were incomplete, although most of these were excluded for other reasons (for example they are small non-acute hospitals).

This indicator is an efficiency indicator, in which the numerator represents the amount of resources used (expenditure) to generate outputs (measured in a standardised way, that is, as cost-weighted separations).

Timeliness

The reference period for this data set is 2011-12.

Accuracy

For 2011-12, coverage of the NPHEd was essentially complete. Almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT.

States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validation on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked with data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

The data are defined in the NMDSs detailed above.

However, the comparability of the cost per casemix-adjusted separation in any one year is sensitive to a number of deficiencies in available data:

- the proportion of recurrent expenditure that relates to admitted patient care is estimated in different ways in different hospitals and is not always comparable
- capital costs are not included in the numerator. While depreciation information is provided by most jurisdictions, this may vary across states and territories
- only cost weights applicable to acute care separations are available, so these have been applied to all separations, including the 3 per cent that were not acute. The proportions of separations that are not acute vary across states and territories.
- the proportions of patients other than public patients vary across states and territories, and the estimation of medical costs for these patients (undertaken to adjust expenditure to resemble what it would be if all patients had been public

	patients) is subject to error.
	Cells have been suppressed to protect confidentiality (where the numerator would identify a single service provider).
Coherence	The information presented for this indicator is calculated using the same methodology as data published in <i>Australian hospital statistics 2011-12</i> . The denominator for the indicator is based on the reported admitted patient activity, adjusted using cost-weights to derive a 'standard' unit of output as an artificial construct. The estimated number of cost-weighted separations (particularly using constant AR-DRGs and AR-DRG cost weights over time) is for comparison purposes only.
Accessibility	Time series analysis of this indicator is not recommended. The AIHW provides a variety of products that draw upon the NHMD and the NPHEd. Published products available on the AIHW website include: <ul style="list-style-type: none"> • <i>Australian hospital statistics</i> with associated Excel tables • Interactive data cubes for Public hospital establishments.
Interpretability	Supporting information on the quality and use of the NPHEd and NHMD are published annually in <i>Australian hospital statistics</i> (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, changes in accounting methods and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Public hospital establishments and Admitted patient care are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following key data gaps/issues: <ul style="list-style-type: none"> • the proportion of recurrent expenditure that relates to admitted patient care is estimated in different ways in different hospitals and is not always comparable • only cost weights applicable to acute care separations are available, so these have been applied to all separations, including the 3 per cent that were not acute. • the proportion of patients other than public patients can vary, and the estimation of medical costs for these patients (undertaken to adjust expenditure to resemble what it would be if all patients had been public patients) is subject to error. • Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.
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Relative stay index

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Relative Stay Index
Measure (computation)	Relative stay indexes (RSIs) are calculated as the number of observed patient days ¹ for separations in selected AR-DRGs, divided by the number of expected patient days ² , standardised for casemix (based on national figures). An RSI greater than 1.0 indicates that an average patient's length of stay is higher than expected given the casemix for the group of separations of interest. An RSI of less than 1.0 indicates that the length of stay was less than expected. The standardisation for casemix (based on AR-DRG version 6.0x and the age of the patient for each separation) allows comparisons to be made that take into account variation in types of services provided; however, it does not take into account other influences on length of stay, such as Indigenous status. The RSI method includes acute care separations only, and excludes separations for patients who died or were transferred within 2 days of admission, or with a length of

stay greater than 120 days. Excluded from the analysis were:

- AR-DRGs for rehabilitation (such as Z60A *Rehabilitation with catastrophic/severe complications or comorbidities*)
- predominantly same-day AR-DRGs (such as R63Z *Chemotherapy* and L61Z *Admit for renal dialysis*)
- AR-DRGs with a length of stay component in the definition
- *Error* AR-DRGs

Data source/s

The NHMD is the source of data on casemix adjusted separations for public hospitals. The NHMD is based on the NMDS for Admitted patient care. Casemix adjusted separations are calculated by the application of cost weights sourced from the Independent Hospital Pricing Authority's National Hospital Cost Data Collection for each separation's recorded AR-DRG.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The Australian Institute of Health and Welfare Act 1987, in conjunction with compliance to the Privacy Act 1988 (Cwth), ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au

Data for the NESWTDC were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

<http://www.aihw.gov.au/nhissc/>

<http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in all public and private acute and psychiatric hospitals, free-standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories may also be included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

The scope of the analysis includes public hospitals that provide mainly acute care.

Timeliness	These are the hospitals in the public hospital peer groups of Principal referral and specialist women's and children's hospitals, Large hospitals, Medium hospitals, and Small acute hospitals. Excluded are Small non-acute hospitals, Multi-purpose services, Hospices, Rehabilitation hospitals, Mothercraft hospitals, Other non-acute hospitals, Psychiatric hospitals, and hospitals in the Unpeered and other hospitals peer group. Also excluded are hospitals for which expenditure or admitted patient care data were incomplete, although most of these were excluded for other reasons (for example they are Small non-acute hospitals).
Accuracy	<p>The reference period for this data set is 2012-13.</p> <p>Almost all public hospitals provided data for the NHMD, with the exception of a Mothercraft hospital in the ACT.</p> <p>States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validation on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked with data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.</p> <p>The comparability of the RSI in any one year is sensitive to a number of deficiencies in available data:</p> <ul style="list-style-type: none"> • only cost weights applicable to acute care separations are available, so these have been applied to all separations, including the 3 per cent that were not acute. The proportions of separations that are not acute vary across states and territories. • the proportions of patients other than public patients vary across states and territories, and the estimation of medical costs for these patients (undertaken to adjust expenditure to resemble what it would be if all patients had been public patients) is subject to error. <p>Cells have been suppressed to protect confidentiality (where the numerator would identify a single service provider).</p>
Coherence	<p>The information presented for this indicator is calculated using the same methodology as data published in <i>Australian hospital statistics 2012-13</i>.</p> <p>The denominator for the indicator is based on the reported admitted patient activity, adjusted using cost-weights to derive a 'standard' unit of output as an artificial construct. The estimated number of cost-weighted separations (particularly using constant AR-DRGs and AR-DRG cost weights over time) is for comparison purposes only.</p> <p>Comparisons with RSIs presented in <i>Australian hospital statistics 2003-04</i> (AIHW 2005) and earlier reports should be made with caution, because the indexes for earlier years were calculated using AR-DRG version 4, for reports from 2004-05 to 2009-10, the RSIs were calculated using AR-DRG versions 5.0/5.1/5.2 and for 2010-11 and 2011-12, the RSIs were calculated using AR-DRG versions 6.0/6.0x.</p> <p>Time series analysis of this indicator is not recommended.</p>
Accessibility	<p>The AIHW provides a variety of products that draw upon the NHMD and the NPHEd. Published products available on the AIHW website include:</p> <ul style="list-style-type: none"> • Australian hospital statistics with associated Excel tables • Interactive data cubes for Public hospital establishments.
Interpretability	<p>Supporting information on the quality and use of the NHMD are published annually in <i>Australian hospital statistics</i> (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, changes in accounting methods and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Public hospital establishments and Admitted patient care are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.</p>

Data Gaps/Issues Analysis

Key data gaps/issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • only cost weights applicable to acute care separations are available, so these have been applied to all separations, including the 3 per cent that were not acute. • the proportion of patients other than public patients can vary, and the estimation of
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medical costs for these patients (undertaken to adjust expenditure to resemble what it would be if all patients had been public patients) is subject to error.

- Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

Recurrent cost per non-admitted occasion of service

Data quality information for this indicator has been sourced from the Review with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Recurrent cost per non-admitted occasion of service
Measure (computation)	Recurrent cost per non-admitted occasion of service' is defined as the proportion of recurrent expenditure allocated to patients who were not admitted, divided by the total number of non-admitted patient occasions of service in public hospitals. Occasions of service include examinations, consultations, treatments or other services provided to patients in each functional unit of a hospital. Non-admitted occasions of service (including emergency department presentations and outpatient services) account for a significant proportion of hospital expenditure.
Data source/s	This indicator is calculated using data from states and territories collected by the Review.

Data Quality Framework Dimensions

Institutional environment	Data were supplied by State and Territory health authorities. The State and Territory health authorities receive these data from patient administrative and clinical records. States and territories use these data for service planning, monitoring and internal and public reporting.
Relevance	This indicator does not adjust for the complexity of service — for example, a simple urine glucose test is treated equally with a complete biochemical analysis of all body fluids.
Timeliness	The reference period for this data set is 2012-13.
Accuracy	<p>Inaccurate responses may occur in all data provided to the Review. The Review does not have direct access to records to determine the accuracy of the data provided. However, the Review undertakes validation on receipt of data. Data received from states and territories are checked for completeness, validity and logical errors. Potential errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The Review does not adjust data to account for possible data errors.</p> <p>Errors may occur during the processing of data by the states and territories or at the Review. Processing errors prior to data supply may be found through the validation checks applied by the Review. This indicator is calculated on data that has been reported to the Review. Prior to publication, these data are referred back to jurisdictions for checking and review. The Review does not adjust the data to correct for missing values.</p>
Coherence	<p>Data are not available for two jurisdictions, Victoria and the NT.</p> <p>These data are not comparable across jurisdictions. There is considerable variation among states and territories and between reporting years in the way in which non-admitted patient occasions of service data are collected.</p> <ul style="list-style-type: none">• There are differing admission practices between the states and territories.• There is variation in the types of services provided for non-admitted patients and the type of facility providing these services, for example, states and territories may differ in the extent to which outpatient services are provided in non-hospital settings (such as community health services).• Reporting categories vary across jurisdictions.

- Inconsistencies arising from differences in outsourcing practices. In some cases, for example, outsourced occasions of service can be included in expenditure on non-admitted services, but not in the count of occasions of service.

Statistics on emergency department presentations for non-admitted patients may be affected by variations in reporting practices across states and territories. Although there are national standards for data on non-admitted patient emergency department services there are some variations in how those services are defined and counted across states and territories and over time. For example, there is variation in:

- the point at which the commencement of clinical care is reported
- the point at which the emergency department presentation is reported as completed for those patients subsequently admitted within the emergency department and/or elsewhere in the hospital.

For some jurisdictions, the reporting of outpatient clinic care varied over the periods 2010–11 and 2011–12, in order to align with the reporting requirements for Activity Based Funding. These changes included: the discontinuation of reporting for some activity; the commencement of reporting for some activity; and the re-categorisation of some clinics according to the Tier 2 clinics structure. Therefore, these data may not be comparable with data reported for previous years.

Accessibility Cost per occasion of service data are not widely published elsewhere due to data quality issues. No nationally data collection currently exists which can produce comparable data. Data collection and reporting practices differ greatly across jurisdictions.

Interpretability Supporting information on the quality and use of the data are not publicly available. Metadata such as concepts, classifications and counting rules are not published and are not consistent across jurisdictions.

Definitions are not well developed and could be ambiguous or confusing to the user.

There is little other information available to assist the user such as glossaries, standards, explanatory material, methodological information, user guides or classifications.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- the of recurrent expenditure that relates to occasions of service is estimated in different ways in different hospitals and is not always comparable
- This indicator does not adjust for the complexity of service, it is desirable for data to be casemix adjusted
- Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions
- Data are not available for two jurisdictions, Victoria and the NT.

Patient satisfaction

Data quality information for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Patient satisfaction
Measure (computation)	Measure: Nationally comparable information that indicates levels of patient satisfaction around key aspects of care they received. Numerator: <ul style="list-style-type: none"> • persons who had been to a hospital emergency department in the last 12 months reporting the doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them

- persons who had been to a hospital emergency department in the last 12 months reporting the nurses always or often: listened carefully, showed respect, and spent enough time with them
- persons who had been admitted to a hospital in the last 12 months reporting the doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them
- persons who have been admitted to a hospital in the last 12 months reporting the nurses always or often: listened carefully, showed respect, and spent enough time with them

Denominator:

- persons who had been to a hospital emergency department in the last 12 months, excluding persons who were interviewed by proxy
- persons who had been admitted to a hospital in the last 12 months, excluding persons who were interviewed by proxy

Data source/s ABS Patient Experience Survey, 2013-14.

Data Quality Framework Dimensions

Institutional environment

Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.

For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see [ABS Institutional Environment](#)

Collection authority: The Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975.

Data Compiler(s): Data is compiled by the Health section of the Australian Bureau of Statistics (ABS).

Statistical confidentiality is guaranteed under the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. The ABS notifies the public through a note on the website when an error in data has been identified. The data is withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible.

Relevance

Level of Geography: Data is available by State/Territory, Sex, 2011 SEIFA (Index of Relative Socio-economic Disadvantage) and 2011 Remoteness (major cities, inner and outer regional, remote and very remote Australia).

Data Completeness: All data is available for this indicator from this source.

Numerator/Denominator Source: Same data source.

Data for this indicator was collected for all persons in Australia aged 15 years and over, excluding the following people:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons.
- People living in discrete indigenous communities

The 2011-12 iteration of the Patient Experience survey was the first to include households in very remote areas, (although it still excluded discrete indigenous communities). The 2013-14 iteration continues to include data from very remote areas. The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the Northern Territory. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

Data was self-reported for this indicator. Persons who were interviewed by proxy were

Timeliness	<p>excluded.</p> <p>Collection interval/s: Patient Experience data is collected annually.</p> <p>Data available: The 2013-14 data used for this indicator became available from 28 November 2014.</p> <p>Referenced Period: July 2013 to June 2014.</p>
Accuracy	<p>There are not likely to be revisions to this data after its release.</p> <p>Method of Collection: For this iteration of the Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.</p> <p>The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEx included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.</p> <p>Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEx sample only and estimates obtained using the combined MPHS PEx and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (The majority of MPHS PEx interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience Survey</p> <p>Response rate and sample size: The response rate in 2013-14 to the MPHS PEx was 77 per cent (27 327 fully responding persons) while the response rate to HSS was 83 per cent (8 541 fully responding persons) resulting in a total sample size of 35 868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.</p> <p>Note this is a substantial increase from the 2012-13 sample size of 30 749. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.</p> <p>Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Data for MPHS PEx and HSS were weighted separately.</p> <p>Confidentiality:</p> <p>For the first time in 2013-14, the data has been perturbed. This has been footnoted in the tables. Perturbation is used to minimise the risk of identifying individuals in aggregate statistics. Perturbation involves small random adjustment of the statistics and is considered the most satisfactory technique for avoiding the release of identifiable statistics while maximising the range of information that can be released. These adjustments have a negligible impact on the underlying pattern of the statistics.</p> <p>After perturbation, a given published cell value will be consistent across all tables. However, adding up cell values to derive a total will not necessarily give the same result as published totals.</p> <p>As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a relative standard error between 25 per cent and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.</p> <p>This indicator generally has acceptable levels of sampling error and provides reliable data for most breakdowns. However, RSEs for remote/very remote breakdowns are mostly greater than 25 per cent and should either be used with caution or are considered too unreliable for general use. Similarly, data for the "other" remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data.</p> <p>The data for this indicator is attitudinal, as it collects whether people felt they waited too</p>

	<p>long to get an appointment with a GP, and whether the person felt the health professional in question spent enough time with them, listened carefully and showed them respect (the 'patient satisfaction' questions).</p> <p>Data is used from personal interviews only (i.e. excluding proxy interviews).</p> <p>Explanatory footnotes are provided for each table.</p>
Coherence	<p>Consistency over time: 2009 was the first year data was collected for this indicator.</p> <p>Time series issues for unacceptable waiting times for GPs: Data for 2013-14 is comparable to 2012-13, but not prior to this (ie not comparable to 2011-12 or 2010-11). While the question wording itself did not change, the position in the survey (ie where the question was asked) changed in 2011-12 and again in 2012-13. There has been a noticeable contextual effect with this change in question ordering, and ABS recommends that this data item is not comparable over time. This has been footnoted in the relevant tables.</p> <p>Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.</p> <p>The numerator and denominator are compiled from a single source.</p> <p>Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete indigenous communities in the sample will affect the NT more than it affects other jurisdictions.</p> <p>Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.</p> <p>Collections across populations: Data is collected the same way across all jurisdictions.</p> <p>The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.</p> <p>Due to differences in survey scope, collection methodology and question wording, these data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).</p>
Accessibility	<p>Data publicly available. Tables showing patients experiences with health professionals are available in Health Services: Patient Experiences in Australia, 2009 (cat. no. 4839.0.55.001), Patient Experiences in Australia: Summary of Findings, 2010-11, Patient Experiences in Australia: Summary of Findings, 2011-12, Patient Experiences in Australia: Summary of Findings, 2012-13 and Patient Experiences in Australia: Summary of Findings, 2013-14 (cat. no. 4839.0).</p> <p>Data for this indicator is shown by age, sex, SEIFA and remoteness. Jurisdictional data is not currently publicly available but may be made available in the future.</p> <p>Data is not available prior to public access.</p> <p>Supplementary data is available. Additional data from the Patient Experience Survey is available upon request.</p> <p>Access permission/Restrictions: Customised data requests may incur a charge.</p> <p>Contact Details: For more information, please call the ABS National Information and Referral Service on 1300 135 070.</p>
Interpretability	<p>Context: This data was collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data was collected over a twelve month period and therefore should minimise any seasonality effects in the data.</p> <p>Other Supporting information: The ABS Patient Experience data is published in Patient Experiences in Australia: Summary of Findings, 2013-14 (cat. no. 4839.0). This publication includes explanatory and technical notes.</p> <p>Socioeconomic status definition: The SEIFA Index of Relative Socio-economic Disadvantage uses a broad definition of relative socio-economic disadvantage in terms of people's access to material and social resources, and their ability to participate in society. While SEIFA represents an average of all people living in an area, it does not represent the individual situation of each person. Larger areas are more likely to have greater diversity of people and households.</p> <p>Socioeconomic status derivation: The 2011 SEIFA index of relative socio-economic disadvantage is derived from Census variables related to disadvantage, such as low income, low educational attainment, unemployment, and dwellings without motor vehicles.</p> <p>Socioeconomic status deciles derivation: Deciles are based on an equal number of areas. A score for a collection district (CD) is created by adding together the weighted characteristics of that CD. The scores for all CDs are then standardised to a distribution where the average equals 1000 and roughly two-thirds of the scores lie between 900</p>

and 1100. The CDs are ranked in order of their score, from lowest to highest. Decile 1 contains the bottom 10 per cent of CDs, Decile 2 contains the next 10 per cent of CDs and so on. Further information on SEIFA can be found in the ABS Technical paper [Socio-Economic Indexes for Areas 2011 \(cat. No. 2033.0.55.001\)](#).

Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in Patient Experiences in Australia: Summary of Findings, 2013-14 (cat. no. 4839.0).

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following key data gaps/issues: <ul style="list-style-type: none"> • State and Territory disaggregation of this indicator by Indigenous status is a priority. • State and Territory disaggregation of this indicator by SES is a priority.
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Caesareans and inductions for selected primiparae

Data quality information for this indicator has been sourced from states and territories with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Caesareans and inductions for selected primiparae
Measure (computation)	Caesareans and inductions for selected primiparae' are defined as the number of inductions or caesareans for the selected primiparae divided respectively by the number of the selected primiparae who gave birth. Rates are reported for women aged between 20 and 34 years who have had no previous deliveries, with a vertex presentation (that is, the crown of the baby's head is at the lower segment of the mother's uterus) and a gestation length of 37 to 41 weeks. This group is considered to be low risk parturients, so caesarean or induction rates should be low in their population. Primiparae refers to a woman who has given birth to a liveborn or stillborn infant for the first time. Parturient means 'about to give birth'
Data source/s	This indicator is calculated using data from states and territories.

Data Quality Framework Dimensions

Institutional environment	Data were supplied by State and Territory health authorities. The State and Territory health authorities receive these data from patient administrative and clinical records. This information is usually collected by midwives or other birth attendants. States and territories use these data for service planning, monitoring and internal and public reporting.
Relevance	High intervention rates can indicate a need for investigation, although labour inductions and birth by caesarean section are interventions that are appropriate in some circumstances, depending on the health and wellbeing of mothers and babies.
Timeliness	The reference period for the data is 2013. Collection of data is annual.
Accuracy	Inaccurate responses may occur in all data provided to the Review. The Review does not have direct access to perinatal records to determine the accuracy of the data provided. However, the Review undertakes validation on receipt of data. Data received from states and territories are checked for completeness, validity and logical errors. Potential errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The Review does not adjust data to account for possible data errors. Errors may occur during the processing of data by the states and territories or at the Review. Processing errors prior to data supply may be found through the validation checks applied by the Review. This indicator is calculated on data that has been reported to the Review. Prior to publication, these data are referred back to jurisdictions for checking and review. The Review does not adjust the data to correct for missing values.
Coherence	The age group of women used for this indicator has been changed from 25–29 years

to 20–34 years in the 2015 Report to align with national data definitions. All time series data in attachment tables for the 2015 Report have been backcast by states and territories using the 20–34 year age group. However, data for this indicator are not comparable with data in previous report editions.

Note that because of data editing and subsequent updates of State/Territory databases, numbers reported for this indicator can differ from those in reports published by the states and territories.

Changing levels of Indigenous identification over time and across jurisdictions may also affect the accuracy of compiling a consistent time series in future years.

Accessibility

Data are published by states and territories and are also collected by the AIHW as part of the National Perinatal Data Collection. Note that the AIHW data are available to the Review one year later than that available to the Review by collecting data direct from states and territories.

The AIHW provides a variety of products that draw upon the NPDC. Published products available on the AIHW website are:

- Australia’s mothers and babies annual report
- Aboriginal and Torres Strait Islander mothers and their babies, Australia 2001–2004
- METeOR – online metadata repository
- National health data dictionary.

Ad-hoc data are also available on request (charges apply to recover costs).

Interpretability

Supporting information on the use and quality of the Perinatal NMDS are published annually in Australia’s mothers and babies (Chapter 1), available in hard copy or on the AIHW website. Comprehensive information on the quality of Perinatal NMDS elements are published in Perinatal National Minimum Data Set compliance evaluation 2001 to 2005. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. More detailed information on the quality of Aboriginal and Torres Strait Islander data that might affect interpretation of the indicator was published in Aboriginal and Torres Strait Islander mothers and their babies, Australia 2001–2004 (Chapter 1 and Chapter 5).

Metadata information for this indicator has been published in the AIHW’s online metadata repository — METeOR. Metadata information for the Perinatal NMDS are also published in METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following issues:

- Data are collected direct from states and territories and are not reliable as they are not collected under a NMDS and have had minimal validation. The AIHW data, however, are less timely and are available to the Review one year later than that available to the Review by collecting data direct from states and territories.
- Disaggregation of this indicator for Indigenous status and remoteness by State and Territory is a priority. Further development work on the current data source is required.

Instrument vaginal births

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness—appropriateness
Indicator	Instrument vaginal births
Measure (computation)	‘Instrument vaginal births’ is defined as the number of instrument vaginal births as a percentage of total births. Instrument vaginal births includes forceps and vacuum extraction. The indicator is calculated for women aged 20 to 34 years, with a singleton baby positioned with head towards the cervix at the onset of labour born between 37 and 41 weeks gestation.
Data source/s	This indicator is calculated using data from the AIHW National Perinatal Data

Collection (NPDC).

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) has calculated this indicator. Data were supplied by State and Territory health authorities to the National Perinatal Epidemiology and Statistics Unit (NPESU), a collaborating unit of the Institute. The State and Territory health authorities receive these data from patient administrative and clinical records. This information is usually collected by midwives or other birth attendants. States and territories use these data for service planning, monitoring and internal and public reporting.
Relevance	<p>The National Perinatal Data Collection comprises data items as specified in the Perinatal NMDS plus additional items collected by the states and territories. The purpose of the Perinatal NMDS is to collect information at birth for monitoring pregnancy, childbirth and the neonatal period for both the mother and baby(s).</p> <p>The Perinatal NMDS is a specification for data collected on all births in Australia in hospitals, birth centres and the community. It includes information for all live births and stillbirths of at least 400 grams birthweight or at least 20 weeks gestation. It includes data items relating to the mother, including demographic characteristics and factors relating to the pregnancy, labour and birth; and data items relating to the baby, including birth status (live or stillbirth), sex, gestational age at birth, birth weight, Apgar score and neonatal length of stay.</p>
Timeliness	The reference period for the data is 2011. Collection of data for the NPDC is annual.
Accuracy	<p>Inaccurate responses may occur in all data provided to the Institute. The Institute does not have direct access to perinatal records to determine the accuracy of the data provided. However, the Institute undertakes validation on receipt of data. Data received from states and territories are checked for completeness, validity and logical errors. Potential errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors.</p> <p>Errors may occur during the processing of data by the states and territories or at the AIHW. Processing errors prior to data supply may be found through the validation checks applied by the Institute. This indicator is calculated on data that has been reported to the AIHW. Prior to publication, these data are referred back to jurisdictions for checking and review. The Institute does not adjust the data to correct for missing values. Note that because of data editing and subsequent updates of State/Territory databases, and because data are being reported by place of residence rather than place of birth the numbers reported for this indicator differ from those in reports published by the states and territories. The data are not rounded.</p>
Coherence	Data for this indicator are published in the AIHW National Perinatal Epidemiology and Statistics Unit report <i>National core maternity indicators</i> .
Accessibility	<p>The AIHW provides a variety of products that draw upon the NPDC. Published products available on the AIHW website are:</p> <ul style="list-style-type: none">• Australia's mothers and babies annual report• Aboriginal and Torres Strait Islander mothers and their babies, Australia 2001–2004• National core maternity indicators• METeOR – online metadata repository• National health data dictionary. <p>Ad-hoc data are also available on request (charges apply to recover costs).</p>
Interpretability	<p>Supporting information on the use and quality of the Perinatal NMDS are published annually in Australia's mothers and babies (Chapter 1), available in hard copy or on the AIHW website. Comprehensive information on the quality of Perinatal NMDS elements are published in Perinatal National Minimum Data Set compliance evaluation 2006 to 2009. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. More detailed information on the quality of Aboriginal and Torres Strait Islander data that might affect interpretation of the indicator was published in Aboriginal and Torres Strait Islander mothers and their babies, Australia 2001–2004 (Chapter 1 and Chapter 5).</p> <p>Metadata information for this indicator has been published in the AIHW's online metadata repository — METeOR. Metadata information for the Perinatal NMDS are also published in METeOR, and the National health data dictionary.</p>

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following issues: <ul style="list-style-type: none">• Data are relatively old and may not be representative of current outcomes. Further work is required to ensure availability of more timely data.• Disaggregation of this indicator for Indigenous status and remoteness by State and Territory is a priority. Further development work on the current data source is required.
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Vaginal birth after caesarean section

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness—appropriateness
Indicator	Vaginal birth after caesarean section
Measure (computation)	‘Vaginal delivery following a previous caesarean’ is defined as the percentage of multiparous mothers who have had a previous caesarean, whose current method of birth was either an instrumental or non-instrumental vaginal delivery. Multiparous means a pregnant woman who had at least one previous pregnancy resulting in a live birth or stillbirth. For multiple births, the method of birth of the first born baby was used.
Data source/s	This indicator is calculated using data from the AIHW National Perinatal Data Collection (NPDC).

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) has calculated this indicator. Data were supplied by State and Territory health authorities to the National Perinatal Epidemiology and Statistics Unit (NPESU), a collaborating unit of the Institute. The State and Territory health authorities receive these data from patient administrative and clinical records. This information is usually collected by midwives or other birth attendants. States and territories use these data for service planning, monitoring and internal and public reporting.
Relevance	The National Perinatal Data Collection comprises data items as specified in the Perinatal NMDS plus additional items collected by the states and territories. The purpose of the Perinatal NMDS is to collect information at birth for monitoring pregnancy, childbirth and the neonatal period for both the mother and baby(s). The Perinatal NMDS is a specification for data collected on all births in Australia in hospitals, birth centres and the community. It includes information for all live births and stillbirths of at least 400 grams birthweight or at least 20 weeks gestation. It includes data items relating to the mother, including demographic characteristics and factors relating to the pregnancy, labour and birth; and data items relating to the baby, including birth status (live or stillbirth), sex, gestational age at birth, birth weight, Apgar score and neonatal length of stay.
Timeliness	The reference period for the data is 2012. Collection of data for the NPDC is annual.
Accuracy	Inaccurate responses may occur in all data provided to the Institute. The Institute does not have direct access to perinatal records to determine the accuracy of the data provided. However, the Institute undertakes validation on receipt of data. Data received from states and territories are checked for completeness, validity and logical errors. Potential errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors. Errors may occur during the processing of data by the states and territories or at the AIHW. Processing errors prior to data supply may be found through the validation checks applied by the Institute. This indicator is calculated on data that has been reported to the AIHW. Prior to publication, these data are referred back to jurisdictions for checking and review. The Institute does not adjust the data to correct for missing values. Note that because of data editing and subsequent updates of State/Territory

	databases, and because data are being reported by place of residence rather than place of birth the numbers reported for this indicator differ from those in reports published by the states and territories. The data are not rounded.
Coherence	Data for this indicator are published in the annual report Australia's mothers and babies.
Accessibility	The AIHW provides a variety of products that draw upon the NPDC. Published products available on the AIHW website are: <ul style="list-style-type: none"> • Australia's mothers and babies annual report • Aboriginal and Torres Strait Islander mothers and their babies, Australia 2001–2004 • METeOR – online metadata repository • National health data dictionary. Ad-hoc data are also available on request (charges apply to recover costs).
Interpretability	Supporting information on the use and quality of the Perinatal NMDS are published annually in Australia's mothers and babies (Chapter 1), available in hard copy or on the AIHW website. Comprehensive information on the quality of Perinatal NMDS elements are published in Perinatal National Minimum Data Set compliance evaluation 2006 to 2009. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. More detailed information on the quality of Aboriginal and Torres Strait Islander data that might affect interpretation of the indicator was published in Aboriginal and Torres Strait Islander mothers and their babies, Australia 2001–2004 (Chapter 1 and Chapter 5). Metadata information for this indicator has been published in the AIHW's online metadata repository — METeOR. Metadata information for the Perinatal NMDS are also published in METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following issues: <ul style="list-style-type: none"> • Interpretation of this indicator is ambiguous. There is ongoing debate about the relative risk to both mother and baby of a repeat caesarean section compared with a vaginal birth following a previous caesarean. Low rates of vaginal birth following a previous caesarean may warrant investigation, or on the other hand, they can indicate appropriate clinical caution. When interpreting this indicator, emphasis needs to be given to the potential for improvement. • Data are relatively old and may not be representative of current outcomes. Further work is required to ensure availability of more timely data. • A formal assessment of the extent of under-identification of Indigenous status in the NPDC is required. This will identify whether the data require adjustment, and contribute to improved time series reporting. • Disaggregation of this indicator for SES and remoteness by State and Territory is a priority. Further development work on the current data source is required.
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Perineal status after vaginal birth

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — quality/safety
Indicator	Perineal status after vaginal birth
Measure (computation)	'Perineal status after vaginal birth' is the percentage of mothers with third or fourth degree lacerations to their perineum after a vaginal birth. A 'third degree' laceration or rupture during birth (or a tear following episiotomy) involves the anal sphincter, rectovaginal septum and sphincter NOS. A 'fourth degree' laceration, rupture or tear also involves the anal mucosa and rectal mucosa. For multiple births, the perineal status after birth of the first child was used.
Data source/s	This indicator is calculated using data from the AIHW National Perinatal Data

Collection (NPDC).

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) has calculated this indicator. Data were supplied by State and Territory health authorities to the National Perinatal Epidemiology and Statistics Unit (NPESU), a collaborating unit of the Institute. The State and Territory health authorities receive these data from patient administrative and clinical records. This information is usually collected by midwives or other birth attendants. States and territories use these data for service planning, monitoring and internal and public reporting.
Relevance	<p>The National Perinatal Data Collection comprises data items as specified in the Perinatal NMDS plus additional items collected by the states and territories. The purpose of the Perinatal NMDS is to collect information at birth for monitoring pregnancy, childbirth and the neonatal period for both the mother and baby(s).</p> <p>The Perinatal NMDS is a specification for data collected on all births in Australia in hospitals, birth centres and the community. It includes information for all live births and stillbirths of at least 400 grams birthweight or at least 20 weeks gestation. It includes data items relating to the mother, including demographic characteristics and factors relating to the pregnancy, labour and birth; and data items relating to the baby, including birth status (live or stillbirth), sex, gestational age at birth, birth weight, Apgar score and neonatal length of stay.</p>
Timeliness	The reference period for the data is 2012. Collection of data for the NPDC is annual.
Accuracy	<p>Inaccurate responses may occur in all data provided to the Institute. The Institute does not have direct access to perinatal records to determine the accuracy of the data provided. However, the Institute undertakes validation on receipt of data. Data received from states and territories are checked for completeness, validity and logical errors. Potential errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors.</p> <p>Errors may occur during the processing of data by the states and territories or at the AIHW. Processing errors prior to data supply may be found through the validation checks applied by the Institute. This indicator is calculated on data that has been reported to the AIHW. Prior to publication, these data are referred back to jurisdictions for checking and review. The Institute does not adjust the data to correct for missing values. Note that because of data editing and subsequent updates of State/Territory databases, and because data are being reported by place of residence rather than place of birth the numbers reported for this indicator differ from those in reports published by the states and territories. The data are not rounded.</p>
Coherence	Data for this indicator are published in the annual report Australia's mothers and babies.
Accessibility	<p>The AIHW provides a variety of products that draw upon the NPDC. Published products available on the AIHW website are:</p> <ul style="list-style-type: none">• Australia's mothers and babies annual report• Aboriginal and Torres Strait Islander mothers and their babies, Australia 2001–2004• METeOR – online metadata repository• National health data dictionary. <p>Ad-hoc data are also available on request (charges apply to recover costs).</p>
Interpretability	<p>Supporting information on the use and quality of the Perinatal NMDS are published annually in Australia's mothers and babies (Chapter 1), available in hard copy or on the AIHW website. Comprehensive information on the quality of Perinatal NMDS elements are published in Perinatal National Minimum Data Set compliance evaluation 2006 to 2009. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. More detailed information on the quality of Aboriginal and Torres Strait Islander data that might affect interpretation of the indicator was published in Aboriginal and Torres Strait Islander mothers and their babies, Australia 2001–2004 (Chapter 1 and Chapter 5).</p> <p>Metadata information for this indicator has been published in the AIHW's online metadata repository — METeOR. Metadata information for the Perinatal NMDS are also published in METeOR, and the National health data dictionary.</p>

Data Gaps/Issues Analysis

Key data gaps/issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • Data include all women who gave birth vaginally, including births in public hospitals, private hospitals and outside of hospital, such as homebirths. • Data are relatively old and may not be representative of current outcomes. Further work is required to ensure availability of more timely data. • A formal assessment of the extent of under-identification of Indigenous status in the NPDC is required. This will identify whether the data require adjustment, and contribute to improved time series reporting. • Disaggregation of this indicator for SES and remoteness by State and Territory is a priority. Further development work on the current data source is required.
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Mother's average length of stay

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Mother's average length of stay
Measure (computation)	<p>'Mother's average length of stay' is defined as the total number of patient days for the selected maternity AR-DRG, divided by the number of separations for that AR-DRG. The AR-DRGs are:</p> <ul style="list-style-type: none"> • caesarean delivery without catastrophic or severe complications and comorbidities • vaginal delivery single uncomplicated.
Data source/s	This indicator is calculated using data from the National Hospital Morbidity Database (NHMD), based on the national minimum data set (NMDS) for Admitted patient care.

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.</p> <p>The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.</p> <p>The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.</p> <p>One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.</p> <p>The Australian Institute of Health and Welfare Act 1987, in conjunction with compliance to the Privacy Act 1988 (Cwth), ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.</p> <p>For further information see the AIHW website www.aihw.gov.au</p> <p>Data for the NESWTDC were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):</p>
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	<p>http://www.aihw.gov.au/nhissc/</p> <p>http://meteor.aihw.gov.au/content/index.phtml/itemId/182135</p> <p>The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p>
Relevance	<p>The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.</p> <p>The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.</p>
Timeliness	<p>The reference period for this data set is 2012–13.</p>
Accuracy	<p>For 2012–13, almost all public hospitals provided data for the NHMD. The exception was a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private free-standing day hospital facilities in the ACT, the single private free-standing day hospital in the NT, and a private free-standing day hospital in Victoria.</p> <p>States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors.</p>
Coherence	<p>The information presented for this indicator is calculated using the same methodology as data published in <i>Australian hospital statistics 2012–13</i>.</p> <p>The data can be meaningfully compared across all jurisdictions.</p> <p>Due to changes in the classification between AR-DRG version 5.2, AR-DRG version 6.0 and AR-DRG version 6.0x, the data presented here are not comparable with the data presented in previous reports.</p>
Accessibility	<p>The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:</p> <ul style="list-style-type: none"> • Australian hospital statistics with associated Excel tables • interactive data cubes for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups). <p>These products may be accessed on the AIHW website at: http://www.aihw.gov.au/hospitals/</p>
Interpretability	<p>Supporting information on the quality and use of the NHMD are published annually in Australian hospital statistics (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to note caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Aboriginal and Torres Strait Islander data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the National Minimum Data Set (NMDS) for Admitted patient care is published in the AIHW's online metadata repository, METeOR, and the National health data dictionary.</p> <p>The National health data dictionary can be accessed online at: http://www.aihw.gov.au/publication-detail/?id=10737422826</p> <p>The Data Quality Statement for the National Hospital Morbidity Database can be accessed on the AIHW website at: http://meteor.aihw.gov.au/content/index.phtml/itemId/529483</p>

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following issues: Shorter stays for mothers reduce hospital costs but whether they represent genuine efficiency improvements depends on a number of factors. Shorter stays can, for example, have an adverse effect on the health of some mothers and result in additional costs for in-home care and potential readmissions. The indicator is not adjusted for multiple births born vaginally and without complications but requiring a longer stay to manage breastfeeding.
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Apgar score at five minutes

Data quality information for this indicator has been sourced from states and territories with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Apgar score at five minutes
Measure (computation)	This indicator is defined as the number of live births with an Apgar score of 3 or less, at five minutes post-delivery, as a proportion of the total number of live births by specified birthweight categories. The Apgar score is a numerical score that indicates a baby's condition shortly after birth. Apgar scores are based on an assessment of the baby's heart rate, breathing, colour, muscle tone and reflex irritability. Between 0 and 2 points are given for each of these five characteristics and the total score is between 0 and 10. The Apgar score is routinely assessed at one and five minutes after birth, and subsequently at five minute intervals if it is still low at five minutes.
Data source/s	This indicator is calculated using data from states and territories.

Data Quality Framework Dimensions

Institutional environment	Data were supplied by State and Territory health authorities. The State and Territory health authorities receive these data from patient administrative and clinical records. This information is usually collected by midwives or other birth attendants. States and territories use these data for service planning, monitoring and internal and public reporting.
Relevance	The National Perinatal Data Collection comprises data items as specified in the Perinatal NMDS plus additional items collected by the states and territories. The purpose of the Perinatal NMDS is to collect information at birth for monitoring pregnancy, childbirth and the neonatal period for both the mother and baby(s). The Perinatal NMDS is a specification for data collected on all births in Australia in hospitals, birth centres and the community. It includes information for all live births and stillbirths of at least 400 grams birthweight or at least 20 weeks gestation. It includes data items relating to the mother, including demographic characteristics and factors relating to the pregnancy, labour and birth; and data items relating to the baby, including birth status (live or stillbirth), sex, gestational age at birth, birth weight, Apgar score and neonatal length of stay.
Timeliness	The reference period for the data is 2012. Collection of data is annual.
Accuracy	Inaccurate responses may occur in all data provided to the Institute. The Institute does not have direct access to perinatal records to determine the accuracy of the data provided. However, the Institute undertakes validation on receipt of data. Data received from states and territories are checked for completeness, validity and logical errors. Potential errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors. Errors may occur during the processing of data by the states and territories or at the AIHW. Processing errors prior to data supply may be found through the validation checks applied by the Institute. This indicator is calculated on data that has been reported to the AIHW. Prior to publication, these data are referred back to jurisdictions for checking and review. The Institute does not adjust the data to correct for missing values. Note that because of data editing and subsequent updates of State/Territory

databases, and because data are being reported by place of residence rather than place of birth the numbers reported for this indicator differ from those in reports published by the states and territories. The data are not rounded.

The geographical location code for the area of usual residence of the mother is included in the Perinatal NMDS. Only 0.2 per cent of records were non-residents or could not be assigned to a state or territory of residence. There is no scope in the data element Area of usual residence of mother to discriminate temporary residence of mother for the purposes of accessing birthing services from usual residence. The former may differentially impact populations from remote and very remote areas, where services are not available locally.

Coherence Data for this indicator are published in the annual report Australia's mothers and babies; and biennially in reports such as the Aboriginal and Torres Strait Islander Health Performance Framework report, the Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, and the Overcoming Indigenous Disadvantage report. The numbers presented in these publications will differ slightly from those presented here as this measure excludes multiple births and stillbirths.

Accessibility Changing levels of Indigenous identification over time and across jurisdictions may also affect the accuracy of compiling a consistent time series in future years.

The AIHW provides a variety of products that draw upon the NPDC. Published products available on the AIHW website are:

- Australia's mothers and babies annual report
- Aboriginal and Torres Strait Islander mothers and their babies, Australia 2001–2004
- METeOR – online metadata repository
- National health data dictionary.

Ad-hoc data are also available on request (charges apply to recover costs).

Interpretability Supporting information on the use and quality of the Perinatal NMDS are published annually in Australia's mothers and babies (Chapter 1), available in hard copy or on the AIHW website. Comprehensive information on the quality of Perinatal NMDS elements are published in Perinatal National Minimum Data Set compliance evaluation 2001 to 2005. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. More detailed information on the quality of Aboriginal and Torres Strait Islander data that might affect interpretation of the indicator was published in Aboriginal and Torres Strait Islander mothers and their babies, Australia 2001–2004 (Chapter 1 and Chapter 5).

Metadata information for this indicator has been published in the AIHW's online metadata repository — METeOR. Metadata information for the Perinatal NMDS are also published in METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following issues:

- Data are relatively old and may not be representative of current outcomes. Further work is required to ensure availability of more timely data.
- Disaggregation of this indicator for Indigenous status and remoteness by State and Territory is a priority. Further development work on the current data source is required.

Fetal, neonatal and perinatal deaths

Data quality information for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Fetal, neonatal and perinatal deaths
Measure	<u>Fetal deaths</u>
(computation)	<i>Numerator:</i> Fetal deaths (stillbirth). The birth of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Fetal deaths

by definition include only infants weighing at least 400 grams or of a gestational age of at least 20 weeks.

Denominator: Total number of births (live births and fetal deaths combined).

Computation: The 'fetal death rate' is calculated as the number of fetal deaths divided by the total number of births expressed per 1000 total births, by State or Territory of usual residence of the mother.

Neonatal deaths

Numerator: Neonatal deaths. The death of a live born infant within 28 days of birth.

Denominator: The number of live births registered.

Computation: The 'neonatal death rate' is calculated as the number of neonatal deaths divided by the number of live births expressed per 1000 live births, by state or territory of usual residence of the mother

Perinatal death

Numerator: A perinatal death is a fetal or neonatal death.

Denominator: The total number of births (live births and fetal deaths combined).

Computation: The 'perinatal death rate' is calculated as the number of perinatal deaths divided by the total number of births expressed per 1000 total births, by State or Territory of usual residence of the mother.

Data source/s ABS perinatal deaths are sourced from death registrations administered by the various state and territory Registrars of Births, Deaths and Marriages.

Data Quality Framework Dimensions

Institutional environment

ABS perinatal deaths are sourced from death registrations administered by the various state and territory Registrars of Births, Deaths and Marriages. It is a legal requirement of each state and territory that all neonatal deaths and those fetal deaths of at least 20 weeks gestation or 400 grams birth weight are registered. As part of the registration process, information on the cause of death is either supplied by the medical practitioner certifying the death on a Certificate of Cause of Perinatal Death, or supplied as a result of a coronial investigation.

Death records are provided electronically and/or in paper form to the ABS by individual Registrars on a monthly basis. Each death record contains both demographic data and medical information from the Certificate of Cause of Perinatal Death where available. Information from coronial investigations are provided to the ABS through the National Coroners Information System (NCIS).

For further information on the institutional environment of the Australian Bureau of Statistics (ABS), including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.

Relevance

Perinatal statistics provide valuable information for the analysis of fetal, neonatal and perinatal deaths in Australia. This electronic product presents data at the national and state level on registered perinatal deaths by sex, state of usual residence, main condition in fetus/infant, main condition in mother and Indigenous status. Fetal, neonatal and perinatal death rates are also provided.

The ABS Perinatal Deaths collection includes all perinatal deaths that occurred and were registered in Australia, including deaths of persons whose usual residence is overseas. Deaths of Australian residents that occurred outside Australia may be registered by individual Registrars, but are not included in ABS deaths or perinatal deaths statistics.

From the 2006 reference year, the scope of the perinatal death statistics includes all fetal deaths of at least 20 weeks gestation or at least 400 grams birth weight, and all neonatal deaths (all live born babies who die within 28 days of birth, regardless of gestation or weight) which are:

- registered in Australia for the reference year and are received by the ABS by the end of the March quarter of the subsequent year; and
- registered prior to the reference year but not previously received from the Registrar nor included in any statistics reported for an earlier period.

Data for the 1999 to 2006 reference years based on the revised scope definition of at least 20 weeks gestation or at least 400 grams birth weight was republished in Perinatal Deaths, Australia, 2007(cat. no. 3304.0).

Data in the Perinatal Deaths collection include demographic items, as well as causes

	<p>of death information, which is coded according to the International Classification of Diseases (ICD). ICD is the international standard classification for epidemiological purposes and is designed to promote international comparability in the collection, processing, classification, and presentation of cause of death statistics. The classification is used to classify diseases and causes of disease or injury as recorded on many types of medical records as well as death records. The ICD has been revised periodically to incorporate changes in the medical field. The 10th revision of ICD (ICD-10) is used for the 2009 data.</p>
Timeliness	<p>Perinatal deaths data are published annually and released approximately 15 months after the end of the reference period. Prior to the 2007 reference year, and from the 2010 reference year, ABS perinatal causes of death statistics are published in the annual Causes of Death, Australia (cat. no. 3303.0) collection.</p> <p>Causes of death statistics are released with a view to ensuring that they are fit for purpose when released. To meet user requirements for timely data it is often necessary to obtain information from the administrative source before all information for the reference period is available (e.g. finalisation of coronial proceedings). A balance needs to be maintained between accuracy (completeness) of data and timeliness, taking account of the different needs of users. To address the issues which arise through the publication of causes of death data for open coroners cases, these data are now subject to a revisions process. This process enables the use of additional information relating to coroner certified deaths either 12 or 24 months after initial processing. See Explanatory Notes 28-32 for further information on the revisions process.</p>
Accuracy	<p>Non-sample errors are the main influence on accuracy in datasets such as this which are a complete census of the population rather than a sample. Non-sample error arises from inaccuracies in collecting, recording and processing the data. The most significant of these errors are: mis-reporting of data items; deficiencies in coverage; non-response to particular questions; and processing errors. Every effort is made to minimise non-sample error by working closely with data providers, running quality checks throughout the data processing cycle, training of processing staff, and efficient data processing.</p> <p>The main sources of non-sample error for perinatal deaths data are:</p> <ul style="list-style-type: none"> • completeness of an individual record at a given point in time (e.g. incomplete causes of death information due to non-finalisation of coronial proceedings) • completeness of the dataset e.g. impact of registration lags, processing lags and duplicate records • extent of coverage of the population (whilst all deaths are legally required to be registered some cases may not be registered for an extended time, if at all) • particular data items which would be useful for statistical purposes may not be collected by jurisdictions where that item is not essential for administration purposes • question and 'interviewer' biases given that information for death registrations are supplied about the person by someone else. For example, Indigenous origin as reported by a third party can be different from self reported responses on a form • level of specificity and completeness in coronial reports or doctor's findings on the Certificate of Perinatal Death will impact on the accuracy of coding <p>The ABS has implemented a new revisions process that applies to all coroner certified perinatal deaths registered after 1 January 2007. The revisions process enables the use of additional information relating to coroner certified perinatal deaths as it becomes available over time, resulting in increased specificity of the assigned ICD-10 codes. See Explanatory Notes 28-32 for further information on the revision process.</p>
Coherence	<p>Use of the supporting documentation released with the statistics is important for assessing coherence within the dataset and when comparing the statistics with data from other sources. Changing business rules over time and/or across data sources can affect consistency and hence interpretability of statistical output. The Explanatory Notes in each issue contains information pertinent to the particular release which may impact on comparison over time.</p>
Accessibility	<p>Prior to the 2007 reference year, and from the 2010 reference year, ABS perinatal causes of death statistics are published in Causes of Death, Australia (cat. no. 3303.0).</p> <p>In addition to the information provided in the commentary, a series of data cubes are also available providing detailed breakdowns by cause of death. The ABS observes strict confidentiality protocols as required by the Census and Statistics Act (1905).</p>

This may restrict access to data at a very detailed level which is sought by some users.

If the information you require is not available from the commentary or the data cubes, then the ABS may also have other relevant data available on request. Inquiries should be made to the National Information and Referral Service on 1300 135 070 or by sending an email to client.services@abs.gov.au.

Interpretability

Information on some aspects of statistical quality may be hard to obtain as information on the source data has not been kept over time. This is related to the issue of the administrative rather than statistical purpose of the collection of the source data.

Perinatal Deaths, Australia contains detailed Explanatory Notes, an Appendix and Glossary that provide information on the data sources, terminology, classifications and other technical aspects associated with these statistics.

Data Gaps/Issues Analysis

Key data

gaps/issues

The Steering Committee notes the following issues:

'Fetal death rate' is reported as an indicator because maternity services for admitted patients have some potential to reduce the likelihood of fetal deaths. However, this potential is limited and other factors (such as the health of mothers and the progress of pregnancy before hospital admission) are also important.

Hence, differences in the 'fetal death rate' between jurisdictions are likely to be due to factors outside the control of maternity services for admitted patients. To the extent that the health system influences fetal death rates, the health services that can have an influence include outpatient services, general practice services and maternity services.

As for fetal deaths, a range of factors contribute to neonatal deaths. However, the influence of maternity services for admitted patients is greater for neonatal deaths than for fetal deaths, through the management of labour and the care of sick and premature babies.

12 Mental health management

CONTENTS

12.1 Framework for measuring health management performance	12.2
12.2 Profile of mental health management	12.3
12.3 Framework of performance indicators for mental health management	12.18
12.4 Key performance indicators for mental health management	12.23
12.5 Future directions in performance reporting	12.73
12.6 Definitions of key terms	12.74
12.7 List of attachment tables	12.79
12.8 References	12.83

Attachment tables

Attachment tables are identified in references throughout this chapter by a '12A' prefix (for example, table 12A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). This chapter reports on the Australian, State and Territory governments' management of mental health and mental illnesses through a variety of service types and delivery settings.

Improvements to the reporting of mental health management in this edition include:

- reporting of a new mini-case study on 'Reducing the use of seclusion during an acute episode of mental health inpatient care in the ACT'
- addition of a new measure for Medicare Benefits Schedule (MBS) subsidised services for the 'new client index' indicator

-
- inclusion of new disaggregations (by selected community groups) for the indicators ‘new client index’, ‘primary mental health care for children and young people’ and ‘readmissions to hospital within 28 days of discharge’
 - reporting of a new outcome indicator on the ‘physical health outcomes for people with a mental illness’
 - data quality information (DQI) available for the first time for the indicator ‘rate of seclusion — acute inpatient units’.

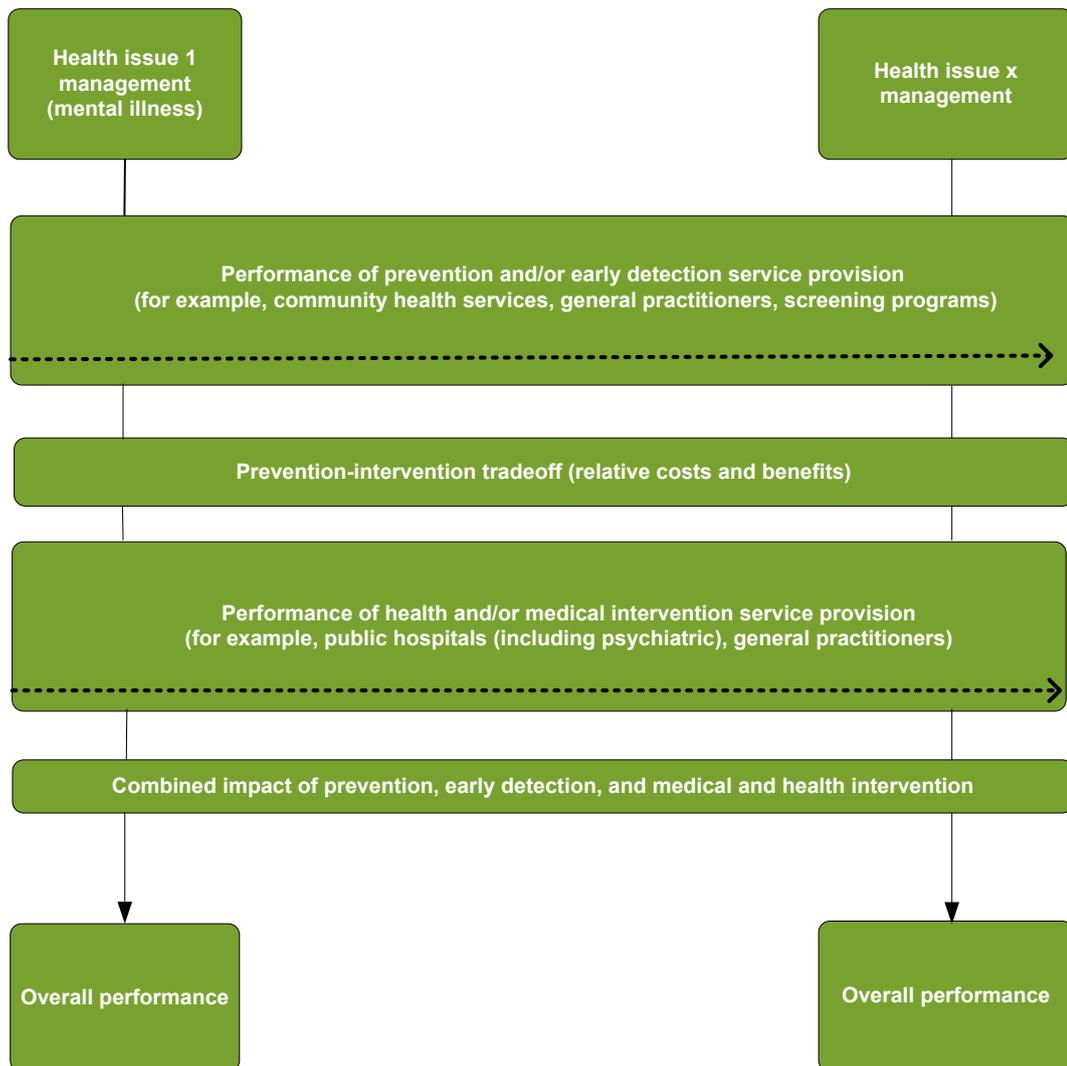
12.1 Framework for measuring health management performance

Health management is the ongoing process beginning with initial client contact and including all actions relating to the client: assessment/evaluation; education of the person, family or carer(s); diagnosis; and treatment. Problems associated with adherence to treatment and liaison with, or referral to, other agencies are also included.

Policy makers are seeking alternative service delivery settings and a more coordinated approach to managing health problems. Measuring performance in the management of a health problem involves measuring the performance of service providers in specific settings, and the overall management of diseases, illnesses and injuries across a spectrum of services, including prevention, early detection and treatment programs. The measurement approach is summarised in figure 12.1.

The appropriate mix of services — including the prevention of illness and injury, medical treatment and the appropriate mix of service delivery mechanisms — is measured by focusing on a specific health management issue. The Health sector overview in this Report outlines the complexities of reporting on the performance of the overall health system in meeting its objectives. Frameworks for public hospitals and primary and community health services report the performance of particular service delivery mechanisms. The mental health management performance framework provides information on the interaction and integration arrangements between General Practitioners (GPs) (as the key providers of primary health), community-based and hospital-based providers in meeting the needs of people with a mental illness.

Figure 12.1 The Australian health system — measurement approach



12.2 Profile of mental health management

Mental health relates to an individual’s ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC and AIHW 1999). The World Health Organization (WHO) describes positive mental health as:

... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001).

Mental health is identified by governments as a national health priority area as are cancer, asthma, cardiovascular health, diabetes mellitus, injury prevention and control, arthritis and

musculoskeletal conditions, and obesity. The national health priority areas represent a large proportion of the total burden of disease and injury in Australia and mental illnesses makes a significant contribution to this total burden (Begg et al. 2007). The total burden comprises the number of ‘years’ lost due to fatal events (years of life lost due to premature death) and non-fatal events (years of ‘healthy’ life lost due to disability). Mental illness is the leading cause of ‘healthy’ life years lost due to disability (Begg et al. 2007).

Mental illness is a term that describes a diverse range of behavioural and psychological conditions. These conditions can affect an individual’s mental health, functioning and quality of life. Each mental illness is unique in its incidence across the lifespan, causal factors and treatments. The most common mental illnesses are anxiety, affective (mood) and substance use disorders. Mental illness also includes low prevalence conditions such as schizophrenia, bipolar disorder and other psychoses, and severe personality disorder (DoHA 2010). While of lower prevalence, these conditions can severely affect people’s ability to function in their daily lives (Morgan et al. 2011).

Specialised mental health management services offered by a range of government and non-government service providers include promotion, prevention, treatment, management, and rehabilitation services. Community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in private practice, counsellors, Aboriginal health workers, Aboriginal mental health workers, public hospitals with specialised psychiatric units and psychiatric hospitals all provide specialised mental health care. In addition, a number of health services provide care to mental health patients in a non-specialised health setting — for example, GPs, Aboriginal community controlled health services, public hospital emergency departments and outpatient departments, and public hospital general wards (as distinct from specialist psychiatric wards). Some people with a mental illness are cared for in residential aged care services.

Mental health is also the subject of programs designed to improve public health. Public health programs require the participation of public hospitals, primary and community health and other, services. The performance of primary and community health services is reported in chapter 10 and the performance of public hospitals is reported in chapter 11.

This chapter focuses on the performance of State and Territory specialised public mental health services that treat the mostly low prevalence, but severe, mental illnesses. It also includes performance data on the mental health services provided by GPs, psychiatrists, psychologists and other allied health professionals under the MBS. Descriptive data are reported on other health services that provide non-specialised mental health care (such as, emergency departments). Some key terms used in mental health management are outlined in section 12.6.

Other health and related services are also important for people with a mental illness, including alcohol and drug treatment services (chapter 10) and aged care services (chapter 13). This Report does not include specific performance information on these services’ treatment of people with a mental illness. Mental health patients often have complex needs that can also affect other government services they receive, such as those

covered in chapter 4 (School education), chapter 8 (Corrective services), chapter 9 (Fire and ambulance services), chapter 14 (Services for people with disability) and chapter 18 (Homelessness services).

Roles and responsibilities

State and Territory governments are responsible for the funding, delivery and management of specialised public mental health services including admitted patient care in hospitals, community-based ambulatory care services and community-based residential care (for further details see the sector scope section later in this chapter). Some of these services are provided by non-government organisations (NGOs), for example governments can fund private and non-government entities to provide admitted patient hospital care. State and Territory governments also fund not for profit, NGOs to provide a range of support services for people with psychiatric disability arising from a mental illness.

The Australian Government is responsible for the funding of the following mental health services and related programs:

- MBS subsidised services provided by GPs (both general and specific mental health items), private psychiatrists and allied mental health professionals (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers)
- Pharmaceutical Benefits Scheme (PBS) funded mental health-related medications
- the Personal Helpers and Mentors and the Carers Respite programs funded through the Department of Social Services (DSS)
- other specific programs, including those provided by the non-government sector, designed to increase the level of social support and community-based care for people with a mental illness and to prevent suicide.

In addition, the Australian Government provides funding for mental health-related services through the Department of Veterans' Affairs (DVA), Department of Defence and the Private Health Insurance Premium Rebates.

From 2009-10 to 2011-12, the Australian Government also provided a specific purpose payment (SPP) to State and Territory governments for health services under the National Healthcare Agreement (NHA). According to the Intergovernmental Agreement on Federal Financial Relations, under which this SPP was provided, State and Territory governments were required to expend the SPP on the health sector, but had budget flexibility to allocate funds within that sector as they deemed appropriate. Consequently, specific mental health funding cannot be separately identified in the Australian Government funding provided to State and Territory governments under the NHA. From 2012-13, the payments made under the SPP were replaced by new funding approaches specified in the National Health Reform Agreement (NHRA), including Activity Based Funding for future years. However,

2012-13 specific payments made to State and Territory health services for mental health cannot be separately identified.

The Australian, State and Territory governments also fund and/or provide other services that people with mental illnesses can access, such as employment, accommodation, income support, rehabilitation, residential aged care and other services for older people and people with disability (see chapters 13 and 14, respectively).

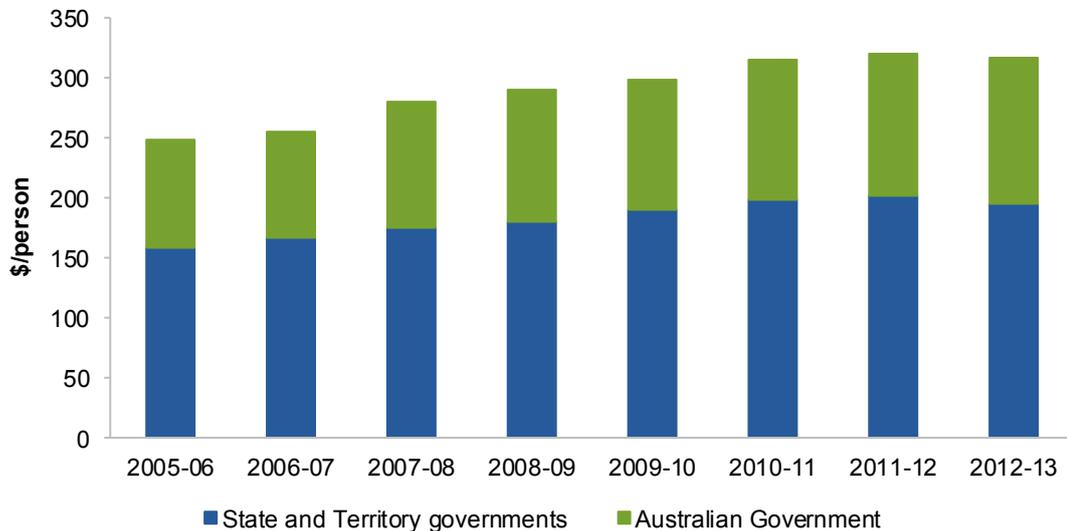
Funding

Real government recurrent expenditure of around \$7.3 billion was allocated to specialised mental health services in 2012-13 (table 12A.4). State and Territory governments made the largest contribution (\$4.5 billion, or 61.9 per cent), although this includes Australian Government funding under the NHRA. The Australian Government spent \$2.8 billion or 38.1 per cent of total government recurrent expenditure on mental health services (table 12A.4). Real average governments' expenditure per person on specialised mental health services in 2012-13 was \$317, an increase from \$249 in 2005-06 (figure 12.2).

Expenditure on MBS subsidised services was the largest component of Australian Government expenditure on mental health services in 2012-13 (\$906.4 million or 32.7 per cent) (table 12A.1). This comprised MBS payments for psychologists and other allied health professionals (social workers and occupational therapists) (14.8 per cent), GP services (7.0 per cent) and consultant psychiatrists (10.9 per cent) (table 12A.1).

Another significant area of Australian Government expenditure on mental health services in 2012-13 was expenditure under the PBS for mental health related medications (\$768.1 million) (table 12A.1). While real expenditure on PBS mental health related medications increased every year between 2005-06 and 2011-12, it steadily decreased as a share of expenditure. In 2012-13, real expenditure on PBS mental health related medications fell to below the 2005-06 value and as a share in total Australian Government expenditure on mental health services it decreased to 27.7 per cent, compared to 43.0 per cent in 2005-06 (table 12A.1). For details on the remainder of the Australian Government's expenditure for mental health services see table 12A.1.

Figure 12.2 **Real recurrent governments' expenditure on mental health services, by funding source (2012-13 dollars)^{a, b, c}**

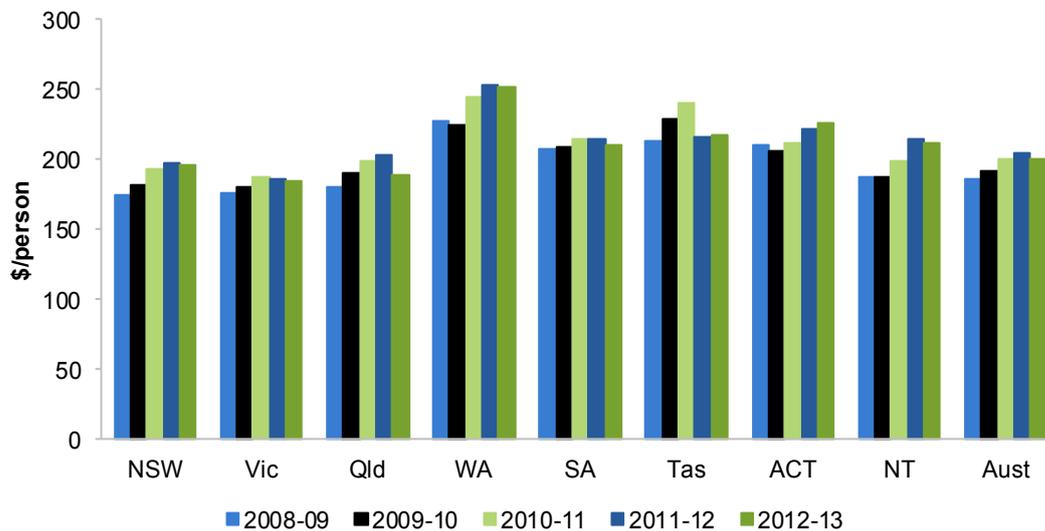


^a Real expenditure for all years (2012-13 dollars), using the implicit price deflators for general government final consumption expenditure on hospitals and nursing homes (table 12A.96). ^b State and Territory governments' expenditure includes expenditure sourced from 'other revenue' that includes patient fees and reimbursement by third party compensation insurers and from Australian Government funding provided under the Australian Health Care Agreement base grants/National Healthcare Agreement (NHA) specific purpose payment (SPP)/National Health Reform Agreement (NHRA). ^c Australian Government expenditure includes a small amount of funding provided for State and Territory governments' specialised mental health services, see table 12A.3 for details.

Source: Department of Health (unpublished); Australian Institute of Health and Welfare (AIHW) (unpublished) Mental Health Establishments (MHE) National Minimum Data Set (NMDS); table 12A.4.

Real expenditure per person on State and Territory governments' specialised public mental health services is reported in figure 12.3. Recurrent expenditure on State and Territory governments' specialised public mental health services includes expenditure funded from all sources, including the Australian Government.

Figure 12.3 Real recurrent expenditure on State and Territory governments' specialised public mental health services (2012-13 dollars)^{a, b, c, d, e}

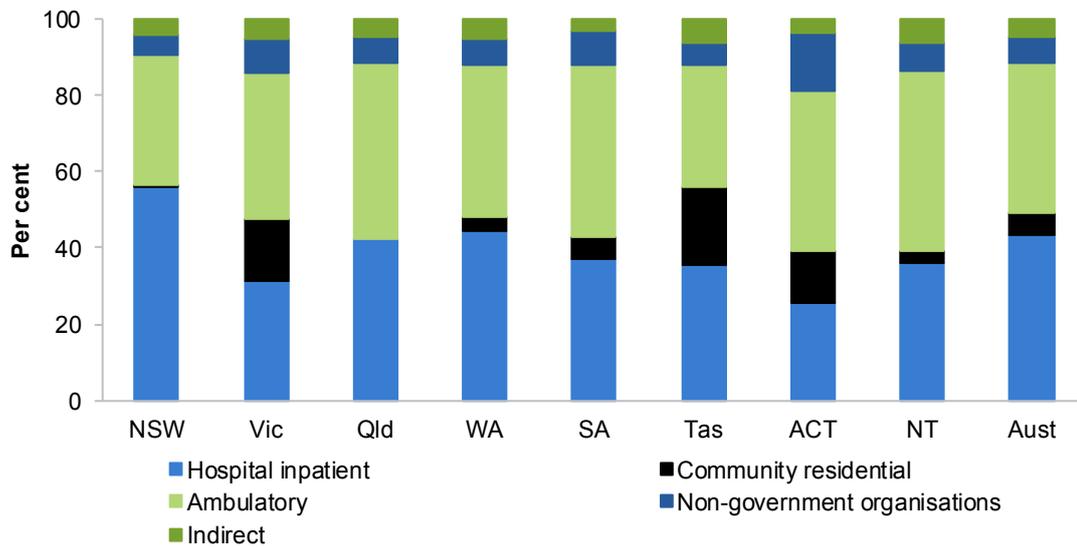


^a Real expenditure (2012-13 dollars), using State and Territory implicit price deflators for general government final consumption on hospitals and nursing homes (table 12A.96). ^b Estimates of State and Territory governments' spending include funding from other revenue and Australian Government funds. ^c Depreciation is excluded for all years. Depreciation estimates are reported in table 12A.5. ^d Expenditure data on State and Territory governments' specialised public mental health services by source of funding are presented in table 12A.3. ^e The quality of the NSW Mental Health Establishments (MHE) National Minimum Data Set (NMDS) 2010-11 data has been affected by the reconfiguration of the service system during the year.

Source: Department of Health (unpublished); State and Territory governments (unpublished); AIHW (unpublished) MHE NMDS; table 12A.2.

Figure 12.4 shows how recurrent expenditure on State and Territory governments' specialised public mental health services was distributed across the different service types in 2012-13.

Figure 12.4 **Recurrent expenditure on State and Territory governments' specialised public mental health services, by service category, 2012-13^{a, b, c, d, e}**



^a Includes all State and Territory governments' expenditure on specialised public mental health services, regardless of source of funds. ^b Depreciation is excluded. Depreciation estimates are reported in table 12A.5. ^c The differential reporting of clinical service providers and non-government organisations (NGOs) artificially segregates the mental health data. Given that the role of NGOs varies across states and territories, the level of expenditure on NGOs does not necessarily reflect the level of community support services available. ^d Hospital inpatient expenditure can include expenditure on government funded public hospital services managed and operated by private and non-government entities. ^e Queensland does not report any in-scope government operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non-campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non-acute admitted patient services.

Source: AIHW (unpublished) MHE NMDS; table 12A.6.

Size and scope of sector

Prevalence of mental illness and high/very high levels of psychological distress

According to the National Survey of Mental Health and Wellbeing (SMHWB), in 2007, 20.0 ± 1.1 per cent of adults aged 16–85 years (or approximately 3.2 million adults) met the criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months before the survey (table 12A.76). A further 25.5 ± 1.4 per cent of adults aged 16–85 years had experienced a mental disorder at some point in their life, but did not have symptoms in the previous 12 months (table 12A.76).

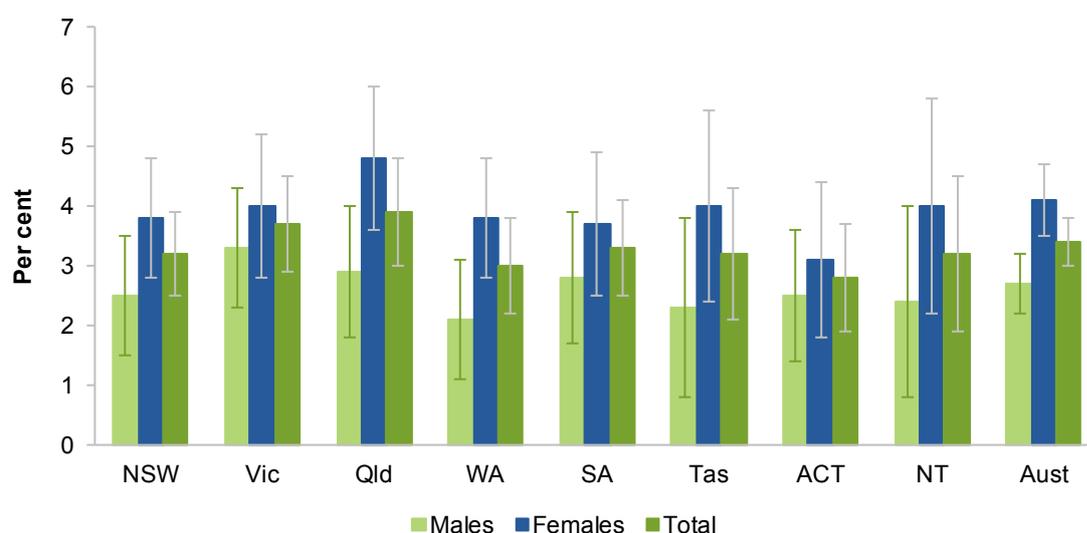
A proxy measure of the overall mental health and wellbeing of the population is the Kessler 10 (K10) psychological distress scale. Data from the 2007 SMHWB show that people with a lifetime mental disorder who had symptoms in the previous 12 months

(20.0 ± 1.1 per cent of the total population), were significantly overrepresented in the populations who had high or very high levels of psychological distress — 57.1 ± 5.1 per cent and 79.6 ± 7.2 per cent of these populations respectively (table 12A.7). Analysis of the 1997 SMHWB showed a strong association between a high/very high K10 score and a current diagnosis of anxiety and affective disorders (ABS 2012). According to the Australian Bureau of Statistics (ABS), which uses the K10 instrument in the SMHWB and National Health Surveys (NHS), the K10:

... is a scale designed to measure non-specific psychological distress, based on questions about negative emotional states experienced in the past 30 days. ... it is not a diagnostic tool, but an indicator of current psychological distress, where very high levels of distress may signify a need for professional help. It is also useful for estimating population need for mental health services (ABS 2012).

Females had higher proportions of very high levels of psychological distress than males in 2011-12 (figure 12.5). People with disability or restrictive long term health condition and people in low socioeconomic areas also reported higher proportions of very high levels of psychological distress than other community groups (table 12A.9). In 2012-13, 29.4 ± 2.1 per cent of Aboriginal and Torres Strait Islander Australians aged 18 years or over reported high/very high levels of psychological distress (table 12A.15). After adjusting for age, this was 2.7 times the rate for non-Indigenous adults. Tables 12A.8–16 contain additional data on high/very high levels of psychological distress.

Figure 12.5 Adults with very high levels of psychological distress, by gender, 2011-12^{a, b, c}



^a Adults are defined as people aged 18 years and over. ^b Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population. ^c Data for the NT should be used with care as exclusion of very remote areas from the National Health Survey (NHS) translates to the exclusion of around 23 per cent of the NT population.

Source: ABS (unpublished) Australian Health Survey (AHS) 2011–13 (2011-12 National Health Survey (NHS) component); table 12A.8.

Mental health services — overview

There are a range of government provided or funded services that are specifically designed to meet the needs of people with mental health issues; the key services are the following:

- MBS subsidised mental health specific services — provided by GPs, psychiatrists, psychologists or other allied health professionals on a fee for service basis that are partially or fully funded under Medicare.
- Admitted patient care in hospitals — services provided to admitted patients in stand-alone psychiatric hospitals or in specialised psychiatric units in acute hospitals.
- Community-based mental health services, comprising:
 - ambulatory care services provided by outpatient clinics (hospital and clinic based), mobile assessment and treatment teams, day programs and other services dedicated to assessment, treatment, rehabilitation and care
 - specialised residential services that provide beds in the community, staffed onsite (24 hour and non 24 hour) by mental health professionals
 - not-for-profit, NGO services, funded by the Australian, State and Territory governments to provide community support for people with psychiatric disability, including accommodation, outreach to people living in their own homes, residential rehabilitation units, recreational programs, self-help and mutual support groups, carer respite services and system-wide advocacy (DoHA 2010).

There are a range of other health services provided and/or funded by governments that make a significant contribution to the mental health treatment of people with a mental illness, but are not specialised mental health services: MBS subsidised GP general consultations that are mental health-related, emergency departments and admitted patient mental health-related care provided in general wards. Tables 12A.30–32 provide information on these non-specialised services provided in hospitals.

MBS subsidised mental health services

GP mental health services

GPs are often the first type of service accessed by people seeking help when suffering from a mental illness (AIHW 2014). GPs can diagnose, manage and treat mental illnesses and they also refer patients to more specialised service providers such as psychiatrists and psychologists (see other MBS subsidised services below).

According to the Bettering the Evaluation and Care of Health (BEACH) (an annual survey collected from a sample of approximately 1000 GPs), 12.3 per cent of GP encounters (an estimated 15.8 million MBS subsidised services) were mental health-related in 2012-13 (table 12A.18). Under the BEACH survey, a mental health-related encounter is defined as one at which a mental health-related problem is managed. Problems managed reflect the

GP's understanding of the health problem presented by the patient. These encounters comprise those billed as general surgery consultations and those billed under specific mental health MBS items.

A GP can manage more than one problem at a single encounter. In 2012-13, 13.1 mental health-related problems were managed per 100 encounters (table 12A.20). Depression was the most frequently reported mental health-related problem managed (4.2 per 100 GP encounters), representing around one third of all mental health-related problems managed (table 12A.20 and AIHW 2014). Anxiety (2.1 per 100 GP encounters) and sleep disturbance (1.6 per 100 GP encounters) were the next most common mental health-related problems (table 12A.20). The most common form of GP management for a mental health-related problem was the prescription, supply or recommendation of a medication (AIHW 2014).

GPs can provide services under specific mental health MBS items (GP Mental Health Treatment Plan, Focussed Psychological Strategies and Family Group Therapy). In 2012-13, 2.4 million MBS subsidised specific mental health MBS items (105.2 per 1000 people) were provided by GPs (table 12A.17).

Other MBS subsidised services

In 2012-13, 6.1 million other MBS subsidised mental health-related services were provided by psychiatrists, psychologists and other allied health professionals (table 12A.17). This comprised 3.7 million provided by psychologists, 2.1 million services provided by psychiatrists, and 255 129 services provided by other allied health professionals (table 12A.17). This was equivalent to 163.2 psychologist services, 93.3 psychiatrist services, and 11.1 other allied health services per 1000 people (table 12A.17).

Specialised admitted patient and community-based mental health services — service use, patient days, beds and staffing

Service use

Estimating activity across the publicly funded specialised mental health services sector, which comprises admitted patient care and community-based mental health services, is problematic as the way activity is measured differs across the service types. Service activity is reported by separations for admitted patient care, episodes for community-based residential care, contacts for community-based ambulatory care and number of participants accessing the targeted community care (mental health) services funded by the Department of Social Services (DSS). Other service use data for the NGOs are not available.

There were 93 602 separations with specialised psychiatric care in public acute hospitals and 10 073 specialised psychiatric care separations in public psychiatric hospitals in 2012-13 (table 12A.22). Schizophrenia accounted for a large proportion of separations

with specialised psychiatric care in public hospitals (19.4 per cent in public acute hospitals and 18.0 per cent in public psychiatric hospitals) (table 12A.22). Ambulatory-equivalent specialised psychiatric care is also provided in public hospitals. In 2009-10, the latest year for which data are published, there were 5193 of these separations from public acute hospitals and 132 in public psychiatric hospitals (table 12A.23).

There were 6535 episodes of community-based residential care in 2012-13 (table 12A.25). Schizophrenia, schizotypal and delusional disorders (F20–29) as a principal diagnosis accounted for the largest proportion of these episodes (51.5 per cent of episodes with a specified principal diagnosis) (AIHW 2014). There were 6.3 million community-based ambulatory care patient contacts (excludes Victoria for which data were not available), equivalent to 371.1 contacts per 1000 people, in 2012-13 (table 12A.24). For those contacts with a mental health disorder specified, the largest proportion was for the principal diagnosis of schizophrenia (22.1 per cent) (AIHW 2014).

In 2012-13, there were 117 793 participants in the targeted community care (Mental Health) program across three service types (15 066 for Personal Helpers and Mentors (PHaMs), 68 406 for Family Mental Health Support Services and 34 321 for Mental Health Respite: Carer Support) (table 12A.29). Mood disorder was the most prevalent diagnosis for PHaMs participants at the time of entry to a service (64.6 per cent of participants had this diagnosis, although not necessarily as a primary diagnosis as participants could be counted as having more than one) (DSS 2013).

Data on service use by Indigenous status are available, but comparisons are not necessarily accurate because Aboriginal and Torres Strait Islander patients are not always correctly identified (table 12A.25). Differences in rates of service use could also reflect other factors, including the range of social and physical infrastructure services available to Aboriginal and Torres Strait Islander Australians, and differences in the complexity, incidence and prevalence of illnesses between Aboriginal and Torres Strait Islander and non-Indigenous Australians.

Patient days, beds and staffing

Activity can also be measured across State and Territory governments' specialised public mental health services by accrued mental health patient days, mental health beds and full time equivalent (FTE) direct care staff. Admitted patient care and community-based residential (24 hour staffed) accrued patient days per 1000 people for 2012-13 are included in figure 12.6.

Figure 12.6 **Accrued mental health patient days, 2012-13^{a, b, c}**

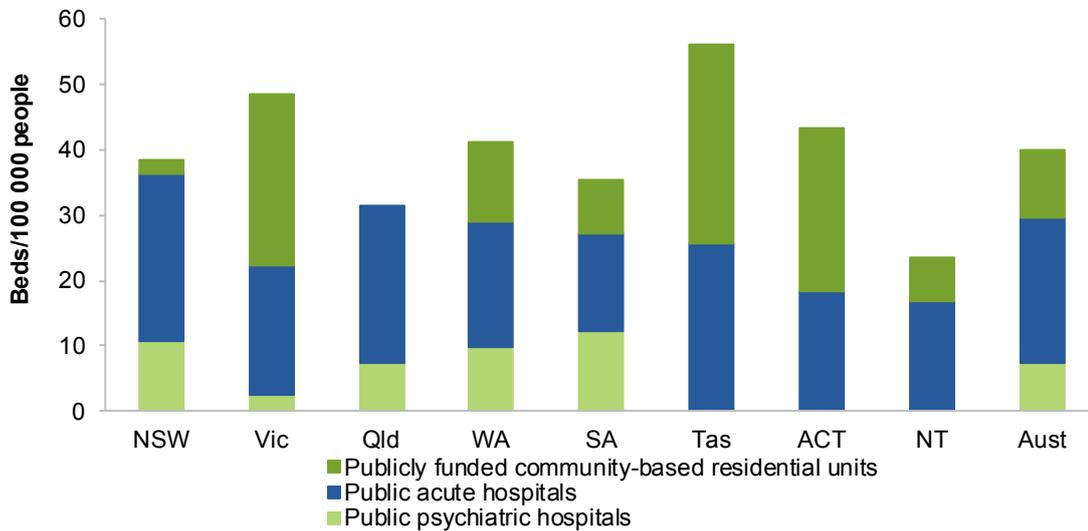


^a Hospital patient days include those funded by government, but provided by services managed and operated by private and non-government entities. ^b Queensland does not report any in-scope government operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non-campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non-acute admitted patient services. ^c The ACT and the NT do not have non-acute hospital units.

Source: AIHW (unpublished) MHE NMDS; table 12A.21.

Beds are counted as those that can provide overnight accommodation for patients admitted to hospital or residential services (see section 12.6 for more details). Figure 12.7 presents the number of beds per 100 000 people by service setting, in 2012-13. These data show the differences in service mix across states and territories.

Figure 12.7 **Mental health beds in public hospitals and publicly funded community-based residential units, 2012-13^{a, b, c, d}**

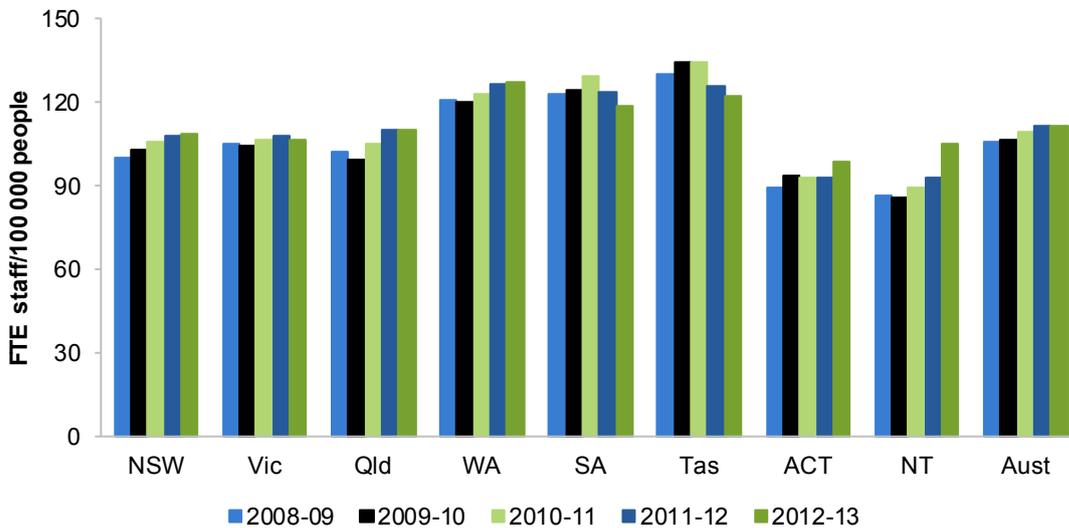


^a Includes beds in public hospitals and publicly funded community-based residential units. ^b Hospital beds can include government funded beds managed and operated by private and non-government entities. ^c Queensland does not report any in scope government operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non-campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non-acute admitted patient services. ^d Tasmania, the ACT and the NT do not have public psychiatric hospitals.

Source: AIHW (unpublished) MHE NMDS; table 12A.26.

Figure 12.8 reports FTE direct care staff per 100 000 people employed across the admitted patient and community-based (ambulatory and residential) service areas. Nursing staff comprise the largest FTE component of direct care staff employed in specialised public mental health services. Across Australia in 2012-13, there were 67.3 nurses per 100 000 people, compared with 25.5 allied health care staff, 13.5 medical staff and 4.9 other personal care staff (table 12A.27). FTE direct care staff employed by service setting, are reported in table 12A.28.

Figure 12.8 FTE health professional direct care staff^{a, b}



^a Includes staff within the health professional categories of 'medical', 'nursing', 'allied health' and 'other personal care'. Section 12.6 provides detailed definitions for these staffing categories. ^b The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year.

Source: AIHW (unpublished) MHE NMDS; table 12A.27.

Case study

Box 12.1 contains a case study on reducing the use of seclusion in specialised mental health acute inpatient units.

Box 12.1 Reducing the use of seclusion during an acute episode of mental health inpatient care in the ACT

Seclusion is the confinement of a consumer at any time of the day or night alone in a room or area from which free exit is prevented. Seclusion is used during inpatient episodes of care where there is a need to secure the safety of the consumer and the safety of others, at a time when the consumer requires safe containment due to the volatile nature of their behaviour and mental illness. However, before strategies to reduce the use of seclusion had been introduced in the ACT, the use of seclusion had been broadened to be:

- a preventative option to de-escalate a difficult situation even when it was not always clear if there was an immediate safety issue
- an option rather than a last resort due to other issues such as adequate staff coverage of the inpatient facility at the time, number of other 'at risk' consumers, the level of acuity of the group of consumers being cared for at the time and the general level of experience of staff in dealing with difficult, volatile situations.

Cultural change on the 'appropriate' use of seclusion began in the ACT around 2009-10. The issue of the use of seclusion and the circumstances leading to a seclusion episode were examined more closely to identify triggers, alternative options, staff training and consumer input into the understanding of events that contribute to seclusion for some consumers. The plan was to introduce pro-active strategies to prevent or reduce (where possible) the likelihood of circumstances that lead to a seclusion event. Around this time, the ACT was also included as a 'beacon site' for the National Seclusion and Restraint Project, which provided additional incentives to learn and contribute to the broader issue of seclusion in mental health.

The ACT seclusion review committee was created, comprising clinical staff of the inpatient facility, consumers and carer representatives and operational management of the inpatient facility. The committee reviewed each episode of seclusion focusing on systemic issues that may lead to seclusion being considered and which could be influenced. A number of issues were identified regarding the mental state of the consumer prior to the event, environmental conditions, use of alternative strategies and pro-active interventions that could be introduced before a situation requiring seclusion developed.

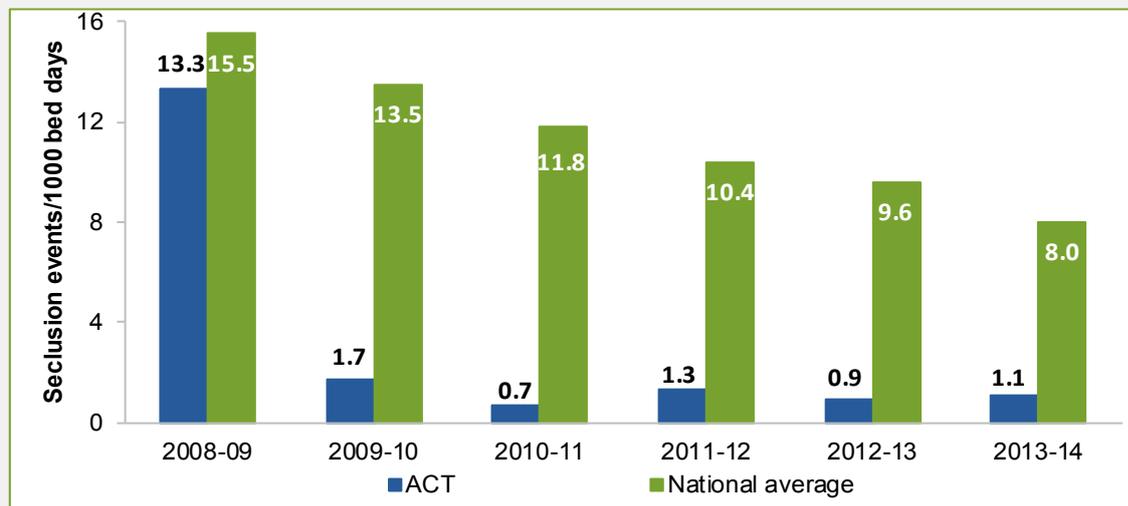
- Feedback and input from consumers was critical in evaluating the use of alternative diversion tactics and de-escalating potential triggers of unpredictable behaviour before they become a safety issue. Key to this was the approach taken by staff including less obtrusive observance of consumers that was seen as not challenging by the consumer in their altered mental state, the environment, staff mix and the understanding of the acute nature of new consumers entering the inpatient facility.
- Staff and consumer experience and knowledge were key to adopting an attitude of supportive care rather than coercive control to change behaviour when circumstances were recognised as potentially volatile. A degree of trust and open communication between staff and consumers was required along with a particular set of skills and experience. It was recognised that what works in one situation may not necessarily work in another as staff and consumers respond variably in different circumstances. Supportive cooperation is needed in each situation, allowing the consumer a degree of control over their own behaviour and staff exercising some restraint in their own responses to de-escalate a situation.

Box 12.1 (continued)

- Time was identified as an important element. Given enough time, potentially volatile triggers can be averted in most situations. Time for the consumer to recognise and understand what is happening and time for the staff member to observe and take pro-active action. Time works best in a non-threatening environment. Whether a threat is real or imagined, staff and consumers have demonstrated they have the capacity to make alternative choices other than ones that lead to the need for seclusion.

The aim in the ACT is to eliminate the need for seclusion wherever possible and to provide safe alternatives that promote the wellbeing of consumers, staff and visitors. Seclusion may still be necessary in some situations, but these are now the exception rather than the rule and seclusion is seen as a last resort when the safety of anyone involved reaches a critical threshold.

The effectiveness of the ACT approach is demonstrated by the reduction in, and ongoing low, seclusion rates since 2008-09 (table 12A.50).



Along with the adoption of the seclusion review committee, other changes were occurring in the ACT mental health service system that may have influenced these seclusion results, including the introduction of additional services (Mental Health Assessment Unit) and the Step-up and Step-down services in the community. It is also acknowledged that as public mental health clinical services are provided by one central organisation in the ACT, it is easier to implement cultural change than in most jurisdictions.

Source: ACT Government (unpublished); AIHW (2014).

12.3 Framework of performance indicators for mental health management

Preventing the onset of mental illness is challenging, primarily because individual illnesses have many origins. Most efforts have been directed at treating mental illness when it occurs, determining the most appropriate setting for providing treatment and emphasising early intervention.

The framework of performance indicators for mental health services draws on governments' broad objectives for national mental health policy, as encompassed in the *National Mental Health Policy 2008* (box 12.2). The performance indicator framework reports on the equity, effectiveness and efficiency of mental health services. It covers a number of service delivery types (MBS subsidised, admitted patient and community-based services) and includes outcome indicators of system-wide performance.

Box 12.2 Broad objectives and policy directions of National Mental Health Policy

The *National Mental Health Policy 2008* has an emphasis on whole of government mental health reform and commits the Australian, State and Territory governments to the continual improvement of Australia's mental health system. The key broad objectives are to:

- promote the mental health and well-being of the Australian community and, where possible, prevent the development of mental health problems and mental illness
- reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community
- promote recovery from mental health problems and mental illness
- assure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.

The key policy directions are summarised as follows:

- Rights and responsibilities of people with mental health problems and mental illness will be acknowledged and respected.
- Mental health promotion will support destigmatisation and assist people to be emotionally resilient, cope with negative experiences and participate in the community.
- The proportion of people with mental health problems, mental illness and people at risk of suicide will be reduced.
- Emerging mental health problems or mental illnesses will receive early intervention to minimise the severity and duration of the condition and to reduce its broader impacts.
- People will receive timely access to high quality, coordinated care appropriate to their conditions and circumstances.
- People with mental health problems and mental illness will enjoy full social, political and economic participation in their communities.
- The crucial role of carers will be acknowledged and respected and they will be provided with appropriate support to enable them to fulfil their role.
- The mental health workforce will be appropriately trained and adequate in size and distribution to meet the need for care.
- Across all sectors, mental health services should be monitored and evaluated to ensure they are of high quality and achieving positive outcomes.
- Research and evaluation efforts will generate new knowledge about mental health problems and mental illness that can reduce the impact of these conditions.

National Mental Health Strategy

In 1991, Australian Health Ministers signed the *Mental Health Statement of Rights and Responsibilities*. This Statement seeks to ensure that consumers, carers, advocates, service providers and the community are aware of their rights and responsibilities and can be confident in exercising them (Australian Health Ministers 1991). The Statement underpins the National Mental Health Strategy (NMHS) endorsed by Australian, State and Territory governments in 1992 (AIHW 2008). During 2011-12, the Statement was updated to align with the *National Mental Health Policy 2008* and Australia's international obligations with respect to the *United Nations Convention on the Rights of Persons with Disabilities* and the *United Nations Convention on the Rights of the Child*.

The NMHS was established to guide the reform agenda for mental health in Australia across the whole of government. The NMHS consists of the National Mental Health Policy and the National Mental Health Plan. The National Mental Health Policy describes the broad aims and objectives of the NMHS. The National Mental Health Plan describes the approach to implementing the aims and objectives of the Policy. A fourth plan (2009–2014) was endorsed by all Australian Health Ministers in September 2009. The fourth plan aimed to strengthen the accountability framework with Australian, State and Territory governments by developing targets and data sources for a set of indicators and to provide annual progress reports to Council of Australian Governments (COAG) (AHMC 2009). These indicators were the primary vehicle for monitoring the progress of these governments in achieving national mental health reform under the fourth plan.

COAG National Healthcare Agreement and National Health Reform

COAG has agreed six National Agreements (NAs) 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 NHA covers the area of health and aged care, and health indicators in the National Indigenous Reform Agreement (NIRA) establish specific outcomes for reducing the level of disadvantage experienced by Aboriginal and Torres Strait Islander Australians. Both agreements include sets of performance indicators. The Steering Committee collates NIRA performance information for analysis by the Department of Prime Minister and Cabinet. Performance indicators reported in this chapter are aligned with health performance indicators in the most recent version of the NHA, where relevant.

From 2009-10 to 2011-12, the Australian Government provided a SPP to State and Territory governments for health services under the NHA. From 2012-13, the payments made under the SPP were replaced by new funding approaches specified in the NHRA, including Activity Based Funding for future years. Specific payments made to State and Territory health services for mental health cannot be separately identified in 2012-13.

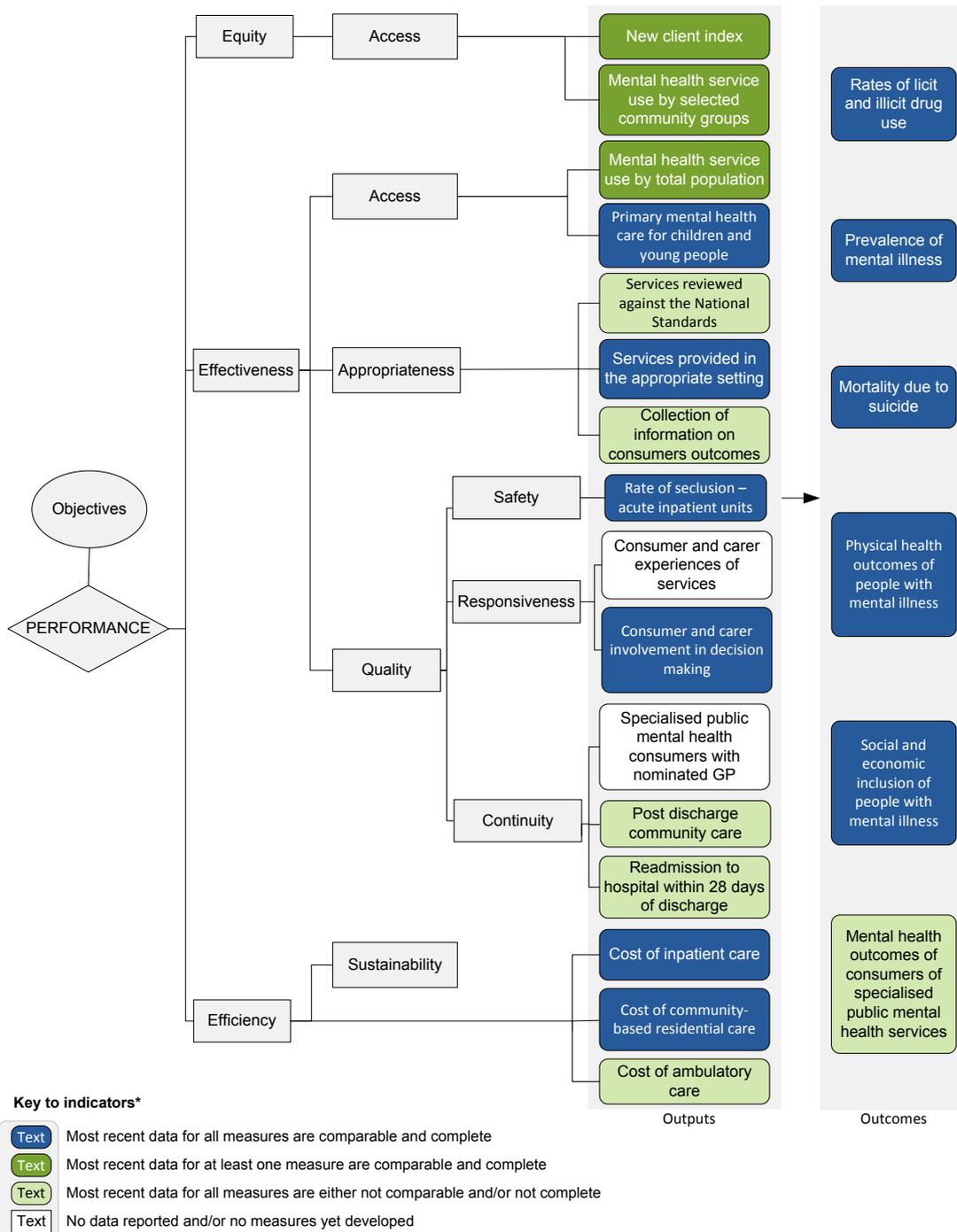
Performance indicator framework

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of mental health management services (figure 12.9). The performance indicator framework shows which data are complete and comparable in the 2015 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report wide perspective (see chapter 1, section 1.6).

The Report's statistical context chapter contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (chapter 2).

Data quality information is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the ABS' data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and key data gaps and issues identified by the Steering Committee. All DQI for the 2015 Report can be found at www.pc.gov.au/rogs/2015.

Figure 12.9 Mental health management performance indicator framework



12.4 Key performance indicators for mental health management

Outputs

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

Equity — access — new client index

‘New client index’ is an indicator of governments’ objective to provide mental health services in an equitable manner (box 12.3). Population treatment rates are relatively low and it might be difficult for a new client to access specialised public mental health services if resources are already utilised by existing clients.

Box 12.3 New client index

‘New client index’ is defined by two measures, the proportions of total clients under the care of:

- State and Territory governments’ specialised public mental health services who were new clients
- Medicare Benefits Schedule (MBS) subsidised mental health services provided by private psychiatrists, General Practitioners (GPs) and allied health providers, who were new clients.

A new client is a consumer who has not been seen/received a mental health service in the five years preceding the initial contact with a service in the relevant reference period.

A high or increasing proportion of total clients who are new might be desirable, as it suggests it is easier for new clients to access mental health services. However, results are difficult to interpret. The appropriate balance between providing ongoing care to existing clients who have continuing needs and meeting the needs of new clients is unknown.

This indicator does not provide information on whether the services are appropriate or adequate for the needs of the people receiving them (new or existing clients), or correctly targeted to those clients who are most in need.

Data reported for the proportions of total clients under the care of State and Territory specialised public mental health services who were new clients are:

- comparable (subject to caveats) within most jurisdictions over time, but are not comparable across jurisdictions or over time for Tasmania
- incomplete for the current reporting period. All required 2012-13 data are not available for Victoria.

(Continued next page)

Box 12.3 (continued)

Data reported for the proportions of total clients under the care of MBS subsidised ambulatory mental health services who were new clients are:

- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period. All required 2013-14 data are available.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

The proportions of total clients of specialised public mental health services who are new are reported in figure 12.10. Data are reported by age, gender, Socio-Economic Indexes for Areas (SEIFA) quintiles, Indigenous status and remoteness in table 12A.34.

Figure 12.10 Proportion of total clients of State and Territory specialised public mental health services who are new^{a, b, c, d, e}

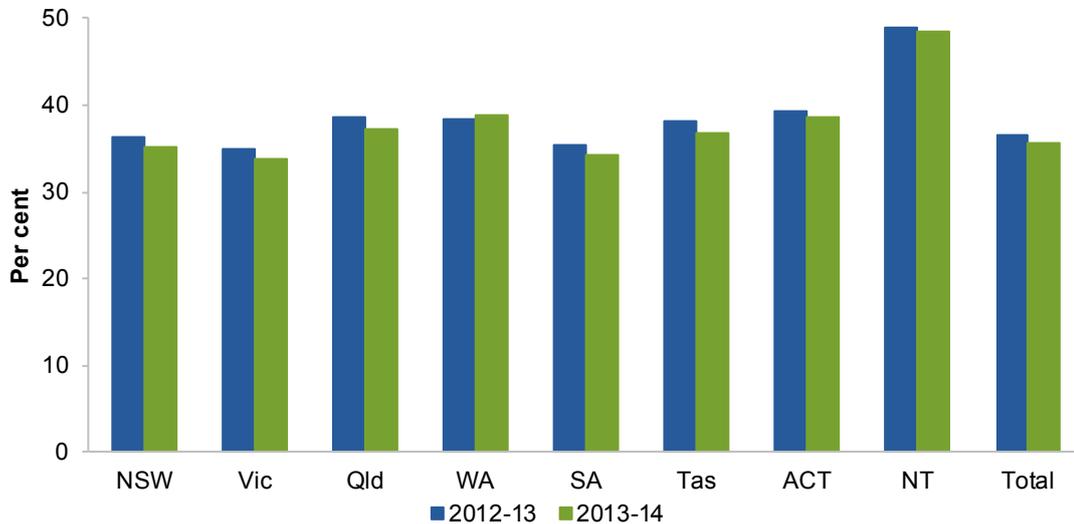


^a Clients in receipt of services include all people who received one or more community-based ambulatory service contact or had one or more day of inpatient or community-based residential care in the data period. ^b A new client is a consumer who had not been seen in the five years preceding the first contact with a State or Territory specialised public mental health service. ^c The approach to identifying unique clients differs across jurisdictions. Some have a State-wide unique patient identifier, others use a statistical linkage key. For SA, the client counts are not unique, but are an aggregation of three separate databases. ^d Victorian 2011-12 and 2012-13 data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. ^e Industrial action in Tasmania has limited the available data quality and quantity for 2011-12 and 2012-13.

Source: State and Territory governments (unpublished); table 12A.33.

The proportions of total clients of MBS subsidised ambulatory mental health services who are new are reported in figure 12.11.

Figure 12.11 Proportion of total clients of MBS subsidised mental health services who are new^{a, b, c}



^a A new client is defined as a patient who has not previously used a Medicare Benefits Schedule (MBS) mental health item in the five years preceding the first use of a MBS mental health item in the reference period. ^b Data are calculated based on date of processing of specified MBS mental health items. ^c State/Territory is allocated based on the postcode recorded for the person at the first service event within each reference period year.

Source: Department of Health (unpublished); table 12A.35.

Equity — access — mental health service use by selected community groups

‘Mental health service use by selected community groups’ is an indicator of governments’ objective to provide mental health services in an equitable manner, including access to services by selected community groups such as Aboriginal and Torres Strait Islander Australians (box 12.4).

Box 12.4 Mental health service use by selected community groups

'Mental health service use by selected community groups' is defined by two measures:

- proportion of the population in a selected community group using State and Territory specialised public mental health services, compared with the proportion of the population outside the selected community group using State and Territory specialised public mental health services
- proportion of the population in a selected community group using MBS subsidised mental health services provided by private psychiatrists, GPs and allied health providers (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers), compared with the proportion of the population outside the selected community group using MBS subsidised mental health services.

The selected community groups reported are Aboriginal and Torres Strait Islander Australians, people from outer regional, remote and very remote locations and people residing in low socioeconomic areas. For MBS subsidised mental health services, data by socioeconomic status are reported by decile and quintile, at the national level only.

This indicator is difficult to interpret. It does not measure access according to need, that is, according to the prevalence of mental illness across the selected community groups. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness. It also does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

Data reported for the 'proportion of the population in a selected community group using State and Territory specialised public mental health services' measure are:

- comparable (subject to caveats) across jurisdictions, but a break in series means that data from 2012-13 are not comparable to previous years' data — previously data were restricted to counts of people receiving one or more service contact provided by community-based ambulatory services, now they also includes people using inpatient and residential care services
- incomplete for the current reporting period (subject to caveats). All required 2012-13 data are not available for Victoria.

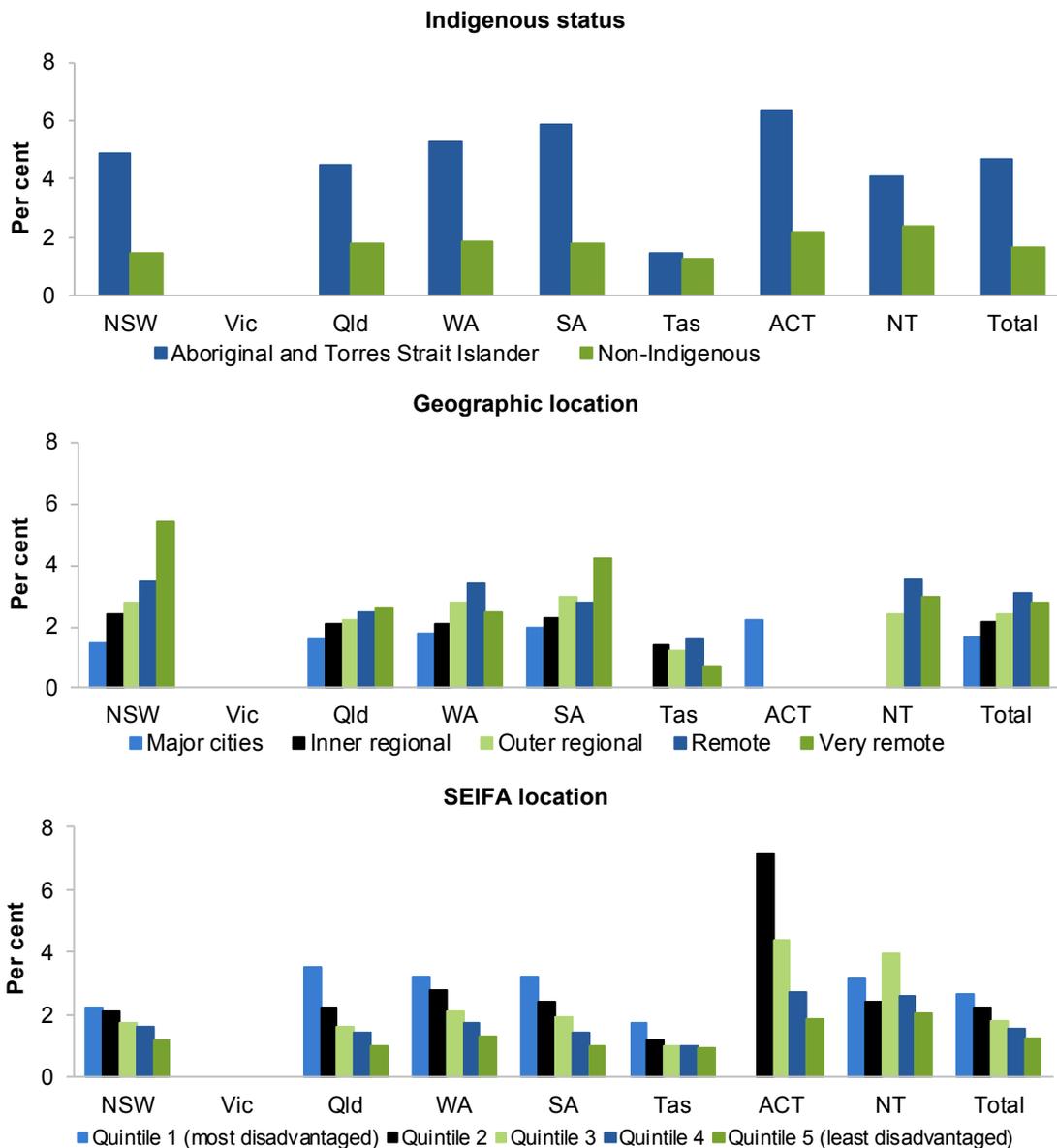
Data reported for the 'proportion of the population in a selected community group using MBS subsidised ambulatory mental health services' measure are:

- comparable (subject to caveats) across jurisdictions, but a break in series means that data from 2011-12 by geographic location and Socio-Economic Indexes for Areas (SEIFA) are not comparable to previous years' data
- complete for the current reporting period (subject to caveats). All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

The proportions of the population using State and Territory specialised public mental health services in 2012-13, by selected community groups are reported in figure 12.12. The results are not available for Victoria.

Figure 12.12 Population using State and Territory specialised public mental health services, by selected community group, 2012-13^{a, b, c, d, e, f, g}

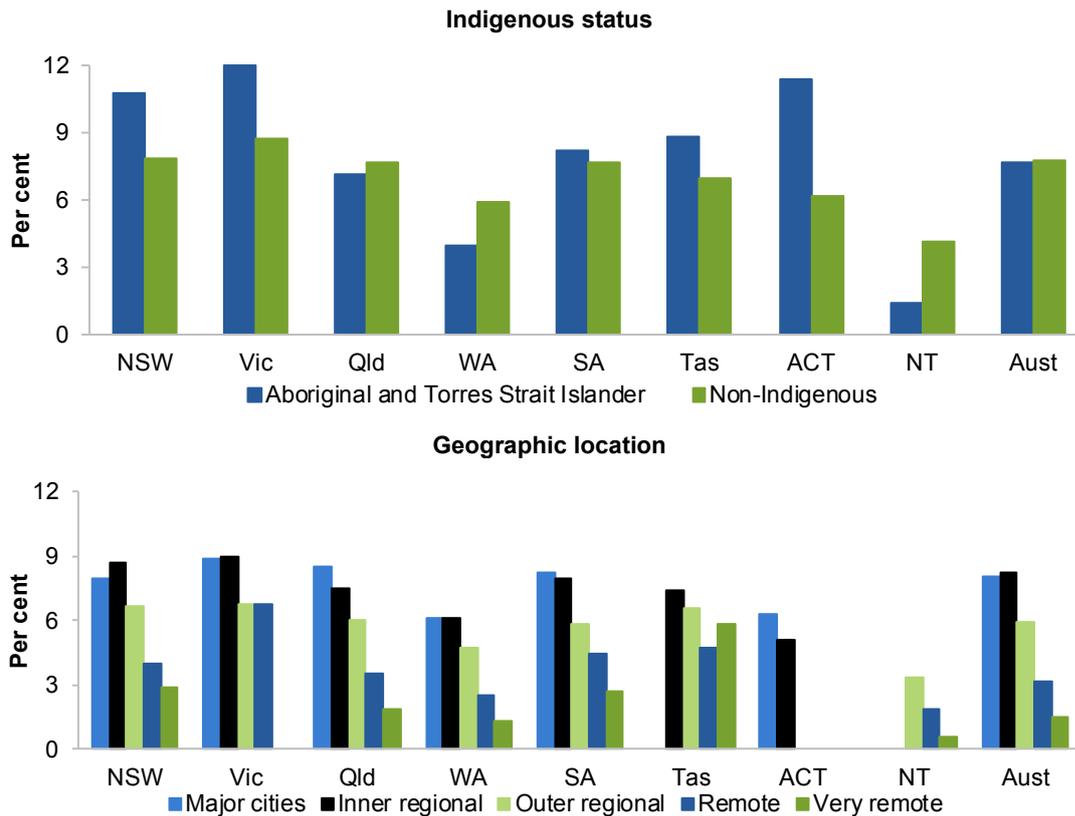


SEIFA = Socio Economic Indexes for Areas. ^a Proportions are age standardised to the Australian population as at 30 June 2001. ^b State and Territory specialised public mental health services are counts of people receiving one or more services provided by inpatient or community-based ambulatory or residential services. ^c Data are not available for Victoria. ^d Industrial action during 2012-13 in Tasmania has limited the available data quality and quantity of the community-based ambulatory mental health care data; which represents a large proportion of the overall figures. ^e Disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider, except the NT for which the majority of the data were based on the location of the service. ^f The ACT does not have outer regional, remote or very remote locations. ACT data are not published for inner regional areas. Data for Quintile 1 are not published for the ACT. ^g The NT does not have major cities or inner regional locations.

Source: AIHW (unpublished), derived from data provided by State and Territory governments; State and Territory governments (unpublished) specialised mental health services data; tables 12A.36-38.

The proportions of the population using MBS subsidised mental health services, by selected community groups, are reported in figure 12.13 (data by socioeconomic status are available by decile and quintile at the national level only in tables 12A.38 and 12A.40).

Figure 12.13 Population using MBS subsidised mental health services, by selected community group, 2012-13^{a, b, c, d}



^a Proportions are age standardised to the Australian population as at 30 June 2001. ^b MBS subsidised services are those mental health specific services provided under the general MBS and by the Department of Veterans' Affairs (DVA). The specific Medicare items included are detailed in table 12A.41. ^c Disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider. However, where a state or territory does not have a particular remoteness category a rate cannot be calculated. ^d Victoria does not have very remote areas. Tasmania does not have major cities. The ACT does not have outer regional, remote or very remote locations. The NT does not have major cities or inner regional locations.

Source: AIHW (unpublished), derived from data provided by the Australian Government; Department of Health (unpublished) and Department of Veterans' Affairs (DVA) (unpublished), Medicare Benefits Schedule (MBS) Statistics data; tables 12A.36-37.

Further data on the use of State and Territory specialised public mental health services and MBS subsidised mental health services by community groups are in tables 12A.39-40. Data on the use of private hospital mental health services are also contained in tables 12A.36-38 and 12A.40-41.

Effectiveness — access — mental health service use by total population

‘Mental health service use by total population’ is an indicator of governments’ objective to provide equitable access to mental health services for all people who need them (box 12.5). An estimate of the population who need mental health services is not available, so the indicator is reported as a proportion of the total population using services.

Box 12.5 **Mental health service use by total population**

‘Mental health service use by total population’ is defined as the proportion of the population using a State and Territory specialised public mental health service or a MBS subsidised mental health service. Data are reported separately for State and Territory specialised public mental health services and MBS subsidised mental health services. Data from the 2007 National Survey of Mental Health and Wellbeing (SMHWB) on the proportion of people who had a lifetime mental disorder with symptoms in the 12 months before the survey who used any service for mental health are also reported in tables 12A.42-43.

This indicator is difficult to interpret. It does not measure access according to need, that is, according to the prevalence of mental illness across jurisdictions. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need. People with a mental illness can have low rates of service use due to them choosing not to access services, appropriate services are unavailable, lack of awareness that services are available and negative experiences associated with the previous use of services (AHMC 2008). In addition, it might not be appropriate for all people with a mental illness to use a service, for example, some can seek and receive assistance from outside the health system (AHMC 2008).

Data reported for the ‘proportion of the population using State and Territory specialised public mental health services’ measure are:

- comparable (subject to caveats) across jurisdictions and over time for all jurisdictions, except Tasmania — previously data were restricted to counts of people receiving one or more service contacts provided by community-based ambulatory services, now the time series data include people using inpatient and residential care services
- incomplete for the current reporting period (subject to caveats). All required 2012-13 data are not available for Victoria.

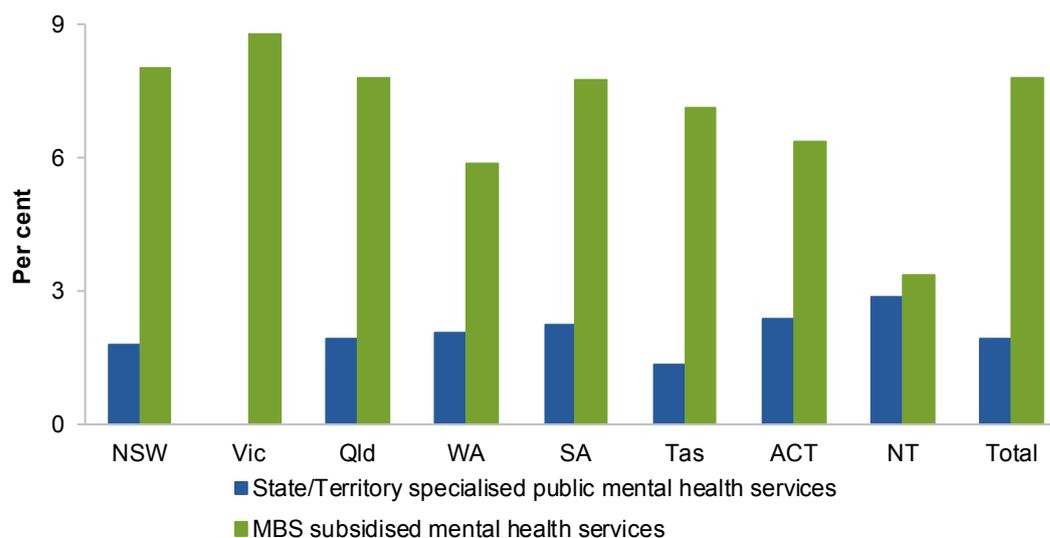
Data reported for the ‘proportion of the population using MBS subsidised mental health services’ measure are:

- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

In 2012-13, 1.9 per cent and 7.8 per cent of the total population received State and Territory specialised public mental health services and MBS subsidised services (MBS general and DVA), respectively (figure 12.14).

Figure 12.14 **Population receiving mental health services, by service type, 2012-13^{a, b, c, d, e}**



^a Rates are age standardised to the Australian population as at 30 June 2001. ^b State and Territory specialised public mental health services are counts of people receiving one or more services provided by inpatient or community-based ambulatory or residential services. ^c MBS subsidised mental health services are those specific mental health services provided under the general MBS and DVA by psychiatrists, clinical psychologists, GPs and other allied health services. The specific MBS items included are detailed in table 12A.41. People seen by more than one provider type are counted only once. ^d Data for State and Territory specialised public mental health services are not available for Victoria due to service level collection gaps resulting from protected industrial action during this period. Industrial action during 2012-13 in Tasmania has limited the available data quality and quantity of the community-based ambulatory mental health care data; which represents a large proportion of the overall figures. ^e The total only includes those jurisdictions that have provided data.

Source: AIHW (unpublished) derived from data provided by Australian, State and Territory governments; State and Territory governments (unpublished) specialised mental health services data; Department of Health (unpublished) and DVA (unpublished), MBS Statistics data; table 12A.41.

Effectiveness — access — primary mental health care for children and young people

‘Primary mental health care for children and young people’ is an indicator of governments’ objective to prevent, where possible, the development of mental health problems and mental illness and undertake early intervention for mental health problems and mental illness (box 12.6). Early identification of and intervention in mental illnesses for children and young people can result in better outcomes.

Box 12.6 Primary mental health care for children and young people

'Primary mental health care for children and young people' is defined as the proportion of young people aged under 25 years who received a primary mental health care service subsidised through the MBS. Data are also reported by four age cohorts: pre-school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years).

High or increasing proportions of young people who had contact with primary mental health care services subsidised through the MBS is desirable.

This indicator does not provide information on whether the services are appropriate for the needs of the young people receiving them, or correctly targeted to those young people most in need. It also does not measure access according to need, that is, according to the prevalence of mental illness across jurisdictions. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.

Data reported for this indicator are:

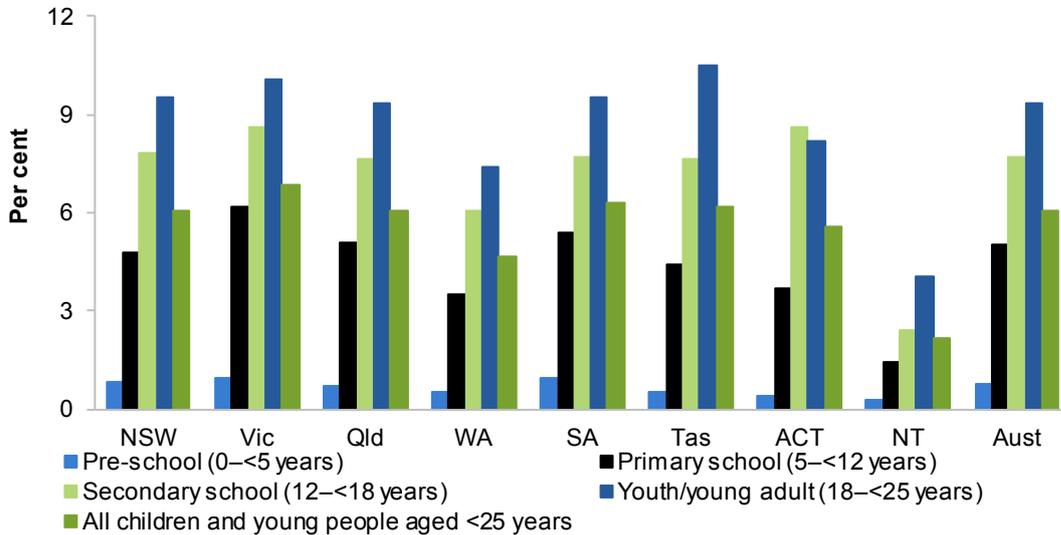
- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2013-14 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Results for this indicator should be interpreted with caution. Primary mental health care for children and young people can be accessed from services other than those that are MBS subsidised. Other providers of primary mental health care to young people include community health centres, Aboriginal Community Controlled Health Services, school counsellors and health nurses and university and Technical and Further Education counselling services. A component of the mental health care provided by State and Territory specialised public mental health services could also be considered primary mental health care for young people, but this cannot be reliably differentiated from other care types (NMHPSC 2011a).

In 2013-14, 6.1 per cent of all children and young people (aged under 25 years) had received MBS subsidised primary mental health care services (figure 12.15). Data on the proportion of young people who had received MBS subsidised primary mental health care services by Indigenous status, remoteness areas, SEIFA, gender and service type are in tables 12A.45-46.

Figure 12.15 Children and young people who received MBS subsidised primary mental health care, 2013-14



Source: Department of Health (unpublished); table 12A.44.

Effectiveness — appropriateness — services reviewed against the National Standards

‘Services reviewed against the National Standards’ is an indicator of governments’ objective to provide mental health services that are appropriate (box 12.7). It is a process indicator of appropriateness, reflecting progress made in meeting the national standards for mental health care (see box 12.8 for details on the relevant standards).

Box 12.7 Services reviewed against the National Standards

'Services reviewed against the National Standards' is defined as the proportion of expenditure on specialised public mental health services that had completed a review by an external accreditation agency against the National Standards for Mental Health Services (NSMHS). Services were assessed as level 1, level 2, level 3, or level 4 where these levels are defined as:

- *Services at level 1* — services reviewed by an external accreditation agency and judged to have met all National Standards.
- *Services at level 2* — services reviewed by an external accreditation agency and judged to have met some but not all National Standards.
- *Services at level 3* — services (i) in the process of being reviewed by an external accreditation agency but the outcomes are not known, or (ii) booked for review by an external accreditation agency.
- *Services at level 4* — services that do not meet criteria detailed under levels 1 to 3.

A high or increasing proportion of expenditure on specialised public mental health services that had completed a review by an external accreditation agency against the NSMHS and that had been assessed as level 1 is desirable.

The indicator does not provide information on whether the standards or assessment process are appropriate. In addition, services that had not been assessed do not necessarily deliver services of lower quality. Some services that had not completed an external review included those that were undergoing a review and those that had booked for review and were engaged in self-assessment preparation.

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time, but are not comparable across jurisdictions
- complete for the current reporting period (subject to caveats). All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Revised *National Standards for Mental Health Services* (NSMHS) were released in September 2010 and provide a blueprint for new and existing services to guide quality improvement and service enhancement activities. The standards have been broadened to include non-government community mental health services and private office based services as well as specialised public mental health services. Implementation guidelines have also been released.

Box 12.8 outlines the 2010 NSMHS against which public mental health services are now assessed. External accreditation agencies, such as the Australian Council on Healthcare Standards, undertake accreditation of a parent health organisation (for example, a hospital) that can cover a number of specialised services, including mental health services. Accreditation of a parent organisation does not currently require a mental health service to be separately assessed against the National Standards; rather, assessment against the National Standards must be specifically requested and involves a separate review process.

Box 12.8 **The 2010 National Standards for Mental Health Services**

The first NSMHS were developed under the *First National Mental Health Plan 1993–1998*. Revised NSMHS were released in September 2010 and provide a blueprint for new and existing services to guide quality improvement and service enhancement activities. The 2010 NSMHS comprise 10 overarching standards:

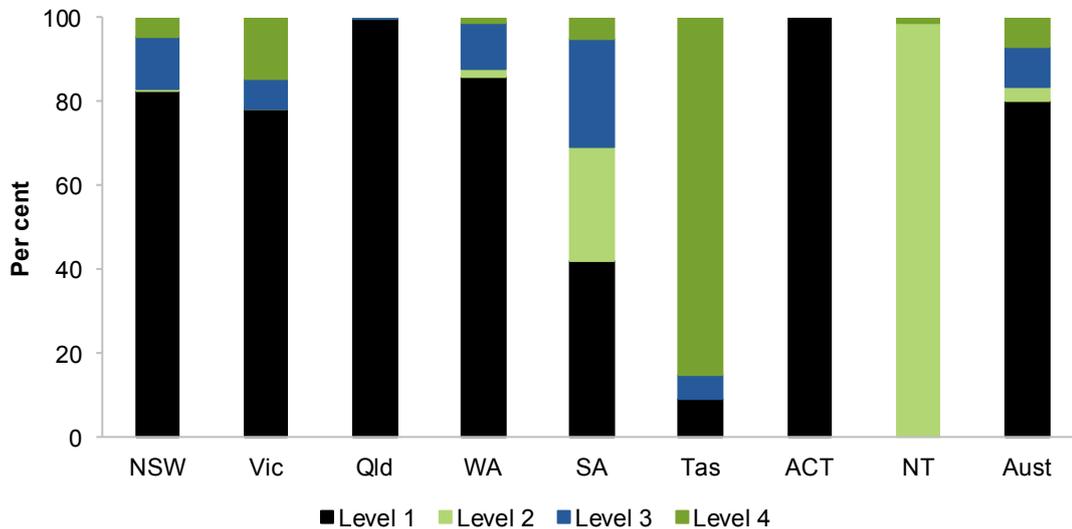
1. Rights and responsibilities
2. Safety
3. Consumer and carer participation
4. Diversity responsiveness
5. Promotion and prevention
6. Consumers
7. Carers
8. Governance, leadership and management
9. Integration
10. Delivery of care.

In future, services will be required to undergo accreditation against the ten new national safety and quality health service standards mandated by the Australian Commission on Safety and Quality in Health Care (ACSQHC) and the revised 2010 NSMHS. Reaccreditation against the 2010 NSMHS was to be undertaken by 2014. However, services indicated their preference to undertake NSMHS reaccreditation in conjunction with the accreditation against the ACSQHC standards which were implemented from January 2013 onwards.

Source: AHMC (2010) and Department of Health (unpublished).

Figure 12.16 shows the proportion of expenditure on specialised public mental health services that had completed an external review against the NSMHS and met ‘all standards’ (level 1). Figure 12.16 also shows the proportions of expenditure on specialised public mental health services that had completed an external review against the NSMHS and met ‘some but not all standards’ (level 2), were either in the process of being reviewed by an external accreditation agency but the outcomes were not known, or that had booked for review by an external accreditation agency (level 3); and those that did not meet criteria detailed under levels 1 to 3 (level 4).

Figure 12.16 **Share of expenditure on specialised public mental health services reviewed against the NSMHS, by assessment level, 30 June 2013^{a, b}**



^a Data are based on expenditure on individual service units within mental health organisations, not at the whole organisation level. However, there is variation across jurisdictions in the method used to assign an assessment level (1, 2, 3 or 4) to a service unit. In some jurisdictions, if an organisation with multiple service units is assessed at a particular level all the organisation's units are 'counted' at that assessment level. In other jurisdictions, service units are 'counted' individually at assessment levels and assessment levels may or may not be consistent across the units within an organisation. The approach can also vary across organisations within a single jurisdiction. ^b Box 12.7 contains definitions of the assessment levels.

Source: AIHW (unpublished) MHE NMDS; table 12A.47.

Effectiveness — appropriateness — services provided in the appropriate setting

'Services provided in the appropriate setting' is an indicator of governments' objective to provide mental health services in community-based settings wherever possible (box 12.9).

Box 12.9 **Services provided in the appropriate setting**

'Services provided in the appropriate setting' is defined as the proportion of State and Territory governments' recurrent expenditure on specialised mental health services (excluding aged care community residential expenditure) that was on community-based services. Community-based services are defined as ambulatory care, adult residential services and non-government organisations (NGOs). Aged care community residential expenditure is excluded to improve comparability.

A high or increasing proportion of recurrent expenditure spent on community-based services is desirable, reflecting a greater reliance on services that are based in community settings.

Data reported for this indicator are:

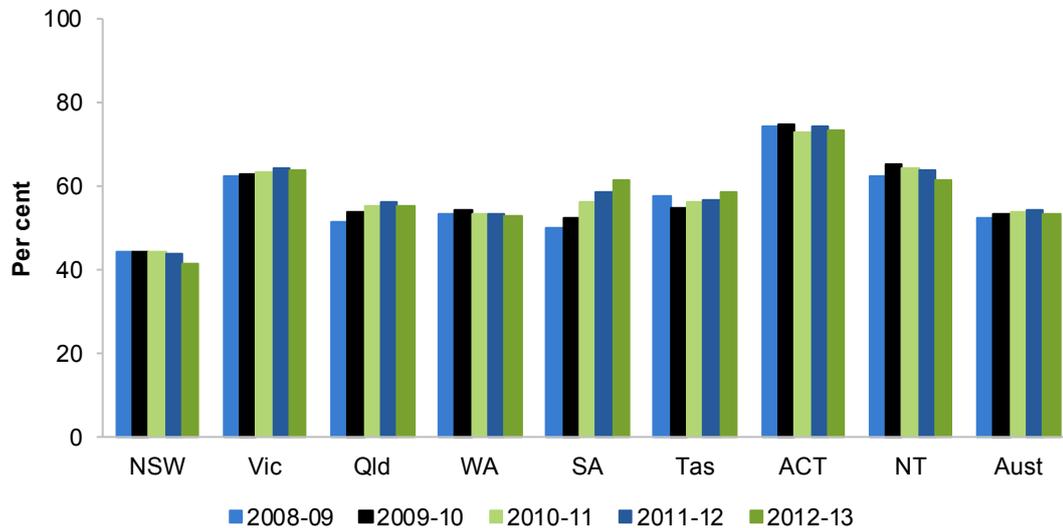
- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2012-13 data are available for all jurisdictions

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

The development of local, comprehensive mental health service systems is advocated by the NMHS. Mental health services must be capable of responding to the individual needs of people with mental illnesses and of providing continuity of care to enable consumers to move between services as their needs change. More appropriate mental health treatment options can be provided by encouraging the treatment of patients in community-based settings, rather than in stand-alone psychiatric hospitals and public (non-psychiatric) hospitals.

Figure 12.17 shows recurrent expenditure on community-based services as a proportion of total expenditure on specialised public mental health services.

Figure 12.17 **Recurrent expenditure on community-based services as a proportion of total expenditure on specialised public mental health services^{a, b, c, d}**



^a Community-based expenditure includes expenditure on ambulatory, NGO grants and adult residential services. Aged care residential expenditure is excluded to improve comparability. ^b Total expenditure on specialised public mental health services excludes indirect/residual expenditure that could not be apportioned directly to services and aged care community residential expenditure. ^c Queensland does not report any in-scope government operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non-campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non-acute admitted patient services. ^d The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year.

Source: AIHW (unpublished) MHE NMDS; table 12A.48.

Effectiveness — appropriateness — collection of information on consumers' outcomes

'Collection of information on consumers' outcomes' is an indicator of governments' objective that consumer outcomes be monitored (box 12.10). It is a process indicator, reflecting the capability of services in establishing systems to collect information on consumers' mental health outcomes.

Box 12.10 Collection of information on consumers' outcomes

'Collection of information on consumers' outcomes' is defined as the proportion of specialised public mental health service episodes with completed clinical mental health outcome measures data, by client type (people in ongoing community-based care, people discharged from community-based care and people discharged from hospital).

High or increasing proportions of episodes for which information on consumers' mental health outcomes is collected is desirable.

This indicator monitors the uptake of the routine National Outcomes Casemix Collection. It does not provide information on whether consumers had appropriate outcomes.

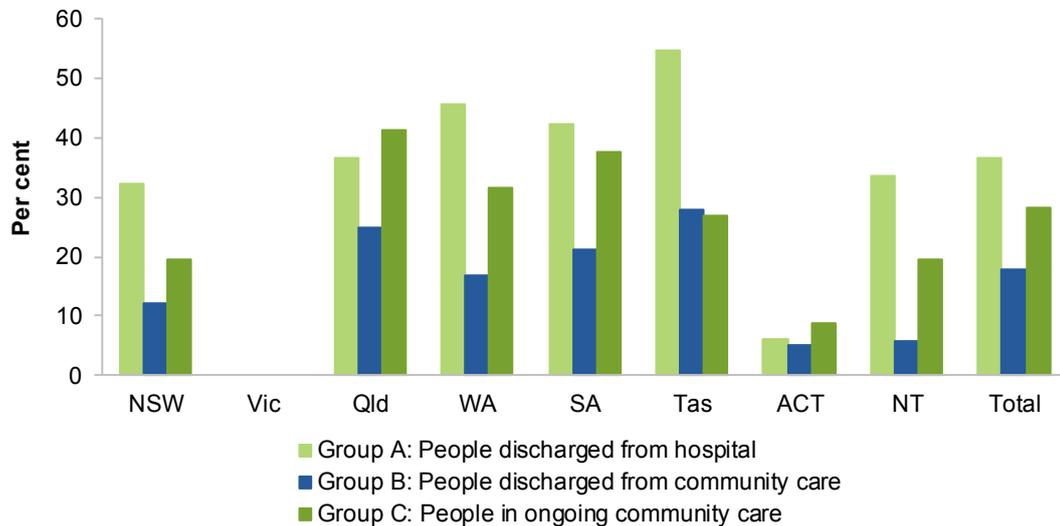
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- incomplete for the current reporting period. All required data for 2012-13 are not available for Victoria.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

The estimated proportions of specialised public mental health service episodes for which information on consumers' mental health outcomes is collected are shown in figure 12.18.

Figure 12.18 **Estimated proportion of episodes for which ‘complete’ consumer outcome measures were collected, 2012-13^{a, b, c}**



^a These data were prepared by the Australian Mental Health Outcomes and Classification Network, using data submitted by State and Territory governments to the Australian Government (Department of Health). To be counted as an episode for which consumer outcome measures are collected, data need to be completed correctly (a specified minimum number of items completed) and have a ‘matching pair’ — that is, a beginning and end rating are needed to enable an outcome score to be determined. ^b Victorian data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. ^c Industrial action in Tasmania has limited the available data quality and quantity of community data.

Source: Australian Mental Health Outcomes and Classification Network (unpublished), Australian Government Department of Health; table 12A.49.

Quality — safety — rate of seclusion — acute inpatient units

‘Rate of seclusion — acute inpatient units’ is an indicator of governments’ objective that services are of a high quality and safe (box 12.11). The reduction, and where possible elimination of, seclusion and restraint in specialised public mental health services is a national safety priority for specialised public mental health services (NMHWG 2005).

Box 12.11 **Rate of seclusion — acute inpatient units**

'Rate of seclusion — acute inpatient units' is defined as the number of seclusion events per 1000 bed days in specialised public mental health acute inpatient units. Seclusion involves a patient being confined at any time of the day or night alone in a room or area from which it is not within their control to leave (NMHWG 2005; NMHPSC 2011b). See section 12.6 for further details on seclusion and how 'seclusion events' are defined.

A low or decreasing number of seclusion events per 1000 bed days (or where possible none) in specialised public mental health inpatient units is desirable.

The indicator does not provide any information on the duration of seclusion events. Information on the duration of seclusion events if reported alongside this indicator would provide a better understanding of performance in relation to the use and management of seclusion in inpatient units.

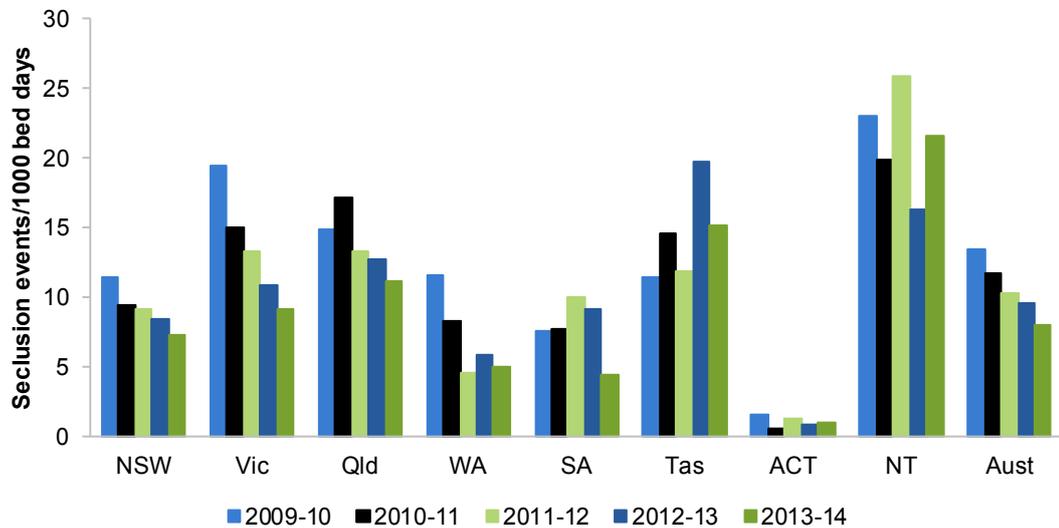
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required data for 2013-14 are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Data on the number of seclusion events per 1000 bed days in specialised public mental health acute inpatient units are shown in figure 12.19. Legislation (a Mental Health Act or equivalent) or mandatory policy governs the use of seclusion in each State and Territory and the definition of 'seclusion' can vary across jurisdictions (NMHPSC 2011b). Data reported by target population are included in table 12A.51.

Figure 12.19 **Rate of seclusion**^{a, b, c, d}



^a Data are from a number of ad hoc seclusion data collections for specialised mental health public acute hospital services conducted by the Safety and Quality Partnership Standing Committee of the Mental Health, Drug and Alcohol Principal Committee, in partnership with the relevant state and territory authorities. ^b Variation in jurisdictional legislation may result in differences in the definition of a seclusion event. Data reported by jurisdictions may therefore vary and comparisons should be made with caution. ^c Due to the low ratio of beds per person in the NT compared with other jurisdictions, the apparent rate of seclusion is inflated when reporting seclusion per bed day compared with reporting on a population basis. ^d Further detailed notes on jurisdictions' seclusion collections are in table 12A.50.

Source: AIHW (2014) *Mental Health Services in Australia Online*, mhsa.aihw.gov.au/home/ (accessed 17 December 2014); table 12A.50.

Quality — responsiveness — consumer and carer experiences of services

'Consumer and carer experiences of services' is an indicator of governments' objective that services are of a high quality and responsive to the needs of consumers and their carers (box 12.12). Consumers and their carers should have positive experiences in all mental health service areas with clinicians and services provided. Both are important aspects of the NMHS.

Box 12.12 **Consumer and carer experiences of services**

'Consumer and carer experiences of services' is yet to be defined.

Data for this indicator were not available for the 2015 Report.

Quality — responsiveness — consumer and carer involvement in decision making

‘Consumer and carer involvement in decision making’ is an indicator of governments’ objective that consumers and carers are involved at the service delivery level, where they have the opportunity to influence the services they receive (box 12.13). Consumer and carer involvement is an important aspect of the NMHS.

Box 12.13 Consumer and carer involvement in decision making

‘Consumer and carer involvement in decision making’ is defined by two measures:

- the number of paid full time equivalent (FTE) consumer staff per 1000 FTE direct care, consumer and carer staff
- the number of paid FTE carer staff per 1000 FTE direct care, consumer and carer staff.

High or increasing proportions of paid FTE direct care, consumer and carer staff who are consumer/carers staff implies better opportunities for consumers and carers to be involved at the service delivery level, where they can influence the services received.

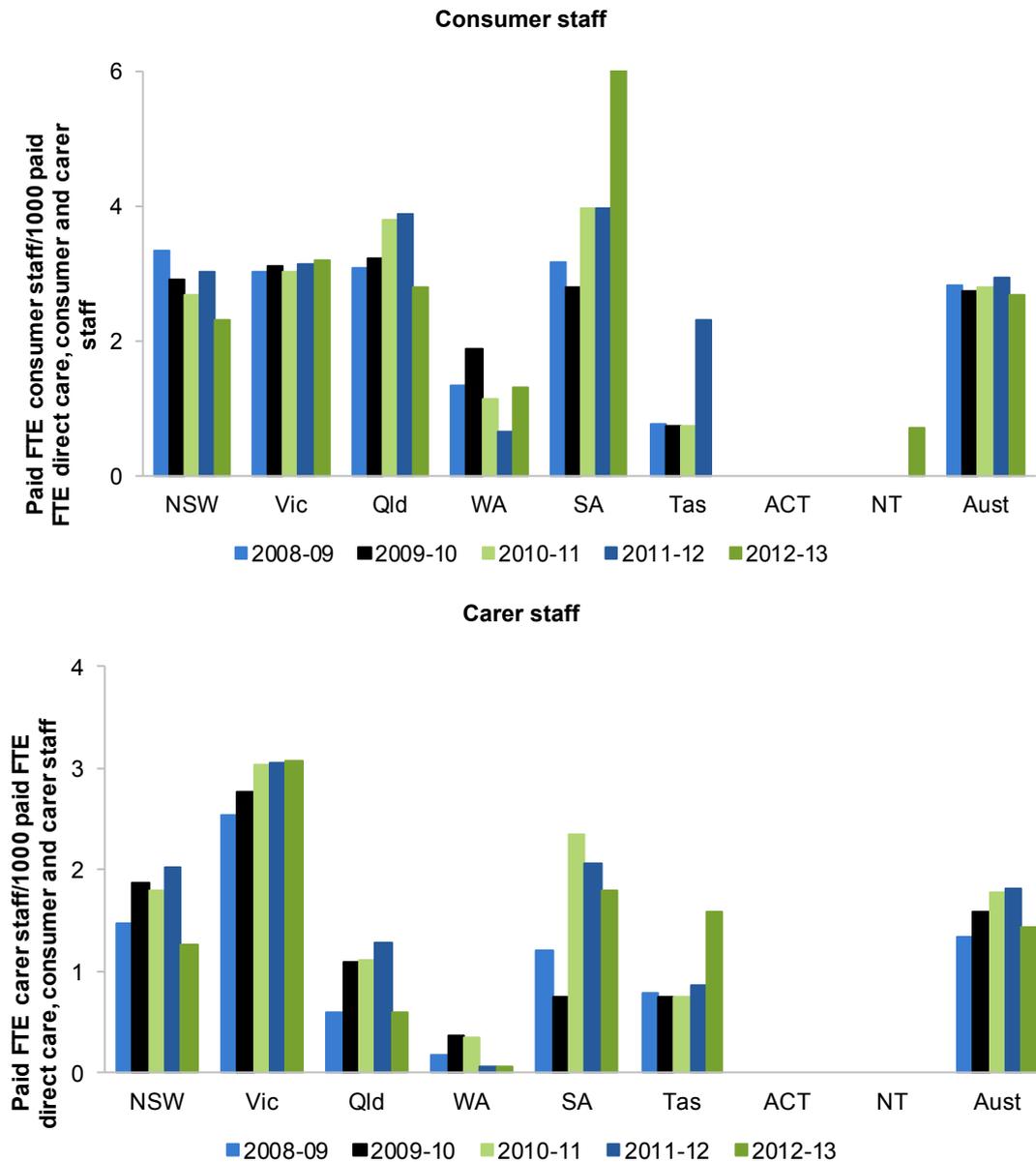
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions, but a break in series means that data from 2010-11 are not comparable to data from previous years
- complete for the current reporting period (subject to caveats). All required data for 2012-13 are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Figure 12.20 reports the number of paid FTE consumer and carer staff per 1000 paid FTE direct care, consumer and carer staff.

Figure 12.20 **Paid FTE consumer or carer staff per 1000 paid FTE direct care, consumer and carer staff**^{a, b, c, d, e, f}



^a Data up to 2009-10 were restricted to consumer/carer consultants. From 2010-11, the definitions were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. Comparisons between data up to 2009-10 with data from 2010-11 should not be made. ^b The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. ^c WA has advised that this information does not represent the full range of consumer and carer participation (see table 12A.52 for further details). ^d Tasmania did not employ consumer staff in 2012-13. ^e The ACT do not employ consumer and carer staff. ^f The NT do not employ carer staff and employed consumer staff in 2012-13 only.

Source: AIHW (unpublished) MHE NMDS; table 12A.52.

Quality — continuity — specialised public mental health service consumers with nominated GP

‘Specialised public mental health service consumers with nominated GP’ is an indicator of governments’ objective to provide continuity of care in the delivery of mental health services. GPs can be an important point of contact for those with a mental illness (box 12.14).

Box 12.14 Specialised public mental health service consumers with nominated GP

‘Proportion of specialised public mental health service consumers with nominated GP’ is yet to be defined.

Data for this indicator were not available for the 2015 Report.

Quality — continuity — post discharge community care

‘Post discharge community care’ is an indicator of governments’ objective to provide continuity of care in the delivery of mental health services (box 12.15).

Box 12.15 Post discharge community care

‘Post discharge community care’ is defined as the proportion of admitted patient overnight acute separations from psychiatric inpatient services for which a community-based ambulatory mental health care contact was recorded in the seven days following separation.

A high or increasing rate of community follow up within the first seven days of discharge from hospital is desirable.

This indicator does not measure the frequency of contacts recorded in the seven days following separation. It also does not distinguish qualitative differences between phone and face-to-face community contacts. Only community-based ambulatory contact made by State and Territory specialised public mental health services are included. Where clinical follow up is managed outside these services (for example, by private psychiatrists or GPs), these contacts are not included.

Data reported for this indicator are:

- comparable (subject to caveats) within most jurisdictions over time, but are not comparable across jurisdictions or over time for Tasmania
- incomplete for the current reporting period. All required 2012-13 data are not available for Victoria.

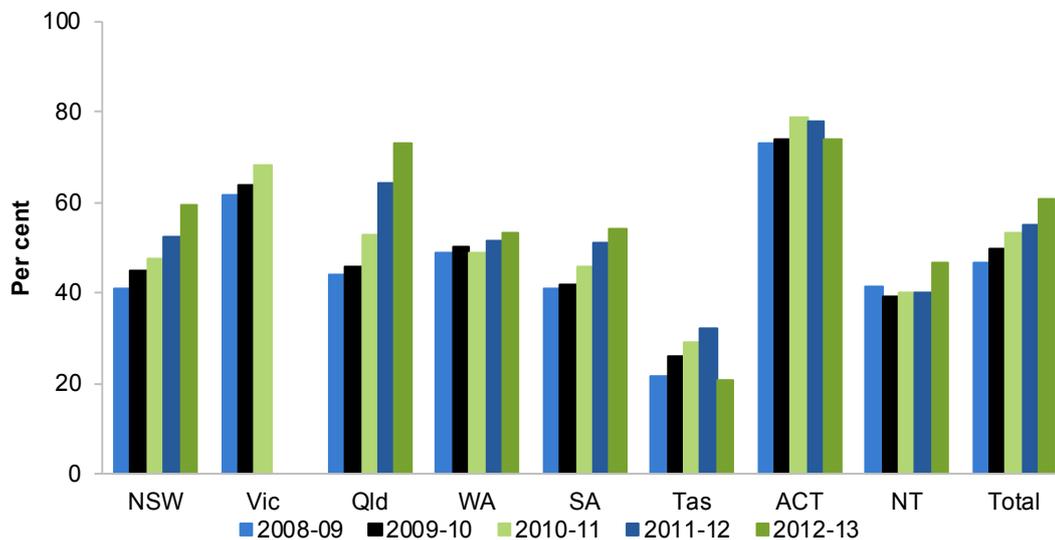
Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital (AHMC 2012). A community support system for people

who are discharged from hospital after an acute psychiatric episode is essential to maintain clinical and functional stability and to minimise the need for hospital readmission (NMHPSC 2011a).

Data on the rates of community follow-up for people within the first seven days of discharge from an acute inpatient psychiatric unit are reported in figure 12.21. Community follow-up rates data by Indigenous status, remoteness areas, SEIFA, age groups and gender are in tables 12A.54-55.

Figure 12.21 **Community follow-up for people within the first seven days of discharge from acute inpatient psychiatric units^{a, b, c, d, e, f}**



^a Community-based ambulatory mental health contacts counted for determining whether follow-up occurred are restricted to those in which the consumer participated, except for the NT where the data include all contacts (the NT has advised that the effect on the indicator is immaterial). Contacts made on the day of discharge are also excluded. ^b Due to data supply issues, totals for 2011-12 and 2012-13 should be interpreted with caution. The total only includes those jurisdictions that have provided data. ^c Victorian data are not available for 2011-12 and 2012-13 due to service level collection gaps resulting from protected industrial action during this period. ^d Industrial action in Tasmania has limited the available data quality and quantity of community data for 2011-12 and 2012-13. ^e Data are not comparable across jurisdictions. States and territories vary in their capacity to accurately track post discharge follow-up between hospital and community service organisations, due to the lack of unique patient identifiers. SA data and Tasmanian data before 2012-13 are not based on unique patient identifiers or data matching approaches. Results for these jurisdictions could appear 'lower' relative to jurisdictions that are able to track utilisation across services. ^f For 2012-13, the ACT has refined its calculation methodology and comparisons to earlier years' results should be made with caution.

Source: AIHW (unpublished), from data provided by State and Territory governments' health authorities; table 12A.53.

Quality — continuity — readmissions to hospital within 28 days of discharge

‘Readmissions to hospital within 28 days of discharge’ is an indicator of governments’ objective to provide effective care and continuity of care in the delivery of mental health services (box 12.16).

Box 12.16 Readmissions to hospital within 28 days of discharge

‘Readmissions to hospital within 28 days of discharge’ is defined as the proportion of admitted patient overnight separations from public psychiatric acute inpatient services that were followed by readmission to public psychiatric acute inpatient services within 28 days of discharge.

A low or decreasing rate of readmissions to hospital within 28 days of discharge from hospital is desirable. Readmissions following a recent discharge can indicate that inpatient treatment was either incomplete or ineffective, or that follow up care was inadequate to maintain people out of hospital (NMHPSC 2011a).

Readmission rates are affected by factors other than deficiencies in specialised public mental health services, such as the cyclic and episodic nature of some illnesses or other issues that are beyond the control of the mental health system (NMHWG Information Strategy Committee Performance Indicator Drafting Group 2005).

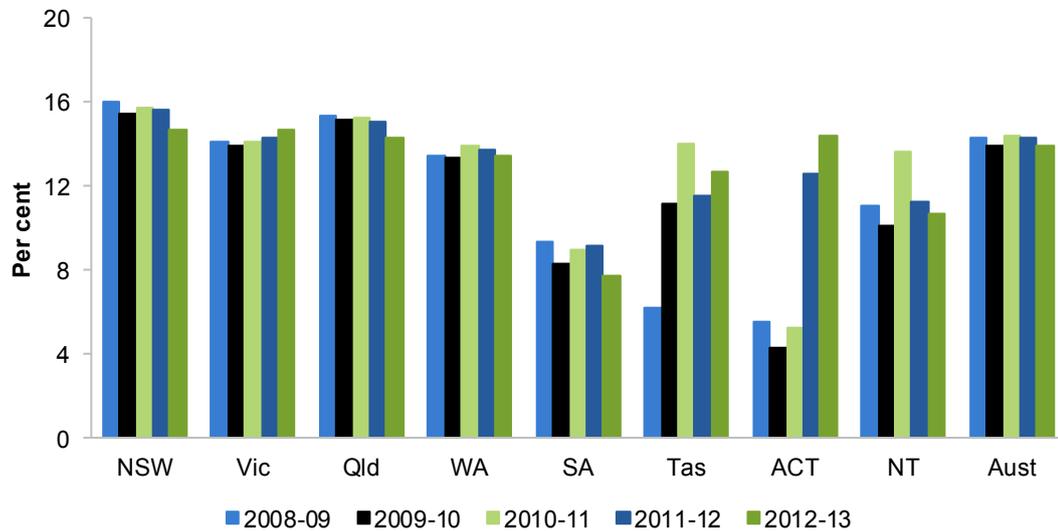
Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time, but are not comparable across jurisdictions
- complete for the current reporting period (subject to caveats). All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Data on the rates of readmission to hospital within 28 days of discharge are reported in figure 12.22. Rates of readmission to hospital within 28 days of discharge by Indigenous status, remoteness areas, SEIFA, age group and gender are in table 12A.57.

Figure 12.22 Readmissions to hospital within 28 days of discharge from acute psychiatric units^{a, b}



^a No distinction is made between planned and unplanned readmissions because data collection systems in most Australian mental health services do not include a reliable and consistent method to distinguish a planned from an unplanned admission to hospital. ^b For 2012-13, the ACT has refined its calculation methodology and comparisons to earlier years' results should be made with caution.

Source: AIHW (unpublished), from data provided by State and Territory governments' health authorities; table 12A.56.

Efficiency — Sustainability

The Steering Committee has identified sustainability as an area for reporting but no indicators have yet been identified.

Efficiency — cost of inpatient care

'Cost of inpatient care' is an indicator of governments' objective that specialised public mental health services are delivered in an efficient manner (box 12.17).

Box 12.17 Cost of inpatient care

'Cost of inpatient care' is defined by two measures:

- 'Cost per inpatient bed day' is defined as the cost of providing inpatient services per inpatient bed day — data are disaggregated by hospital and care type (psychiatric hospitals [acute units and non-acute units] and general hospitals [acute and non-acute units]) and by inpatient target population (acute units only).
- 'Average length of stay' is defined as the number of inpatient patient days divided by the number of separations in the reference period — data are disaggregated by inpatient target population (acute units only). Patient days for clients who separated in the reference period (2012-13) that were during the previous period (2011-12) are excluded. Patient days for clients who remain in hospital (that is, are not included in the separations data) are included.

These measures are considered together for the inpatient acute units by target population to provide a 'proxy' measure to improve understanding of service efficiency. Average inpatient bed day costs can be reduced with longer lengths of stay because the costs of admission, discharge and more intensive treatment early in a stay are spread over more days of care.

A low or decreasing cost per inpatient bed day combined with similar or shorter average lengths of stay can indicate more efficient service delivery, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

This indicator does not account for differences in the client mix. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. More suitable measures for mental health services would be cost per casemix adjusted separation, for which cost is adjusted to take into account the type and complexity of cases, and the relative stay index (that also adjusts for casemix) similar to those presented for public hospitals (chapter 11). Data for these measures are not yet available, as casemix funding has not been applied to specialised mental health services.

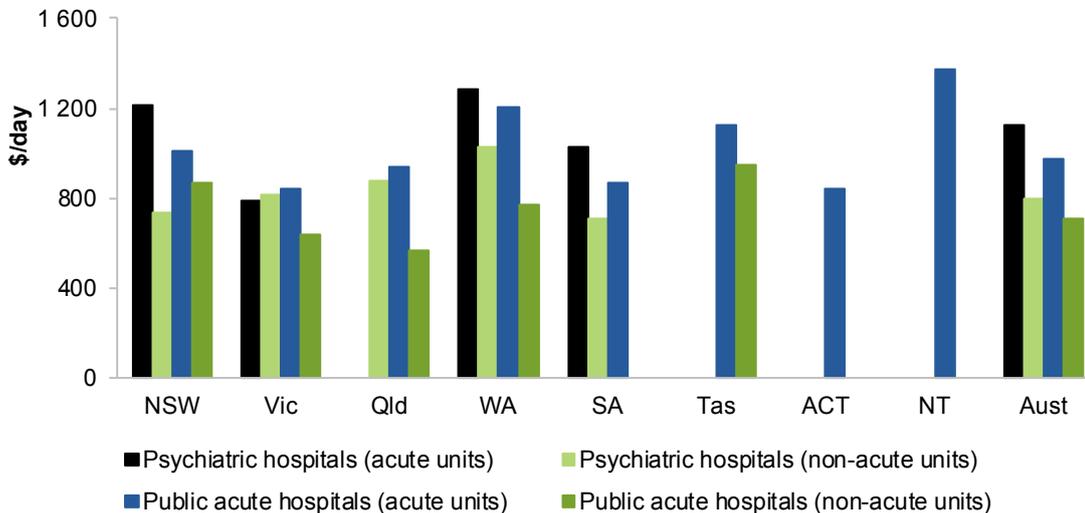
Data reported for the two measures for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2012-13 data are available for all jurisdictions providing the services.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Data on average recurrent cost per inpatient bed day by hospital (psychiatric and public acute) and care type (acute or non-acute) are reported in figure 12.23. Costs per inpatient bed day and average length of stay data for acute units by inpatient target population (for psychiatric and public acute hospitals combined) are presented in figure 12.24. Data for forensic services are included for costs per inpatient bed day only as the length of stay is dependent on factors outside the control of the specialised public mental health services. Data for cost per inpatient bed day for all units by target population are included in table 12A.58.

Figure 12.23 **Average recurrent cost per inpatient bed day, public hospitals, by hospital and care type, 2012-13^{a, b, c, d, e, f, g}**

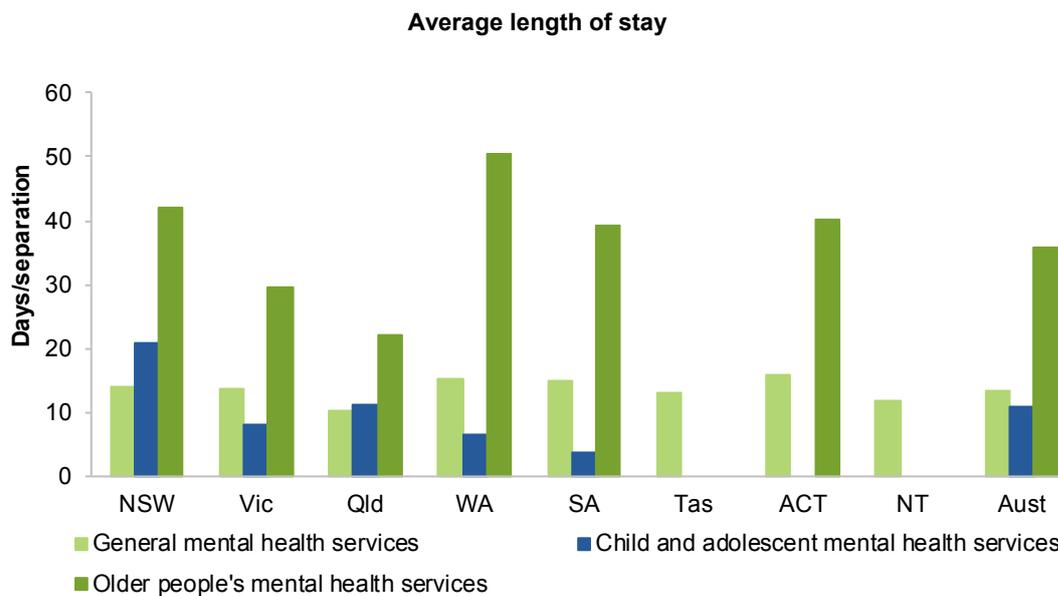
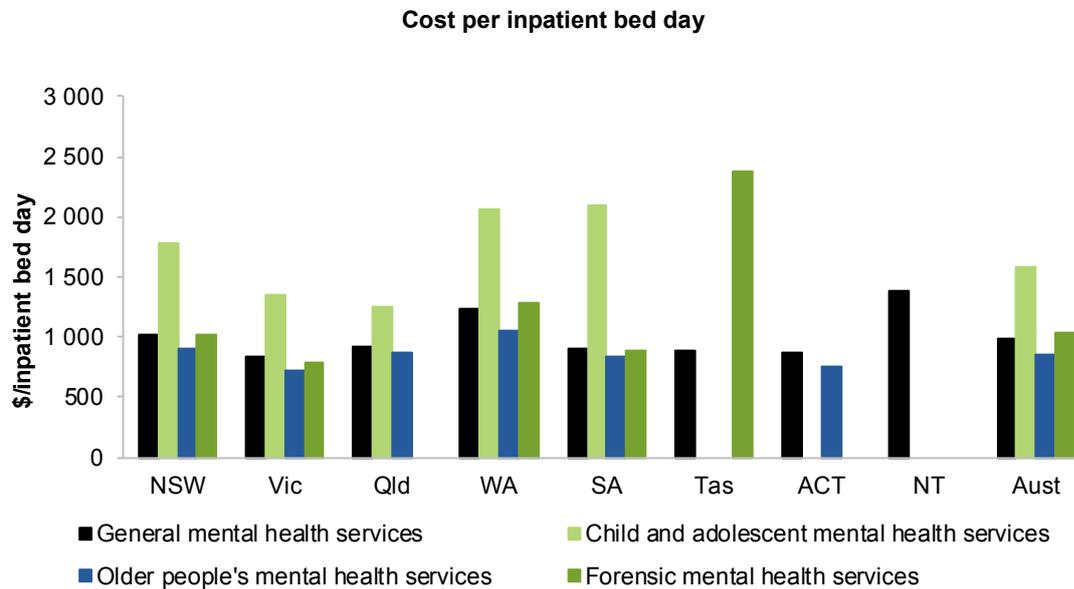


^a Depreciation is excluded. ^b Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). ^c Mainstreaming has occurred at different rates across jurisdictions. Victorian data for psychiatric hospitals comprise mainly forensic services, because nearly all general psychiatric treatment occurs in mainstreamed units in general acute hospitals. This means the client profile and service costs are very different from those of a jurisdiction in which general psychiatric treatment still occurs mostly in psychiatric hospitals. ^d Hospital inpatient expenditure can include expenditure on government funded public hospital services managed and operated by private and non-government entities. ^e Queensland data for public acute hospitals include costs associated with extended treatment services (campus-based and non-campus-based) that report through general acute hospitals. Queensland does not provide acute services in psychiatric hospitals. ^f Tasmania, the ACT and the NT do not have psychiatric hospitals. ^g SA, the ACT and the NT do not have non-acute units in general/public acute hospitals.

Source: AIHW (unpublished) MHE NMDS; table 12A.61.

Data on ‘average length of stay’ should be considered with caution. The quality of the separations data used to derive them is variable across jurisdictions. Until recently, these separations data were not subject to in depth scrutiny. It is expected that the quality of these data will improve over time. In addition, the ‘average length of stay’ data reported here may not match data reported elsewhere (such as the Australian Institute of Health and Welfare’s [AIHW’s] Mental Health Services in Australia publication) due to differences in scope, for example these data include separations and days within the reference period only.

Figure 12.24 **Costs for inpatient care in acute units of public hospitals, by target population, 2012-13^{a, b, c, d, e, f, g}**



^a Depreciation is excluded. ^b Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). ^c Hospital inpatient expenditure can include expenditure on government funded public hospital services managed and operated by private and non-government entities. ^d Queensland provides older people's mental health inpatient services using a number of different service models; however, the majority of older people's acute care is reported through general adult units, which limits comparability with jurisdictions that report these services differently. Additionally, Queensland does not report any acute forensic services; however, forensic patients can and do access acute care through general units, which may also impact on the comparability of both cost and length of stay data. ^e Tasmania does not provide, or cannot separately identify, child and adolescent mental health services or older people's mental health services. ^f The ACT does not have separate forensic or child and adolescent mental health inpatient services. ^g The NT has general mental health services only.

Source: AIHW (unpublished) MHE NMDS; tables 12A.59-60.

Efficiency — cost of community-based residential care

‘Cost of community-based residential care’ is an indicator of governments’ objective that mental health services be delivered in an efficient manner (box 12.18).

Box 12.18 Cost of community-based residential care

‘Cost of community-based residential care’ is defined as the average cost per day for specialised public mental health services of providing community-based residential care.

A low or decreasing average cost can indicate efficiency, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

The indicator does not account for differences in the client mix. The client mix in community-based services can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of more complex patients in community-based residential settings.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2012-13 data are available for all jurisdictions providing the services.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

These data are likely to be affected by institutional changes occurring as a result of the NMHS (for example, a shift to the delivery of services in mainstream settings). Differences across jurisdictions in the types of patient admitted to community-based residential care affect average costs in these facilities. Average recurrent costs to government per patient day for these services are reported for both the care of adults and the care of older people. The distinction is made to reflect the differing unit costs of treating the two groups.

The average recurrent cost per patient day for community-based residential care services is presented in table 12.1. For general adult units in 2012-13, the average cost per patient day for 24 hour staffed community-based residential care was an estimated \$469 nationally. For non-24 hour staffed community-based residential units, the average cost per patient day was \$165 nationally. For State or Territory governments that had community-based older people’s residential care units in 2012-13, the average recurrent cost per patient day for 24 hour staffed services was \$382 nationally (table 12.1).

Table 12.1 Average recurrent cost per inpatient day for community-based residential services, by target population and staffing provided, 2012-13^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld^c</i>	<i>WA^d</i>	<i>SA^d</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^{d, e}</i>	<i>Aust</i>
General adult units									
24 hour staffed	184	515	..	408	456	641	672	353	469
Non-24 hour staffed	108	156	..	161	228	248	120	..	165
Older people's care units									
24 hour staffed	237	367	..	..	..	829	257	..	382

^a Depreciation is excluded. ^b Costs are not adjusted for differences in the complexity of cases across states and territories and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). ^c Queensland does not report any in-scope government operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non-campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non-acute admitted patient services. ^d WA, SA and the NT do not have any older people's care units. ^e The NT does not have any non-24 hour general adult units. .. Not applicable.

Source: AIHW (unpublished) MHE NMDS; table 12A.62.

Efficiency — cost of ambulatory care

'Cost of ambulatory care' is an indicator of governments' objective that mental health services be delivered in an efficient manner (box 12.19).

Box 12.19 Cost of ambulatory care

Cost of ambulatory care' is defined by two measures:

- average cost per treatment day of ambulatory care provided by community-based specialised public mental health services
- average number of community treatment days per episode of ambulatory care provided by community-based specialised public mental health services. This measure is provided along with average costs as frequency of servicing is the main driver of variation in care costs. It is equivalent to the 'length of stay' efficiency measure for public hospitals.

An episode of ambulatory care is a three month period of ambulatory care for an individual registered consumer where the consumer was under 'active care' (one or more treatment days in the period). Community-based periods relate to the following four fixed three monthly periods: January to March, April to June, July to September, and October to December. Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode.

Low or decreasing average cost or fewer community treatment days can indicate greater efficiency although, efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

(Continued next page)

Box 12.19 (continued)

The measures do not account for differences in the consumer mix. The consumer mix in community-based services can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of consumers with more complex conditions in community-based ambulatory settings.

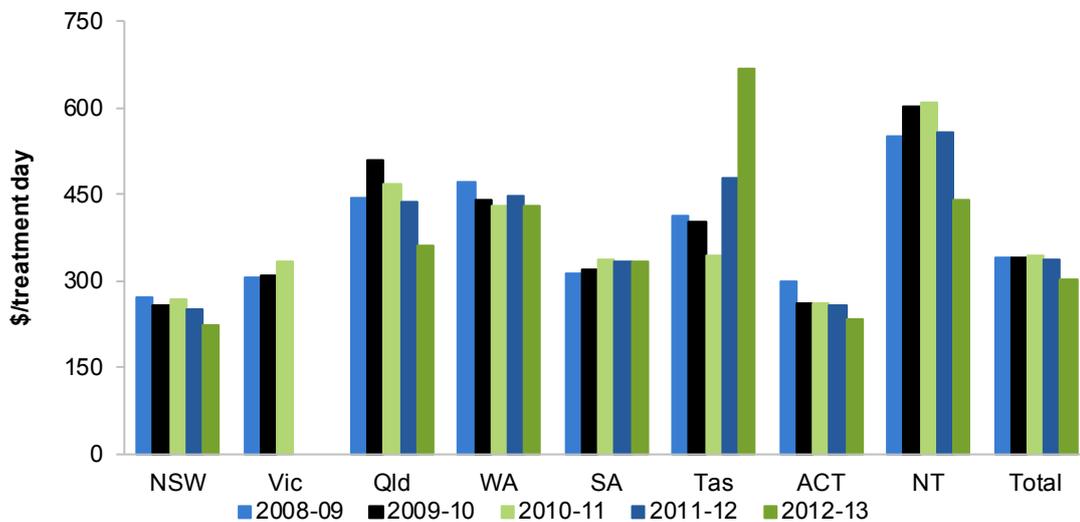
Data reported for the two measures are:

- comparable (subject to caveats) within most jurisdictions over time, but are not comparable across jurisdictions or for Tasmania over time
- incomplete for the current reporting period. All required data for 2012-13 are not available for Victoria.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Average recurrent cost per treatment day of ambulatory care data are shown in figure 12.25 and average treatment days per episode of ambulatory care data are shown in figure 12.26.

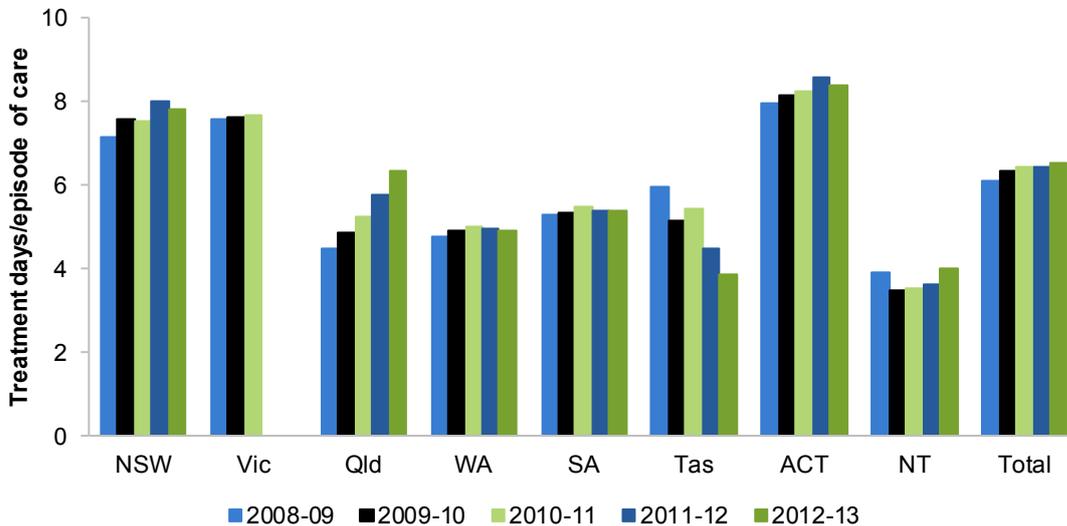
Figure 12.25 Average recurrent cost per treatment day of ambulatory care (2012-13 dollars)^{a, b, c, d, e, f}



^a Real expenditure (2012-13 dollars), using State and Territory implicit price deflators for general government final consumption on hospital and nursing home services (table 12A.96). ^b Recurrent expenditure data used to derive this measure have been adjusted (that is, reduced) to account for the proportion of clients in the community mental health care (CMHC) NMDS that were defined as 'non-uniquely identifiable consumers'. Therefore, it does not match recurrent expenditure on ambulatory care reported elsewhere. ^c 'Non-uniquely identifiable consumers' have been excluded from the episodes of ambulatory care. ^d The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. ^e Victorian 2011-12 and 2012-13 data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. ^f Industrial action in Tasmania has limited the available data quality and quantity of community data for 2011-12 and 2012-13.

Source: AIHW (unpublished) CMHC NMDS; AIHW (unpublished) MHE NMDS; table 12A.63.

Figure 12.26 **Average treatment days per episode of ambulatory care**^{a, b, c, d}



^a 'Non-uniquely identifiable consumers' have been excluded from the episodes of ambulatory care and treatment days data. ^b The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. ^c Data are not available for Victoria for 2011-12 and 2012-13 due to an industrial dispute leading to reduced collection rates. The total only includes those jurisdictions that have provided data. ^d Industrial action in Tasmania has limited the available data quality and quantity of community data for 2011-12 and 2012-13.

Source: AIHW (unpublished) CMHC NMDS; AIHW (unpublished) MHE NMDS; table 12A.63.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the services delivered) (see chapter 1, section 1.5).

The output indicators reported above focus on specialised public mental health services provided by State and Territory governments (although the indicators 'new client index', 'mental health service use by selected community groups', 'mental health service use by total population' and 'primary mental health care for children and young people' include measures of access to MBS subsidised services). The outcome indicators identified and/or reported here reflect the performance of governments (including the mental health sector) against the broad objectives of the NMHS.

The whole of government approach within the *Fourth National Mental Health Plan 2009–2014* acknowledges that many of the determinants of good mental health, and of mental illness, are influenced by factors beyond the health system. The fourth plan identifies that the mental health sector must form partnerships with other sectors in order to develop successful interventions (AHMC 2009).

Rates of licit and illicit drug use

‘Rates of licit and illicit drug use’ is an indicator of governments’ objective under the NMHS to prevent the development of mental health problems and mental illness where possible, by reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery (box 12.20). High rates of substance use and abuse in young people can contribute to the onset of, and poor recovery from, mental illness (NMHPSC 2011a).

Box 12.20 Rates of licit and illicit drug use

‘Rates of licit and illicit drug use’ is defined as the proportion of people aged 14 years or over who use specific licit and illicit drugs in the preceding 12 months. The specific drugs include: alcohol, cannabis, ecstasy, cocaine, meth/amphetamine, hallucinogens, Gamma hydroxybutyrate (GHB), inhalants, and heroin.

A low or decreasing proportion of people aged 14 years or over using specific licit and illicit drugs is desirable. It suggests a reduction in the risk factors that contribute to the onset of mental illness and prevent longer term recovery.

Many of the risk and protective factors that impact on a person’s propensity to use licit or illicit drugs lie outside the ambit of the mental health system. These include environmental, sociocultural and economic factors — for example, adverse childhood experiences (such as sexual abuse) and exposure to domestic violence can increase the risk of substance abuse. A reduction in the prevalence of drug use, therefore, will be a result of a coordinated response across a range of collaborating agencies including education, justice and community services.

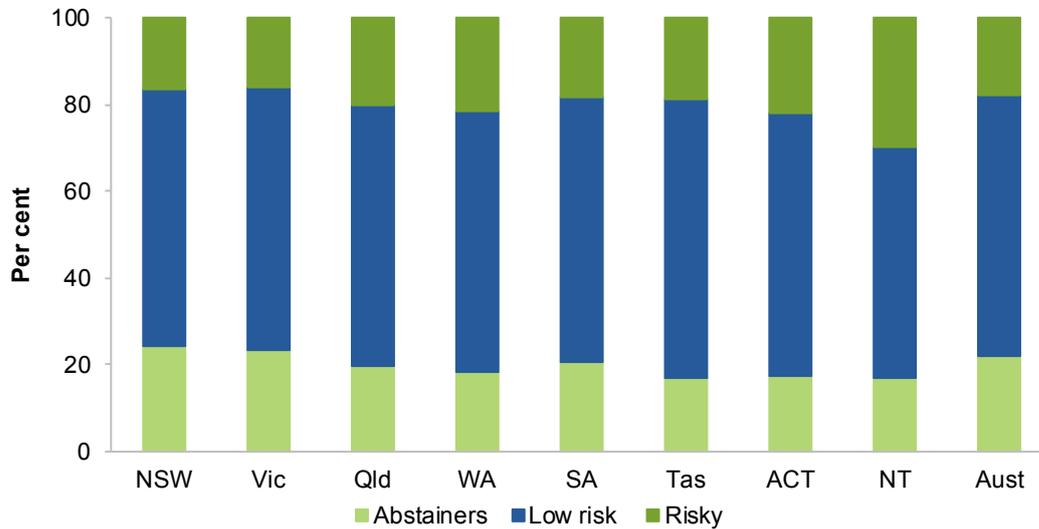
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions, but data for 2013 and 2010 are not comparable to data for 2007
- complete for the current reporting period (subject to caveats). All required 2013 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Alcohol is the substance most commonly used and abused, and is a major cause of death, injury and illness in Australia (AHMC 2012). In 2013, 18.2 per cent of people aged 14 years or over drank alcohol at levels considered ‘risky’ for developing long-term health problems (figure 12.27). Further data from the 2013, 2010 and/or 2007 National Drug Strategy Household Surveys on alcohol use and lifetime and single occasion risk status are in tables 12A.65, 12A.68-69 and 12A.70-71.

Figure 12.27 Use of alcohol in last 12 months, by people aged 14 years or over, lifetime risk status, 2013^{a, b, c}

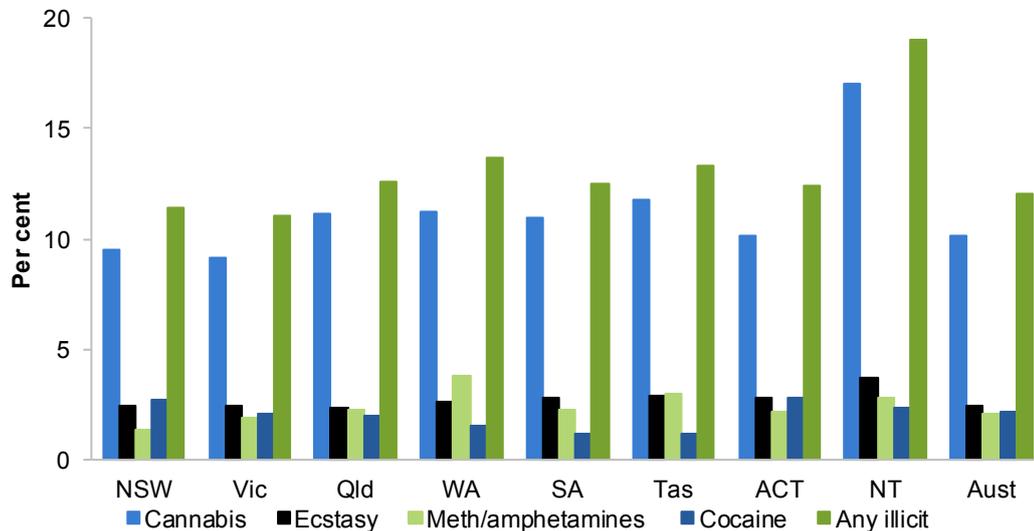


^a Abstainers — people who did not consume alcohol in the previous 12 months. ^b Low risk — people who on average, had no more than two standard drinks per day. ^c Risky — people who on average, had more than two standard drinks per day.

Source: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra; table 12A.64.

Cannabis, ecstasy, cocaine and meth/amphetamines are the most widely used illicit drugs in Australia (figure 12.28). Data across the 2007, 2010 and 2013 surveys show that people using illicit drugs had higher levels of psychological distress and a higher proportion of people with a mental illness used illicit drugs than those without a mental illness (table 12A.73). National data on the use of these illicit drugs from 1995 to 2013 by age group are in table 12A.72. Data for 2007, 2010 and 2013 on illicit drug use by social characteristics are in table 12A.74.

Figure 12.28 Use of selected illicit drugs in last 12 months, by people aged 14 years or over, 2013^a

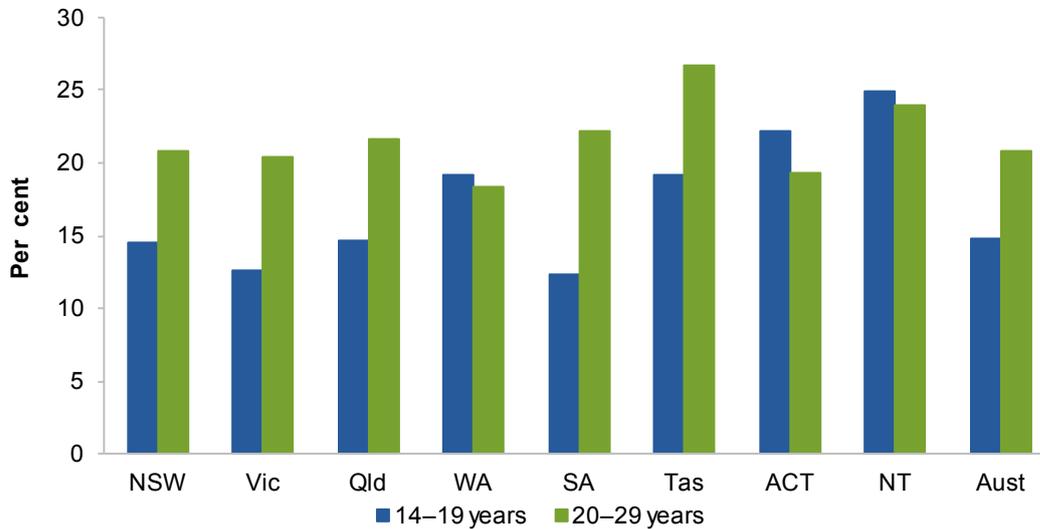


^a The following estimates have a Relative Standard Error (RSE) of between 25 per cent and 50 per cent and should be considered with caution: use of cocaine in SA, use of ecstasy and meth/amphetamine in Tasmania and the use of meth/amphetamine and cocaine in the NT. The use of cocaine in Tasmania is subject to a RSE greater than 50 per cent and is considered too unreliable for general use.

Source: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra; table 12A.66.

Younger people's usage of cannabis and meth/amphetamines is of particular concern for their associated mental health problems (AHMC 2012). Cannabis use can precipitate schizophrenia in people who have a family history, increase the risk of psychosis symptoms and also exacerbate the schizophrenia symptoms (AHMC 2012). Psychosis symptoms are also associated with meth/amphetamine use and dependent meth/amphetamine users can also suffer from a range of co-morbid mental health problems (AHMC 2012). Figure 12.29 shows the rates of use of cannabis by young people. National data on the use of meth/amphetamine by age group are in table 12A.72.

Figure 12.29 **Recent use of cannabis, in last 12 months, by young people, 2013**



^a The estimates for SA, Tasmania and the ACT for people aged 14-19 years have RSEs of between 25 per cent and 50 per cent and should be considered with caution.

Source: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra; table 12A.67.

Prevalence of mental illness

‘Prevalence of mental illness’ is an indicator of governments’ objective under the NMHS to prevent the development of mental health problems and mental illness where possible (box 12.21).

Box 12.21 Prevalence of mental illness

'Prevalence of mental illness' is defined as the proportion of the total population who have a mental illness. Proportions are reported for all people, for males and females and for people of different ages, by disorder type.

A low or decreasing prevalence of mental illness can indicate that measures to prevent mental illness have been effective.

A reduction in the prevalence of mental illness can be brought about by preventative activities to stop an illness occurring, or by increasing access to effective treatments for those who have an illness (AHMC 2012). Many of the risk and protective factors that can affect the development of mental health problems and mental illness are outside the scope of the mental health system, in sectors that affect the daily lives of individuals and communities. These include environmental, sociocultural and economic factors — for example, adverse childhood experiences (such as sexual abuse) and exposure to domestic violence can increase the risk of mental illness, whereas employment is recognised as important in supporting good mental health. A reduction in the prevalence of mental illness, therefore, will be a result of a coordinated response across a range of collaborating agencies including education, justice and community services. Not all mental illnesses are preventable and a reduction in the effect of symptoms and an improved quality of life will be a positive outcome for many people with a mental illness.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions
- complete for the current reporting period (subject to caveats). All required 2007 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Prevalence of mental illness data are from the 2007 SMHWB, the latest prevalence estimates available. The 2007 SMHWB was designed to provide reliable estimates at the national level, not at the State and Territory level; however, jurisdictional data are available in table 12A.75. National data on the prevalence of mental illness by disorder, age, sex and social characteristics are reported in tables 12A.76-78.

The SMHWB provided prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders, affective disorders and substance use disorders, but did not measure the prevalence of some severe mental disorders, such as schizophrenia and bipolar disorder. The *National Survey of Psychotic Illness 2010* provides information on the one month treated prevalence of these and other psychotic illnesses. In 2010, there were an estimated 3.1 cases of psychotic illness per 1000 adult population (aged 18–64 years), for which there was a contact with public specialised mental health services. Males had a higher treated prevalence rate than females (3.7 cases compared to 2.4 cases per 1000 adult population). Males aged 25–34 years had the highest rate at 5.2 cases per 1000 population (Morgan et al. 2011).

Mortality due to suicide

‘Mortality due to suicide’ is an indicator of governments’ objective under the NMHS to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk (box 12.22).

Box 12.22 Mortality due to suicide

‘Mortality due to suicide’ is defined as the suicide rate per 100 000 people. The suicide rate is reported for all people, for males and females, for people of different ages (including those aged 15–24 years), people living in capital cities, people living in other urban areas, people living in rural areas, Aboriginal and Torres Strait Islander and non-Indigenous Australians.

A low or decreasing suicide rate per 100 000 people is desirable.

While mental health services contribute to reducing suicides, other government services also have a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by severe mental illness, some of whom have either attempted, or indicated an intention, to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of other government agencies, NGOs and other special interest groups. Any effect on suicide rates, therefore, will be a result of a coordinated response across a range of collaborating agencies, including education, housing, justice and community services.

Many factors outside the control of mental health services can influence a person’s decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with an increased risk of suicidal behaviour. Other factors that can influence suicide rates include economic growth rates, which affect unemployment rates and social disadvantage. Often a combination of these factors can increase the risk of suicidal behaviour.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data are not comparable across time periods for some disaggregations (see the attachment tables 12A.81–83 for details)
- complete for the current reporting period (subject to caveats). All required 2012 or 2008–2012 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

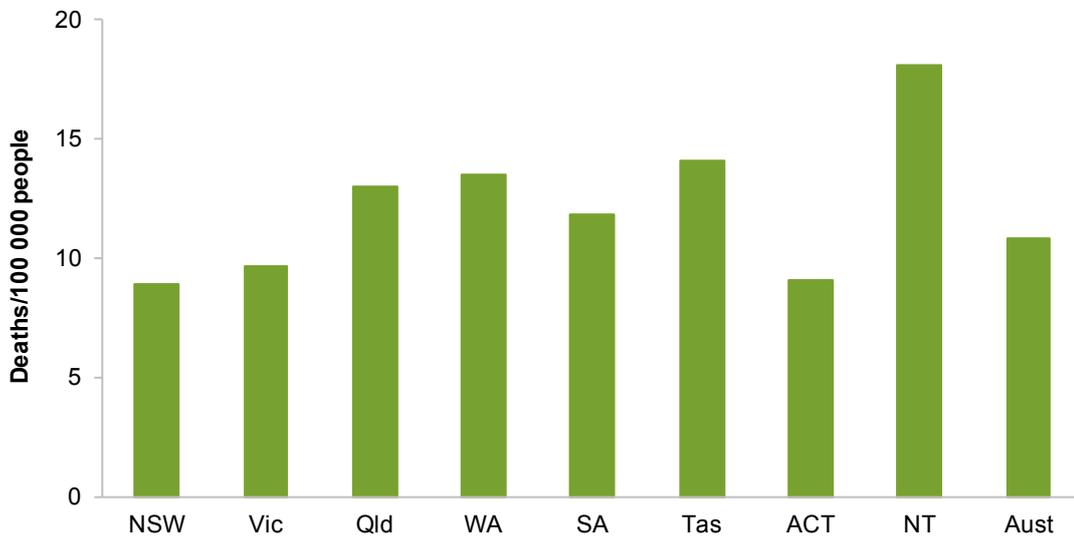
People with a mental illness are at a higher risk of suicide than are the general population. They are also at a higher risk of death from other causes, such as cardiovascular disease (Coghlan et al. 2001; Joukamaa et al. 2001; Sartorius 2007; Lawrence, Hancock and Kisely 2013).

All Coroner certified deaths registered after 1 January 2006 are subject to a revisions process. The revisions process enables the use of additional information relating to Coroner certified deaths either 12 or 24 months after initial processing. This increases the specificity of the assigned International Classification of Diseases (ICD) 10 codes over

time (ABS 2010). Each year of data is now released as preliminary, revised and final. For further information on this revisions process see the DQI for this indicator.

In the period 2008–2012, 12 073 deaths by suicide were recorded in Australia (table 12A.81) — equivalent to 10.8 deaths per 100 000 people (figure 12.30). The rate for males (16.8 per 100 000 males) was over three times that for females (5.1 per 100 000 females) in the period 2008–2012 — a ratio that was relatively constant over all age groups, except for those aged 85 years or over where the male suicide rate was around six times the female rate (figure 12.31). Table 12A.82 shows suicide death rates per 100 000 people aged 15–24 years for all jurisdictions.

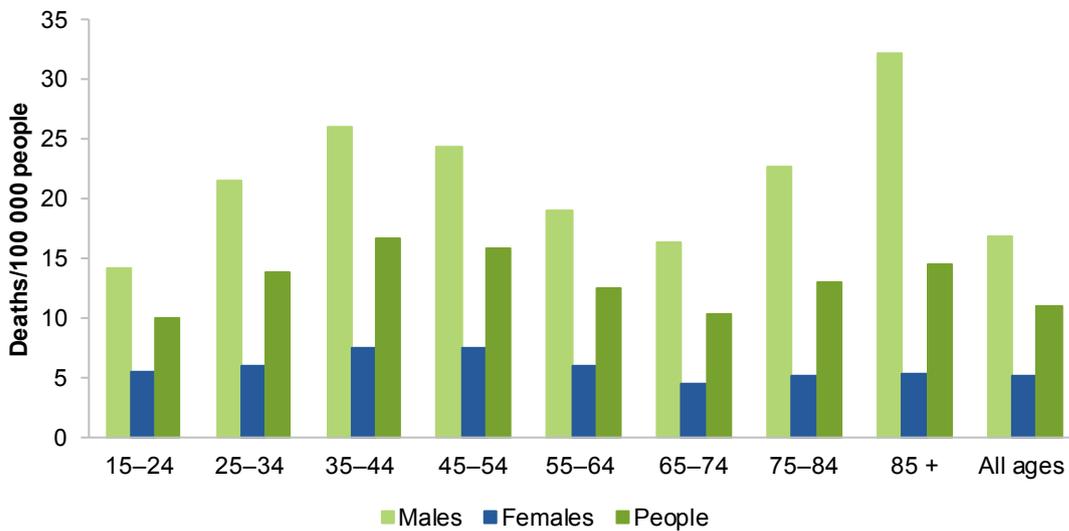
Figure 12.30 **Suicide rates, 5 year average, 2008–2012**^{a, b, c}



^a Suicide deaths include International Classification of Diseases (ICD) 10 codes X60-X84 and Y87.0. ^b The death rate is age standardised to the midyear 2001 population. ^c Causes of death data for 2008–2010 have undergone revision/s and are now considered final. Causes of death data for 2011 have been revised and are subject to further revisions. Causes of death data for 2012 are preliminary and subject to a revisions process.

Source: ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.81.

Figure 12.31 Suicide rates, by age and sex, 2008–2012^{a, b, c}

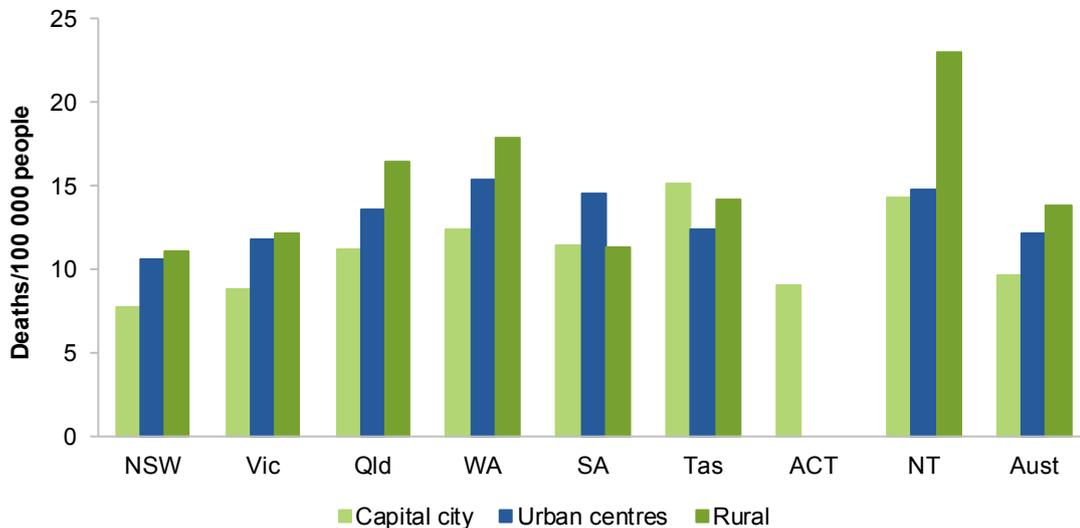


^a Suicide deaths include ICD 10 codes X60–X84 and Y87.0. ^b Age-specific death rates are calculated as the number of suicides for an age group per 100 000 population in the same age group, for the period 2008–2012. ^c Causes of death data for 2008–2010 have undergone revisions and are now considered final. Causes of death data for 2011 have been revised and are subject to further revisions. Causes of death data for 2012 are preliminary and subject to a revisions process.

Source: ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.80.

Nationally the suicide rate in the period 2008–2012 was higher in rural areas. There were 9.7 suicides per 100 000 people in capital cities and 12.2 suicides per 100 000 people in urban centres, compared with 13.8 suicides per 100 000 people in rural areas in Australia (figure 12.32). Tables 12A.79 and 12A.81–83 contain time series suicide data.

Figure 12.32 Suicide rates, by area, 2008–2012^{a, b, c, d, e}



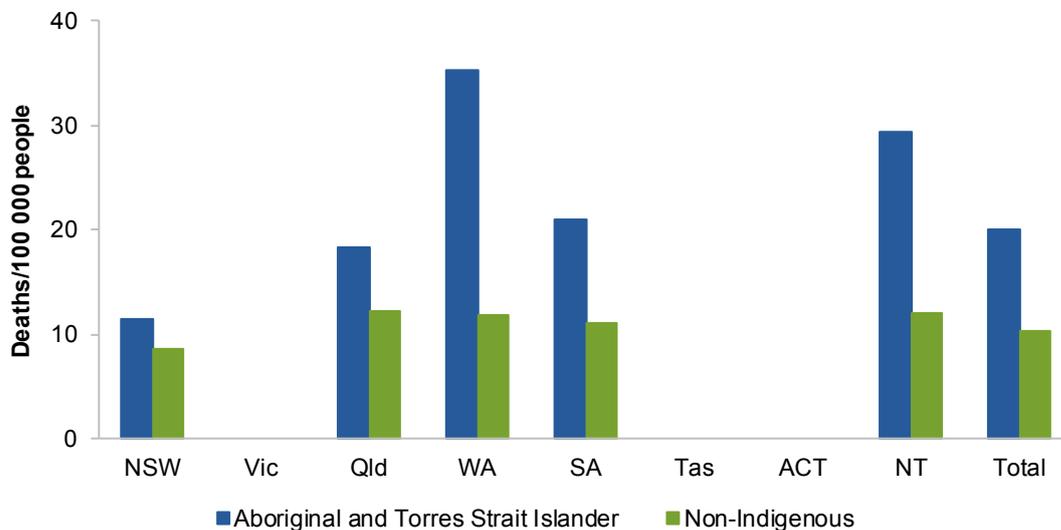
^a The capital city, urban centres and rural groupings are based on the ABS' Significant Urban Areas classification (Cat. no. 1270.0.55.004). Capital cities comprise Statistical Area 2s classified as capital cities. Urban centres comprise all Statistical Area 2s within a state which are classified as having or contributing to an urban area with a population of 10 000 or greater, excluding capital cities. Rural areas are those Statistical Area 2s which are not within a capital city or urban centre. ^b The suicide rate is directly age standardised to the midyear 2001 population. ^c Suicides are reported by year of registration of death. ^d Causes of death data for 2008–2010 have undergone revisions and are now considered final. Causes of death data for 2011 have been revised and are subject to further revisions. Causes of death data for 2012 are preliminary and subject to a revisions process. ^e The ACT does not have any 'urban centres'. Data for ACT 'rural' areas are not published.

Source: ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.83.

Aboriginal and Torres Strait Islander suicide rates are presented for NSW, Queensland, WA, SA and the NT (figure 12.33). After adjusting for differences in the age structure of the two populations, the suicide rate for Aboriginal and Torres Strait Islander Australians during the period 2008–2012, for the reported jurisdictions, was higher than the corresponding rate for non-Indigenous Australians.

Care needs to be taken when interpreting these data because data for Aboriginal and Torres Strait Islander Australians are incomplete and data for some jurisdictions are not published. Aboriginal and Torres Strait Islander Australians are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The rate calculations have not been adjusted for differences in the completeness of identification of Aboriginal and Torres Strait Islander deaths across jurisdictions.

Figure 12.33 **Suicide rates, by Indigenous status, 2008–2012**^{a, b, c, d, e, f}



^a Deaths from suicides are deaths with ICD 10 codes X60–X84 and Y87.0. ^b Suicide rates are age standardised. ^c Data on deaths of Aboriginal and Torres Strait Islander Australians are affected by differing levels of coverage of deaths of Aboriginal and Torres Strait Islander people across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between Aboriginal and Torres Strait Islander and non-Indigenous data. ^d Deaths with a ‘not stated’ Indigenous status are excluded. ^e Causes of death data for 2008–2010 have undergone revisions and are now considered final. Causes of death data for 2011 have been revised and are subject to further revisions. Causes of death data for 2012 are preliminary and subject to a revisions process. ^f Total data are for NSW, Queensland, WA, SA, and the NT combined, based on the state or territory of usual residence. Data has been included for these five states and territories only as there is evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.

Source: ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.84.

Physical health outcomes for people with a mental illness

‘Physical health outcomes for people with a mental illness’ is an indicator of governments’ objective to promote the recovery of people with a mental illness and to provide high quality services that are appropriate to the conditions and circumstances of people with a mental illness (box 12.23).

Box 12.23 **Physical health outcomes for people with a mental illness**

'Physical health outcomes for people with a mental illness' is defined by two measures:

- Proportion of people with a mental illness (compared with the proportion of people without a mental illness) who are exposed to particular health risk factors:
 - obese/overweight
 - daily smokers
 - at risk of long term harm from alcohol.
- Proportion of people with a mental illness (compared with the proportion of people without a mental illness) who experienced a long-term physical health condition (cancer, diabetes, arthritis, cardiovascular disease and asthma).

Low or decreasing proportions of people with a mental illness who are subject to particular health risk factors and who experience a long-term physical health condition are desirable.

The relationship between a person's physical and mental health is complex. Poor physical health can exacerbate mental health problems and poor mental health can lead to poor physical health. In addition, some psychiatric medications that are prescribed to treat mental health conditions are known to lead to worse physical health outcomes. A person's decision to take medications to improve mental health, is often made with the knowledge that their physical health will suffer (NMHC 2012).

Data reported for this indicator are:

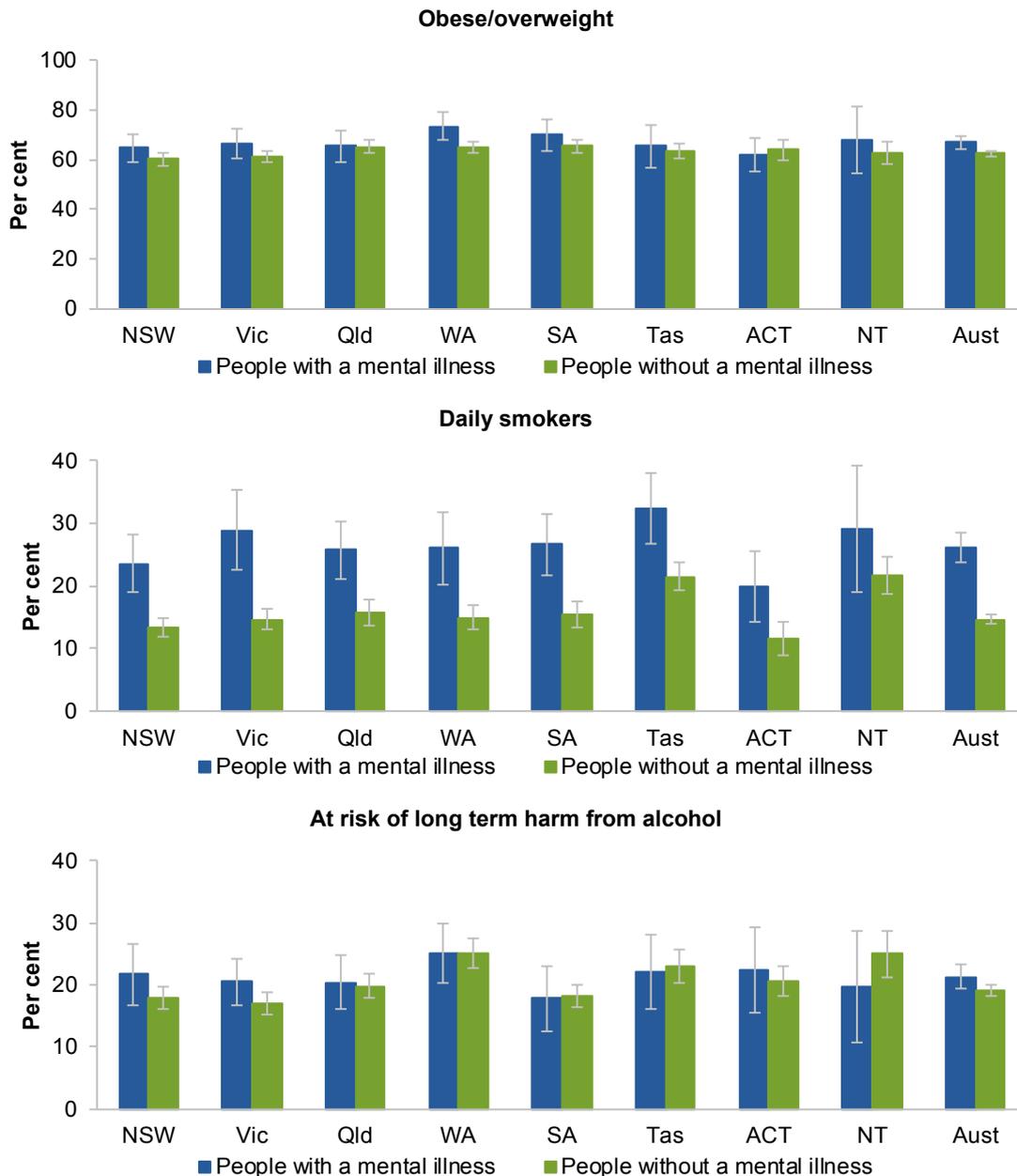
- comparable (subject to caveats) across jurisdictions (no time series data are reported)
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is under development.

Greater exposure to particular health risk factors can contribute to poorer physical health outcomes. People with a mental illness have higher daily smoking rates than people without a mental illness (26.1 ± 2.4 per cent, compared with 14.7 ± 0.8 per cent in 2011-12) (figure 12.34). However, the proportions of people who are obese/overweight or at risk of long term harm from alcohol are similar for those with and without a mental illness. Nationally, in 2011-12, the proportions of people with a mental illness who were:

- obese/overweight was 67.0 ± 2.5 per cent, compared with 62.4 ± 1.2 per cent for people without a mental illness
- at risk of long term harm from alcohol was 21.3 ± 2.0 per cent, compared to 19.0 ± 0.9 per cent for people without a mental illness (figure 12.34).

Figure 12.34 **Adults who are exposed to particular health risk factors, by mental illness status, 2011-12^{a, b}**



^a People with a mental illness are defined as those who self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions. ^b Estimates have been age standardised to the 2001 estimated resident population.

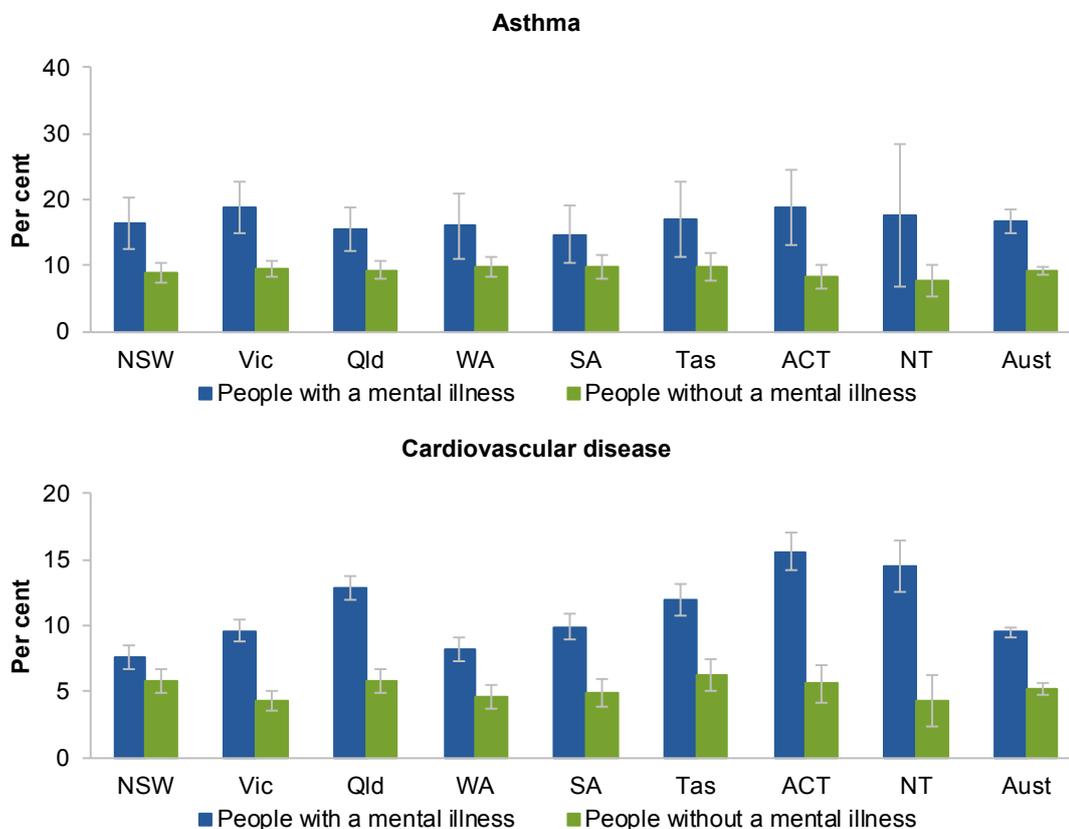
Source: ABS (unpublished) AHS 2011-13 (2011-12 NHS component), Cat. no. 4364.0; table 12A.85.

People with a mental illness are also more likely to have a long-term health condition. Nationally, in 2011-12, the proportion of people with a mental illness who had:

- asthma was 16.7 ± 1.8 per cent, compared to 9.2 ± 0.7 per cent for people without a mental illness
- cardiovascular disease was 9.5 ± 1.2 per cent, compared to 5.2 ± 0.4 per cent for people without a mental illness (figure 12.35).

Table 12A.86 also shows data for cancer, arthritis and diabetes.

Figure 12.35 **Adults with long-term health conditions, by mental illness status, 2011-12^{a, b}**



^a People with a mental illness are defined as those who self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions. ^b Estimates have been age standardised to the 2001 estimated resident population.

Source: ABS (unpublished) AHS 2011-13 (2011-12 NHS component), Cat. no. 4364.0; table 12A.86.

Social and economic inclusion of people with a mental illness

‘Social and economic inclusion of people with a mental illness’ is an indicator of governments’ objective to improve mental health and facilitate recovery from illness

through encouraging meaningful participation in recreational, social, employment and other activities in the community (box 12.24).

Box 12.24 Social and economic inclusion of people with a mental illness

‘Social and economic inclusion of people with a mental illness’ is defined by two measures:

- proportion of people aged 16–64 years with a mental illness who are employed, compared with the equivalent proportion for people without a mental illness
- proportion of people aged 16–30 years with a mental illness who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (studying full or part time), compared with the equivalent proportion for people without a mental illness.

A high or increasing proportion of people with a mental illness aged 16–64 years who are employed is desirable. A high or increasing proportion of people aged 16–30 years with a mental illness who are employed and/or are enrolled for study is also desirable.

This indicator measures employment participation relative to the total population aged 16–64 years, as distinct from the labour force (that is, people who are employed or unemployed, but actively looking for work). Some people can choose not to participate in the labour force (that is, they are not working or actively looking for work). Data on the proportion of people aged 16–64 years who are unemployed or not in the labour force (by mental illness status) are in table 12A.87. It also does not provide information on whether for those employed or enrolled for study, their jobs/studies are appropriate or meaningful.

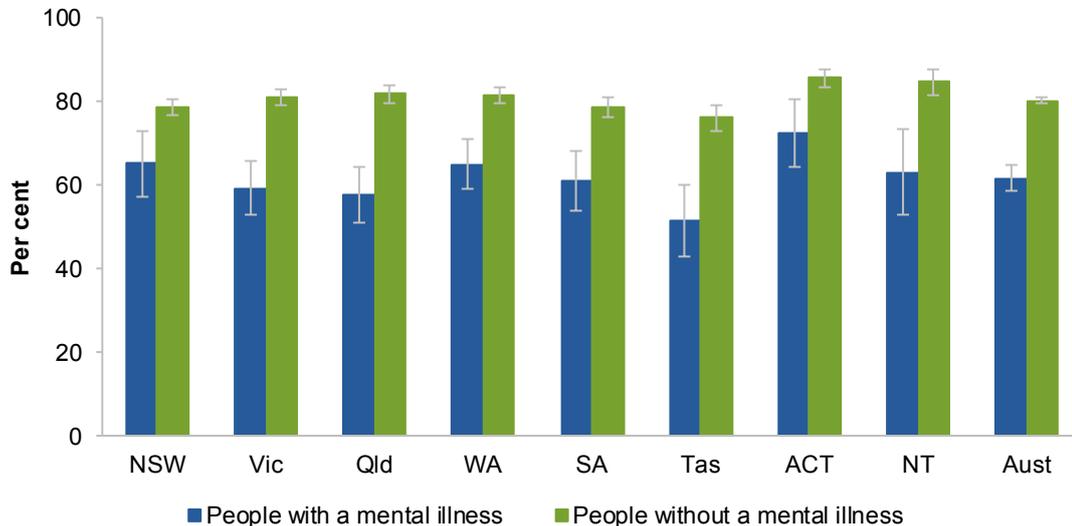
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and overtime depending on the source, that is 2011-12 NHS data are comparable to 2007-08 NHS data, but not to 2007 SMHWB data
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Mental illness can act as a barrier to gaining and maintaining employment (AHMC 2012). Nationally, in 2011-12, the proportion of all Australians with a mental illness who were employed was 61.7 ± 3.1 per cent, compared to 80.3 ± 0.9 per cent for those without a mental illness (figure 12.36).

Figure 12.36 **People aged 16–64 years who are employed, by mental illness status, 2011-12^{a, b}**



^a People with a mental illness are defined as those who self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions. ^b Estimates have been age standardised to the 2001 estimated resident population.

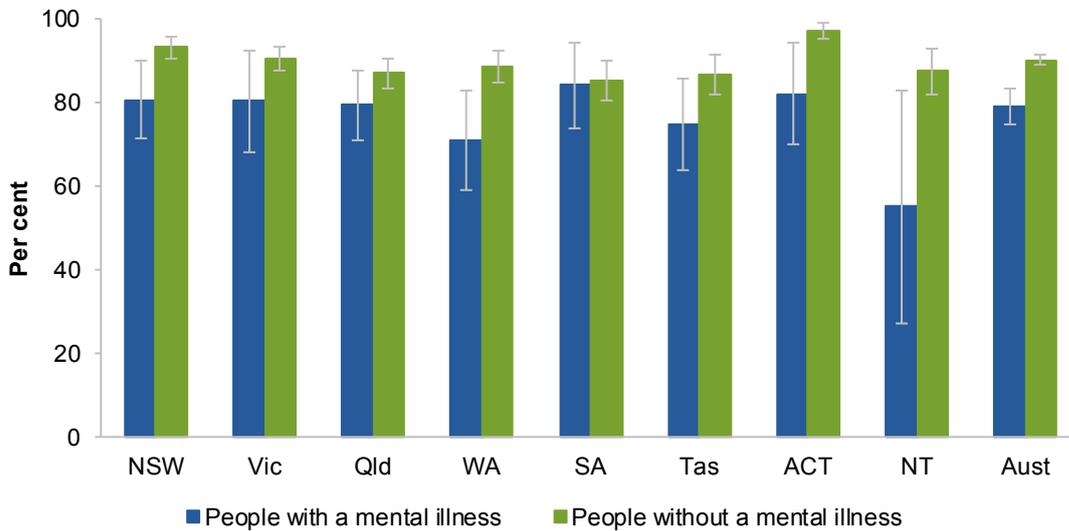
Source: ABS (unpublished) AHS 2011–13 (2011-12 NHS component), Cat. no. 4364.0; table 12A.87.

Data from the 2007-08 National Health Survey and the 2007 SMHWB on the labour force and employment participation of people who had a mental illness/disorder are in tables 12A.89, 12A.91 and 12A.93.

Mental illness in early adult years can lead to disrupted education and premature exit from school or tertiary training, or disruptions in the transition from school to work (AHMC 2012). The effect of these disruptions can be long term, restricting the person’s ability to participate in a range of social and vocational activities over their lifetime (AHMC 2012).

Nationally, in 2011-12, the proportion of people aged 16–30 years with a mental illness who were employed and/or are enrolled for study in a formal secondary or tertiary qualification was 79.2 ± 4.2 per cent, compared to 90.2 ± 1.2 per cent for those without a mental illness (figure 12.37). Data from the 2007-08 NHS and the 2007 SMHWB on the participation of people aged 16–30 years in the labour force and/or in education or training are in tables 12A.90 and 12A.92-93.

Figure 12.37 People aged 16–30 years who were employed and/or are enrolled for study in a formal secondary or tertiary qualification, by mental illness status, 2011-12^{a, b}



^a People with a mental illness are defined as those who self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions. ^b Estimates have been age standardised to the 2001 estimated resident population.

Source: ABS (unpublished) AHS 2011–13 (2011-12 NHS component), Cat. no. 4364.0; table 12A.88.

Mental health outcomes of consumers of specialised public mental health services

‘Mental health outcomes of consumers of specialised public mental health services’ is an indicator of governments’ objective to improve the effectiveness and quality of service delivery and outcomes and promote recovery from mental health problems and mental illness (box 12.25).

Box 12.25 Mental health outcomes of consumers of specialised public mental health services

'Mental health outcomes of consumers of specialised public mental health services' is defined as the proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes. Data are also reported on the proportion who experienced no significant change or a significant deterioration in their mental health outcomes. Data are reported by three consumer types: people in ongoing community-based care, people discharged from community-based care and people discharged from a hospital psychiatric inpatient unit.

Results are difficult to interpret as there are a range of mental health clinical outcomes for people treated in specialised public mental health services and 'best practice' outcomes are unknown (AHMC 2012). A high or increasing proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes is desirable.

The assessment of a consumer's clinical mental health outcomes is based on the changes reported in a consumer's 'score' on a rating scale known as the Health of the Nation Outcomes Scale (HoNOS), or for children and adolescents, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) (AHMC 2012). Outcome scores are classified based on effect size — a statistic used to assess the magnitude of a treatment effect (AHMC 2012). The effect size is based on the ratio of the difference between the pre- and post-scores to the standard deviation of the pre-score (AHMC 2012). Individual episodes are classified as 'significant improvement' if the effect size index is greater than or equal to positive 0.5; 'no change' if the index is between 0.5 and zero; and 'significant deterioration' if the effect size index is less than or equal to -0.5 (AHMC 2012).

This indicator has many technical and conceptual issues. The outcome measurement tool is imprecise. A single 'average score' does not reflect the complex service system in which services are delivered across multiple settings (inpatient, community and residential) and provided as both discrete, short term episodes of care and prolonged care over indefinite periods (AHMC 2012). The approach separates a consumer's care into segments (hospital versus the community) rather than tracking the person's overall outcomes across treatment settings. In addition, consumers' outcomes are measured from the clinician's perspective and not as the 'lived experience' from the consumer's viewpoint (AHMC 2012).

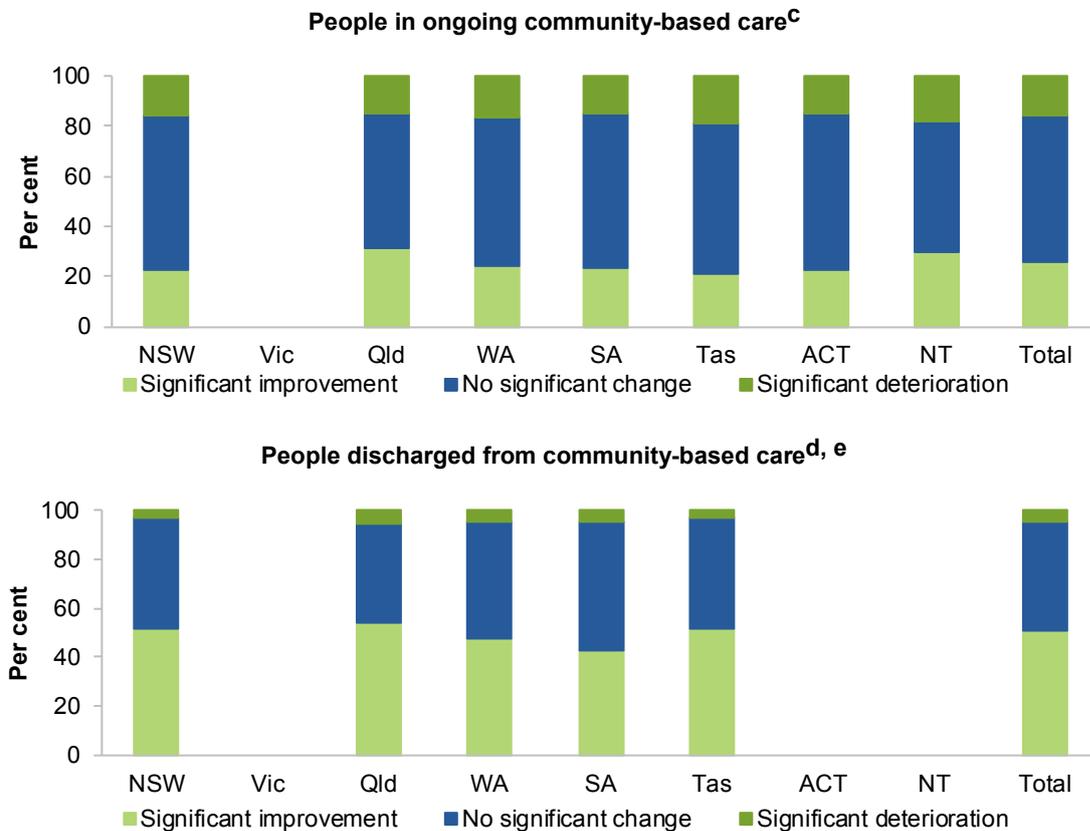
Data reported for this indicator are:

- not comparable across jurisdictions or over time due to differences in the quality of the data and the proportion of episodes for which completed outcomes data are available
- incomplete for the current reporting period. All required data for 2012-13 are not available for Victoria.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Nationally, in 2012-13, 26.1 per cent of people in ongoing community-based care, 50.8 per cent of people discharged from community-based care and 72.1 per cent of people discharged from a hospital psychiatric inpatient unit showed a significant improvement in their mental health clinical outcomes (figures 12.38-39). Caution is required in interpreting results across states and territories. Data are of variable quality and there are different levels of coverage across states and territories (AHMC 2012).

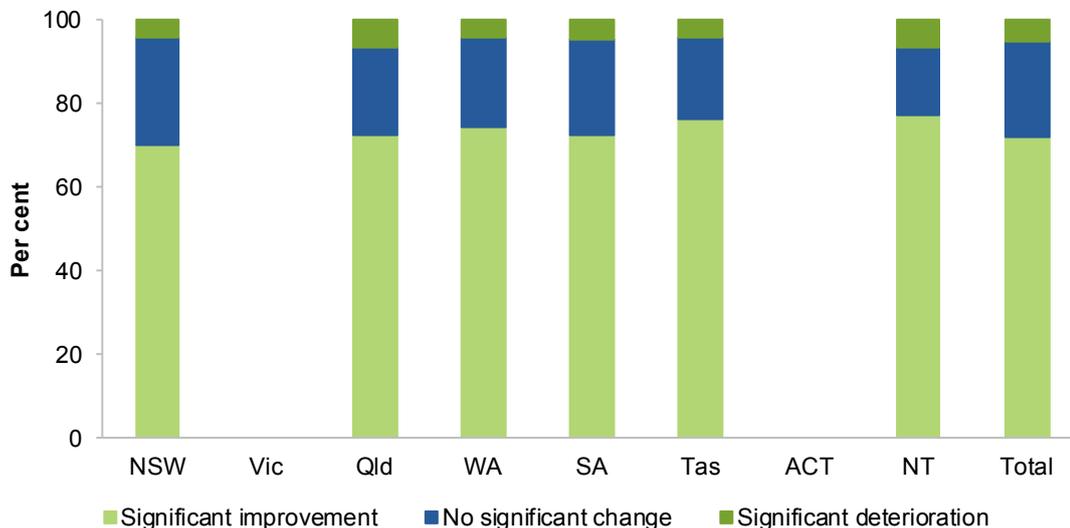
Figure 12.38 Mental health outcomes of consumers of State and Territory community-based specialised public mental health services, 2012-13^{a, b}



^a Victorian data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. ^b Industrial action in Tasmania has limited the available data quality and quantity of community data. ^c Data comprise people receiving relatively long term community-based care. Data include people who were receiving care for the whole of 2012-13, and those who commenced community-based care sometime after 1 July 2012 who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June 2013). Outcome scores were calculated as the difference between the total score recorded on the first occasion rated and the last occasion rated in the year. ^d Data comprise people who received relatively short term community-based care. The defining characteristic of the group is that the episode of community-based care commenced, and was completed, within 2012-13. Outcome scores were calculated as the difference between the total score recorded at admission to, and discharge, from community-based care. People whose episode of community-based care was completed because they were admitted to hospital are not included. ^e The ACT and NT data are not published due to insufficient observations.

Source: Australian Mental Health Outcomes and Classification Network (unpublished), Australian Government Department of Health; table 12A.94.

Figure 12.39 **Mental health outcomes of consumers discharged from State or Territory inpatient mental health services, 2012-13^{a, b, c}**



^a Data comprise people who received a discrete episode of inpatient care within a psychiatric unit. The defining characteristic of the group is that the episode of inpatient care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission and discharge. The analysis excludes episodes where the length of stay was three days or less because it is not meaningful to compare admission and discharge ratings for short duration episodes. ^b Victorian data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. ^c The ACT data are not published due to insufficient observations.

Source: Australian Mental Health Outcomes and Classification Network (unpublished), Australian Government Department of Health; table 12A.94.

12.5 Future directions in performance reporting

Priorities for future reporting on mental health management include the following:

- developing an estimate of the number of people who need mental health services so that access to services can be measured in terms of need
- improving reporting on government funded non-government entities to include information on their activity and the outcomes of the consumers of these services
- identifying indicators that relate to the performance framework dimension of sustainability
- improving reporting on outcomes to include indicators that relate to the participation of people with a mental illness in meaningful social and recreational activities
- further developing the measurement and reporting on the clinical mental health outcomes of consumers of specialised public mental health services.

12.6 Definitions of key terms

General terms

General practice

The organisational structure in which one or more GPs provide and supervise health care for a 'population' of patients. This definition includes medical practitioners who work solely with one specific population, such as women's health or Aboriginal and Torres Strait Islander health.

Health management

The ongoing process beginning with initial client contact and including all actions relating to the client. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.

Incidence rate

Proportion of the population experiencing a disorder or illness for the first time during a given period (often expressed per 100 000 people).

Separation

An episode of care for an admitted patient, which can be a total hospital stay, or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care.

Mental health

Acute services

Services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short term treatment. Acute services can:

- focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric illness for whom there has been an acute exacerbation of symptoms
- target the general population or be specialised in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, youth and forensic mental health services.

Accrued mental health patient days

Mental health care days are days of admitted patient care provided to admitted patients in psychiatric hospitals, designated psychiatric units and days of residential care provided to residents in residential mental health services. Accrued mental health care days can also be referred to as occupied bed days in specialised mental health services. The days to be counted are only those days occurring within the reference period, that is from 1 July to the following 30 June for the relevant period, even if the patient/resident was admitted prior to the reference period or discharged after the reference period. The key basic rules to calculate the number of accrued mental health care days are as follows:

- For a patient admitted and discharged on different days, all days are counted as mental health care days except the day of discharge and any leave days.
- Admission and discharge on the same day are equal to one patient day.
- Leave days involving an overnight absence are not counted.
- A patient day is recorded on the day of return from leave.

Affective disorders

A mood disturbance, including mania, hypomania, bipolar affective disorder, depression and dysthymia.

Ambulatory care services

Mental health services dedicated to the assessment, treatment, rehabilitation or care of non-admitted inpatients, including but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment

	teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.
Anxiety disorders	Feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive–compulsive disorder and post-traumatic stress disorder.
Average available beds	The number of beds available to provide overnight accommodation for patients admitted to hospital (other than neonatal cots [non-special-care] and beds occupied by hospital-in-the-home patients) or to specialised residential mental health care, averaged over the counting period. Beds are available only if they are suitably located and equipped to provide care and the necessary financial and human resources can be provided.
Child and adolescent mental health services	Services principally targeted at children and young people up to the age of 18 years. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on children or adolescents. These services can include a forensic component.
Co-located services	Psychiatric inpatient services established physically and organisationally as part of a general hospital.
Community-based residential services	Staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. To be defined as community-based residences, the services must: provide residential care to people with mental illnesses or psychiatric disability; be located in a community setting external to the campus of a general hospital or psychiatric institution; employ onsite staff for at least some part of the day; and be government funded.
Co-morbidity	The simultaneous occurrence of two or more illnesses such as depressive illness with anxiety disorder, or depressive disorder with anorexia.
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.
Consumer involvement in decision making	Consumer participation arrangements in public sector mental health service organisations according to the scoring hierarchy (levels 1–4) developed for monitoring State and Territory performance under Medicare Agreements Schedule F1 indicators.
Cost per inpatient bed day	The average patient day cost according to the inpatient type.
Depression	A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Sleep, appetite and concentration can be affected.
Forensic mental health services	Services principally providing assessment, treatment and care of mentally ill individuals whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained. This includes prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.
General mental health services	Services that principally target the general adult population (18–65 years old) but that can provide services to children, adolescents or older people. Includes, therefore, those services that cannot be described as specialised child and adolescent, youth, older people's or forensic services. General mental health services include hospital units whose principal function is to provide some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on specific clinical disorders within the adult population (for example, postnatal depression, anxiety disorders).
Mental illness	A diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.

Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental illness.
Mental health promotion	Actions taken to maximise mental health and wellbeing among populations and individuals. It is aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the 'coping' capacity of communities, families and individuals by giving power, knowledge, skills and necessary resources.
Mental illness prevention	Interventions that occur before the initial onset of an illness to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and mental illnesses.
Mortality rate from suicide	The proportion of the population who die as a result of suicide.
Non-acute services	<p>Non-acute services are defined by two categories:</p> <ul style="list-style-type: none"> • Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to mid-term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. • Extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which can include high levels of severe unremitting symptoms of mental illness. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.
Non-government organisations	Private not-for-profit community managed organisations that receive State and Territory government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the non-government organisation sector can include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.
Older people's mental health services	Services principally targeting people in the age group 65 years or over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged people. These services can include a forensic component. Excludes general mental health services that may treat older people as part of a more general service.
Outpatient services — community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. They can include outreach or domiciliary care as an adjunct to services provided from the centre base.
Outpatient services — hospital-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. They can include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Percentage of facilities accredited	The percentage of facilities providing mental health services that are accredited according to the National Standards for Mental Health Services.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of illnesses.
Psychiatrist	A medical practitioner with specialist training in psychiatry.

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 health care services.
Public (non-psychiatric) hospital	A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around-the-clock, comprehensive, qualified nursing services, as well as other necessary professional services.
Schizophrenia	A combination of signs and symptoms that can include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions, and restrictions in thought, speech and goal directed behaviour.
Seclusion	<p>Seclusion is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. The intended purpose of the confinement is not relevant in determining what is or is not seclusion. Seclusion applies even if the consumer agrees or requests the confinement (NMHPSC 2011b).</p> <p>The awareness of the consumer that they are confined alone and denied exit is not relevant in determining what is or is not seclusion. The structure and dimensions of the area to which the consumer is confined is not relevant in determining what is or is not seclusion. The area may be an open area, for example, a courtyard. Seclusion does not include confinement of consumers to High Dependency sections of gazetted mental health units, unless it meets the definition (AIHW 2013).</p>
Seclusion event	An event is when a consumer enters seclusion and when there is a clinical decision to cease seclusion. Following the clinical decision to cease seclusion, if a consumer re-enters seclusion within a short period of time this would be considered a new seclusion event. The term 'seclusion event' is utilised to differentiate it from the different definitions of 'seclusion episode' used across jurisdictions (NMHPSC 2011b).
Specialised mental health inpatient services	Services provided to admitted patients in stand-alone psychiatric hospitals or specialised psychiatric units located within general hospitals.
Specialised mental health services	Services whose primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental illness or psychiatric disability. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function. This criterion applies regardless of the source of funds.
Specialised residential services	Services provided in the community that are staffed by mental health professionals on a non-24 or 24-hour basis.
Staffing categories (mental health)	<p>Medical officers: all medical officers employed or engaged by the organisation on a full time or part time basis. Includes visiting medical officers who are engaged on an hourly, sessional or fee-for-service basis.</p> <p>Psychiatrists and consultant psychiatrists: medical officers who are registered to practice psychiatry under the relevant State or Territory medical registration board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.</p> <p>Psychiatry registrars and trainees: medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.</p> <p>Other medical officers: medical officers employed or engaged by the organisation who are not registered as psychiatrists within the State or Territory, or as formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.</p> <p>Nursing staff: all categories of registered nurses and enrolled nurses, employed or engaged by the organisation.</p> <p>Registered nurses: people with at least a three year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. This is a comprehensive category and</p>

includes general and specialised categories of registered nurses.

Enrolled nurses: refers to people who are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states).

Diagnostic and health professionals (allied health professionals): qualified staff (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, and other diagnostic and health professionals.

Social workers: people who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Psychologists: people who are registered as psychologists with the relevant State or Territory registration board.

Occupational therapists: people who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists.

Other personal care staff: attendants, assistants, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or who are undergoing training in nursing or allied health professions.

Administrative and clerical staff: staff engaged in administrative and clerical duties. Excludes medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties, who should be counted under their appropriate occupational categories. Civil engineers and computing staff are included in this category.

Domestic and other staff: staff involved in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.

Stand-alone psychiatric hospitals

Health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand-alone' category regardless of whether they are under the management control of a general hospital. A health establishment that operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus can also be a stand-alone hospital if the following criteria are not met:

- a single organisational or management structure covers the acute care hospital and the psychiatric hospital
- a single employer covers the staff of the acute care hospital and the psychiatric hospital
- the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus
- the patients of the psychiatric hospital are regarded as patients of the single integrated health service.

Substance use disorders

Disorders in which drugs or alcohol are used to such an extent that behaviour becomes maladaptive, social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug can be psychological (as in substance misuse) or physiological (as in substance dependence).

Youth mental health services

Services principally targeting children and young people generally aged 16-25 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

12.7 List of attachment tables

Attachment tables are identified in references throughout this chapter by a ‘12A’ prefix (for example, table 12A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

Table 12A.1	Real estimated Australian Government expenditure on mental health services (2012-13 dollars) (\$million)
Table 12A.2	Real estimated recurrent expenditure on State and Territory governments specialised mental health services (2012-13 dollars)
Table 12A.3	Real estimated expenditure on State and Territory governments’ specialised mental health services, by funding source (2012-13 dollars) (\$million)
Table 12A.4	Real Australian, State and Territory governments expenditure on specialised mental health services (2012-13 dollars) (\$million),
Table 12A.5	Depreciation (current prices) (\$million)
Table 12A.6	Total state and territory recurrent expenditure on specialised mental health services (current prices)
Table 12A.7	Functioning and quality of life measures, by 12-month mental disorder status, 2007 (per cent)
Table 12A.8	Age standardised rate of adults with very high levels of psychological distress, by State and Territory, 2011-12
Table 12A.9	Age standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2011-12
Table 12A.10	Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2011-12
Table 12A.11	Age standardised rate of adults with very high levels of psychological distress, by State and Territory, 2007-08
Table 12A.12	Age standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2007-08
Table 12A.13	Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2007-08
Table 12A.14	Level of psychological distress K10, 2007-08 (per cent)
Table 12A.15	Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, by Indigenous status, 2011-13
Table 12A.16	Level of psychological distress K10, 2004-05 (per cent)
Table 12A.17	Mental health care specific MBS items processed
Table 12A.18	GP mental health-related encounters (general and mental health specific)
Table 12A.19	GP mental health-related encounters (general and mental health specific), 2012-13
Table 12A.20	The 10 most frequent GP managed mental health-related problems, by gender, 2012-13
Table 12A.21	Mental health patient days

Table 12A.22	Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type
Table 12A.23	Ambulatory-equivalent mental health-related separations with specialised psychiatric care, by principal diagnosis and hospital type, 2009-10
Table 12A.24	Community mental health service contacts, by sex and age group
Table 12A.25	Specialised mental health care reported, by Indigenous status
Table 12A.26	Available beds in specialised mental health services
Table 12A.27	Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people)
Table 12A.28	FTE direct care staff employed in specialised mental health services, by service setting (per 100 000 people)
Table 12A.29	Targeted Community Care (Mental Health) DSS Program participants (number), 2012-13
Table 12A.30	Admitted patient mental health-related separations without specialised psychiatric care, by principal diagnosis in ICD-10-AM groupings, 2012-13
Table 12A.31	Ambulatory-equivalent mental health-related separations without specialised psychiatric care, by principal diagnosis and hospital type, 2009-10
Table 12A.32	Mental health-related emergency department occasions of service in public hospitals, by episode end status, 2011-12
Table 12A.33	New clients as a proportion of total clients under the care of State or Territory specialised public mental health services
Table 12A.34	New clients as a proportion of total clients under the care of State or Territory specialised public mental health services, by selected characteristics, 2012-13
Table 12A.35	Proportion of total clients of MBS subsidised mental health services who are new
Table 12A.36	Proportion of people receiving clinical mental health services by service type and Indigenous status
Table 12A.37	Proportion of people receiving clinical mental health services by service type and remoteness area
Table 12A.38	Proportion of people receiving clinical mental health services by service type and SEIFA
Table 12A.39	Proportion of people receiving clinical public mental health services, by age group and gender, 2012-13
Table 12A.40	Proportion of people receiving clinical mental health services, by service type and SEIFA IRSD deciles (age-standardised rate)
Table 12A.41	Proportion of people receiving clinical mental health services by service type
Table 12A.42	Services used for mental health problems, Australia, 2007 (per cent)
Table 12A.43	Services used for mental health, by mental disorder status, 2007 (per cent)
Table 12A.44	Young people who had contact with MBS subsidised primary mental health care services, by age group
Table 12A.45	Proportion of young people (aged < 25 years) who had contact with MBS subsidised primary mental health care services, by selected characteristics (per cent)
Table 12A.46	Proportion of young people (aged < 25 years) who had contact with MBS subsidised primary mental health care services, by service type (per cent)

Table 12A.47	Specialised public mental health services reviewed against National Standards for Mental Health Services, 30 June
Table 12A.48	Recurrent expenditure on community-based services as a proportion of total spending on mental health services (per cent)
Table 12A.49	Specialised public mental health services episodes with completed consumer outcomes measures collected
Table 12A.50	Rate of seclusion in public specialised mental health acute inpatient units (per 1000 bed days)
Table 12A.51	Rate of seclusion in public specialised mental health acute inpatient units (per 1000 patient days), by target population
Table 12A.52	Consumer and carer participation
Table 12A.53	Rates of community follow-up for people within the first seven days of discharge from hospital
Table 12A.54	Rate of community follow up within first seven days of discharge from a psychiatric admission, by State and Territory, by Indigenous status and remoteness
Table 12A.55	Rate of community follow up within first seven days of discharge from a psychiatric admission, by age group, gender and SEIFA quintiles, 2012-13
Table 12A.56	Readmissions to hospital within 28 days of discharge
Table 12A.57	Readmissions to hospital within 28 days of discharge, by selected characteristics, 2012-13
Table 12A.58	Average recurrent costs per inpatient bed day, public hospitals, by target population (2012-13 dollars)
Table 12A.59	Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2012-13 dollars)
Table 12A.60	Average length of stay, public hospitals acute units, by target population (no. of days)
Table 12A.61	Average recurrent cost per inpatient bed day, by public hospital type (2012-13 dollars)
Table 12A.62	Average recurrent cost per patient day for community residential services (2012-13 dollars)
Table 12A.63	Average cost, and treatment days per episode, of ambulatory care
Table 12A.64	Risk status recent drinkers (in last 12 months) aged 14 years or over, 2013 (per cent)
Table 12A.65	Recent drinkers lifetime and single occasion risk, people aged 14 years or older, by social characteristics, 2013 (per cent)
Table 12A.66	Recent alcohol and illicit drug use, people aged 14 years or over, by substance, 2013 (per cent)
Table 12A.67	Use of cannabis, by age group, 2013 (per cent)
Table 12A.68	Risk status recent drinkers (in last 12 months) aged 14 years or over, 2010 (per cent)
Table 12A.69	Recent alcohol and illicit drug use, people aged 14 years or over, by substance, 2010 (per cent)

Table 12A.70	Lifetime risk status recent drinkers (in last 12 months) aged 14 years or over, by age group (per cent)
Table 12A.71	Single occasion risk status recent drinkers (in last 12 months) aged 14 years or over, by age group (per cent)
Table 12A.72	Selected illicit drug use, by substance and age group (per cent)
Table 12A.73	Selected illicit drug use by people aged 18 years or over, by level of psychological distress and self-reported health conditions (per cent)
Table 12A.74	Illicit drug use, people aged 14 years or older, by social characteristics (per cent)
Table 12A.75	Prevalence of lifetime mental disorders among adults aged 16–85 years, 2007 (per cent)
Table 12A.76	Prevalence of lifetime mental disorders among adults aged 16–85 years, by sex, 2007 (per cent)
Table 12A.77	Prevalence of lifetime mental disorders among adults, by age, 2007 (per cent)
Table 12A.78	Prevalence of lifetime mental disorders among adults, by disadvantage and section of state, 2007 (per cent)
Table 12A.79	Suicides and mortality rate, by sex, Australia
Table 12A.80	Suicides and mortality rate, by age and sex, Australia
Table 12A.81	Suicide deaths and death rate
Table 12A.82	Suicide deaths and death rate of people aged 15–24 years
Table 12A.83	Suicide deaths and suicide death rate, by area
Table 12A.84	Suicide deaths, by Indigenous status, 2008–2012
Table 12A.85	Age-standardised proportions of adults by health risk factors and mental illness status, 2011-12
Table 12A.86	Age-standardised proportions of adults by long term health conditions and mental illness status, 2011-12
Table 12A.87	Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2011-12 (per cent)
Table 12A.88	Age standardised proportion of the population aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part-time), by mental health status, 2011-12 (per cent)
Table 12A.89	Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2007-08 (per cent)
Table 12A.90	Population aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part-time), by mental health status, 2007-08 (per cent)
Table 12A.91	Labour force and employment participation among adults aged 16–64 years, by mental disorder status, 2007 (per cent)
Table 12A.92	Education, training and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent)
Table 12A.93	Labour force and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent)
Table 12A.94	Clinical outcomes of people receiving various types of mental health care provided by State and Territory public mental health services (per cent)

-
- Table 12A.95** People who received mental health care provided by State and Territory public mental health services and who significantly improved, by service type and age group (per cent)
- Table 12A.96** Deflators used to calculate real State and Territory mental health expenditure
- Table 12A.97** Estimated resident populations used in mental health per head calculations

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12A Mental health management — attachment

Definitions for the indicators and descriptors in this attachment are in section 12.6 of the chapter. Unsourced information was obtained from the Australian, State and Territory governments.

Data in this Report are examined by the Health Working Group, but have not been formally audited by the Secretariat.

Data reported in the attachment tables are the most accurate available at the time of data collection. Historical data may have been updated since the last edition of RoGS.

This file is available in Adobe PDF format on the Review web page (www.pc.gov.au/gsp).

Attachment contents

Table 12A.1	Real estimated Australian Government expenditure on mental health services (2012-13 dollars) (\$million)
Table 12A.2	Real estimated recurrent expenditure on State and Territory governments specialised mental health services (2012-13 dollars)
Table 12A.3	Real estimated expenditure on State and Territory governments' specialised mental health services, by funding source (2012-13 dollars) (\$million)
Table 12A.4	Real Australian, State and Territory governments expenditure on specialised mental health services (2012-13 dollars) (\$million),
Table 12A.5	Depreciation (current prices) (\$million)
Table 12A.6	Total state and territory recurrent expenditure on specialised mental health services (current prices)
Table 12A.7	Functioning and quality of life measures, by 12-month mental disorder status, 2007 (per cent)
Table 12A.8	Age standardised rate of adults with very high levels of psychological distress, by State and Territory, 2011-12
Table 12A.9	Age standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2011-12
Table 12A.10	Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2011-12
Table 12A.11	Age standardised rate of adults with very high levels of psychological distress, by State and Territory, 2007-08
Table 12A.12	Age standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2007-08
Table 12A.13	Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2007-08
Table 12A.14	Level of psychological distress K10, 2007-08 (per cent)
Table 12A.15	Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, by Indigenous status, 2011-13
Table 12A.16	Level of psychological distress K10, 2004-05 (per cent)
Table 12A.17	Mental health care specific MBS items processed
Table 12A.18	GP mental health-related encounters (general and mental health specific)
Table 12A.19	GP mental health-related encounters (general and mental health specific), 2012-13
Table 12A.20	The 10 most frequent GP managed mental health-related problems, by gender, 2012-13
Table 12A.21	Mental health patient days
Table 12A.22	Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type
Table 12A.23	Ambulatory-equivalent mental health-related separations with specialised psychiatric care, by principal diagnosis and hospital type, 2009-10
Table 12A.24	Community mental health service contacts, by sex and age group
Table 12A.25	Specialised mental health care reported, by Indigenous status
Table 12A.26	Available beds in specialised mental health services

Attachment contents

Table 12A.27	Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people)
Table 12A.28	Full time equivalent (FTE) direct care staff employed in specialised mental health services, by service setting (per 100 000 people)
Table 12A.29	Targeted Community Care (Mental Health) DSS Program participants (number), 2012-13
Table 12A.30	Admitted patient mental health-related separations without specialised psychiatric care, by principal diagnosis in ICD-10-AM groupings, 2012-13
Table 12A.31	Ambulatory-equivalent mental health-related separations without specialised psychiatric care, by principal diagnosis and hospital type, 2009-10
Table 12A.32	Mental health-related emergency department occasions of service in public hospitals, by episode end status, 2011-12
Table 12A.33	New clients as a proportion of total clients under the care of State or Territory specialised public mental health services
Table 12A.34	New clients as a proportion of total clients under the care of State or Territory specialised public mental health services, by selected characteristics, 2012-13
Table 12A.35	Proportion of total clients of MBS subsidised mental health services who are new
Table 12A.36	Proportion of people receiving clinical mental health services by service type and Indigenous status
Table 12A.37	Proportion of people receiving clinical mental health services by service type and remoteness area
Table 12A.38	Proportion of people receiving clinical mental health services by service type and SEIFA
Table 12A.39	Proportion of people receiving clinical public mental health services, by age group and gender, 2012-13
Table 12A.40	Proportion of people receiving clinical mental health services, by service type and SEIFA IRSD deciles (age-standardised rate)
Table 12A.41	Proportion of people receiving clinical mental health services, by service type
Table 12A.42	Services used for mental health problems, Australia, 2007 (per cent)
Table 12A.43	Services used for mental health, by mental disorder status, 2007 (per cent)
Table 12A.44	Young people who had contact with MBS-subsidised primary mental health care services, by age group
Table 12A.45	Proportion of young people (aged < 25 years) who had contact with MBS subsidised primary mental health care services, by selected characteristics (per cent)
Table 12A.46	Proportion of young people (aged < 25 years) who had contact with MBS subsidised primary mental health care services, by service type (per cent)
Table 12A.47	Specialised public mental health services reviewed against National Standards for Mental Health Services, 30 June
Table 12A.48	Recurrent expenditure on community-based services as a proportion of total spending on mental health services (per cent)
Table 12A.49	Specialised public mental health services episodes with completed consumer outcomes measures collected
Table 12A.50	Rate of seclusion in public specialised mental health acute inpatient units (per 1000 bed days)

Attachment contents

Table 12A.51	Rate of seclusion in public specialised mental health acute inpatient units (per 1000 patient days), by target population
Table 12A.52	Consumer and carer participation
Table 12A.53	Rates of community follow-up for people within the first seven days of discharge from hospital
Table 12A.54	Rate of community follow up within first seven days of discharge from a psychiatric admission, by State and Territory, by Indigenous status and remoteness
Table 12A.55	Rate of community follow up within first seven days of discharge from a psychiatric admission, by age group, gender and SEIFA quintiles, 2012-13
Table 12A.56	Readmissions to hospital within 28 days of discharge
Table 12A.57	Readmissions to hospital within 28 days of discharge, by selected characteristics, 2012-13
Table 12A.58	Average recurrent costs per inpatient bed day, public hospitals, by target population (2012-13 dollars)
Table 12A.59	Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2012-13 dollars)
Table 12A.60	Average length of stay, public hospitals acute units, by target population (no. of days)
Table 12A.61	Average recurrent cost per inpatient bed day, by public hospital type (2012-13 dollars)
Table 12A.62	Average recurrent cost per patient day for community residential services (2012-13 dollars)
Table 12A.63	Average cost, and treatment days per episode, of ambulatory care
Table 12A.64	Risk status recent drinkers (in last 12 months) aged 14 years or over, 2013 (per cent)
Table 12A.65	Recent drinkers lifetime and single occasion risk, people aged 14 years or older, by social characteristics, 2013 (per cent)
Table 12A.66	Recent alcohol and illicit drug use, people aged 14 years or over, by substance, 2013 (per cent)
Table 12A.67	Use of cannabis, by age group, 2013 (per cent)
Table 12A.68	Risk status recent drinkers (in last 12 months) aged 14 years or over, 2010 (per cent)
Table 12A.69	Recent alcohol and illicit drug use, people aged 14 years or over, by substance, 2010 (per cent)
Table 12A.70	Lifetime risk status recent drinkers (in last 12 months) aged 14 years or over, by age group (per cent)
Table 12A.71	Single occasion risk status recent drinkers (in last 12 months) aged 14 years or over, by age group (per cent)
Table 12A.72	Selected illicit drug use, by substance and age group (per cent)
Table 12A.73	Selected illicit drug use by people aged 18 years or over, by level of psychological distress and self-reported health conditions (per cent)
Table 12A.74	Illicit drug use, people aged 14 years or older, by social characteristics (per cent)
Table 12A.75	Prevalence of lifetime mental disorders among adults aged 16–85 years, 2007 (per cent)

Attachment contents

Table 12A.76	Prevalence of lifetime mental disorders among adults aged 16–85 years, by sex, 2007 (per cent)
Table 12A.77	Prevalence of lifetime mental disorders among adults, by age, 2007 (per cent)
Table 12A.78	Prevalence of lifetime mental disorders among adults, by disadvantage and section of state, 2007 (per cent)
Table 12A.79	Suicides and mortality rate, by sex, Australia
Table 12A.80	Suicides and mortality rate, by age and sex, Australia
Table 12A.81	Suicide deaths and death rate
Table 12A.82	Suicide deaths and death rate of people aged 15–24 years
Table 12A.83	Suicide deaths and suicide death rate, by area
Table 12A.84	Suicide deaths, by Indigenous status, 2008–2012
Table 12A.85	Age-standardised proportions of adults by health risk factors and mental illness status, 2011-12
Table 12A.86	Age-standardised proportions of adults by long term health conditions and mental illness status, 2011-12
Table 12A.87	Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2011-12 (per cent)
Table 12A.88	Age standardised proportion of the population aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part-time), by mental health status, 2011-12 (per cent)
Table 12A.89	Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2007-08 (per cent)
Table 12A.90	Population aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part-time), by mental health status, 2007-08 (per cent)
Table 12A.91	Labour force and employment participation among adults aged 16–64 years, by mental disorder status, 2007 (per cent)
Table 12A.92	Education, training and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent)
Table 12A.93	Labour force and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent)
Table 12A.94	Clinical outcomes of people receiving various types of mental health care provided by State and Territory public mental health services (per cent)
Table 12A.95	People who received mental health care provided by State and Territory public mental health services and who significantly improved, by service type and age group (per cent)
Table 12A.96	Deflators used to calculate real State and Territory mental health expenditure
Table 12A.97	Estimated resident populations used in mental health per head calculations

TABLE 12A.1

Table 12A.1 **Real estimated Australian Government expenditure on mental health services (2012-13 dollars) (\$million)**
(a), (b), (c)

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
Mental health specific payments to states and territories (d)	87.5	86.5	91.9	89.9	3.8	6.7	19.1	50.4
National programs and initiative (Department of Health and Ageing [DoHA] managed) (e)	116.9	131.1	254.8	239.1	235.9	278.4	321.7	435.5
National programs and initiative (Families, Housing, Community Services and Indigenous Affairs [FaHCSIA] managed) (f)	–	10.2	95.3	158.8	149.7	149.1	155.7	180.6
National programs and initiative (DVA managed) (g)	153.9	165.9	165.5	174.8	168.2	165.5	162.1	168.9
Department of Defence-funded programs (h)	..	..	..	..	16.0	22.4	22.0	24.3
National Suicide Prevention Program (i)	10.6	20.4	21.4	22.8	23.2	25.5	53.1	55.4
MBS — Psychiatrists (j)	270.5	272.0	274.9	276.2	276.8	284.7	291.3	300.8
MBS — General practitioners (k)	285.4	177.6	154.6	192.9	209.6	241.6	203.9	194.4
MBS — Psychologists/Allied Health (l)	2.9	65.8	202.5	271.5	322.4	371.9	380.5	411.2
Pharmaceutical Benefits Schedule (m)	779.3	782.5	802.9	822.9	824.4	852.7	854.9	768.1
Private Health Insurance Premium Rebates (n)	71.1	76.0	85.1	81.4	99.6	98.9	114.9	106.4
Research (o)	33.7	36.6	43.7	51.4	56.9	61.9	63.9	67.1
National Mental Health Commission (p)	..	..	..	..	..	..	2.7	6.8
TOTAL	1 811.9	1 824.5	2 192.5	2 381.8	2 386.4	2 559.2	2 645.9	2 770.0
<i>Per cent</i>								
Mental health specific payments to states and territories (d)	4.8	4.7	4.2	3.8	0.2	0.3	0.7	1.8
National programs and initiative (DOHA managed) (e)	6.5	7.2	11.6	10.0	9.9	10.9	12.2	15.7
National programs and initiative (FaHCSIA managed) (f)	0.0	0.6	4.3	6.7	6.3	5.8	5.9	6.5
National programs and initiative (DVA managed) (g)	8.5	9.1	7.5	7.3	7.0	6.5	6.1	6.1
Department of Defence-funded programs (h)	..	..	..	..	0.7	0.9	0.8	0.9
National Suicide Prevention Program (i)	0.6	1.1	1.0	1.0	1.0	1.0	2.0	2.0

TABLE 12A.1

Table 12A.1 **Real estimated Australian Government expenditure on mental health services (2012-13 dollars) (\$million)**
(a), (b), (c)

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
MBS — Psychiatrists (j)	14.9	14.9	12.5	11.6	11.6	11.1	11.0	10.9
MBS — General practitioners (k)	15.8	9.7	7.1	8.1	8.8	9.4	7.7	7.0
MBS — Psychologists/Allied Health (l)	0.2	3.6	9.2	11.4	13.5	14.5	14.4	14.8
Pharmaceutical Benefits Schedule (m)	43.0	42.9	36.6	34.5	34.5	33.3	32.3	27.7
Private Health Insurance Premium Rebates (n)	3.9	4.2	3.9	3.4	4.2	3.9	4.3	3.8
Research (o)	1.9	2.0	2.0	2.2	2.4	2.4	2.4	2.4
National Mental Health Commission (p)	..	..	..	..	..	..	0.1	0.2
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

- (a) Detailed notes on how estimates specific to Commonwealth mental health specific expenditure are derived are provided in the AIHW Mental Health Services in Australia on-line publication. See <http://mhsa.aihw.gov.au/resources/expenditure/data-source/>.
- (b) Estimated Australian Government expenditure shown in the table covers only those areas of expenditure that have a clear and identifiable mental health purpose. A range of other expenditure, both directly and indirectly related to provision of support for people affected by mental illness, is not covered in the table.
- (c) Constant price expenditure for all years expressed in 2012-13 prices using the general government final consumption expenditure on hospital and nursing home services. Details provided in table 12A.96.
- (d) *Mental health specific payments to states and territories:* For years up to 2008-09, this category covers specific payments made to states and territories by the Australian Government for mental health reform under the Medicare Agreements 1993-98, and Australian Health Care Agreements 1998-2003 and 2008-09. From July 2009, the Australian Government provided special purpose payments (SPP) to State and Territory governments under the National Healthcare Agreement (NHA) that do not specify the amount to be spent on mental health or any other health area. As a consequence, specific mental health funding cannot be identified under the NHA. From 2008-09 onwards, the amounts include: National Perinatal Depression Plan – Payments to States, National Partnership - Supporting Mental Health Reform and specific payments to Tasmania under the Tasmanian Health Assistance Package. Note that the expenditure reported here excludes payments to states and territories for the development of subacute mental health beds made under Schedule E of the National Partnership Agreement - Improving Public Hospital Services, which will total \$175 million over the period 2010-11 to 2013-14. Mental-health specific payments for 2010-11 cannot be separately identified from payments for other categories of subacute beds made to states and territories.

Table 12A.1 **Real estimated Australian Government expenditure on mental health services (2012-13 dollars) (\$million)**
(a), (b), (c)

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
(e) <i>National programs and initiatives (Department of Health and Ageing [from September 2013 it is the Department of Health] managed):</i> This category of expenditure includes the expenditure groups described in the AIHW <i>Mental Health Services in Australia</i> on-line publication. See http://mhsa.aihw.gov.au/resources/expenditure/data-source/ .								
(f) <i>National programs and initiatives (Families, Housing, Community Services and Indigenous Affairs [FaHCSIA] [from September 2013 it is the Department of Social Services] managed):</i> Expenditure on FaHCSIA-managed COAG Action Plan programs refers to funding outlays on three initiatives funded by the Australian Government under the COAG Action Plan on Mental Health (Personal Helpers and Mentors, More Respite Care Places to Help Families and Carers, Community based programmes to help families coping with mental illness).								
(g) <i>National programs and initiatives (Department of Veterans' Affairs [DVA] managed):</i> This category of expenditure includes the groups described in the AIHW <i>Mental Health Services in Australia</i> on-line publication. See http://mhsa.aihw.gov.au/resources/expenditure/data-source/ .								
(h) <i>Department of Defence-funded programs:</i> This is the first year that Defence has reported mental health specific expenditure. Expenditure reporting commences at 2009-10, and covers a range of mental health programs and services delivered to ADF personnel. Increased expenditure over the period reflects, in part, increased accuracy of data capture. Details of the ADF Mental Health Strategy are available at http://www.defence.gov.au/health/dmh/i-dmh.htm .								
(i) <i>National Suicide Prevention Program:</i> Expenditure reported includes all Australian Government allocations made under the national program, including additional funding made available under the COAG Action Plan and the 2010-11 and 2011-12 Federal Budgets.								
(j) <i>Medicare Benefits Schedule – Psychiatrists:</i> Expenditure reported refers to benefits paid for services by consultant psychiatrists processed in each of the index years. The amounts reported exclude payments made by the Department of Veterans' Affairs under the Repatriation Medical Benefits Schedule. These are included under the Department of Veterans' Affairs expenditure.								

Table 12A.1 **Real estimated Australian Government expenditure on mental health services (2012-13 dollars) (\$million)**
(a), (b), (c)

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
(k) <i>Medicare Benefits Schedule – General Practitioners (GP)</i> : Prior to 2006-07, General Practitioner mental health-related expenditure was based on a crude estimate of 6.1 per cent of total MBS benefits paid for GP attendances, and derived from data and assumptions as detailed in the National Mental Health Report 2007. This estimate was historical and aimed to recognise that, although few mental health specific items were available in the MBS to accurately monitor GP mental health service provision, GPs are a significant provider of services to people with mental illness. Commencing November 2006, new mental health specific GP items were introduced under the Better Access to Mental Health Care initiative. To incorporate these changes, GP expenditure reported for 2006-07 is based on total MBS benefits paid against these new mental health specific items, plus an additional 6.1 per cent of total GP Benefits paid in the period preceding the introduction of the new items (July and November 2006). For 2007-08 and future years, expenditure on GP mental health care is based solely on benefits paid against MBS mental health specific GP items, which are predominantly the Better Access GP mental health items plus a small number of other items that were created in the years preceding the introduction of the Better Access initiative. This method provides a significantly lower expenditure figure than obtained using the 6.1 per cent estimate of previous years because it is conservative and does not attempt to assign a cost to the range of GP mental health work that is not billed as a specific mental health item. Comparisons of GP mental health related expenditure reported pre- and post-2006-07 are therefore not valid as the apparent decrease reflects the different approach to counting GP mental health services.								
(l) <i>Medicare Benefits Schedule – Psychologists/Allied Health</i> : Expenditure refers to MBS benefits paid for Clinical Psychologists, Psychologists, Social Workers and Occupational Therapists under the new items introduced through the Better Access to Mental Health Care initiative on 1 November 2006, plus a small number of Psychologist/Allied health items that were created under the Enhanced Primary Care program in the years preceding the introduction of the Better Access initiative.								
(m) <i>Pharmaceutical Benefits Scheme</i> : Expenditure under the Pharmaceutical Benefits Scheme refers to all Australian Government benefits for psychiatric medication in each of the index years, defined as drugs included in the following classes of the Anatomical Therapeutic Chemical Drug Classification System: antipsychotics (except prochlorperazine); anxiolytics; hypnotics and sedatives; psychostimulants; and antidepressants. Expenditure on Clozapine, funded under the Highly Specialised Drugs Program, has been included for all years, including Clozapine dispensed through public hospitals. The amounts reported exclude payments made by the Department of Veterans' Affairs under the Repatriation Pharmaceutical Benefits Schedule. These are included under the Department of Veterans' Affairs expenditure.								
(n) <i>Private Health Insurance Premium Rebates</i> : Estimates of the 'mental health share' of Australian Government Private Health Insurance Rebates are derived from a combination of sources and based on the assumption that a proportion of Australian Government outlays designed to increase public take up of private health insurance have subsidised private psychiatric care in hospitals. The methodology underpinning these estimates is described in the AIHW Mental Health Services in Australia on-line publication. See http://mhsa.aihw.gov.au/resources/expenditure/data-source/ .								
(o) <i>Research</i> : Research funding represents the value of mental health related grants administered by the National Health and Medical Research Council (NHMRC) during the relevant year. Data were sourced from the NHMRC website: http://www.nhmrc.gov.au/grants/research-funding-statistics-and-data/mental-health-1 , accessed 13 February 2014.								

Table 12A.1 **Real estimated Australian Government expenditure on mental health services (2012-13 dollars) (\$million)**
(a), (b), (c)

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
(p) <i>National Mental Health Commission</i> : The Commission commenced operation in January 2012								

.. Not applicable.

Source: Department of Health (Australian Government) (unpublished).

TABLE 12A.2

Table 12A.2 Real estimated recurrent expenditure on State and Territory governments specialised mental health services (2012-13 dollars) (a), (b), (c), (d)

	<i>NSW (e)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Real recurrent expenditure (\$ million)</i>									
2005-06	1 071.0	845.2	579.0	411.9	271.9	85.5	57.2	34.1	3 355.8
2006-07	1 116.2	872.6	646.2	432.4	301.5	97.3	66.5	37.3	3 570.0
2007-08	1 167.7	905.2	730.3	470.3	317.5	104.3	69.0	39.8	3 804.1
2008-09	1 225.9	938.2	771.5	502.2	331.9	106.6	74.1	41.7	3 992.1
2009-10	1 295.7	977.3	829.1	508.9	338.0	116.0	73.7	42.8	4 181.4
2010-11	1 385.8	1 026.7	883.3	565.6	350.4	122.4	77.2	45.7	4 457.1
2011-12	1 433.2	1 038.0	918.8	603.7	352.3	110.4	82.2	50.0	4 588.6
2012-13	1 440.9	1 046.3	873.4	623.6	349.2	111.2	85.7	50.3	4 580.6
<i>Real expenditure per person (\$)</i>									
2005-06	159.42	168.26	146.06	202.90	176.03	175.19	171.43	164.45	165.22
2006-07	164.47	170.97	159.34	208.19	193.10	198.02	196.39	176.98	173.07
2007-08	169.64	174.09	175.56	220.26	201.12	210.39	200.62	183.50	181.01
2008-09	175.09	176.58	180.44	227.33	207.72	212.52	210.98	187.23	185.89
2009-10	182.45	180.34	189.84	224.79	208.82	229.13	205.94	187.69	191.23
2010-11	193.01	186.81	199.09	243.90	214.64	239.98	211.58	198.50	201.02
2011-12	197.75	186.21	203.58	252.88	214.15	215.73	221.67	215.10	204.07
2012-13	196.07	184.22	189.41	252.21	210.07	217.04	225.91	212.30	199.97

- (a) Constant price expenditure expressed in 2012-13 prices using the State and Territory implicit price deflators for general government final consumption expenditure on hospital and nursing home services (table 12A.96).
- (b) Estimates of expenditure on State and Territory governments specialised mental health services include revenue from other sources (including patient fees and reimbursement by third party compensation insurers), Australian government funding provided under the Australian Health Care Agreement base grants/NHA SPP, 'other Australian Government funds', Australian Government mental health specific payments to states and territories and funding provided through the Department of Veterans' Affairs.
- (c) Depreciation is excluded for all years.

Table 12A.2 **Real estimated recurrent expenditure on State and Territory governments specialised mental health services (2012-13 dollars) (a), (b), (c), (d)**

	<i>NSW (e)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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(d) Due to the ongoing validation of National Minimum Data Set (NMDS), data could differ from previous reports.

(e) The quality of the NSW 2010-11 Mental Health Establishments (MHE) NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

Source: Australian Institute of Health and Welfare (AIHW) (unpublished) Mental Health Establishments National Minimum Data Set (MHE NMDS); Australian Government (unpublished); ABS (various issues), Australian Demographic Statistics, December (various years), Cat. no. 3101.0.

TABLE 12A.3

Table 12A.3 **Real estimated expenditure on State and Territory governments' specialised mental health services, by funding source (2012-13 dollars) (\$million) (a), (b), (c), (d)**

	<i>NSW</i> (e)	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i> (f)
<i>2005-06</i>									
State/Territory funds	1 003.9	794.1	547.8	396.7	256.4	79.7	54.3	32.3	3 165.2
Australian Government funds									–
Mental health specific payments to states and territories (g)	26.7	21.1	17.4	9.2	6.8	2.6	1.9	1.8	87.5
Department of Veterans' Affairs (h)	10.6	10.1	1.1	2.1	3.8	0.2	0.2	–	28.1
Total Australian Government funds	37.3	31.2	18.6	11.2	10.6	2.8	2.1	1.8	115.6
Other revenue	29.8	19.9	12.6	3.9	4.9	3.0	0.8	0.1	75.0
Total funds	1 071.0	845.2	579.0	411.9	271.9	85.5	57.2	34.1	3 355.8
<i>2006-07</i>									
State/Territory funds	1 057.6	808.7	614.0	416.2	287.1	91.6	63.7	35.5	3 374.2
Australian Government funds									
Mental health specific payments to states and territories (g)	28.0	19.9	17.1	8.8	6.9	2.0	1.8	1.8	86.4
Department of Veterans' Affairs (h)	8.7	9.1	3.4	3.3	3.6	0.5	0.2	–	28.8
Total Australian Government funds	36.7	29.1	20.4	12.1	10.5	2.6	2.0	1.8	115.2
Other revenue	21.9	34.9	11.8	4.0	3.9	3.2	0.8	–	80.6
Total funds	1 116.2	872.6	646.2	432.4	301.5	97.3	66.5	37.3	3 570.0
<i>2007-08</i>									
State/Territory funds	1 110.0	849.8	699.0	454.5	301.6	97.8	65.7	37.1	3 615.4
Australian Government funds									
Mental health specific payments to states and territories (g)	28.8	21.6	18.1	9.3	6.8	2.5	2.5	2.1	91.9
Department of Veterans' Affairs (h)	8.6	7.1	2.6	2.8	4.1	0.3	0.3	–	25.8
Total Australian Government funds	37.4	28.7	20.8	12.1	11.0	2.8	2.8	2.2	117.7
Other revenue	20.4	26.7	10.6	3.6	4.9	3.7	0.6	0.4	71.0

TABLE 12A.3

Table 12A.3 **Real estimated expenditure on State and Territory governments' specialised mental health services, by funding source (2012-13 dollars) (\$million) (a), (b), (c), (d)**

	<i>NSW</i> (e)	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i> (f)
Total funds	1 167.7	905.2	730.3	470.3	317.5	104.3	69.0	39.8	3 804.1
<i>2008-09</i>									
State/Territory funds	1 172.7	876.1	737.9	486.2	312.4	98.3	71.0	39.8	3 794.5
Australian Government funds									
Mental health specific payments to states and territories (g)	28.4	21.2	18.2	9.3	6.6	2.2	2.1	1.8	89.9
Department of Veterans' Affairs (h)	8.7	10.9	4.0	4.1	5.0	0.6	0.1	–	33.3
Total Australian Government funds	37.2	32.1	22.2	13.4	11.6	2.8	2.2	1.8	123.3
Other revenue	16.0	30.0	11.4	2.6	7.9	5.5	0.9	–	74.3
Total funds	1 225.9	938.2	771.5	502.2	331.9	106.6	74.1	41.7	3 992.1
<i>2009-10</i>									
State/Territory funds	1 273.2	932.7	813.2	503.0	328.0	111.1	72.4	42.5	4 076.1
Australian Government funds									
Mental health specific payments to states and territories (g)	1.0	0.9	0.6	0.5	0.3	0.2	0.1	0.2	3.8
Department of Veterans' Affairs (h)	9.6	9.6	4.2	2.5	4.0	0.6	0.4	–	30.9
Total Australian Government funds	10.7	10.5	4.8	3.0	4.2	0.7	0.5	0.2	34.7
Other revenue	11.8	34.1	11.1	2.8	5.7	4.2	0.8	–	70.6
Total funds	1 295.7	977.3	829.1	508.9	338.0	116.0	73.7	42.8	4 181.4
<i>2010-11</i>									
State/Territory funds	1 346.5	975.4	865.6	560.2	342.2	119.4	75.5	45.4	4 330.2
Australian Government funds									
Mental health specific payments to states and territories (g)	1.9	1.6	1.3	0.8	0.5	0.2	0.2	0.2	6.8
Department of Veterans' Affairs (h)	10.1	10.4	3.7	2.2	4.4	0.4	0.3	–	31.5

TABLE 12A.3

Table 12A.3 **Real estimated expenditure on State and Territory governments' specialised mental health services, by funding source (2012-13 dollars) (\$million) (a), (b), (c), (d)**

	<i>NSW</i> (e)	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i> (f)
Total Australian Government funds	12.0	12.0	5.0	3.0	4.9	0.6	0.5	0.2	38.3
Other revenue	27.3	39.2	12.7	2.4	3.3	2.4	1.2	0.1	88.7
Total funds	1 385.8	1 026.7	883.3	565.6	350.4	122.4	77.2	45.7	4 457.1
<i>2011-12</i>									
State/Territory funds	1 400.5	979.5	895.7	592.5	342.0	106.9	80.5	49.4	4 447.0
Australian Government funds									
Mental health specific payments to states and territories (g)	6.3	4.1	3.4	2.7	1.4	0.3	0.6	0.4	19.1
Department of Veterans' Affairs (h)	9.8	9.2	2.9	1.8	4.0	0.5	0.3	–	28.5
Total Australian Government funds	16.1	13.3	6.3	4.5	5.3	0.8	0.9	0.5	47.6
Other revenue	16.7	45.2	16.8	6.7	5.0	2.7	0.9	0.1	94.0
Total funds	1 433.2	1 038.0	918.8	603.7	352.3	110.4	82.2	50.0	4 588.6
<i>2012-13</i>									
State/Territory funds	1 394.5	971.7	841.0	609.2	338.4	105.0	83.6	49.1	4 392.5
Australian Government funds									
Mental health specific payments to states and territories (g)	15.3	10.6	10.1	6.0	3.7	2.9	0.8	1.1	50.4
Department of Veterans' Affairs (h)	11.2	11.6	3.9	4.0	4.2	0.5	0.5	–	35.9
Total Australian Government funds	26.5	22.2	13.9	10.0	7.9	3.3	1.3	1.1	86.3
Other revenue	19.9	52.4	18.4	4.4	2.9	2.9	0.8	0.1	101.8
Total funds	1 440.9	1 046.3	873.4	623.6	349.2	111.2	85.7	50.3	4 580.6

(a) Constant price expenditure expressed in 2012-13 prices using the State and Territory implicit price deflators for general government final consumption expenditure on hospital and nursing home services (table 12A.96).

(b) Estimates of State and Territory government funds include Australian government funding provided under the Australian Health Care Agreement base grants/NHA SPP.

Table 12A.3 Real estimated expenditure on State and Territory governments' specialised mental health services, by funding source (2012-13 dollars) (\$million) (a), (b), (c), (d)

	NSW (e)	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (f)
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- (c) Depreciation excluded for all years.
- (d) Due to the ongoing validation of NMDS, data could differ from previous reports.
- (e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.
- (f) The Australian total for mental health specific payments to states and territories differ slightly to those in table 12A.1 as in that table the deflator for Australia is used, whereas in this table State or Territory specific deflators are used and the Australian total is the sum of states and territories.
- (g) Mental health specific payments to states and territories: For years up to 2008-09, this category covers specific payments made to states and territories by the Australian Government for mental health reform under the Medicare Agreements 1993-98, and Australian Health Care Agreements 1998-2003 and 2008-09. From July 2009, the Australian Government provided SPPs to State and Territory governments under the NHA that do not specify the amount to be spent on mental health or any other health area. As a consequence, specific mental health funding cannot be identified under the NHA. From 2008-09 onwards, the amounts include: National Perinatal Depression Plan – Payments to States, the National Partnership - Supporting Mental Health Reform and specific payments to Tasmania under the Tasmanian Health Assistance Package. Note that the expenditure reported here excludes payments to states and territories for the development of subacute mental health beds made under Schedule E of the National Partnership Agreement – Improving Public Hospital Services, which will total \$175 million over the period 2010-11 to 2013-14. Mental-health specific payments for 2010-11 cannot be separately identified from payments for other categories of subacute beds made to states and territories.
- (h) *Department of Veterans' Affairs*: refers to payments for mental health care provided in public hospitals for veterans. Non-admitted costs are not included as relevant data sets are incomplete or unavailable. There were no DVA mental health-related public hospital services claimed in the NT in 2010-11 or 2005-06.

– Nil or rounded to zero.

Source: AIHW (unpublished) MHE NMDS; Department of Health (Australian Government) (unpublished).

Table 12A.4 **Real Australian, State and Territory governments expenditure on specialised mental health services (2012-13 dollars) (\$million), (a), (b), (c), (d)**

	<i>Aust</i>
<i>Real expenditure (\$million)</i>	
<i>State and Territory governments</i>	
2005-06	3 240.2
2006-07	3 454.8
2007-08	3 686.4
2008-09	3 868.8
2009-10	4 146.7
2010-11	4 418.9
2011-12	4 540.9
2012-13	4 494.3
<i>Australian Government</i>	
2005-06	1 811.9
2006-07	1 824.5
2007-08	2 192.5
2008-09	2 381.8
2009-10	2 386.4
2010-11	2 559.2
2011-12	2 645.9
2012-13	2 770.0
Total	
2005-06	5 052.1
2006-07	5 279.3
2007-08	5 878.9
2008-09	6 250.6
2009-10	6 533.1
2010-11	6 978.1
2011-12	7 186.8
2012-13	7 264.3
<i>Expenditure per person</i>	
<i>State and Territory governments</i>	
2005-06	159.52
2006-07	167.49
2007-08	175.41
2008-09	180.15
2009-10	189.64
2010-11	199.30
2011-12	201.95
2012-13	196.20

Table 12A.4 **Real Australian, State and Territory governments expenditure on specialised mental health services (2012-13 dollars) (\$million), (a), (b), (c), (d)**

	<i>Aust</i>
<i>Australian Government</i>	
2005-06	89.21
2006-07	88.45
2007-08	104.32
2008-09	110.91
2009-10	109.14
2010-11	115.42
2011-12	117.67
2012-13	120.93
Total	
2005-06	248.73
2006-07	255.93
2007-08	279.73
2008-09	291.06
2009-10	298.78
2010-11	314.72
2011-12	319.62
2012-13	317.13
<i>Proportion of expenditure</i>	
<i>State and Territory governments</i>	
2005-06	64.1
2006-07	65.4
2007-08	62.7
2008-09	61.9
2009-10	63.5
2010-11	63.3
2011-12	63.2
2012-13	61.9
<i>Australian Government</i>	
2005-06	35.9
2006-07	34.6
2007-08	37.3
2008-09	38.1
2009-10	36.5
2010-11	36.7
2011-12	36.8
2012-13	38.1

Table 12A.4 Real Australian, State and Territory governments expenditure on specialised mental health services (2012-13 dollars) (\$million), (a), (b), (c), (d)

	<i>Aust</i>
(a) Constant price expenditure expressed in 2012-13 prices using the State and Territory and Australian total implicit price deflators for general government final consumption expenditure on hospital and nursing home services (table 12A.96).	
(b) Estimates of State and Territory government funds include other revenue and Australian government funding provided under the Australian Health Care Agreement base grants/NHA SPP.	
(c) Depreciation excluded for all years.	
(d) Due to the ongoing validation of NMDS, data could differ from previous reports.	
<i>Source:</i> AIHW (unpublished) MHE NMDS; Department of Health (Australian Government), unpublished; ABS (various issues), <i>Australian Demographic Statistics</i> , December (various years), Cat. no. 3101.0.	

Table 12A.5 **Depreciation (current prices) (\$million) (a), (b)**

	<i>NSW (c)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2005-06	15.3	7.4	8.5	4.3	0.1	–	0.3	–	35.7
2006-07	12.4	7.2	9.7	4.1	–	–	–	–	33.4
2007-08	13.8	11.3	9.1	3.5	0.4	–	–	0.5	38.8
2008-09	9.0	12.9	8.2	4.1	3.2	–	–	–	37.5
2009-10	14.4	19.7	7.7	4.3	2.5	–	–	–	48.5
2010-11	13.2	29.6	9.2	4.3	1.5	–	–	–	57.9
2011-12	13.6	26.3	9.1	4.8	1.1	–	–	–	54.8
2012-13	15.8	20.3	7.1	4.0	–	–	–	–	47.3

(a) See the *AIHW Mental Health Services in Australia* on-line publication (<http://mhsa.aihw.gov.au/resources/expenditure/data-source/>) for a full description of the derivation of expenditure estimates.

(b) Due to the ongoing validation of NMDS, data could differ from previous reports.

(c) The quality of the NSW 2010-11 MHE NMDS data has been affected by the reconfiguration of the service system during the year.

– Nil or rounded to zero.

Source: AIHW (unpublished) MHE NMDS.

TABLE 12A.6

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	Vic	Qld (g)	WA	SA	Tas (h)	ACT	NT	Aust
<i>2005-06</i>									
<i>Recurrent expenditure (\$million)</i>									
Public psychiatric hospital	191.2	30.2	65.7	63.1	81.3	..	..	..	431.4
Public acute hospital	266.1	193.6	177.1	92.1	36.6	22.5	9.0	10.4	807.6
<i>Total inpatient expenditure (i)</i>	457.3	223.8	242.7	155.2	117.9	22.5	9.0	10.4	1 239.0
Community residential	24.4	121.9	..	4.9	2.8	16.0	5.9	0.3	176.3
Ambulatory	307.7	269.6	159.8	142.2	79.3	25.2	23.9	12.4	1 020.2
Non-government organisations	31.7	61.1	25.3	16.5	14.7	1.7	5.1	3.1	159.3
Indirect	64.2	32.2	26.8	7.2	5.1	5.0	2.2	2.0	144.7
Total expenditure	885.4	708.6	454.6	326.1	219.9	70.4	46.2	28.2	2 739.4
<i>Per cent</i>									
Public psychiatric hospital	21.6	4.3	14.4	19.3	37.0	..	..	..	15.7
Public acute hospital	30.1	27.3	39.0	28.3	16.7	32.0	19.5	36.8	29.5
<i>Total inpatient expenditure (i)</i>	51.7	31.6	53.4	47.6	53.6	32.0	19.5	36.8	45.2
Community residential	2.8	17.2	..	1.5	1.3	22.8	12.9	0.9	6.4
Ambulatory	34.8	38.0	35.1	43.6	36.1	35.7	51.7	44.1	37.2
Non-government organisations	3.6	8.6	5.6	5.1	6.7	2.4	11.1	10.9	5.8
Indirect	7.2	4.5	5.9	2.2	2.3	7.1	4.8	7.3	5.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>2006-07</i>									
<i>Recurrent expenditure (\$million)</i>									
Public psychiatric hospital	189.2	32.9	70.4	66.9	80.0	..	..	..	439.4
Public acute hospital	310.2	206.2	190.0	98.6	55.0	29.8	14.2	10.3	914.3
<i>Total inpatient expenditure (i)</i>	499.4	239.1	260.4	165.5	135.0	29.8	14.2	10.3	1 353.8
Community residential	27.8	124.7	..	6.5	3.0	18.5	6.9	0.3	187.7

TABLE 12A.6

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	Vic	Qld (g)	WA	SA	Tas (h)	ACT	NT	Aust
Ambulatory	332.9	283.9	208.9	154.5	88.5	27.7	27.4	15.2	1 139.0
Non-government organisations	40.5	64.3	32.5	18.0	21.8	3.3	5.3	4.1	189.8
Indirect	63.2	43.0	29.3	10.7	4.8	4.3	1.9	2.1	159.1
Total expenditure	963.8	754.9	531.1	355.2	253.1	83.5	55.7	32.1	3 029.3
<i>Per cent</i>									
Public psychiatric hospital	19.6	4.4	13.3	18.8	31.6	..	..	..	14.5
Public acute hospital	32.2	27.3	35.8	27.8	21.7	35.7	25.5	32.1	30.2
<i>Total inpatient expenditure (i)</i>	51.8	31.7	49.0	46.6	53.4	35.7	25.5	32.1	44.7
Community residential	2.9	16.5	..	1.8	1.2	22.1	12.4	1.1	6.2
Ambulatory	34.5	37.6	39.3	43.5	35.0	33.2	49.3	47.5	37.6
Non-government organisations	4.2	8.5	6.1	5.1	8.6	3.9	9.5	12.8	6.3
Indirect	6.6	5.7	5.5	3.0	1.9	5.1	3.4	6.6	5.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>2007-08</i>									
<i>Recurrent expenditure (\$million)</i>									
Public psychiatric hospital	181.5	39.7	77.8	67.5	80.6	..	..	..	447.1
Public acute hospital	340.7	221.1	221.5	113.0	60.2	34.2	16.0	11.7	1 018.5
<i>Total inpatient expenditure (i)</i>	522.2	260.8	299.3	180.6	140.8	34.2	16.0	11.7	1 465.5
Community residential	15.1	131.3	..	9.1	6.3	19.3	7.4	0.5	189.1
Ambulatory	372.7	303.4	249.2	174.6	98.7	29.2	27.1	16.4	1 271.3
Non-government organisations	60.4	65.6	39.4	21.1	24.5	4.7	6.1	3.8	225.6
Indirect	66.8	42.0	33.2	13.7	5.7	4.7	3.3	2.4	171.9
Total expenditure	1 037.1	803.2	621.1	399.1	276.0	92.1	59.9	34.8	3 323.4
<i>Per cent</i>									
Public psychiatric hospital	17.5	4.9	12.5	16.9	29.2	..	..	..	13.5

TABLE 12A.6

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	Vic	Qld (g)	WA	SA	Tas (h)	ACT	NT	Aust
Public acute hospital	32.9	27.5	35.7	28.3	21.8	37.1	26.7	33.5	30.6
<i>Total inpatient expenditure (i)</i>	50.3	32.5	48.2	45.2	51.0	37.1	26.7	33.5	44.1
Community residential	1.5	16.3	..	2.3	2.3	21.0	12.4	1.3	5.7
Ambulatory	35.9	37.8	40.1	43.7	35.8	31.7	45.2	47.1	38.3
Non-government organisations	5.8	8.2	6.3	5.3	8.9	5.1	10.2	11.0	6.8
Indirect	6.4	5.2	5.3	3.4	2.1	5.2	5.5	7.0	5.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>2008-09</i>									
<i>Recurrent expenditure (\$million)</i>									
Public psychiatric hospital	181.5	37.2	80.6	74.3	80.7	..	..	..	454.4
Public acute hospital	405.6	241.0	227.8	124.4	66.0	35.9	16.4	13.0	1 130.1
<i>Total inpatient expenditure (i)</i>	587.2	278.2	308.4	198.7	146.8	35.9	16.4	13.0	1 584.5
Community residential	13.9	142.2	..	12.9	9.1	19.1	9.9	0.9	208.0
Ambulatory	401.9	323.5	285.2	193.4	113.3	32.1	31.4	17.2	1 397.8
Non-government organisations	57.7	70.0	46.1	23.7	24.0	4.7	6.2	3.6	236.0
Indirect	54.0	45.3	41.8	14.4	6.7	5.3	2.7	3.2	173.3
Total expenditure	1 114.6	859.2	681.5	443.0	299.9	97.0	66.5	37.9	3 599.6
<i>Per cent</i>									
Public psychiatric hospital	16.3	4.3	11.8	16.8	26.9	..	..	..	12.6
Public acute hospital	36.4	28.0	33.4	28.1	22.0	37.0	24.7	34.2	31.4
<i>Total inpatient expenditure (i)</i>	52.7	32.4	45.3	44.9	48.9	37.0	24.7	34.2	44.0
Community residential	1.2	16.6	..	2.9	3.0	19.7	14.8	2.3	5.8
Ambulatory	36.1	37.7	41.9	43.6	37.8	33.0	47.2	45.4	38.8
Non-government organisations	5.2	8.1	6.8	5.3	8.0	4.8	9.3	9.6	6.6
Indirect	4.8	5.3	6.1	3.2	2.2	5.5	4.0	8.4	4.8

TABLE 12A.6

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	Vic	Qld (g)	WA	SA	Tas (h)	ACT	NT	Aust
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>2009-10</i>									
<i>Recurrent expenditure (\$million)</i>									
Public psychiatric hospital	221.2	43.8	86.9	75.4	72.8	..	..	..	500.2
Public acute hospital	416.8	252.1	244.1	131.5	74.8	43.1	16.6	12.9	1 192.0
<i>Total inpatient expenditure (i)</i>	638.0	296.0	331.0	206.8	147.7	43.1	16.6	12.9	1 692.2
Community residential	11.9	152.3	..	14.9	9.0	20.2	10.6	1.3	220.3
Ambulatory	434.3	344.6	338.4	206.6	123.4	34.0	30.9	19.4	1 531.6
Non-government organisations	68.3	74.7	50.3	25.8	30.2	5.5	7.9	3.7	266.3
Indirect	65.5	56.6	46.9	14.1	6.9	6.3	2.5	2.8	201.7
Total expenditure	1 218.1	924.2	766.6	468.2	317.2	109.2	68.6	40.1	3 912.1
<i>Per cent</i>									
Public psychiatric hospital	18.2	4.7	11.3	16.1	23.0	..	..	..	12.8
Public acute hospital	34.2	27.3	31.8	28.1	23.6	39.5	24.3	32.2	30.5
<i>Total inpatient expenditure (i)</i>	52.4	32.0	43.2	44.2	46.6	39.5	24.3	32.2	43.3
Community residential	1.0	16.5	..	3.2	2.9	18.6	15.5	3.2	5.6
Ambulatory	35.7	37.3	44.1	44.1	38.9	31.2	45.1	48.3	39.1
Non-government organisations	5.6	8.1	6.6	5.5	9.5	5.0	11.5	9.3	6.8
Indirect	5.4	6.1	6.1	3.0	2.2	5.8	3.6	7.0	5.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>2010-11</i>									
<i>Recurrent expenditure (\$million)</i>									
Public psychiatric hospital	244.0	42.2	90.4	82.1	66.8	..	..	..	525.5
Public acute hospital	449.7	271.3	254.0	151.1	75.0	44.5	18.6	14.3	1 278.5
<i>Total inpatient expenditure (i)</i>	693.7	313.5	344.4	233.2	141.8	44.5	18.6	14.3	1 804.0

TABLE 12A.6

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	Vic	Qld (g)	WA	SA	Tas (h)	ACT	NT	Aust
Community residential	12.3	164.4	..	17.7	11.8	21.0	10.0	1.5	238.7
Ambulatory	467.4	368.8	364.4	221.4	135.7	36.2	32.3	20.9	1 647.2
Non-government organisations	72.6	80.4	65.6	28.5	36.5	7.7	8.6	3.4	303.2
Indirect	69.2	58.3	60.7	24.6	6.3	7.0	3.0	3.3	232.2
Total expenditure	1 315.3	985.4	835.0	525.5	331.9	116.4	72.5	43.3	4 225.4
<i>Per cent</i>									
Public psychiatric hospital	18.6	4.3	10.8	15.6	20.1	..	..	..	12.4
Public acute hospital	34.2	27.5	30.4	28.8	22.6	38.2	25.6	33.0	30.3
<i>Total inpatient expenditure (i)</i>	52.7	31.8	41.2	44.4	42.7	38.2	25.6	33.0	42.7
Community residential	0.9	16.7	..	3.4	3.5	18.1	13.8	3.4	5.6
Ambulatory	35.5	37.4	43.6	42.1	40.9	31.1	44.6	48.3	39.0
Non-government organisations	5.5	8.2	7.9	5.4	11.0	6.6	11.9	7.8	7.2
Indirect	5.3	5.9	7.3	4.7	1.9	6.0	4.1	7.5	5.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>2011-12</i>									
<i>Recurrent expenditure (\$million)</i>									
Public psychiatric hospital	235.0	40.8	97.4	88.8	63.8	..	..	..	525.8
Public acute hospital	507.8	274.6	267.5	167.2	73.6	40.6	19.4	16.0	1 366.7
<i>Total inpatient expenditure (i)</i>	742.8	315.4	364.9	256.0	137.5	40.6	19.4	16.0	1 892.5
Community residential	12.7	164.1	..	21.6	18.4	19.8	11.0	1.5	249.2
Ambulatory	497.3	394.4	401.5	240.3	144.5	34.3	35.4	23.3	1 770.9
Non-government organisations	70.3	83.6	69.4	31.8	33.5	6.5	10.5	3.6	309.3
Indirect	68.4	56.1	55.5	31.9	8.6	6.3	2.8	4.3	233.9
Total expenditure	1 391.6	1 013.6	891.3	581.5	342.5	107.5	79.2	48.6	4 455.8

TABLE 12A.6

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	Vic	Qld (g)	WA	SA	Tas (h)	ACT	NT	Aust
<i>Per cent</i>									
Public psychiatric hospital	16.9	4.0	10.9	15.3	18.6	..	..	..	11.8
Public acute hospital	36.5	27.1	30.0	28.8	21.5	37.7	24.5	32.9	30.7
<i>Total inpatient expenditure (i)</i>	53.4	31.1	40.9	44.0	40.1	37.7	24.5	32.9	42.5
Community residential	0.9	16.2	..	3.7	5.4	18.5	13.9	3.1	5.6
Ambulatory	35.7	38.9	45.0	41.3	42.2	31.9	44.7	47.9	39.7
Non-government organisations	5.1	8.3	7.8	5.5	9.8	6.1	13.3	7.3	6.9
Indirect	4.9	5.5	6.2	5.5	2.5	5.9	3.5	8.8	5.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>2012-13</i>									
<i>Recurrent expenditure (\$million)</i>									
Public psychiatric hospital	216.2	40.5	94.4	91.4	57.9	..	..	..	500.4
Public acute hospital	591.1	286.3	276.9	186.7	72.3	39.7	22.0	17.8	1 492.8
<i>Total inpatient expenditure (i)</i>	807.4	326.8	371.3	278.1	130.1	39.7	22.0	17.8	1 993.2
Community residential	8.1	172.1	..	23.2	19.2	22.2	11.7	1.6	258.1
Ambulatory	491.8	401.6	401.2	248.0	157.0	36.1	35.7	23.5	1 794.8
Non-government organisations	76.1	89.4	58.9	41.7	31.7	6.5	13.3	3.6	321.2
Indirect	57.5	56.4	41.9	32.7	11.2	6.8	3.0	3.3	212.7
Total expenditure	1 440.9	1 046.3	873.4	623.6	349.2	111.2	85.7	49.7	4 580.0
<i>Per cent</i>									
Public psychiatric hospital	15.0	3.9	10.8	14.7	16.6	..	..	..	10.9
Public acute hospital	41.0	27.4	31.7	29.9	20.7	35.7	25.7	35.8	32.6
<i>Total inpatient expenditure (i)</i>	56.0	31.2	42.5	44.6	37.3	35.7	25.7	35.8	43.5
Community residential	0.6	16.4	..	3.7	5.5	20.0	13.7	3.1	5.6
Ambulatory	34.1	38.4	45.9	39.8	45.0	32.4	41.6	47.3	39.2

TABLE 12A.6

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	<i>NSW (f)</i>	<i>Vic</i>	<i>Qld (g)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (h)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Non-government organisations	5.3	8.5	6.7	6.7	9.1	5.8	15.5	7.2	7.0
Indirect	4.0	5.4	4.8	5.2	3.2	6.1	3.5	6.6	4.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

- (a) Expenditure is current prices for all years and includes all spending, regardless of source of funds.
- (b) Depreciation is excluded for all years.
- (c) See the AIHW *Mental Health Services in Australia* on-line publication (<http://mhsa.aihw.gov.au/resources/expenditure/data-source/>) for a full description of the derivation of expenditure estimates.
- (d) Due to the ongoing validation of NMDS, data could differ from previous reports.
- (e) Totals may not add due to rounding
- (f) The quality of the NSW 2010-11 *MHE NMDS* data has been affected by the reconfiguration of the service system during the year.
- (g) Queensland does not fund community residential services, however, it funds a number of extended treatment services, both campus and non-campus based, which provide longer term inpatient treatment and rehabilitation services with a full clinical staffing 24 hours a day seven days a week. In addition, Queensland have advised that funding to non-government services for psychiatric disability support services is administered either by Queensland Health or Disability Services Queensland (DSQ).
- (h) For Tasmania, in 2005-06, non-government organisations (NGOs) providing residential services were included for the first time in the community residential category. As these NGOs are now categorised as residential services, NGO funding has decreased from previous years. Indirect/residual expenditure represents State indirect/residual expenditure. If organisational indirect expenditure were included this expenditure would have been \$10 719 100.
- (i) Includes expenditure on public hospital services managed and operated by private and non-government entities.
- .. Not applicable.

Source: AIHW (unpublished) MHE NMDS; State and Territory governments (unpublished).

Table 12A.7 Functioning and quality of life measures, by 12-month mental disorder status, 2007 (per cent) (a)

	<i>Any 12-month mental disorder (b)</i>	<i>No 12-month mental disorder</i>	<i>Total</i>
<i>Level of psychological distress (c)</i>			
Low	10.9 ± 1.1	89.1 ± 1.0	100.0
Moderate	32.0 ± 2.6	68.0 ± 2.5	100.0
High	57.1 ± 5.1	42.9 ± 5.1	100.0
Very high	79.6 ± 7.2	20.4 ± 7.1	100.0
<i>Disability status (d)</i>			
Profound/severe	42.9 ± 8.2	57.1 ± 8.2	100.0
Moderate/mild	32.1 ± 5.5	67.9 ± 5.6	100.0
Schooling/employment restriction only	43.4 ± 7.1	56.6 ± 7.1	100.0
No disability/no specific limitations or restrictions	16.6 ± 1.1	83.4 ± 1.1	100.0
<i>Days out of role (e)</i>			
0 days	14.7 ± 1.3	85.3 ± 1.3	100.0
1 to 7 days	28.5 ± 2.5	71.5 ± 2.5	100.0
More than 7 days	42.0 ± 5.2	58.0 ± 5.2	100.0
<i>Suicidal behaviour</i>			
Ideation (f)	71.7 ± 8.7	28.3 ± 8.7	100.0
Plans	77.5 ± 12.6	22.5* ± 12.6	100.0
Attempts	94.2 ± 9.0	5.8** ± 8.9	100.0
No suicidal behaviours	18.7 ± 1.1	81.3 ± 1.1	100.0
<i>Total people aged 16–85 years</i>	20.0 ± 1.1	80.0 ± 1.1	100.0

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A ** indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution. A *** indicates a RSE of greater than 50 per cent. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(b) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(c) Level of psychological distress is measured by the Kessler Psychological Distress Scale (K10), from which a score of 10 to 50 is produced. Higher scores indicate a higher level of distress; low scores indicate a low level of distress. Scores are grouped as follows: Low 10–15, Moderate 16–21, High 22–29, and Very high 30–50.

(d) Disability status relates to whether a person has disability, a core-activity limitation (mild, moderate, severe or profound), or a schooling or employment restriction.

(e) People who were unable to carry out or had to cut down on their usual activities in the 30 days prior to interview. Total includes 'not stated'.

(f) Suicidal ideation refers to the presence of serious thoughts about committing suicide.

Source: ABS (2008) *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, Cat. no. 4326.0.

TABLE 12A.8

Table 12A.8 **Age standardised rate of adults with very high levels of psychological distress, by State and Territory, 2011-12 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
<i>Age standardised proportion</i>										
Males	%	2.5	3.3	2.9	2.1	2.8	2.3*	2.5	2.4*	2.7
Females	%	3.8	4.0	4.8	3.8	3.7	4.0	3.1	4.0	4.1
Total	%	3.2	3.7	3.9	3.0	3.3	3.2	2.8	3.2	3.4
<i>Relative standard errors</i>										
Males	%	20.2	15.5	18.6	23.9	20.3	32.2	22.1	34.5	9.5
Females	%	13.4	15.7	13.2	14.1	16.8	20.7	20.7	23.0	7.1
Total	%	12.0	11.7	12.1	13.0	12.7	17.7	15.4	20.1	5.9
<i>95 per cent confidence intervals</i>										
Males	±	1.0	1.0	1.1	1.0	1.1	1.5	1.1	1.6	0.5
Females	±	1.0	1.2	1.2	1.0	1.2	1.6	1.3	1.8	0.6
Total	±	0.7	0.8	0.9	0.8	0.8	1.1	0.9	1.3	0.4

(a) Denominator includes a small number of persons for whom levels of psychological distress were unable to be determined.

(b) Adults are defined as persons aged 18 years and over.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults).

(d) Estimates with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

(e) Data for the NT should be used with care as exclusion of very remote areas from the *National Health Survey* 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.

Table 12A.9 Age standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2011-12 (a), (b), (c), (d)

	<i>Age standardised proportion (%)</i>	<i>Relative standard error (%)</i>	<i>95 % confidence interval (±)</i>
<i>Remoteness of residence</i>			
Major cities	3.3	8.0	0.5
Inner regional	3.8	12.8	0.9
Outer regional	3.5	19.2	1.3
Remote	2.9*	42.1	2.4
Very remote (e)	..	..	..
<i>SEIFA of residence (quintiles) (f)</i>			
Quintile 1	5.4	12.6	1.3
Quintile 2	4.1	8.8	0.7
Quintile 3	3.5	12.7	0.9
Quintile 4	2.8	13.3	0.7
Quintile 5	1.9	17.2	0.6
<i>SEIFA of residence (deciles) (f)</i>			
Decile 1	5.7	15.9	1.8
Decile 2	5.2	17.4	1.8
Decile 3	3.9	14.8	1.1
Decile 4	4.2	14.5	1.2
Decile 5	4.1	17.5	1.4
Decile 6	2.9	15.8	0.9
Decile 7	3.0	18.8	1.1
Decile 8	2.7	21.5	1.1
Decile 9	2.0	23.8	1.0
Decile 10	1.7*	25.3	0.9
<i>Disability status</i>			
With disability or restrictive long-term health condition	8.2	6.7	1.1
No disability or restrictive long-term health condition	1.1	9.4	0.2

SEIFA = Socio-Economic Indexes for Areas

- (a) Denominator includes a small number of persons for whom levels of psychological distress were unable to be determined
- (b) Adults are defined as persons aged 18 years and over.
- (c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18).
- (d) Estimates with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.
- (e) Very remote data was not collected in the 2011-12 component of the 2011-13 AHS.
- (f) Socioeconomic Index for Areas, Index of relative disadvantage. Quintile/decile 1 contains areas of most disadvantage
- .. Not applicable.

Table 12A.9 **Age standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2011-12 (a), (b), (c), (d)**

	<i>Age standardised proportion (%)</i>	<i>Relative standard error (%)</i>	<i>95 % confidence interval (\pm)</i>
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Source: ABS (unpublished) *Australian Health Survey 2011-13 (2011-12 NHS component)*, Cat. no. 4364.0.

TABLE 12A.10

Table 12A.10 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2011-12 (a), (b), (c), (d)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
<i>Age standardised proportion</i>										
<i>Remoteness of residence</i>										
Major cities	%	10.6	10.7	10.6	10.3	10.5	..	9.1	..	10.6
Inner regional	%	9.9	13.1	11.9	13.3	11.0*	8.8	–	..	11.4
Outer regional/remote	%	8.3*	13.2*	9.9	9.8	16.8	10.4	..	9.0	10.8
Very remote (e)	%
<i>SEIFA of residence (quintiles) (f)</i>										
Quintile 1	%	15.9	16.4	19.6	16.5	17.6	11.2	np	11.1	16.7
Quintile 2	%	14.0	13.0	11.9	13.4	12.5	9.3	11.4*	6.8*	12.9
Quintile 3	%	11.0	11.6	11.3	10.3	8.2	10.2	11.0*	10.0*	10.9
Quintile 4	%	8.3	9.6	7.7	6.7	5.9*	6.7*	10.6	9.1*	8.1
Quintile 5	%	5.7	7.8	8.1	8.3	10.1	5.9*	7.3	6.8*	7.4
<i>Disability status</i>										
With disability or restrictive long-term health condition	%	21.2	26.6	21.4	22.1	24.3	17.4	17.5	20.4	22.7
No disability or restrictive long-term health condition	%	5.2	4.8	5.1	4.7	5.1	3.8	4.4	3.8	5.0
Total	%	10.4	11.4	10.8	10.6	11.4	9.1	9.1	9.0	10.8
<i>Relative standard errors</i>										
<i>Remoteness of residence</i>										
Major cities	%	6.5	6.9	8.4	8.0	8.5	–	9.7	..	3.4
Inner regional	%	16.9	13.4	13.7	22.4	29.3	10.5	–	..	7.3
Outer regional/remote	%	44.2	31.7	22.0	19.2	19.2	16.9	..	15.0	11.5
Very remote (e)	%

TABLE 12A.10

Table 12A.10 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2011-12 (a), (b), (c), (d)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
<i>SEIFA of residence (quintiles) (f)</i>										
Quintile 1	%	12.7	11.9	17.3	13.4	13.1	14.2	np	23.5	7.8
Quintile 2	%	12.2	12.6	11.9	15.2	11.9	17.4	34.7	36.8	5.2
Quintile 3	%	17.6	12.2	10.6	17.4	21.2	16.5	26.4	30.6	6.1
Quintile 4	%	17.1	15.9	16.1	16.5	29.7	28.7	15.9	25.6	9.6
Quintile 5	%	19.8	20.9	16.4	19.2	24.7	47.7	16.9	28.4	9.0
<i>Disability status</i>										
With disability or restrictive long-term health condition	%	9.5	7.1	7.7	8.1	8.5	11.5	13.1	15.3	3.7
No disability or restrictive long-term health condition	%	11.0	10.6	11.7	14.2	12.6	18.7	16.1	21.8	4.8
Total	%	6.7	6.2	6.3	7.2	7.3	8.8	9.7	15.0	3.2
<i>95 per cent confidence intervals</i>										
<i>Remoteness of residence</i>										
Major cities	±	1.4	1.4	1.7	1.6	1.8	..	1.7	..	0.7
Inner regional	±	3.3	3.4	3.2	5.8	6.3	1.8	–	..	1.6
Outer regional/remote	±	7.2	8.2	4.3	3.7	6.3	3.5	..	2.7	2.4
Very remote (e)	±
<i>SEIFA of residence (quintiles) (f)</i>										
Quintile 1	±	4.0	3.8	6.6	4.3	4.5	3.1	np	5.1	2.5
Quintile 2	±	3.3	3.2	2.8	4.0	2.9	3.2	7.7	4.9	1.3
Quintile 3	±	3.8	2.8	2.4	3.5	3.4	3.3	5.7	6.0	1.3
Quintile 4	±	2.8	3.0	2.4	2.1	3.4	3.8	3.3	4.5	1.5
Quintile 5	±	2.2	3.2	2.6	3.1	4.9	5.5	2.4	3.8	1.3

TABLE 12A.10

Table 12A.10 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2011-12 (a), (b), (c), (d)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
<i>Disability status</i>										
With disability or restrictive long-term health condition	±	3.9	3.7	3.2	3.5	4.1	3.9	4.5	6.1	1.7
No disability or restrictive long-term health condition	±	1.1	1.0	1.2	1.3	1.3	1.4	1.4	1.6	0.5
Total	±	1.4	1.4	1.3	1.5	1.6	1.6	1.7	2.7	0.7

SEIFA = Socio-Economic Indexes for Areas

(a) Total includes a small number of persons for whom levels of psychological distress were unable to be determined

(b) Adults are defined as persons aged 18 years and over.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18).

(d) Estimates with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

(e) Very remote data was not collected in the 2011-12 component of the 2011-13 AHS. Data for the NT should be used with care as exclusion of very remote areas from the National Health Survey translates to the exclusion of around 23 per cent of the NT population.

(f) Socioeconomic Index for Areas, Index of relative disadvantage. Quintile/decile 1 contains areas of most disadvantage

.. Not applicable. – Nil or rounded to zero. **np** Not published.

Source: ABS (unpublished) *Australian Health Survey 2011-13 (2011-12 NHS component)*, Cat. no. 4364.

TABLE 12A.11

Table 12A.11 **Age standardised rate of adults with very high levels of psychological distress, by State and Territory, 2007-08 (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Age standardised proportion (c)</i>										
Males	%	3.2	3.0	2.0	2.3	3.5	*2.5	np	np	2.8
Females	%	4.8	4.0	4.1	3.3	3.5	*4.0	np	np	4.1
Total	%	4.0	3.5	3.1	2.8	3.5	3.3	3.4	np	3.5
<i>Relative standard errors (d)</i>										
Males	%	18.0	23.0	20.3	22.1	19.8	31.4	np	np	9.2
Females	%	16.1	16.0	15.5	17.8	18.6	26.0	np	np	9.3
Total	%	11.9	13.3	13.5	13.6	13.8	20.0	17.6	np	6.7
<i>95 per cent confidence intervals</i>										
Males	±	1.1	1.3	0.8	1.0	1.4	1.5	np	np	0.5
Females	±	1.5	1.2	1.2	1.2	1.3	2.0	np	np	0.8
Total	±	0.9	0.9	0.8	0.8	1.0	1.3	1.2	np	0.5

(a) Psychological distress levels derived from the K10. Denominator includes a small number of people for whom levels of psychological distress were unable to be determined

(b) Adults are defined as people aged 18 years and over.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults).

(d) Estimates with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

np Not published.

Source: ABS (unpublished) *National Health Survey, 2007-08*, Cat. no. 4364.0.

Table 12A.12 Age standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2007-08 (a), (b)

	<i>Proportion (c)</i>	<i>Relative standard error (%) (d)</i>	<i>95 % confidence interval (\pm)</i>
<i>Remoteness of residence</i>			
Major cities	3.6	8.0	0.6
Inner regional	3.3	11.5	0.8
Outer regional	3.0	14.7	0.9
Remote	*3.2	32.5	2.0
Very remote (e)	..	..	..
<i>SEIFA of residence (quintiles)</i>			
Quintile 1	6.5	9.5	1.2
Quintile 2	3.7	12.7	0.9
Quintile 3	3.3	15.1	1.0
Quintile 4	2.1	16.1	0.7
Quintile 5	2.3	19.0	0.9
<i>SEIFA of residence (deciles)</i>			
Decile 1	8.1	12.2	1.9
Decile 2	5.1	12.3	1.2
Decile 3	4.1	16.1	1.3
Decile 4	3.2	19.3	1.2
Decile 5	3.7	23.7	1.7
Decile 6	2.7	17.0	0.9
Decile 7	2.1	22.6	0.9
Decile 8	2.2	22.1	1.0
Decile 9	*2.9	25.2	1.4
Decile 10	*1.5	27.0	0.8
<i>Disability status</i>			
With disability or restrictive long-term health condition	7.3	6.4	0.9
No disability or restrictive long-term health condition	1.0	16.4	0.3
Total	3.5	6.7	0.5

SEIFA = Socio-Economic Indexes for Areas

(a) Adults are defined as people aged 18 years and over.

(b) Psychological distress levels derived from the K10. Denominator includes a small number of people for whom levels of psychological distress were unable to be determined.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults).

(d) Estimate with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

(e) Very remote data were not collected in the 2007-08 NHS.

Table 12A.12 **Age standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2007-08 (a), (b)**

	<i>Proportion (c)</i>	<i>Relative standard error (%) (d)</i>	<i>95 % confidence interval (\pm)</i>
..	Not applicable.		

Source: ABS (unpublished) *National Health Survey, 2007-08*, Cat. no. 4364.0.

TABLE 12A.13

Table 12A.13 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2007-08 (a), (b)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Age standardised proportion (c)</i>										
<i>Remoteness of residence</i>										
Major cities	%	13.4	11.9	11.2	9.7	12.3	..	10.9	..	12.1
Inner regional	%	12.1	11.7	11.9	10.9	*13.3	11.6	–	..	11.9
Outer regional/remote	%	*12.2	8.5	13.0	*9.6	14.2	9.9	..	*13.4	11.8
Very remote (d)	%
<i>SEIFA of residence (quintiles)</i>										
Quintile 1	%	20.1	18.6	15.8	19.3	20.4	15.9	np	np	18.6
Quintile 2	%	13.2	14.0	12.4	9.3	13.8	8.7	np	np	12.6
Quintile 3	%	11.4	11.5	11.4	14.3	13.1	9.0	*20.5	np	11.9
Quintile 4	%	9.8	8.5	*7.8	8.2	9.0	*6.7	12.4	np	8.9
Quintile 5	%	10.1	10.0	9.5	*3.9	9.9	*9.4	7.1	*23.4	9.2
<i>Disability status</i>										
With disability or restrictive long-term health condition	%	23.4	21.0	18.7	17.9	24.8	19.9	19.4	np	21.0
No disability or restrictive long-term health condition	%	6.3	5.3	6.8	5.1	5.2	4.8	4.6	np	5.9
<i>Gender</i>										
Males	%	10.2	8.5	9.0	8.6	12.2	9.0	9.8	np	9.6
Females	%	15.4	15.0	14.0	11.4	13.8	12.5	12.0	15.1	14.4
Total	%	12.8	11.8	11.5	10.0	13.0	10.8	10.9	*13.4	12.0
<i>Relative standard errors (e)</i>										
<i>Remoteness of residence</i>										
Major cities	%	6.6	7.9	10.1	8.7	8.3	..	9.3	..	3.6
Inner regional	%	14.9	15.8	14.1	22.3	26.3	12.6	–	..	7.0

TABLE 12A.13

Table 12A.13 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2007-08 (a), (b)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Outer regional/remote	%	26.4	24.4	12.2	27.4	19.8	14.0	..	36.8	7.3
Very remote (d)	%
<i>SEIFA of residence (quintiles)</i>										
Quintile 1	%	8.2	12.6	11.3	13.7	12.9	12.6	np	np	5.1
Quintile 2	%	15.3	14.3	11.6	16.9	18.5	16.9	np	np	7.0
Quintile 3	%	15.5	13.7	12.0	16.3	17.0	24.2	29.9	np	6.9
Quintile 4	%	13.6	17.8	25.7	17.0	22.1	28.8	15.9	np	8.6
Quintile 5	%	15.2	17.6	21.5	29.8	16.6	32.4	16.1	44.5	7.8
<i>Disability status</i>										
With disability or restrictive long-term health condition	%	6.7	7.8	9.2	8.5	8.0	11.8	9.4	np	3.9
No disability or restrictive long-term health condition	%	9.4	12.5	14.5	14.0	15.5	19.6	17.4	np	5.5
<i>Gender</i>										
Males	%	9.6	11.3	12.9	10.8	12.1	14.3	14.3	np	4.5
Females	%	7.2	8.0	7.8	9.3	9.9	14.1	10.4	18.3	4.0
Total	%	5.7	6.6	7.7	7.2	8.3	9.3	9.4	36.8	3.1
<i>95 per cent confidence intervals</i>										
<i>Remoteness of residence</i>										
Major cities	±	1.7	1.8	2.2	1.6	2.0	..	2.0	..	0.9
Inner regional	±	3.5	3.6	3.3	4.7	6.9	2.8	–	..	1.6
Outer regional/remote	±	6.3	4.1	3.1	5.2	5.5	2.7	..	9.7	1.7
Very remote (d)	±
<i>SEIFA of residence (quintiles)</i>										
Quintile 1	±	3.2	4.6	3.5	5.2	5.2	3.9	np	np	1.8

TABLE 12A.13

Table 12A.13 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2007-08 (a), (b)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Quintile 2	±	4.0	3.9	2.8	3.1	5.0	2.9	np	np	1.7
Quintile 3	±	3.5	3.1	2.7	4.6	4.4	4.3	12.0	np	1.6
Quintile 4	±	2.6	3.0	3.9	2.7	3.9	3.8	3.9	np	1.5
Quintile 5	±	3.0	3.5	4.0	2.3	3.2	5.9	2.2	20.4	1.4
<i>Disability status</i>										
With disability or restrictive long-term health condition	±	3.1	3.2	3.4	3.0	3.9	4.6	3.6	np	1.6
No disability or restrictive long-term health condition	±	1.2	1.3	1.9	1.4	1.6	1.8	1.6	np	0.6
<i>Gender</i>										
Males	±	1.9	1.9	2.3	1.8	2.9	2.5	2.7	np	0.8
Females	±	2.2	2.4	2.1	2.1	2.7	3.4	2.4	5.4	1.1
Total	±	1.4	1.5	1.7	1.4	2.1	2.0	2.0	9.7	0.7

SEIFA = Socio-Economic Indexes for Areas

(a) Adults are defined as people aged 18 years and over.

(b) Psychological distress levels derived from the K10. Denominator includes a small number of people for whom levels of psychological distress were unable to be determined.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults).

(d) Very remote data were not collected in the 2007-08 NHS.

(e) Estimate with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

– Nil or rounded to zero. **np** Not published. .. Not applicable.

Source: ABS (unpublished) *National Health Survey, 2007-08*, Cat. no. 4364.0.

TABLE 12A.14

Table 12A.14 Level of psychological distress K10, 2007-08 (per cent) (a), (b)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (c)	Aust
<i>Males</i>									
18–64 years									
Low (10–15)	70.6 ± 3.4	72.4 ± 3.4	70.2 ± 4.2	68.3 ± 3.8	67.9 ± 4.4	75.2 ± 5.3	69.3 ± 3.6	np	70.5 ± 1.7
Moderate (16–21)	19.1 ± 2.7	18.7 ± 3.4	19.9 ± 3.5	22.8 ± 4.0	19.2 ± 2.4	15.7 ± 4.5	20.6 ± 3.2	np	19.6 ± 1.6
High (22–29) & Very high (30–50)	10.3 ± 2.1	8.9 ± 2.3	9.9 ± 2.5	8.9 ± 2.1	12.9 ± 3.5	9.1 ± 2.7	10.1 ± 2.8	np	9.9 ± 1.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
65 years or over									
Low (10–15)	77.1 ± 5.2	83.7 ± 4.8	75.2 ± 6.7	82.8 ± 7.0	74.0 ± 6.4	73.1 ± 8.5	74.2 ± 10.8	np	78.7 ± 2.8
Moderate (16–21)	12.6 ± 4.2	9.5 ± 4.1	19.3 ± 6.0	10.7* ± 6.0	16.4 ± 5.9	15.6 ± 6.7	18.5* ± 12.3	np	13.3 ± 2.4
High (22–29) & Very high (30–50)	10.3 ± 4.1	6.8 ± 2.7	5.5* ± 3.1	6.5* ± 4.5	9.6* ± 4.7	11.3* ± 6.8	7.4* ± 6.3	np	8.0 ± 1.8
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
Total									
Low (10–15)	71.7 ± 3.2	74.1 ± 2.8	71.0 ± 3.9	70.4 ± 3.3	69.0 ± 3.5	74.8 ± 4.8	69.8 ± 3.7	63.9 ± 17.1	71.8 ± 1.6
Moderate (16–21)	18.1 ± 2.4	17.3 ± 2.8	19.8 ± 3.2	21.1 ± 3.5	18.7 ± 2.0	15.7 ± 4.1	20.3 ± 3.6	23.9* ± 14.1	18.6 ± 1.4
High (22–29) & Very high (30–50)	10.3 ± 1.9	8.6 ± 1.9	9.2 ± 2.3	8.6 ± 1.8	12.3 ± 3.1	9.5 ± 2.7	9.8 ± 2.7	12.3* ± 12.2	9.6 ± 0.9
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>Females</i>									
18–64 years									
Low (10–15)	60.9 ± 3.0	61.4 ± 3.5	58.4 ± 3.9	68.1 ± 3.3	62.1 ± 4.0	65.0 ± 4.8	61.0 ± 3.7	np	61.4 ± 1.5
Moderate (16–21)	23.7 ± 2.9	22.7 ± 2.9	26.6 ± 3.8	19.7 ± 3.2	23.0 ± 3.1	21.3 ± 4.0	27.4 ± 3.5	np	23.6 ± 1.5
High (22–29) & Very high (30–50)	15.4 ± 2.4	15.8 ± 2.4	15.1 ± 2.5	12.2 ± 2.4	14.8 ± 3.1	13.7 ± 4.0	11.6 ± 2.5	np	15.0 ± 1.2
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
65 years and over									
Low (10–15)	65.1 ± 5.1	70.7 ± 7.2	75.1 ± 6.2	75.4 ± 5.6	76.5 ± 5.2	70.4 ± 7.2	67.7 ± 8.4	np	70.5 ± 3.0
Moderate (16–21)	19.5 ± 5.1	18.1 ± 5.6	16.6 ± 5.2	16.5 ± 5.2	15.6 ± 4.3	22.4 ± 6.5	18.3 ± 7.4	np	18.1 ± 2.6

TABLE 12A.14

Table 12A.14 Level of psychological distress K10, 2007-08 (per cent) (a), (b)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (c)	Aust
High (22–29) & Very high (30–50)	15.4 ± 3.7	11.2* ± 5.5	8.3 ± 3.8	8.1 ± 3.5	7.8 ± 3.4	7.2* ± 3.9	14.0 ± 6.7	np	11.5 ± 2.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
Total									
Low (10–15)	61.7 ± 2.6	63.1 ± 3.3	61.0 ± 3.7	69.3 ± 2.8	65.0 ± 3.5	66.0 ± 3.9	61.9 ± 3.4	59.0 ± 19.6	63.0 ± 1.4
Moderate (16–21)	23.0 ± 2.6	21.9 ± 2.5	25.0 ± 3.4	19.2 ± 2.6	21.6 ± 2.8	21.5 ± 3.6	26.2 ± 3.2	26.6 ± 14.5	22.7 ± 1.4
High (22–29) & Very high (30–50)	15.4 ± 2.2	15.0 ± 2.4	14.0 ± 2.1	11.5 ± 2.2	13.4 ± 2.6	12.4 ± 3.2	11.9 ± 2.4	14.4* ± 9.7	14.4 ± 1.1
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
People									
18–64 years									
Low (10–15)	65.8 ± 2.2	66.9 ± 2.2	64.2 ± 2.9	68.2 ± 2.8	65.0 ± 3.2	70.0 ± 3.4	65.1 ± 2.6	np	66.0 ± 1.1
Moderate (16–21)	21.4 ± 1.9	20.7 ± 2.1	23.3 ± 2.6	21.3 ± 2.7	21.1 ± 1.9	18.5 ± 2.6	24.0 ± 2.4	np	21.6 ± 1.1
High (22–29) & Very high (30–50)	12.8 ± 1.5	12.4 ± 1.7	12.5 ± 1.9	10.5 ± 1.7	13.8 ± 2.5	11.5 ± 2.2	10.9 ± 2.1	np	12.4 ± 0.8
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
65 years and over									
Low (10–15)	70.7 ± 3.7	76.7 ± 4.6	75.2 ± 4.9	78.9 ± 4.5	75.4 ± 4.0	71.6 ± 5.5	70.7 ± 6.1	np	74.3 ± 2.3
Moderate (16–21)	16.3 ± 3.5	14.1 ± 3.3	17.9 ± 4.2	13.7 ± 4.1	16.0 ± 3.4	19.3 ± 4.4	18.4 ± 6.2	np	15.9 ± 1.9
High (22–29) & Very high (30–50)	13.0 ± 3.0	9.2 ± 3.4	6.9 ± 2.7	7.3 ± 2.7	8.6 ± 3.0	9.1 ± 3.7	10.9 ± 4.8	np	9.9 ± 1.4
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
Total									
Low (10–15)	66.6 ± 2.0	68.5 ± 2.0	65.9 ± 2.7	69.8 ± 2.4	67.0 ± 2.6	70.3 ± 3.0	65.8 ± 2.5	61.6 ± 15.4	67.3 ± 1.0
Moderate (16–21)	20.5 ± 1.8	19.6 ± 1.8	22.4 ± 2.3	20.1 ± 2.3	20.2 ± 1.6	18.7 ± 2.2	23.3 ± 2.4	25.1 ± 12.0	20.7 ± 1.0
High (22–29) & Very high (30–50)	12.9 ± 1.4	11.9 ± 1.5	11.6 ± 1.7	10.0 ± 1.4	12.9 ± 2.1	11.0 ± 1.9	10.9 ± 2.0	13.3* ± 8.1	12.0 ± 0.7
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 12A.14 **Level of psychological distress K10, 2007-08 (per cent) (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
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- (a) Derived from the Kessler Psychological Distress Scale–10 items (K10). This is a scale of non-specific psychological distress based on 10 questions about negative emotional states in the 4 weeks prior to interview. The K10 is scored from 10 to 50, with higher scores indicating a higher level of distress; low scores indicate a low level of distress. Scores are grouped as follows: Low 10–15, Moderate 16–21, High 22–29, and Very high 30–50.
- (b) A '*' indicates a RSE of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use. These estimates are not published.
- (c) Separate estimates for the NT are not available for some estimates from this survey, but the NT contributes to national estimates.
- (d) Totals include not stated.

np Not published.

Source: ABS (unpublished) *National Health Survey, 2007-08*, Cat. no. 4364.0.

TABLE 12A.15

Table 12A.15 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, by Indigenous status, 2011-13 (a), (b), (c), (d), (e)**

	<i>unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
<i>Age standardised proportion (%)</i>										
Aboriginal and Torres Strait Islander	rate	30.5	31.5	30.3	28.5	32.8	26.3	30.9	21.6	29.4
Non-Indigenous	rate	9.9	11.3	11.5	10.9	12.2	9.9	8.9	8.2	10.8
<i>Relative standard errors</i>										
Aboriginal and Torres Strait Islander	%	8.2	7.8	7.0	5.9	7.4	10.4	16.8	8.8	3.6
Non-Indigenous	%	6.8	6.1	6.5	7.8	7.4	9.0	9.1	13.2	3.0
<i>95 per cent confidence intervals</i>										
Aboriginal and Torres Strait Islander	±	4.9	4.8	4.1	3.3	4.8	5.4	10.2	3.7	2.1
Non-Indigenous	±	1.3	1.3	1.5	1.7	1.8	1.8	1.6	2.1	0.6

(a) Levels of psychological distress are derived from the Kessler Psychological Distress Scale (K5). Denominator includes a small number of persons for whom levels of psychological distress were unable to be determined.

(b) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (10 year ranges from 18 years).

(c) Adults are defined as persons aged 18 years and over.

(d) Totals for Aboriginal and Torres Strait Islander persons exclude a small number of persons for whom responses were provided by proxy but who were not present at interview.

(e) Data for the NT should be used with care as exclusion of very remote areas from the *National Health Survey* translates to the exclusion of around 23 per cent of the NT population.

Source: ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Survey component) and ABS (unpublished) *Australian Health Survey 2011-13* (2011-12 NHS component).

TABLE 12A.16

Table 12A.16 Level of psychological distress K10, 2004-05 (per cent) (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
2004-05									
Males									
18–64 years									
Low (10–15)	65.9	64.8	64.5	68.1	64.7	68.9	65.8	na	65.6
Moderate (16–21)	23.3	23.8	23.4	22.1	24.5	19.7	24.8	na	23.3
High (22–29) & Very high (30–50)	10.7	11.1	11.9	9.8	10.5	11.1	9.4	na	11.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
65 years and over									
Low (10–15)	71.4	73.9	66.0	80.9	76.1	74.4	65.5	na	72.4
Moderate (16–21)	17.7	15.7	19.8	13.0	18.5	15.7	25.4	na	17.2
High (22–29) & Very high (30–50)	10.9*	9.8*	14.0*	6.0	5.3*	9.9*	9.1	na	10.2
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
Total									
Low (10–15)	66.8	66.2	64.7	69.9	66.7	69.8	65.8	na	66.6
Moderate (16–21)	22.4	22.6	22.9	20.9	23.5	19.0	24.8	na	22.4
High (22–29) & Very high (30–50)	10.8	10.9	12.2	9.2	9.6	10.9	9.4	na	10.8
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
Females									
18–64 years									
Low (10–15)	58.6	55.0	58.1	63.3	58.4	63.8	55.5	na	58.1
Moderate (16–21)	26.6	28.2	25.1	21.2	26.1	21.0	29.2	na	26.0
High (22–29) & Very high (30–50)	14.6	16.5	16.8	15.4	15.5	15.3	15.3	na	15.8
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
65 years and over									
Low (10–15)	65.0	63.8	61.9	75.1	69.5	68.3	60.9	na	65.4

TABLE 12A.16

Table 12A.16 Level of psychological distress K10, 2004-05 (per cent) (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
Moderate (16–21)	21.8	26.4	23.8	16.7	19.3	21.5	29.0	na	22.8
High (22–29) & Very high (30–50)	13.1	9.3	14.1	8.1	11.2	10.2	10.1	na	11.6
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
Total									
Low (10–15)	59.8	56.6	58.7	65.2	60.6	64.6	56.2	na	59.4
Moderate (16–21)	25.8	27.9	24.9	20.5	24.7	21.1	29.2	na	25.5
High (22–29) & Very high (30–50)	14.4	15.2	16.4	14.3	14.6	14.3	14.6	na	15.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
People									
18–64 years									
Low (10–15)	62.3	59.9	61.3	65.7	61.6	66.3	60.6	na	61.8
Moderate (16–21)	25.0	26.0	24.3	21.7	25.3	20.4	27.0	na	24.7
High (22–29) & Very high (30–50)	12.7	13.8	14.4	12.6	13.0	13.2	12.4	na	13.4
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
65 years and over									
Low (10–15)	67.9	68.4	63.8	77.8	72.5	71.1	63.0	na	68.6
Moderate (16–21)	20.0	21.6	21.9	15.0	18.9	18.9	27.3	na	20.2
High (22–29) & Very high (30–50)	12.1	9.5	14.1	7.2*	8.6	10.0*	9.7	na	11.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
Total									
Low (10–15)	63.2	61.3	61.6	67.5	63.6	67.2	60.9	na	62.9
Moderate (16–21)	24.1	25.3	23.9	20.7	24.1	20.1	27.0	na	24.0
High (22–29) & Very high (30–50)	12.6	13.1	14.3	11.8	12.2	12.6	12.1	na	13.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0

(a) Psychological distress as measured by the Kessler 10 scale.

Table 12A.16 **Level of psychological distress K10, 2004-05 (per cent) (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
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(b) A '*' indicates that an estimate has a RSE of between 25 per cent and 50 per cent and should be used with caution.

(c) Separate estimates for the NT are not available for this survey, but the NT contributes to national estimates.

(d) Totals include not stated.

na Not available (small numbers not reported for privacy reasons).

Source: ABS (2006) *National Health Survey 2004-05*, Cat. no. 4362.0, Canberra.

TABLE 12A.17

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>2007-08</i>									
<i>Number of services</i>									
Psychiatrist services									
Initial consultations new patient (c)	28 805	23 009	16 671	7 022	7 423	1 513	1 182	317	85 942
Patient attendances (d)	546 004	585 193	327 045	114 737	162 878	36 725	18 471	3 547	1 794 600
Group psychotherapy	15 850	18 137	2 898	870	567	2 877	146	15	41 360
Interview with non-patient	1 982	1 987	1 601	439	433	126	48	18	6 634
Telepsychiatry	643	92	334	15	9	2	11	19	1 125
Case conferencing	80	763	41	42	47	38	4	–	1 015
Electroconvulsive therapy (e)	5 280	5 327	4 886	1 480	1 216	790	45	2	19 026
Total psychiatrist services	598 644	634 508	353 476	124 605	172 573	42 071	19 907	3 918	1 949 702
GP mental health specific services									
GP mental health care plans	407 865	335 835	209 549	106 349	80 756	23 307	14 934	5 095	1 183 690
Focussed psychological strategies	13 254	10 350	7 051	1 474	4 168	414	376	46	37 133
Total GP mental health specific services	421 119	346 185	216 600	107 823	84 924	23 721	15 310	5 141	1 220 823
Psychologist services									
Psychological therapy — clinical psychologists	208 032	174 404	69 774	114 269	49 556	20 361	11 577	1 404	649 377
Focussed psychological strategies — psychologists	402 284	431 801	237 281	54 998	48 985	22 620	19 001	3 699	1 220 669
Enhanced primary care — psychologists	3 056	2 213	1 731	263	356	127	28	14	7 788
Total psychologist services	613 372	608 418	308 786	169 530	98 897	43 108	30 606	5 117	1 877 834
Other allied health services									

TABLE 12A.17

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Focussed psychological strategies — occupational therapist	5 830	3 826	1 999	1 563	1 642	494	3	82	15 439
Focussed psychological strategies — social worker	26 594	25 519	12 119	5 505	5 052	1 571	135	375	76 870
Enhanced Primary Care — mental health worker (f)	1 045	599	323	37	375	18	3	—	2 400
Total allied health services	33 469	29 944	14 441	7 105	7 069	2 083	141	457	94 709
<i>Rate per 1000 people (g)</i>									
Psychiatrist services	86.4	120.9	83.6	58.5	108.4	84.9	58.4	18.0	92.1
GP mental health specific services	60.8	66.0	51.2	50.6	53.3	47.8	44.9	23.6	57.6
Psychologist services	88.5	116.0	73.0	79.6	62.1	87.0	89.8	23.5	88.7
Other allied health services	4.8	5.7	3.4	3.3	4.4	4.2	0.4	2.1	4.5
<i>2008-09</i>									
<i>Number of services</i>									
<i>Psychiatrist services</i>									
Initial consultations new patient (c)	31 484	25 495	17 220	8 055	7 418	1 785	1 266	306	93 029
Patient attendances (d)	543 800	583 020	330 605	117 929	162 032	37 344	17 961	3 831	1 796 522
Group psychotherapy	20 082	17 924	2 479	678	574	3 106	201	30	45 074
Interview with non-patient	2 848	2 594	1 948	439	552	112	73	15	8 581
Telepsychiatry	752	78	447	26	8	1	15	29	1 356
Case conferencing	190	734	97	44	37	31	9	2	1 144
Electroconvulsive therapy (e)	5 425	6 326	5 462	1 852	1 628	589	103	6	21 391
Assessment and treatment of pervasive developmental disorder	32	65	22	5	—	—	—	1	125
Total psychiatrist services	604 613	636 236	358 280	129 023	172 254	42 968	19 628	4 220	1 967 222

TABLE 12A.17

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
GP mental health specific services									
GP mental health care	520 403	434 383	290 904	138 410	111 352	28 783	19 020	6 688	1 549 943
Focussed psychological strategies	13 238	10 693	6 037	1 115	3 261	249	345	226	35 164
Family group therapy	6 696	6 144	1 000	274	560	161	85	16	14 936
Total GP mental health specific services	540 337	451 220	297 941	139 799	115 173	29 193	19 450	6 930	1 600 043
Psychologist services									
Psychological therapy — clinical psychologists	298 137	226 729	111 728	145 385	77 824	28 968	14 297	1 767	904 835
Focussed psychological strategies — psychologists	517 849	550 951	315 067	76 491	59 519	23 591	25 367	4 963	1 573 798
Enhanced primary care — psychologists	2 705	1 858	1 413	267	178	88	68	14	6 591
Assessment and treatment of pervasive developmental disorder	1 180	2 196	399	348	244	101	87	20	4 575
Total psychologist services	819 871	781 734	428 607	222 491	137 765	52 748	39 819	6 764	2 489 799
Other allied health services									
Focussed psychological strategies — occupational therapist	9 207	7 689	3 373	1 951	2 956	519	182	10	25 887
Focussed psychological strategies — social worker	42 707	41 722	17 111	9 107	7 860	2 451	449	133	121 540
Enhanced Primary Care — mental health worker (f)	1 059	742	298	39	169	13	—	2	2 322
Total allied health services	52 973	50 153	20 782	11 097	10 985	2 983	631	145	149 749
<i>Rate per 1000 people (g)</i>									
Psychiatrist services	85.9	118.6	82.4	58.5	106.9	85.9	56.4	19.0	90.9
GP mental health specific services	76.7	84.1	68.5	63.4	71.4	58.4	55.9	31.3	73.9

TABLE 12A.17

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Psychologist services	116.4	145.7	98.5	100.9	85.5	105.4	114.5	30.5	115.0
Other allied health services	7.5	9.3	4.8	5.0	6.8	6.0	1.8	0.7	6.9
<i>2009-10</i>									
<i>Number of services</i>									
Psychiatrist services									
Initial consultations new patient (c)	34 265	26 289	17 780	8 249	7 264	1 902	1 385	366	97 511
Patient attendances (d)	543 765	577 090	338 197	124 506	160 934	36 999	17 554	3 822	1 802 867
Group psychotherapy	22 013	16 144	2 504	669	563	3 190	135	21	45 239
Interview with non-patient	4 238	3 093	2 613	428	593	131	59	18	11 173
Telepsychiatry	733	117	697	29	107	8	19	9	1 719
Case conferencing	302	884	93	93	36	21	5	–	1 434
Electroconvulsive therapy (e)	5 715	6 320	6 642	2 217	1 565	720	123	24	23 326
Assessment and treatment of pervasive developmental disorder	50	69	68	np	16	np	–	–	212
Total psychiatrist services	611 081	630 006	368 594	136 206	171 078	42 976	19 280	4 260	1 983 481
GP mental health specific services									
GP mental health care	581 755	343 420	492 773	154 864	127 135	32 634	8 789	20 543	1 761 913
Focussed psychological strategies	13 609	9 101	6 078	1 289	3 135	451	285	318	34 266
Family group therapy	6 080	895	5 833	244	516	92	13	97	13 770
Total GP mental health specific services	601 444	353 416	504 684	156 397	130 786	33 177	9 087	20 958	1 809 949
Psychologist services									
Psychological therapy — clinical psychologists	343 733	277 745	146 601	168 215	97 566	33 247	17 445	2 617	1 087 169
Focussed psychological strategies — psychologists	614 418	640 812	390 393	93 016	68 990	27 300	28 131	6 143	1 869 203

TABLE 12A.17

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Enhanced primary care — psychologists	2 968	1 834	1 322	358	239	95	58	28	6 902
Assessment and treatment of pervasive developmental disorder	1 863	3 323	1 170	555	441	93	117	155	7 717
Total psychologist services (h)	962 998	923 714	539 486	262 144	167 236	60 735	45 751	8 959	2 971 023
Other allied health services									
Focussed psychological strategies — occupational therapist	13 062	9 474	np	3 940	2 267	1 075	259	np	34 194
Focussed psychological strategies — social worker	51 896	58 436	24 164	11 255	10 964	4 001	1 073	292	162 081
Enhanced Primary Care — mental health worker (f)	np	np	680	120	78	8	np	7	2 669
Total allied health services (h)	65 889	68 753	28 960	13 351	15 273	5 084	1 336	307	198 953
<i>Rate per 1000 people (g)</i>									
Psychiatrist services	85.0	114.6	82.4	60.0	104.7	85.0	54.3	18.7	89.5
GP mental health specific services	83.6	64.3	112.8	68.9	80.0	65.6	25.6	92.0	81.7
Psychologist services	133.9	168.1	120.6	115.5	102.4	120.2	128.9	39.3	134.1
Other allied health services	9.2	12.5	6.5	5.9	9.3	10.1	3.8	1.3	9.0
<i>2010-11</i>									
<i>Number of services</i>									
Psychiatrist services									
Initial consultations new patient (c)	35 803	27 131	19 866	8 591	7 099	1 741	1 582	312	102 125
Patient attendances (d)	557 867	576 962	344 504	124 555	154 924	35 592	18 856	3 945	1 817 205
Group psychotherapy	22 572	15 306	2 411	557	400	2 818	242	68	44 374

TABLE 12A.17

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Interview with non-patient	5 953	3 915	4 219	475	668	152	173	16	15 571
Telepsychiatry	941	149	1 184	127	182	18	14	18	2 633
Case conferencing	517	956	209	145	160	22	10	7	2 026
Electroconvulsive therapy (e)	12 621	13 809	15 951	4 404	4 350	2 268	275	72	53 750
Assessment and treatment of pervasive developmental disorder	55	69	54	3	12	4	1	—	198
Total psychiatrist services	636 329	638 297	388 398	138 857	167 795	42 615	21 153	4 438	2 037 882
GP mental health specific services									
GP mental health care	676 154	579 248	397 898	175 073	147 956	38 433	24 211	8 728	2 047 701
Focussed psychological strategies	17 504	10 485	8 606	1 512	3 332	716	424	326	42 905
Family group therapy	5 626	4 755	769	212	603	147	95	15	12 222
Total GP mental health specific services	699 284	594 488	407 273	176 797	151 891	39 296	24 730	9 069	2 102 828
Psychologist services									
Psychological therapy — clinical psychologists	399 144	333 786	184 361	175 818	116 009	35 023	23 066	3 043	1 270 250
Focussed psychological strategies — psychologists	694 950	693 592	445 505	111 650	73 850	36 235	28 534	6 933	2 091 249
Enhanced primary care — psychologists	2 844	1 889	1 312	430	217	125	61	9	6 887
Assessment and treatment of pervasive developmental disorder	2 065	3 626	1 367	726	414	39	144	64	8 445
Total psychologist services (h)	1 099 029	1 032 894	632 552	288 627	190 492	71 422	51 805	10 049	3 376 870
Other allied health services									
Focussed psychological strategies — occupational therapist	18 101	10 304	3 672	2 584	5 407	939	350	9	41 366

TABLE 12A.17

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Focussed psychological strategies — social worker	57 507	71 410	26 016	12 796	12 061	4 478	1 464	259	185 991
Enhanced Primary Care — mental health worker (f)	1 222	1 143	744	341	141	12	4	3	3 610
Total allied health services (h)	76 832	82 857	30 434	15 721	17 609	5 429	1 818	272	230 972
<i>Rate per 1000 people (g)</i>									
Psychiatrist services	87.5	114.3	85.4	59.9	101.7	83.7	58.4	19.3	90.7
GP mental health specific services	96.2	106.4	89.5	76.3	92.0	77.2	68.3	39.5	93.6
Psychologist services	151.1	184.9	139.1	124.6	115.4	140.2	143.1	43.7	150.2
Other allied health services	10.6	14.8	6.7	6.8	10.7	10.7	5.0	1.2	10.3
<i>2011-12</i>									
<i>Number of services</i>									
Psychiatrist services									
Initial consultations new patient (c)	37 346	29 634	21 864	9 406	7 124	1 651	1 536	290	108 877
Patient attendances (d)	561 520	590 523	368 265	124 548	154 032	33 233	17 079	3 465	1 852 665
Group psychotherapy	26 936	14 018	3 005	580	254	1 470	208	105	46 576
Interview with non-patient	6 079	5 614	5 411	374	895	150	174	24	18 721
Telepsychiatry	872	148	1 122	55	47	28	21	8	2 301
Case conferencing	966	1 716	378	161	159	20	15	6	3 421
Electroconvulsive therapy (e)	5 350	7 020	8 094	2 366	2 004	980	139	33	25 986
Assessment and treatment of pervasive developmental disorder	68	78	61	16	np	np	np	np	230
Total psychiatrist services	639 137	648 751	408 200	137 511	164 522	37 536	19 182	3 938	2 058 777
GP mental health specific services									
GP mental health care	699 492	605 877	417 905	167 758	150 998	39 415	25 166	9 506	2 116 117

TABLE 12A.17

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Focussed psychological strategies	15 866	10 090	7 387	1 428	2 709	817	266	129	38 692
Family group therapy	5 217	4 321	712	137	661	125	58	7	11 238
Electroconvulsive therapy (i)	6 964	6 987	8 406	2 753	2 094	1 084	163	32	28 483
Total GP mental health specific services	727 541	627 275	434 410	172 076	156 462	41 441	25 653	9 674	2 194 532
Clinical psychologist services									
Total clinical psychologist services	428 948	365 900	214 421	174 908	127 577	35 887	27 315	3 133	1 378 089
Other psychologist services									
Focussed psychological strategies — psychologists	677 689	673 360	442 712	111 347	76 946	36 903	24 859	7 086	2 050 902
Enhanced primary care — psychologists	4 119	2 770	1 920	578	410	104	85	42	10 028
Assessment and treatment of pervasive developmental disorder	2 642	4 659	1 660	789	509	90	132	113	10 594
Total other psychologist services (h)	684 502	680 798	446 365	112 717	77 865	37 097	25 076	7 277	2 071 697
Other allied health services									
Focussed psychological strategies — occupational therapist	17 266	10 666	4 116	2 354	6 168	770	275	32	41 647
Focussed psychological strategies — social worker	55 398	73 476	26 691	11 812	12 393	4 085	1 709	269	185 833
Enhanced Primary Care — mental health worker (f)	1 128	1 246	659	328	np	np	np	np	3 614
Total allied health services (h)	73 801	85 465	31 466	14 495	18 800	4 863	1 991	301	231 182
<i>Rate per 1000 people (g)</i>									
Psychiatrist services	88.2	116.4	90.4	57.6	100.0	73.4	51.7	16.9	91.6

TABLE 12A.17

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
GP mental health specific services	100.4	112.5	96.3	72.1	95.1	81.0	69.2	41.6	97.6
Clinical psychologist services	59.2	65.6	47.5	73.3	77.6	70.1	73.7	13.5	61.3
Other psychologist services	94.4	122.1	98.9	47.2	47.3	72.5	67.6	31.3	92.1
Other allied health services	10.2	15.3	7.0	6.1	11.4	9.5	5.4	1.3	10.3
<i>2012-13</i>									
<i>Number of services</i>									
Psychiatrist services									
Initial consultations new patient (c)	40 822	31 180	24 188	8 944	7 362	2 019	1 443	226	116 335
Patient attendances (d)	577 986	595 569	401 566	127 066	156 869	35 329	15 793	2 392	1 914 411
Group psychotherapy	26 746	11 591	2 224	208	281	1 942	226	np	43 319
Interview with non-patient	8 112	7 283	8 467	453	1 043	186	174	26	25 790
Telepsychiatry	698	233	1 292	60	31	np	35	np	2 365
Case conferencing	1 256	1 844	427	217	367	26	15	np	4 162
Electroconvulsive therapy (e)	6 326	8 070	8 906	2 788	1 972	921	177	np	29 241
Assessment and treatment of pervasive developmental disorder	89	60	140	np	np	np	np	np	298
Total psychiatrist services	662 042	655 834	447 217	139 745	167 927	40 426	17 870	2 834	2 136 042
GP mental health specific services									
GP mental health care	773 175	672 556	467 101	178 659	156 920	42 226	29 846	11 046	2 333 319
Focussed psychological strategies	13 650	8 818	6 595	1 255	1 825	350	153	np	32 724
Family group therapy	4 977	4 298	1 187	166	717	129	73	7	11 569
Electroconvulsive therapy (i)	7 857	8 313	8 494	3 212	1 990	809	228	np	30 983
Total GP mental health specific services	799 662	693 990	483 378	183 292	161 453	43 514	30 302	11 173	2 408 612

TABLE 12A.17

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Clinical psychologist services									
Total clinical psychologist services	483 570	427 987	244 465	182 566	139 446	45 195	30 079	3 302	1 558 063
Other psychologist services									
Focussed psychological strategies — psychologists	734 906	696 416	456 268	112 805	86 778	34 537	27 443	6 878	2 158 106
Enhanced primary care — psychologists	4 219	2 442	1 802	641	219	75	251	np	9 670
Assessment and treatment of pervasive developmental disorder	2 371	5 278	1 602	942	611	114	137	69	11 145
Total other psychologist services (h)	741 606	704 157	459 732	114 388	87 608	34 730	27 871	6 969	2 179 161
Other allied health services									
Focussed psychological strategies — occupational therapist	19 827	12 263	4 988	2 538	7 205	828	434	np	48 123
Focussed psychological strategies — social worker	54 615	80 110	30 181	13 386	17 178	4 289	2 160	258	202 280
Enhanced Primary Care — mental health worker (f)	938	1 364	1 598	381	204	np	np	np	4 513
Total allied health services (h)	75 385	93 793	36 864	16 325	24 590	5 130	2 610	302	255 129
<i>Rate per 1000 people (g)</i>									
Psychiatrist services	90.1	115.5	97.0	56.5	101.0	78.9	47.1	12.0	93.3
GP mental health specific services	108.8	122.2	104.8	74.1	97.1	84.9	79.8	47.2	105.2
Clinical psychologist services	65.8	75.4	53.0	73.8	83.9	88.2	79.2	13.9	68.0
Other psychologist services	100.9	124.0	99.7	46.3	52.7	67.8	73.4	29.4	95.1
Other allied health services	10.3	16.5	8.0	6.6	14.8	10.0	6.9	1.3	11.1

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(a)	State and territory is based on the postcode of the mailing address of the patient as recorded by Medicare Australia. Provider type is based on the MBS item numbers claimed.								
(b)	A listing of the MBS items associated with each of the categories is available in the Medicare Benefits Schedule and General practice data source sections of the <i>Mental Health Services in Australia</i> (various issues), (http://mhsa.aihw.gov.au/home/).								
(c)	Includes consultations in consulting room, hospital and home visits.								
(d)	Includes attendances in consulting room, hospital and other locations.								
(e)	Data for electroconvulsive therapy may include services provided by medical practitioners other than psychiatrists.								
(f)	Mental health workers include psychologists, mental health nurses, occupational therapists, social workers and Aboriginal health workers.								
(g)	Crude rates based on the preliminary Australian estimated resident population as at 31 December mid-point of financial year.								
(h)	Totals for other psychologist and other allied health services include specific services for Aboriginal and Torres Strait Islander Australians that were introduced on 1 November 2008.								
(i)	This item is for the initiation of management of anaesthesia for electroconvulsive therapy and includes data for services provided by medical practitioners other than GPs.								

– Nil or rounded to zero. **np** Not published.

Source: AIHW (various issues) *Mental Health Services in Australia* (various years) (available at <http://mhsa.aihw.gov.au/home/>).

TABLE 12A.18

Table 12A.18 **GP mental health-related encounters (general and mental health specific) (a)**

	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13
<i>Total GP encounters that are mental health-related (per cent)</i>	10.4	10.8	11.7	11.4	11.7	12.1	12.3
<i>Estimated number of mental health-related encounters (b)</i>	10 713 000	11 862 000	13 202 000	13 283 000	13 931 000	14 956 000	15 842 000
<i>Lower 95% confidence limit</i>	10 261 000	11 280 000	12 661 000	12 714 000	13 353 000	14 250 000	15 187 000
<i>Upper 95% confidence limit</i>	11 165 000	12 375 000	13 678 000	13 881 000	14 426 000	15 614 000	16 474 000
<i>Estimated number of mental health-related encounters per 1000 population (b), (c)</i>	519.4	564.4	614.8	607.5	628.3	664.3	691.6
<i>Lower 95% confidence limit</i>	497.5	536.7	589.6	581.5	602.2	633.0	663.0
<i>Upper 95% confidence limit</i>	541.3	588.9	636.9	634.8	650.6	693.6	719.2

(a) The confidence intervals show that the difference between some of the years is not statistically significant.

(b) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of Medicare services for non-Referral (GP) Attendances (excluding practice nurse items) as reported by the Department of Human Services (see Mental Health Services in Australia for more details).

(c) Crude rate is based on the Australian estimated resident population as at 31 December of the reference year.

Source: AIHW (2014) *Mental Health Services in Australia* (available at <http://mhsa.aihw.gov.au/home/>).

TABLE 12A.19

Table 12A.19 **GP mental health-related encounters (general and mental health specific), 2012-13**

	<i>Per cent of total mental health-related encounters (a)</i>	<i>Rate (per 100 encounters)</i>	<i>95% LCL</i>	<i>95% UCL</i>	<i>Encounters per 1000 population (b)</i>
<i>Age group</i>					
Less than 15 years	3.8	4.0	3.4	4.6	136.4
15–24 years	7.8	11.8	10.8	12.7	396.3
25–34 years	12.9	15.0	13.9	16.2	607.7
35–44 years	17.7	18.6	17.3	19.9	866.1
45–54 years	18.1	17.0	15.8	18.2	926.5
55–64 years	14.5	12.3	11.5	13.0	870.0
65 years or over	25.4	10.2	9.6	10.9	1 214.1
<i>Sex</i>					
Male	41.3	11.7	11.1	12.4	565.5
Female	58.7	12.7	12.2	13.3	759.0
<i>Indigenous status (c)</i>					
Aboriginal and Torres Strait Islander	1.9	15.2	12.6	17.8	554.1
Non-Indigenous	98.1	12.4	11.8	13.0	613.4
<i>Remoteness area of usual residence</i>					
Major cities	71.3	12.1	11.4	12.7	672.7
Inner regional	19.1	13.5	12.3	14.6	686.6
Outer regional	8.7	12.1	10.9	13.4	639.6
Remote and very remote	1.0	10.5	7.3	13.8	295.7
Total	100.0	12.3	11.8	12.8	670.6

LCL—lower confidence limit; UCL—upper confidence limit.

Table 12A.19 **GP mental health-related encounters (general and mental health specific), 2012-13**

<i>Per cent of total mental health-related encounters (a)</i>	<i>Rate (per 100 encounters)</i>	<i>95% LCL</i>	<i>95% UCL</i>	<i>Encounters per 1000 population (b)</i>
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(a) The percentages shown do not include those encounters for which the demographic information was missing or not reported.

(b) Estimated encounter rates were directly age-standardised, with the exception of age, which is a crude rate.

(c) Information on this variable was missing or not reported for more than 9 per cent of encounters.

Source: AIHW (2014) *Mental Health Services in Australia* (available at <http://mhsa.aihw.gov.au/home/>).

TABLE 12A.20

Table 12A.20 **The 10 most frequent GP managed mental health-related problems, by gender, 2012-13**

	<i>Per cent of total mental health-related encounters (a)</i>	<i>Rate (per 100 encounters)</i>	<i>95% LCL</i>	<i>95% UCL</i>
<i>Males</i>				
Depression	27.3	3.4	3.1	3.7
Anxiety	13.4	1.7	1.5	1.9
Sleep disturbance	12.7	1.6	1.4	1.8
Acute stress reaction	4.2	0.5	0.4	0.6
Tobacco abuse	6.4	0.8	0.7	0.9
Dementia	4.0	0.5	0.4	0.6
Schizophrenia	5.1	0.6	0.5	0.7
Drug abuse	4.6	0.6	0.3	0.9
Alcohol abuse	4.1	0.5	0.4	0.6
Affective psychosis	2.3	0.3	0.2	0.4
Other	15.7	2.0	1.7	2.2
Total (a)	100.0	12.5	11.7	13.2
<i>Females</i>				
Depression	35.1	4.7	4.5	5.0
Anxiety	18.1	2.4	2.2	2.6
Sleep disturbance	11.3	1.5	1.4	1.7
Acute stress reaction	6.6	0.9	0.8	1.0
Tobacco abuse	3.9	0.5	0.5	0.6
Dementia	5.0	0.7	0.5	0.9
Schizophrenia	2.4	0.3	0.3	0.4
Drug abuse	2.1	0.3	0.1	0.5
Alcohol abuse	1.6	0.2	0.2	0.2
Affective psychosis	2.3	0.3	0.3	0.4
Other	11.0	1.5	1.3	1.6
Total (a)	100.0	13.5	12.8	14.1
<i>Total</i>				
Depression	31.9	4.2	3.9	4.4
Anxiety	16.2	2.1	1.9	2.3
Sleep disturbance	11.9	1.6	1.4	1.7
Acute stress reaction	5.6	0.7	0.7	0.8
Tobacco abuse	4.9	0.6	0.6	0.7

Table 12A.20 **The 10 most frequent GP managed mental health-related problems, by gender, 2012-13**

	<i>Per cent of total mental health-related encounters (a)</i>	<i>Rate (per 100 encounters)</i>	<i>95% LCL</i>	<i>95% UCL</i>
Dementia	4.6	0.6	0.5	0.7
Schizophrenia	3.5	0.5	0.4	0.5
Drug abuse	3.2	0.4	0.2	0.6
Alcohol abuse	2.6	0.3	0.3	0.4
Affective psychosis	2.3	0.3	0.3	0.4
Other	13.3	1.7	1.6	1.9
Total (a)	100.0	13.1	12.4	13.7

LCL—lower confidence limit; UCL—upper confidence limit.

(a) Totals may not add due to rounding.

Source: AIHW (2014) *Mental Health Services in Australia* (available at <http://mhsa.aihw.gov.au/home/>).

TABLE 12A.21

Table 12A.21 **Mental health patient days (a), (b), (c)**

	NSW (d), (e)	Vic	Qld (f)	WA (g)	SA	Tas	ACT (h)	NT (h)	Aust
<i>Patient days</i>									
<i>Acute units</i>									
2005-06	468 925	325 855	216 029	167 257	117 148	30 681	15 342	11 266	1 352 503
2006-07	502 521	328 817	216 505	165 365	120 755	28 219	16 419	11 854	1 390 455
2007-08	501 388	322 087	222 006	183 741	119 808	30 924	18 539	10 990	1 409 483
2008-09	525 512	334 711	224 395	181 426	115 412	31 291	19 884	11 517	1 444 148
2009-10	531 649	332 677	226 762	182 647	114 605	29 615	21 484	10 877	1 450 316
2010-11	536 310	345 369	228 406	177 733	117 123	29 249	22 941	11 518	1 468 649
2011-12	541 039	343 809	230 274	188 644	115 761	32 148	23 163	10 489	1 485 327
2012-13	558 928	339 719	227 282	192 445	109 927	28 749	26 097	12 943	1 496 090
<i>Nonacute units</i>									
2005-06	256 893	55 745	225 242	44 800	90 200	9 074	..	..	681 954
2006-07	252 391	56 837	222 783	50 751	84 637	9 482	..	..	676 881
2007-08	279 349	63 428	219 026	36 838	77 836	7 128	..	..	683 605
2008-09	265 820	54 667	215 715	38 357	65 509	9 125	..	..	649 193
2009-10	285 494	53 712	213 343	40 061	59 746	8 531	..	..	660 887
2010-11	287 011	54 293	216 365	51 600	56 073	9 779	..	..	675 121
2011-12	286 731	51 032	209 993	47 013	46 036	10 011	..	..	650 816
2012-13	290 358	60 106	218 517	44 201	43 626	7 843	..	..	664 651
<i>24-hour staffed community residential</i>									
2005-06	73 112	321 675	..	11 380	8 635	34 155	13 981	..	462 938
2006-07	73 773	338 377	..	12 006	9 232	34 697	14 023	..	482 108
2007-08	42 051	352 741	..	14 888	15 277	27 194	13 599	1 737	467 487
2008-09	37 375	344 623	..	24 725	20 649	28 727	14 262	3 550	473 911
2009-10	35 355	351 719	..	33 008	20 187	30 172	15 416	3 841	489 698
2010-11	34 503	353 996	..	17 605	22 529	29 958	14 961	4 144	477 696

TABLE 12A.21

Table 12A.21 **Mental health patient days (a), (b), (c)**

	NSW (d), (e)	Vic	Qld (f)	WA (g)	SA	Tas	ACT (h)	NT (h)	Aust
2011-12	40 567	363 985	..	30 073	34 397	27 333	15 367	4 828	516 550
2012-13	38 328	362 911	..	30 459	40 158	22 777	16 045	4 413	515 091
<i>Patient days per 1000 people</i>									
<i>Acute units</i>									
2005-06	69.8	64.9	54.5	82.4	75.8	62.9	46.0	54.3	66.6
2006-07	74.1	64.4	53.4	79.6	77.3	57.4	48.5	56.2	67.4
2007-08	72.8	61.9	53.4	86.1	75.9	62.4	53.9	50.7	67.1
2008-09	75.1	63.0	52.5	82.1	72.2	62.4	56.6	51.8	67.2
2009-10	74.9	61.4	51.9	80.7	70.8	58.5	60.0	47.8	66.3
2010-11	74.7	62.8	51.5	76.6	71.7	57.3	62.9	50.0	66.2
2011-12	74.7	61.7	51.0	79.0	70.4	62.8	62.5	45.1	66.1
2012-13	76.1	59.8	49.3	77.8	66.1	56.1	68.8	54.6	65.3
<i>Nonacute units</i>									
2005-06	38.2	11.1	56.8	22.1	58.4	18.6	..	..	33.6
2006-07	37.2	11.1	54.9	24.4	54.2	19.3	..	..	32.8
2007-08	40.6	12.2	52.7	17.3	49.3	14.4	..	..	32.5
2008-09	38.0	10.3	50.5	17.4	41.0	18.2	..	..	30.2
2009-10	40.2	9.9	48.8	17.7	36.9	16.8	..	..	30.2
2010-11	40.0	9.9	48.8	22.3	34.3	19.2	..	..	30.4
2011-12	39.6	9.2	46.5	19.7	28.0	19.6	..	..	28.9
2012-13	39.5	10.6	47.4	17.9	26.2	15.3	..	..	29.0
<i>24-hour staffed community residential</i>									
2005-06	10.9	64.0	..	5.6	5.6	70.0	41.9	..	22.8
2006-07	10.9	66.3	..	5.8	5.9	70.6	41.4	..	23.4
2007-08	6.1	67.8	..	7.0	9.7	54.8	39.5	8.0	22.2
2008-09	5.3	64.9	..	11.2	12.9	57.3	40.6	16.0	22.1

TABLE 12A.21

Table 12A.21 **Mental health patient days (a), (b), (c)**

	NSW (d), (e)	Vic	Qld (f)	WA (g)	SA	Tas	ACT (h)	NT (h)	Aust
2009-10	5.0	64.9	..	14.6	12.5	59.6	43.1	16.9	22.4
2010-11	4.8	64.4	..	7.6	13.8	58.7	41.0	18.0	21.5
2011-12	5.6	65.3	..	12.6	20.9	53.4	41.5	20.8	23.0
2012-13	5.2	63.9	..	12.3	24.2	44.4	42.3	18.6	22.5

- (a) See AIHW *Mental Health Services in Australia* on-line publication (<http://mhsa.aihw.gov.au/resources/expenditure/data-source/>) for a full description of the derivation of patient day estimates.
- (b) Due to the ongoing validation of NMDS, data could differ from previous reports.
- (c) Hospital patient days include those provided in services funded by government, but managed and operated by private and non-government entities.
- (d) Caution is required when interpreting NSW data. Seven residential mental health services in 2006–07 were reclassified as non-acute older person specialised hospital services in 2007–08, reflecting a change in function of those units.
- (e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.
- (f) Queensland does not fund community residential services; however, it funds a number of campus based and non-campus based extended treatment services. Data from these services are included as non-acute units.
- (g) Caution is required when interpreting WA data. Several residential services that reported as 24-hour staffed services in 2009-10 transitioned to a non-24-hour staffed model of care as of 1 July 2010–11. In addition, a review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010–11 collection, to more accurately reflect the function of these services.
- (h) The ACT and the NT did not have non-acute hospital units.
.. Not applicable.

Source: AIHW (unpublished) MHE NMDS; ABS (various issues), *Australian Demographic Statistics*, December (various years), Cat. no. 3101.0.

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
		no.	no.	no.	%
<i>2005-06</i>					
F00–F03	Dementia	609	188	797	0.9
F04–F09	Other organic mental disorders	599	146	745	0.8
F10	Mental and behavioural disorders due to use of alcohol	1 623	542	2 165	2.4
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	3 464	878	4 342	4.9
F20	Schizophrenia	17 402	3 231	20 633	23.1
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 505	260	1 765	2.0
F22	Persistent delusional disorders	787	163	950	1.1
F23	Acute and transient psychotic disorders	1 309	217	1 526	1.7
F25	Schizoaffective disorders	5 078	1 028	6 106	6.8
F30	Manic episode	449	71	520	0.6
F31	Bipolar affective disorders	7 331	1 157	8 488	9.5
F32	Depressive episode	10 844	1 068	11 912	13.3
F33	Recurrent depressive disorders	3 761	251	4 012	4.5
F34	Persistent mood (affective) disorders	910	109	1 019	1.1
F38, F39	Other and unspecified mood (affective) disorders	143	41	184	0.2
F40	Phobic anxiety disorders	62	14	76	0.1
F41	Other anxiety disorders	994	57	1 051	1.2

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
F42	Obsessive-compulsive disorders	239	22	261	0.3
F43	Reaction to severe stress and adjustment disorders	7 232	1 402	8 634	9.7
F44	Dissociative (conversion) disorders	124	13	137	0.2
F45, F48	Somatoform and other neurotic disorders	79	10	89	0.1
F50	Eating disorders	604	15	619	0.7
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	169	24	193	0.2
F60	Specific personality disorders	3 642	542	4 184	4.7
F61–F69	Disorders of adult personality and behaviour	189	45	234	0.3
F70–F79	Mental retardation	139	53	192	0.2
F80–F89	Disorders of psychological development	168	31	199	0.2
F90	Hyperkinetic disorders	114	11	125	0.1
F91	Conduct disorders	291	53	344	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	170	61	231	0.3
F99	Mental disorder not otherwise specified	251	22	273	0.3
G30	Alzheimer's disease	509	134	643	0.7
	Other factors related to mental and behavioural disorders and substance use (b)	224	357	581	0.7
	Other specified mental health-related principal diagnosis (c)	209	17	226	0.3

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
	Other (d)	4 796	1 022	5 818	6.5
	Total	76 019	13 255	89 274	100.0
<i>2006-07</i>					
F00–F03	Dementia	557	178	735	0.8
F04–F09	Other organic mental disorders	569	133	702	0.8
F10	Mental and behavioural disorders due to use of alcohol	1 980	621	2 601	2.8
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	3 606	981	4 587	5.0
F20	Schizophrenia	17 610	3 014	20 624	22.3
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 456	248	1 704	1.8
F22	Persistent delusional disorders	776	130	906	1.0
F23	Acute and transient psychotic disorders	1 395	211	1 606	1.7
F25	Schizoaffective disorders	5 359	1 021	6 380	6.9
F30	Manic episode	559	69	628	0.7
F31	Bipolar affective disorders	7 935	1 089	9 024	9.8
F32	Depressive episode	11 103	1 065	12 168	13.2
F33	Recurrent depressive disorders	3 701	314	4 015	4.3
F34	Persistent mood (affective) disorders	998	118	1 116	1.2
F38, F39	Other and unspecified mood (affective) disorders	133	30	163	0.2
F40	Phobic anxiety disorders	54	6	60	0.1
F41	Other anxiety disorders	1 160	102	1 262	1.4

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
F42	Obsessive-compulsive disorders	226	24	250	0.3
F43	Reaction to severe stress and adjustment disorders	8 141	1 274	9 415	10.2
F44	Dissociative (conversion) disorders	116	8	124	0.1
F45, F48	Somatoform and other neurotic disorders	81	8	89	0.1
F50	Eating disorders	575	7	582	0.6
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	193	12	205	0.2
F60	Specific personality disorders	3 744	531	4 275	4.6
F61–F69	Disorders of adult personality and behaviour	163	33	196	0.2
F70–F79	Mental retardation	156	44	200	0.2
F80–F89	Disorders of psychological development	175	31	206	0.2
F90	Hyperkinetic disorders	112	9	121	0.1
F91	Conduct disorders	298	32	330	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	190	58	248	0.3
F99	Mental disorder not otherwise specified	267	86	353	0.4
G30	Alzheimer's disease	497	85	582	0.6
	Other factors related to mental and behavioural disorders and substance use (b)	218	324	542	0.6
	Other specified mental health-related principal diagnosis (c)	235	36	271	0.3

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
	Other (d)	5 400	839	6 239	6.7
	Total	79 738	12 771	92 509	100.0
<i>2007-08</i>					
F00–F03	Dementia	592	221	813	0.9
F04–F09	Other organic mental disorders	596	172	768	0.8
F10	Mental and behavioural disorders due to use of alcohol	2 128	690	2 818	3.1
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	3 155	779	3 934	4.3
F20	Schizophrenia	17 250	2 834	20 084	21.9
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 609	260	1 869	2.0
F22	Persistent delusional disorders	817	136	953	1.0
F23	Acute and transient psychotic disorders	1 432	168	1 600	1.7
F25	Schizoaffective disorders	5 354	949	6 303	6.9
F30	Manic episode	532	60	592	0.6
F31	Bipolar affective disorders	7 628	1 157	8 785	9.6
F32	Depressive episode	11 051	1 121	12 172	13.3
F33	Recurrent depressive disorders	2 997	554	3 551	3.9
F34	Persistent mood (affective) disorders	938	116	1 054	1.2
F38, F39	Other and unspecified mood (affective) disorders	145	25	170	0.2
F40	Phobic anxiety disorders	79	11	90	0.1
F41	Other anxiety disorders	1 089	99	1 188	1.3

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
F42	Obsessive-compulsive disorders	236	19	255	0.3
F43	Reaction to severe stress and adjustment disorders	8 501	1 098	9 599	10.5
F44	Dissociative (conversion) disorders	112	11	123	0.1
F45, F48	Somatoform and other neurotic disorders	106	8	114	0.1
F50	Eating disorders	523	6	529	0.6
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	155	9	164	0.2
F60	Specific personality disorders	3 834	614	4 448	4.9
F61–F69	Disorders of adult personality and behaviour	197	73	270	0.3
F70–F79	Mental retardation	147	56	203	0.2
F80–F89	Disorders of psychological development	199	42	241	0.3
F90	Hyperkinetic disorders	106	17	123	0.1
F91	Conduct disorders	262	29	291	0.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	172	58	230	0.3
F99	Mental disorder not otherwise specified	167	101	268	0.3
G30	Alzheimer's disease	491	150	641	0.7
	Other factors related to mental and behavioural disorders and substance use (b)	191	247	438	0.5
	Other specified mental health-related principal diagnosis (c)	296	10	306	0.3
	Other (d)	5 832	823	6 655	7.3

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
	Total	78 919	12 723	91 642	100.0
<i>2008-09</i>					
F00–F03	Dementia	565	163	728	0.7
F04–F09	Other organic mental disorders	600	101	701	0.7
F10	Mental and behavioural disorders due to use of alcohol	2 365	572	2 937	3.0
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	2 827	558	3 385	3.4
F20	Schizophrenia	18 127	2 270	20 397	20.7
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 966	174	2 140	2.2
F22	Persistent delusional disorders	803	108	911	0.9
F23	Acute and transient psychotic disorders	1 338	137	1 475	1.5
F25	Schizoaffective disorders	6 239	733	6 972	7.1
F30	Manic episode	577	51	628	0.6
F31	Bipolar affective disorders	8 622	1 080	9 702	9.9
F32	Depressive episode	14 406	1 105	15 511	15.8
F33	Recurrent depressive disorders	3 433	342	3 775	3.8
F34	Persistent mood (affective) disorders	821	93	914	0.9
F38, F39	Other and unspecified mood (affective) disorders	117	24	141	0.1
F40	Phobic anxiety disorders	65	7	72	0.1
F41	Other anxiety disorders	1 386	107	1 493	1.5
F42	Obsessive-compulsive disorders	210	15	225	0.2

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
F43	Reaction to severe stress and adjustment disorders	8 863	931	9 794	10.0
F44	Dissociative (conversion) disorders	108	7	115	0.1
F45, F48	Somatoform and other neurotic disorders	73	10	83	0.1
F50	Eating disorders	635	6	641	0.7
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	180	8	188	0.2
F60	Specific personality disorders	3 979	550	4 529	4.6
F61–F69	Disorders of adult personality and behaviour	211	58	269	0.3
F70–F79	Mental retardation	190	np	190	0.2
F80–F89	Disorders of psychological development	236	28	264	0.3
F90	Hyperkinetic disorders	85	–	85	0.1
F91	Conduct disorders	311	np	311	0.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	381	25	406	0.4
F99	Mental disorder not otherwise specified	189	64	253	0.3
G30	Alzheimer's disease	452	100	552	0.6
	Other factors related to mental and behavioural disorders and substance use (b)	235	np	235	0.2
	Other specified mental health-related principal diagnosis (c)	349	11	360	0.4
	Other (d)	6 853	1 047	7 900	8.0

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
	Total	87 797	10 562	98 359	100.0
<i>2009-10</i>					
F00–F03	Dementia	534	126	660	0.7
F04–F09	Other organic mental disorders	645	119	764	0.8
F10	Mental and behavioural disorders due to use of alcohol	2 235	560	2 795	3.1
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	2 626	530	3 156	3.4
F20	Schizophrenia	17 155	2 436	19 591	21.4
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 707	221	1 928	2.1
F22	Persistent delusional disorders	770	79	849	0.9
F23	Acute and transient psychotic disorders	1 303	145	1 448	1.6
F25	Schizoaffective disorders	5 376	750	6 126	6.7
F30	Manic episode	511	51	562	0.6
F31	Bipolar affective disorders	7 726	976	8 702	9.5
F32	Depressive episode	11 932	1 139	13 071	14.3
F33	Recurrent depressive disorders	2 631	348	2 979	3.3
F34	Persistent mood (affective) disorders	790	72	862	0.9
F38, F39	Other and unspecified mood (affective) disorders	131	20	151	0.2
F40	Phobic anxiety disorders	71	10	81	0.1
F41	Other anxiety disorders	1 442	131	1 573	1.7
F42	Obsessive-compulsive disorders	230	23	253	0.3

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
F43	Reaction to severe stress and adjustment disorders	8 528	964	9 492	10.4
F44	Dissociative (conversion) disorders	128	13	141	0.2
F45, F48	Somatoform and other neurotic disorders	69	7	76	0.1
F50	Eating disorders	576	9	585	0.6
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	158	10	168	0.2
F60	Specific personality disorders	3 599	578	4 177	4.6
F61–F69	Disorders of adult personality and behaviour	171	31	202	0.2
F70–F79	Mental retardation	144	51	195	0.2
F80–F89	Disorders of psychological development	243	38	281	0.3
F90	Hyperkinetic disorders	80	19	99	0.1
F91	Conduct disorders	331	49	380	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	352	21	373	0.4
F99	Mental disorder not otherwise specified	199	81	280	0.3
G30	Alzheimer's disease	518	88	606	0.7
	Other factors related to mental and behavioural disorders and substance use (b)	227	232	459	0.5
	Other specified mental health-related principal diagnosis (c)	364	7	371	0.4
	Other (d)	7 004	1 063	8 067	8.8

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
	Total	80 506	10 997	91 503	100.0
<i>2010-11</i>					
F00–F03	Dementia	443	61	504	0.5
F04–F09	Other organic mental disorders	618	90	708	0.7
F10	Mental and behavioural disorders due to use of alcohol	2 318	487	2 805	2.9
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	3 517	600	4 117	4.3
F20	Schizophrenia	18 164	2 137	20 301	21.1
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 978	202	2 180	2.3
F22	Persistent delusional disorders	802	97	899	0.9
F23	Acute and transient psychotic disorders	1 318	99	1 417	1.5
F25	Schizoaffective disorders	6 031	792	6 823	7.1
F30	Manic episode	625	47	672	0.7
F31	Bipolar affective disorders	8 147	896	9 043	9.4
F32	Depressive episode	11 874	917	12 791	13.3
F33	Recurrent depressive disorders	2 625	170	2 795	2.9
F34	Persistent mood (affective) disorders	752	69	821	0.9
F38, F39	Other and unspecified mood (affective) disorders	165	13	178	0.2
F40	Phobic anxiety disorders	72	9	81	0.1
F41	Other anxiety disorders	1 612	67	1 679	1.7
F42	Obsessive-compulsive disorders	249	10	259	0.3

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
F43	Reaction to severe stress and adjustment disorders	9 446	928	10 374	10.8
F44	Dissociative (conversion) disorders	149	4	153	0.2
F45, F48	Somatoform and other neurotic disorders	96	2	98	0.1
F50	Eating disorders	616	11	627	0.7
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	174	16	190	0.2
F60	Specific personality disorders	4 146	420	4 566	4.7
F61–F69	Disorders of adult personality and behaviour	162	23	185	0.2
F70–F79	Mental retardation	177	30	207	0.2
F80–F89	Disorders of psychological development	243	23	266	0.3
F90	Hyperkinetic disorders	75	3	78	0.1
F91	Conduct disorders	396	10	406	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	393	8	401	0.4
F99	Mental disorder not otherwise specified	352	–	352	0.4
G30	Alzheimer's disease	511	51	562	0.6
	Other factors related to mental and behavioural disorders and substance use (b)	199	70	269	0.3
	Other specified mental health-related principal diagnosis (c)	271	3	274	0.3
	Other (d)	7 953	1 196	9 149	9.5

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
	Total	86 669	9 561	96 230	100.0
<i>2011-12</i>					
F00–F03	Dementia	446	72	518	0.5
F04–F09	Other organic mental disorders	584	93	677	0.7
F10	Mental and behavioural disorders due to use of alcohol	2 219	391	2 610	2.6
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	4 337	610	4 947	5.0
F20	Schizophrenia	18 190	1 873	20 063	20.1
F21, F24, F28, F29	Schizotypal and other delusional disorders	2 184	232	2 416	2.4
F22	Persistent delusional disorders	856	54	910	0.9
F23	Acute and transient psychotic disorders	1 378	133	1 511	1.5
F25	Schizoaffective disorders	6 137	705	6 842	6.9
F30	Manic episode	627	52	679	0.7
F31	Bipolar affective disorders	8 349	772	9 121	9.1
F32	Depressive episode	12 586	875	13 461	13.5
F33	Recurrent depressive disorders	2 509	135	2 644	2.6
F34	Persistent mood (affective) disorders	781	41	822	0.8
F38, F39	Other and unspecified mood (affective) disorders	256	14	270	0.3
F40	Phobic anxiety disorders	75	2	77	0.1
F41	Other anxiety disorders	1 792	96	1 888	1.9
F42	Obsessive-compulsive disorders	306	18	324	0.3

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
F43	Reaction to severe stress and adjustment disorders	10 180	911	11 091	11.1
F44	Dissociative (conversion) disorders	195	13	208	0.2
F45, F48	Somatoform and other neurotic disorders	83	7	90	0.1
F50	Eating disorders	691	9	700	0.7
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	182	12	194	0.2
F60	Specific personality disorders	4 476	457	4 933	4.9
F61–F69	Disorders of adult personality and behaviour	176	27	203	0.2
F70–F79	Mental retardation	168	47	215	0.2
F80–F89	Disorders of psychological development	242	24	266	0.3
F90	Hyperkinetic disorders	87	16	103	0.1
F91	Conduct disorders	369	36	405	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	386	30	416	0.4
F99	Mental disorder not otherwise specified	245	–	245	0.2
G30	Alzheimer's disease	509	58	567	0.6
	Other factors related to mental and behavioural disorders and substance use (b)	198	438	636	0.6
	Other specified mental health-related principal diagnosis (c)	266	4	270	0.3
	Other (d)	8 211	1 260	9 471	9.5

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
	Total	90 276	9 517	99 793	100.0
<i>2012-13</i>					
F00–F03	Dementia	421	103	524	0.5
F04–F09	Other organic mental disorders	634	112	746	0.7
F10	Mental and behavioural disorders due to use of alcohol	2 201	397	2 598	2.5
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	5 046	638	5 684	5.5
F20	Schizophrenia	18 198	1 815	20 013	19.3
F21, F24, F28, F29	Schizotypal and other delusional disorders	2 275	199	2 474	2.4
F22	Persistent delusional disorders	818	79	897	0.9
F23	Acute and transient psychotic disorders	1 363	125	1 488	1.4
F25	Schizoaffective disorders	6 328	632	6 960	6.7
F30	Manic episode	629	41	670	0.6
F31	Bipolar affective disorders	8 518	753	9 271	8.9
F32	Depressive episode	13 361	781	14 142	13.6
F33	Recurrent depressive disorders	2 608	140	2 748	2.7
F34	Persistent mood (affective) disorders	888	35	923	0.9
F38, F39	Other and unspecified mood (affective) disorders	214	11	225	0.2
F40	Phobic anxiety disorders	81	5	86	0.1
F41	Other anxiety disorders	1 930	108	2 038	2.0
F42	Obsessive-compulsive disorders	325	12	337	0.3

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
F43	Reaction to severe stress and adjustment disorders	10 417	837	11 254	10.9
F44	Dissociative (conversion) disorders	134	9	143	0.1
F45, F48	Somatoform and other neurotic disorders	88	7	95	0.1
F50	Eating disorders	766	12	778	0.8
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	188	7	195	0.2
F60	Specific personality disorders	4 764	456	5 220	5.0
F61–F69	Disorders of adult personality and behaviour	190	29	219	0.2
F70–F79	Mental retardation	143	42	185	0.2
F80–F89	Disorders of psychological development	239	29	268	0.3
F90	Hyperkinetic disorders	61	20	81	0.1
F91	Conduct disorders	258	25	283	0.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	339	19	358	0.3
F99	Mental disorder not otherwise specified	160	644	804	0.8
G30	Alzheimer's disease	556	73	629	0.6
	Other factors related to mental and behavioural disorders and substance use (b)	162	433	595	0.6
	Other specified mental health-related principal diagnosis (c)	806	7	813	0.8
	Other (d)	8 493	1 438	9 931	9.6

TABLE 12A.22

Table 12A.22 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

<i>ICD-10</i>	<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
Total	93 602	10 073	103 675	100.0

(a) Admitted patient separations refers to those non-ambulatory separations when a patient undergoes a hospital's formal admission process, completes an episode of care and 'separates' from the hospital, excluding ambulatory-equivalent separations. Separations for which care type was reported as Newborn with no qualified days and records for Hospital boarders and Posthumous organ procurement have been excluded.

(b) Includes ICD-10-AM codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z54.3, Z61.9, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.

(c) Includes separations for which the principal diagnosis was any other mental health-related principal diagnosis.

(d) Includes all other codes not included as a mental health principal diagnosis.

– Nil or rounded to zero. **np** Not published.

Source: AIHW (various issues) *Mental Health Services in Australia* (various years), (available at <http://mhsa.aihw.gov.au/home/>).

Table 12A.23 Ambulatory-equivalent mental health-related separations with specialised psychiatric care, by principal diagnosis and hospital type, 2009-10

<i>ICD-10</i>		<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
<i>With specialised psychiatric care</i>					
		no.	no.	no.	%
F00–F09	Organic, including symptomatic, mental disorders	5	–	5	0.1
F10–F19	Mental and behavioural disorders due to psychoactive substance use	388	45	433	8.1
F20–F29	Schizophrenia, schizotypal and delusional disorders	367	9	376	7.1
F30–F39	Mood (affective) disorders	565	8	573	10.8
F40–F48	Neurotic, stress-related and somatoform disorders	1 096	43	1 139	21.4
F50–F59	Behavioural syndromes associated with physiological disturbances and physical factors	34	–	34	0.6
F60–F69	Disorders of adult personality and behaviour	191	17	208	3.9
F70–F79	Mental retardation	13	–	13	0.2
F80–F89	Disorders of psychological development	310	np	310	5.8
F90–F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	1 565	np	1 565	29.4
F99	Mental disorder not otherwise specified	np	–	–	–
G30	Alzheimer's disease	np	np	–	–
	Other factors related to mental and behavioural disorders and substance use (a)	159	np	159	3.0
	Other specified mental health-related principal diagnosis (b)	29	–	29	0.5
	Other (c)	463	7	470	8.8
Total		5 193	132	5 325	100.0

(a) Includes ICD-10-AM codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z54.3, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.

(b) Includes separations for which the principal diagnosis was any other mental health-related principal diagnosis.

Table 12A.23 Ambulatory-equivalent mental health-related separations with specialised psychiatric care, by principal diagnosis and hospital type, 2009-10

<i>ICD-10</i>	<i>Public acute hospitals</i>	<i>Public psychiatric hospitals</i>	<i>Total</i>	<i>Per cent</i>
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(c) Includes all other codes not included as a mental health principal diagnosis.

– Nil or rounded to zero. **np** Not published.

Source: AIHW (2013) *Mental Health Services in Australia*, (available at <http://mhsa.aihw.gov.au/home/>).

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>2005-06</i>									
<i>Number</i>									
Males									
Less than 15 years	39 242	61 978	65 976	27 955	23 046	2 652	8 294	1 534	230 677
15–24	135 686	152 875	83 386	30 460	25 441	2 531	28 628	3 871	462 878
25–34	252 587	252 055	108 586	47 572	34 707	4 812	32 443	6 435	739 197
35–44	199 198	194 510	91 381	45 952	32 112	4 062	16 903	4 290	588 408
45–54	113 329	119 193	57 663	32 580	22 076	4 822	12 055	2 162	363 880
55–64	51 652	65 399	33 349	21 487	9 102	1 782	4 657	1 212	188 640
65 years and over	29 325	106 367	26 531	22 786	10 204	5 496	5 092	794	206 595
Total males (a)	821 019	952 377	466 872	228 792	156 688	26 157	108 072	20 298	2 780 275
Females									
Less than 15 years	30 780	38 115	45 103	18 043	13 925	2 195	9 272	649	158 082
15–24	112 548	150 119	79 990	38 489	19 770	4 416	30 477	3 038	438 847
25–34	129 122	153 943	80 377	44 052	21 971	4 023	19 210	4 221	456 919
35–44	121 075	160 153	77 948	44 759	25 206	3 916	14 329	3 616	451 002
45–54	92 416	129 707	64 160	45 469	19 741	4 136	11 232	2 817	369 678
55–64	57 219	74 678	36 751	24 617	12 383	3 048	6 025	1 228	215 949
65 years and over	46 767	174 060	41 180	48 247	22 129	9 058	11 660	488	353 589
Total females (a)	589 927	880 775	425 509	263 676	135 125	30 792	102 205	16 057	2 444 066
People									
Less than 15 years	70 129	100 093	111 085	45 998	37 020	4 864	17 599	2 184	388 972
15–24	248 456	303 005	163 378	68 949	45 224	6 949	59 160	6 909	902 030
25–34	382 257	405 998	188 965	91 624	56 678	8 847	51 733	10 656	1 196 758
35–44	320 939	354 663	169 330	90 711	57 321	7 989	31 307	7 906	1 040 166

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
45–54	206 402	248 900	121 823	78 049	41 817	8 993	23 311	4 979	734 274
55–64	109 218	140 079	70 101	46 103	21 487	4 831	10 691	2 440	404 950
65 years and over	75 010	271 201	67 638	70 777	32 275	14 672	14 202	1 268	547 043
Total (b)	1 832 177	1 833 205	892 393	492 468	302 400	65 576	210 833	36 356	5 665 408
<i>Rate (per 1,000 population) (c)</i>									
Males									
Less than 15 years	57.4	124.0	155.3	132.9	157.0	53.3	260.4	57.8	111.2
15–24	288.7	425.5	287.0	202.1	235.9	77.1	1 037.5	231.8	318.0
25–34	523.7	687.2	382.7	329.6	341.7	168.8	1 215.8	355.3	509.0
35–44	401.5	513.6	308.8	295.2	283.4	119.8	684.2	244.7	388.1
45–54	245.9	346.9	208.6	223.3	201.6	137.5	531.0	146.5	258.3
55–64	141.1	244.0	148.1	192.2	103.2	61.1	275.0	122.4	169.1
65 years and over	72.1	353.6	118.0	208.7	99.1	173.5	362.9	157.9	172.8
Total males (a)	246.3	378.9	232.4	223.8	208.2	111.2	624.3	185.0	274.1
Females									
Less than 15 years	47.4	80.5	111.9	91.6	99.2	46.7	301.5	26.1	80.4
15–24	249.6	435.0	286.1	273.5	192.8	138.9	1 164.8	196.3	315.1
25–34	265.5	417.6	283.4	314.7	222.2	135.6	713.6	238.6	314.7
35–44	241.3	414.3	258.0	292.1	222.7	111.5	565.2	222.3	294.1
45–54	197.9	370.4	230.1	315.2	176.1	115.5	463.4	207.5	259.2
55–64	157.2	274.2	167.9	231.8	136.3	104.2	348.1	156.3	195.1
65 years and over	92.6	463.9	157.3	373.8	168.4	232.0	675.5	110.4	241.7
Total females (a)	173.7	336.1	210.6	259.5	171.8	120.5	594.4	158.6	235.4
Total people									
Less than 15 years	52.6	102.8	134.1	113.0	128.9	50.3	281.1	42.4	96.3

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
15–24	269.8	430.2	286.5	236.6	215.0	107.5	1 100.5	214.7	316.7
25–34	394.6	552.1	333.1	322.2	282.7	152.1	965.1	297.7	412.1
35–44	321.7	463.4	283.1	293.7	253.1	115.8	625.4	233.9	341.1
45–54	222.5	358.8	219.4	269.0	188.7	126.9	496.6	175.7	259.0
55–64	149.6	259.2	157.9	211.5	120.0	82.7	312.2	137.4	182.2
65 years and over	82.3	401.2	139.0	297.1	137.7	207.5	453.8	134.2	205.8
Total (b)	265.1	357.3	221.5	242.2	195.6	130.5	616.3	170.8	274.9
<i>2006-07</i>									
<i>Number</i>									
<i>Males</i>									
Less than 15 years	52 850	65 142	68 238	29 023	26 869	6 118	8 058	1 715	258 013
15–24	157 769	146 075	99 033	35 453	26 836	4 085	26 355	3 735	499 341
25–34	293 437	255 661	136 745	52 831	48 005	6 654	31 352	6 857	831 542
35–44	242 766	200 969	110 867	50 402	44 058	6 020	18 745	5 352	679 179
45–54	147 155	125 412	68 829	35 713	29 942	6 840	11 414	1 893	427 198
55–64	70 202	69 302	37 575	23 399	12 528	2 566	4 170	1 148	220 890
65 years and over	38 374	88 736	31 958	22 163	9 776	6 580	3 974	679	202 240
Total males (a)	1 003 086	955 935	553 343	249 098	198 083	38 926	104 893	21 384	3 124 748
<i>Females</i>									
Less than 15 years	34 800	42 273	49 801	17 356	17 002	4 062	7 953	992	174 239
15–24	127 370	150 159	94 250	44 259	24 824	7 897	28 382	2 767	479 908
25–34	145 183	156 335	92 550	46 035	27 152	5 230	19 528	4 533	496 546
35–44	153 131	161 996	96 595	50 486	34 278	6 774	16 953	3 732	523 945
45–54	121 441	131 390	74 283	48 786	27 710	6 065	11 262	2 825	423 762
55–64	71 887	77 097	43 412	28 175	16 460	3 867	5 556	1 185	247 639
65 years and over	68 461	152 440	46 652	46 821	21 430	15 554	11 044	362	362 764

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total females (a)	722 696	874 196	497 571	282 028	168 894	49 474	102 205	16 401	2 713 465
People									
Less than 15 years	87 685	107 415	118 065	46 379	43 871	10 183	16 055	2 707	432 360
15–24	285 537	296 287	193 287	79 712	51 660	12 014	54 772	6 502	979 771
25–34	439 120	412 062	229 296	98 868	75 157	11 886	50 910	11 390	1 328 689
35–44	396 346	362 993	207 463	100 888	78 348	12 830	35 718	9 084	1 203 670
45–54	269 194	256 802	143 112	84 499	57 653	12 973	22 694	4 718	851 645
55–64	142 214	146 399	80 987	51 574	28 989	6 485	9 726	2 333	468 707
65 years and over	106 985	241 176	78 610	68 984	31 206	22 166	15 018	1 041	565 186
Total (b)	1 828 468	1 830 278	1 050 960	535 809	382 304	93 186	207 487	37 785	5 966 277
<i>Rate (per 1,000 population) (c)</i>									
Males									
Less than 15 years	77.3	129.7	158.8	136.2	183.0	123.3	253.0	64.7	123.8
15–24	331.2	397.0	332.9	229.5	244.3	123.0	955.1	215.2	336.3
25–34	610.1	695.6	477.2	362.0	475.1	237.6	1 174.9	378.4	571.4
35–44	490.4	526.6	369.1	317.5	388.6	179.5	758.8	303.3	445.2
45–54	315.9	359.3	244.4	240.6	270.4	193.2	502.8	126.1	298.9
55–64	187.2	251.3	161.3	201.5	137.9	85.0	246.3	111.5	192.3
65 years and over	92.1	286.4	137.0	195.1	92.9	202.6	283.2	126.1	164.2
Total males (a)	299.2	375.2	271.2	238.1	262.6	165.0	605.3	188.8	304.5
Females									
Less than 15 years	53.5	88.7	122.2	86.9	121.2	87.0	258.6	39.6	88.1
15–24	277.5	424.8	328.1	306.8	237.4	246.6	1 084.7	174.6	337.3
25–34	300.0	426.1	325.5	328.1	276.3	179.2	725.5	254.5	343.0
35–44	304.8	414.6	315.0	325.5	302.9	194.3	668.7	226.5	339.1
45–54	255.9	368.4	259.7	331.3	244.5	166.7	464.6	202.4	291.7

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
55–64	191.4	272.9	190.4	253.8	174.7	127.6	321.0	142.6	215.7
65 years and over	133.2	398.1	172.9	351.7	160.4	391.0	639.8	76.5	242.5
Total females (a)	209.9	330.0	241.6	271.7	214.8	191.9	594.5	155.2	258.1
Total people									
Less than 15 years	65.7	109.8	141.1	112.3	152.8	105.7	256.4	52.5	106.4
15–24	305.3	410.7	330.6	266.8	240.9	184.2	1 018.9	195.8	337.0
25–34	455.1	561.0	401.7	345.4	377.1	207.8	949.8	317.0	457.7
35–44	397.4	470.0	341.8	321.4	345.9	187.5	713.6	266.3	392.0
45–54	286.3	363.9	252.1	285.8	257.3	180.7	483.5	162.9	295.5
55–64	189.5	262.2	175.7	227.0	156.7	107.2	284.0	125.4	204.1
65 years and over	114.9	348.1	156.3	279.6	130.7	306.8	479.9	102.9	207.2
Total (b)	269.7	353.3	256.7	257.9	249.3	189.2	602.9	172.3	288.0
2007-08									
Number									
Males									
Less than 15 years	54 762	54 125	76 331	29 163	29 505	9 447	8 265	1 640	263 238
15–24	184 734	137 121	108 312	36 359	29 943	7 412	24 591	3 215	531 687
25–34	355 111	236 320	153 452	56 300	56 261	11 232	27 680	7 053	903 409
35–44	292 683	197 867	127 742	51 256	51 794	10 167	17 279	4 889	753 677
45–54	183 155	126 146	81 201	37 727	37 971	10 928	10 690	2 409	490 227
55–64	83 938	67 908	42 359	25 594	15 663	4 931	4 259	909	245 561
65 years and over	45 786	82 281	35 607	24 218	11 745	8 410	5 444	528	214 019
Total males (a)	1 200 743	906 012	625 063	260 826	232 893	62 527	98 692	20 646	3 407 402
Females									
Less than 15 years	36 288	36 896	52 758	16 990	16 432	7 796	10 379	778	178 317
15–24	132 106	144 876	100 645	46 955	27 868	11 066	29 435	3 007	495 958

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
25–34	163 717	141 706	101 403	46 049	33 118	8 750	17 649	4 138	516 530
35–44	174 214	158 411	106 223	56 335	44 022	11 435	16 781	3 644	571 065
45–54	132 986	128 081	80 389	48 451	34 139	11 326	12 871	2 556	450 799
55–64	70 774	78 566	44 263	30 097	20 837	6 149	6 496	1 005	258 187
65 years and over	74 591	139 767	51 659	43 517	23 763	19 503	13 565	368	366 733
Total females (a)	785 095	830 400	537 415	288 596	200 195	76 035	108 200	15 500	2 841 436
People									
Less than 15 years	91 158	91 021	129 090	46 156	45 937	17 244	18 646	2 418	441 670
15–24	317 087	281 997	208 957	83 315	57 812	18 478	54 093	6 222	1 027 961
25–34	519 221	378 026	254 855	102 350	89 379	19 982	45 451	11 191	1 420 455
35–44	467 790	356 307	233 965	107 592	95 845	21 603	34 102	8 533	1 325 737
45–54	316 282	254 232	161 590	86 178	72 135	22 255	23 573	4 965	941 210
55–64	154 799	146 484	86 622	55 693	36 500	11 081	10 772	1 914	503 865
65 years and over	120 459	222 048	87 266	67 735	35 508	27 914	19 031	896	580 857
Total (b)	2 072 440	1 736 456	1 162 557	554 558	456 942	147 701	207 467	36 146	6 374 267
<i>Rate (per 1000 population) (c)</i>									
Males									
Less than 15 years	80.1	106.5	173.4	134.1	199.9	189.5	255.5	61.2	125.0
15–24	378.3	361.5	353.3	228.7	269.3	222.5	879.9	181.2	349.0
25–34	730.6	631.2	520.6	370.7	553.2	403.9	1 002.3	377.2	609.2
35–44	590.4	513.6	415.7	315.2	457.8	307.7	683.8	276.6	489.3
45–54	387.5	355.1	281.8	248.4	339.2	305.8	465.1	157.3	337.1
55–64	217.7	238.9	176.0	212.4	167.7	158.2	236.9	84.8	207.3
65 years and over	107.0	258.1	147.5	205.9	109.2	251.8	357.1	91.3	168.8
Total males (a)	353.1	346.3	297.8	241.8	305.1	265.7	558.8	175.8	324.9
Females									

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Less than 15 years	55.8	76.4	126.5	83.3	116.3	166.0	331.4	30.8	89.2
15–24	283.6	403.3	341.4	317.6	263.3	347.2	1 122.1	184.9	342.5
25–34	335.3	380.6	348.1	318.9	333.8	302.8	641.3	225.7	351.3
35–44	345.2	401.1	339.7	356.4	389.0	330.3	650.8	218.3	365.9
45–54	275.6	352.2	273.6	322.3	297.9	307.3	525.9	178.9	304.4
55–64	182.3	268.5	187.1	259.9	214.4	195.8	346.6	114.4	217.1
65 years and over	142.3	357.3	186.1	318.1	175.2	482.3	729.0	72.7	239.8
Total females (a)	225.8	307.3	255.0	270.5	252.1	293.6	619.6	141.3	265.6
Total people									
Less than 15 years	68.3	91.8	150.6	109.5	159.0	178.1	292.9	46.4	107.6
15–24	332.3	381.8	347.5	271.6	266.3	283.4	998.4	182.9	345.9
25–34	532.9	506.2	434.9	345.4	444.8	352.4	824.3	302.2	480.9
35–44	467.6	456.7	377.4	335.5	423.5	319.2	667.9	248.3	427.5
45–54	331.1	353.6	277.7	285.2	318.4	306.6	496.7	167.7	320.7
55–64	200.1	253.9	181.5	235.7	191.5	177.1	293.3	98.1	212.3
65 years and over	126.5	312.7	168.2	266.2	146.0	378.0	562.2	82.6	207.6
Total (b)	289.8	327.1	276.7	256.6	279.4	280.9	591.8	158.6	295.7
<i>2008-09</i>									
<i>Number</i>									
Males									
Less than 15 years	53 539	57 020	69 564	34 115	33 837	9 406	8 128	1 975	267 584
15–24	171 329	133 507	84 433	38 255	35 906	10 491	25 270	4 347	503 538
25–34	313 446	216 375	125 107	60 557	59 071	13 937	27 686	7 559	823 738
35–44	282 427	193 192	105 837	58 506	59 530	14 136	20 277	4 831	738 736
45–54	186 573	125 183	68 080	41 871	42 059	12 907	10 206	2 541	489 420
55–64	84 909	72 207	35 777	25 053	18 046	8 227	5 549	1 236	251 004

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
65 years and over	58 257	79 146	29 029	26 172	13 837	8 911	6 658	455	222 465
Total males (a)	1 156 291	876 648	517 871	285 039	262 412	78 015	103 779	22 955	3 303 010
Females									
Less than 15 years	37 897	37 270	48 266	21 148	19 012	7 034	10 011	1 028	181 666
15–24	136 950	142 510	83 923	53 375	33 094	13 786	31 795	3 405	498 838
25–34	153 624	142 334	81 922	51 410	41 034	10 557	22 738	4 362	507 981
35–44	172 520	155 971	83 097	59 040	51 147	14 705	18 509	3 805	558 794
45–54	137 339	125 192	64 417	52 783	39 505	12 354	13 842	2 274	447 706
55–64	74 183	78 068	35 652	32 153	24 338	7 722	7 771	1 265	261 152
65 years and over	89 167	131 117	43 626	49 024	26 211	20 078	13 861	221	373 305
Total females (a)	805 354	812 501	441 009	319 368	234 382	86 247	118 527	16 371	2 833 759
People									
Less than 15 years	91 569	94 290	117 847	55 269	52 849	16 440	18 141	3 005	449 410
15–24	308 462	276 021	168 356	91 631	69 000	24 277	57 215	7 752	1 002 714
25–34	467 566	358 709	207 029	111 989	100 105	24 494	50 567	11 921	1 332 380
35–44	455 922	349 275	188 938	117 553	110 687	28 912	38 911	8 636	1 298 834
45–54	324 932	250 377	132 497	94 658	81 568	25 305	24 133	4 815	938 285
55–64	159 347	150 275	71 430	57 209	42 386	15 949	13 338	2 501	512 435
65 years and over	147 707	210 324	72 655	75 203	40 059	28 989	20 657	676	596 270
Total (b)	2 051 579	1 689 328	958 921	609 276	525 217	173 788	223 328	39 328	6 270 765
<i>Rate (per 1000 population) (c)</i>									
Males									
Less than 15 years	77.9	110.8	154.6	152.6	227.7	187.8	247.3	72.9	125.3
15–24	345.0	344.6	268.3	234.2	320.5	312.7	901.8	240.7	324.1
25–34	633.6	563.0	411.2	376.7	568.7	497.8	969.5	395.6	540.6

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
35–44	569.4	496.7	337.7	350.9	528.3	432.5	792.8	271.2	475.3
45–54	389.5	346.4	231.3	268.6	372.2	358.5	439.3	163.3	331.0
55–64	215.0	246.9	144.6	200.9	188.7	257.7	299.3	111.0	206.3
65 years and over	132.3	241.1	116.1	214.4	125.6	258.4	419.9	73.8	170.2
Total males (a)	336.2	330.2	241.4	256.3	340.6	329.3	583.8	189.6	309.9
Females									
Less than 15 years	58.0	76.2	113.1	100.7	133.7	148.6	316.0	40.5	89.7
15–24	289.0	387.7	278.3	352.0	309.4	431.3	1 213.5	207.6	337.9
25–34	309.5	373.9	273.8	343.0	406.0	365.8	812.2	231.5	338.0
35–44	341.5	391.6	261.9	367.8	454.4	426.9	709.3	225.5	355.6
45–54	280.7	338.3	214.3	344.0	342.3	332.4	562.2	156.6	297.4
55–64	185.8	258.6	145.9	266.9	243.8	238.0	402.2	136.1	212.9
65 years and over	166.6	327.9	152.7	347.9	190.0	485.9	718.9	41.0	238.4
Total females (a)	227.9	296.4	205.1	292.4	293.9	333.1	673.0	144.4	260.7
Total people									
Less than 15 years	68.3	93.9	134.4	127.4	181.7	168.7	281.1	57.2	108.0
15–24	317.9	365.6	273.2	290.9	315.1	370.6	1 055.2	224.9	330.9
25–34	471.8	468.9	343.1	360.5	488.4	430.8	894.2	314.1	440.2
35–44	455.3	443.6	299.6	359.2	491.4	430.7	753.1	248.9	415.5
45–54	335.6	342.3	222.7	306.1	357.1	345.8	504.3	160.1	314.5
55–64	200.7	252.8	145.3	233.3	216.9	247.8	352.3	122.4	209.7
65 years and over	151.4	288.9	135.6	286.0	161.4	382.4	587.9	58.5	207.5
Total (b)	294.8	313.6	223.5	277.1	335.5	351.5	632.5	167.4	291.9

2009-10

Number

Males

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Less than 15 years	55 617	58 865	64 050	36 263	36 458	11 539	10 502	2 894	276 188
15–24	194 198	136 613	75 322	43 713	37 083	14 725	23 932	4 080	529 666
25–34	360 216	212 696	112 225	68 442	59 549	20 832	30 156	6 456	870 572
35–44	321 520	198 512	96 721	64 902	61 150	17 384	21 995	5 110	787 294
45–54	203 206	128 415	62 759	47 702	46 587	15 444	12 722	2 666	519 501
55–64	95 362	72 427	34 715	28 721	21 436	8 458	7 146	1 171	269 436
65 years and over	66 302	81 070	27 779	31 519	13 287	10 247	11 291	401	241 896
Total males (a)	1 300 584	888 610	473 593	321 343	275 600	98 681	117 749	22 779	3 498 939
Females									
Less than 15 years	42 034	38 740	43 742	25 000	18 535	9 827	11 446	1 187	190 511
15–24	138 723	153 599	78 342	58 934	32 183	16 731	36 918	3 382	518 812
25–34	156 345	146 349	73 952	55 207	44 709	14 281	25 806	4 465	521 114
35–44	183 051	160 410	76 764	63 702	52 955	19 542	20 050	3 716	580 190
45–54	144 038	134 412	59 620	59 271	41 185	16 258	14 457	1 984	471 225
55–64	88 349	80 891	34 718	35 638	25 366	10 308	10 017	1 131	286 418
65 years and over	95 084	132 732	42 704	53 999	25 146	19 118	20 162	336	389 281
Total females (a)	849 771	847 150	409 855	351 908	240 123	106 109	138 868	16 205	2 959 989
People									
Less than 15 years	97 709	97 605	107 792	61 263	54 993	21 423	21 948	4 081	466 814
15–24	333 043	290 216	153 672	102 649	69 267	31 571	60 938	7 462	1 048 818
25–34	516 863	359 201	186 179	123 674	104 258	35 213	56 025	10 921	1 392 334
35–44	505 271	358 974	173 485	128 624	114 176	37 026	42 091	8 826	1 368 473
45–54	347 565	262 865	122 379	106 975	87 781	31 772	27 213	4 650	991 200
55–64	184 322	153 318	69 433	64 362	46 803	18 801	17 163	2 302	556 504
65 years and over	161 548	213 802	70 483	85 522	38 453	29 400	31 453	737	631 398

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total (b)	2 242 034	1 736 010	883 458	680 134	543 348	212 599	257 497	38 984	6 594 064
<i>Rate (per 1000 population) (c)</i>									
Males									
Less than 15 years	80.4	113.1	139.4	159.3	244.5	230.1	314.0	106.0	127.9
15–24	377.6	336.5	229.9	256.0	323.8	430.7	842.1	216.5	328.0
25–34	699.3	526.1	354.3	403.0	556.5	739.1	1 016.4	323.2	547.2
35–44	643.8	504.7	304.2	385.2	545.4	535.3	849.8	281.4	502.1
45–54	419.7	350.5	209.2	300.5	408.5	428.2	541.9	168.5	346.6
55–64	236.6	241.6	137.1	223.9	219.2	260.1	375.8	101.6	216.4
65 years and over	146.0	239.5	106.6	248.6	117.6	287.2	683.5	61.0	178.9
Total males (a)	369.9	325.7	215.1	281.2	352.6	419.0	661.2	182.1	320.5
Females									
Less than 15 years	63.9	78.5	100.5	116.7	129.7	206.9	357.5	46.3	93.0
15–24	285.5	404.7	250.8	375.6	295.9	518.1	1 394.4	201.1	341.5
25–34	303.9	367.5	236.6	349.7	429.4	488.6	886.7	226.9	332.9
35–44	358.6	397.8	238.3	389.8	471.3	569.1	759.8	214.6	364.9
45–54	290.4	357.3	194.1	378.0	354.1	434.8	584.1	134.3	308.1
55–64	215.8	260.4	138.1	285.7	248.8	311.1	504.8	115.3	227.1
65 years and over	173.5	323.7	144.2	372.0	178.6	452.6	1 008.8	58.8	242.1
Total females (a)	235.5	302.5	185.6	312.9	298.4	416.6	780.0	140.4	266.4
Total people									
Less than 15 years	72.4	96.3	120.5	138.6	188.3	219.4	335.3	77.1	110.9
15–24	333.0	369.5	240.1	313.3	310.2	474.9	1 110.0	209.2	334.7
25–34	502.0	447.6	295.8	377.4	493.8	613.4	953.3	275.4	441.1
35–44	500.3	450.6	271.1	387.6	508.6	554.2	805.2	248.8	433.4
45–54	354.6	354.0	201.6	339.0	381.1	432.5	564.3	152.0	327.3

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
55–64	226.9	251.2	137.6	254.4	234.3	286.4	441.7	107.9	222.0
65 years and over	161.2	285.6	126.6	314.5	151.5	377.3	861.6	60.0	213.3
Total (b)	312.1	315.7	197.5	299.7	332.4	420.7	725.4	171.0	297.7
<i>2010-11</i>									
<i>Number</i>									
<i>Males</i>									
Less than 15 years	53 036	57 824	72 813	42 776	32 021	7 000	8 900	2 339	276 709
15–24	206 312	147 891	92 363	54 328	38 495	9 058	27 770	4 397	580 614
25–34	374 096	211 602	128 045	74 158	63 636	14 058	26 754	7 325	899 674
35–44	351 095	204 707	111 891	70 991	65 026	13 116	20 986	5 535	843 347
45–54	214 607	133 645	73 858	51 986	47 926	11 299	14 007	2 788	550 116
55–64	103 602	73 148	38 367	31 831	23 731	5 281	5 971	1 255	283 186
65 years and over	67 449	86 616	31 531	31 509	14 623	8 192	8 124	418	248 462
Total males (a)	1 378 280	915 441	548 876	357 783	285 478	68 048	112 834	24 061	3 690 801
<i>Females</i>									
Less than 15 years	42 780	35 815	51 300	28 703	20 137	6 107	10 502	827	196 171
15–24	161 084	169 999	96 151	70 234	34 661	11 384	39 911	3 040	586 464
25–34	173 977	149 064	82 701	60 239	45 294	9 033	21 600	5 224	547 132
35–44	202 688	171 229	88 749	67 465	54 097	12 340	21 573	4 208	622 349
45–54	158 044	136 234	68 181	65 891	41 782	12 316	13 965	2 163	498 576
55–64	93 863	84 995	41 885	38 616	26 114	8 260	10 058	1 291	305 082
65 years and over	101 540	138 036	45 582	54 456	28 308	15 615	11 783	404	395 724
Total females (a)	938 018	885 380	474 560	385 808	250 423	75 100	129 900	17 160	3 156 349
<i>People</i>									
Less than 15 years	95 881	93 665	124 113	71 479	52 158	13 132	19 402	3 166	472 996
15–24	367 518	317 934	188 540	124 570	73 160	20 501	67 706	7 437	1 167 366

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
25–34	548 366	360 809	210 754	134 403	108 930	23 157	48 373	12 549	1 447 341
35–44	554 048	376 073	200 640	138 490	119 130	25 645	42 569	9 743	1 466 338
45–54	373 577	269 912	142 067	117 887	89 718	23 660	27 974	4 951	1 049 746
55–64	197 940	158 143	80 256	70 453	49 849	13 570	16 029	2 546	588 786
65 years and over	169 546	224 652	77 113	85 985	42 937	23 838	19 907	822	644 800
Total (b)	2 408 488	1 994 752	1 023 502	752 186	560 498	150 689	242 857	41 221	7 174 193
<i>Rate (per 1000 population) (c)</i>									
Males									
Less than 15 years	76.2	112.1	160.5	187.9	216.6	141.5	263.3	86.7	128.6
15–24	418.9	375.4	290.8	319.6	339.4	264.7	926.7	225.6	369.5
25–34	734.7	521.2	409.1	420.3	590.1	481.0	875.6	346.0	564.4
35–44	707.1	525.3	355.8	414.8	586.6	402.0	789.3	298.3	540.4
45–54	440.9	365.3	246.8	320.8	421.1	309.1	591.5	172.8	365.7
55–64	252.2	241.3	151.4	243.2	240.1	156.3	311.2	104.4	224.3
65 years and over	143.9	250.4	118.7	243.7	127.0	218.5	474.7	62.2	179.3
Total males (a)	395.2	337.3	252.2	307.8	366.3	283.1	611.8	186.5	339.1
Females									
Less than 15 years	65.0	73.2	119.3	131.6	142.3	132.0	327.5	32.8	96.1
15–24	342.8	454.1	313.4	440.8	322.3	354.9	1 403.9	184.0	392.3
25–34	342.9	371.5	266.4	363.7	430.9	305.1	717.6	266.3	348.7
35–44	398.7	425.5	276.8	403.0	488.5	362.0	801.5	242.0	391.9
45–54	319.0	361.3	223.0	410.8	361.1	330.3	559.4	145.9	325.5
55–64	225.1	269.1	165.1	295.7	254.3	244.6	501.0	128.0	237.6
65 years and over	181.4	329.9	150.9	361.1	199.0	360.7	567.1	70.0	240.8
Total females (a)	262.2	316.1	216.1	334.4	311.9	290.3	708.3	148.2	284.6
Total people									

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Less than 15 years	70.8	93.2	140.4	160.3	180.3	137.2	294.6	60.6	112.8
15–24	381.9	413.8	301.9	378.3	331.1	309.2	1 159.5	206.5	380.7
25–34	539.5	447.0	338.1	392.9	511.6	393.6	797.5	307.7	457.6
35–44	551.3	474.7	316.0	409.1	537.6	384.4	795.6	271.1	465.7
45–54	380.4	363.3	234.8	365.6	390.9	320.4	575.0	159.9	345.8
55–64	239.1	255.5	158.3	269.4	247.4	200.9	408.3	115.2	231.2
65 years and over	164.8	294.0	135.8	307.0	166.8	295.1	525.3	65.8	212.8
Total (b)	341.4	362.1	234.3	325.4	354.8	301.9	659.9	168.1	326.8
2011-12 (d), (e)									
<i>Number</i>									
Males									
Less than 15 years	55 345	na	81 536	42 604	27 559	8 921	7 537	3 442	226 944
15–24	216 554	na	112 892	53 638	41 286	7 245	32 648	5 441	469 704
25–34	409 178	na	153 979	72 842	65 433	9 027	30 842	7 567	748 868
35–44	381 886	na	135 033	67 868	68 603	7 331	26 509	6 124	693 354
45–54	235 841	na	87 201	51 029	49 904	5 818	14 634	2 998	447 425
55–64	109 607	na	46 872	31 779	25 077	2 377	7 259	1 481	224 452
65 years and over	74 692	na	37 292	32 460	19 286	4 627	7 209	431	175 997
Total males (a)	1 499 608	na	654 897	352 432	297 165	45 374	127 087	27 491	3 004 054
Females									
Less than 15 years	46 038	na	56 586	32 588	20 968	6 887	8 283	1 769	173 119
15–24	180 415	na	117 464	77 430	38 808	10 642	39 588	4 503	468 850
25–34	182 640	na	100 772	62 852	45 980	5 749	24 701	5 940	428 634
35–44	194 485	na	105 091	65 798	56 571	7 198	21 515	5 121	455 779
45–54	160 016	na	81 160	62 452	47 170	6 325	16 430	2 350	375 903
55–64	95 997	na	47 803	38 979	28 823	5 553	8 560	1 458	227 173

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
65 years and over	115 156	na	50 243	51 280	33 037	6 905	12 501	301	269 423
Total females (a)	980 470	na	559 217	391 569	271 368	49 284	132 237	21 445	2 405 590
People									
Less than 15 years	101 432	na	138 122	75 193	48 527	15 830	15 820	5 211	400 135
15–24	397 089	na	230 408	131 068	80 107	17 903	72 236	9 944	938 755
25–34	592 121	na	254 751	135 697	111 452	14 779	55 555	13 507	1 177 862
35–44	576 860	na	240 124	133 668	125 201	14 543	48 024	11 245	1 149 665
45–54	396 524	na	168 363	113 487	97 099	12 148	31 070	5 348	824 039
55–64	206 078	na	94 714	70 762	53 900	7 951	15 819	2 939	452 163
65 years and over	190 403	na	87 535	83 740	52 330	11 545	19 710	732	445 995
Total (b)	2 573 242	na	1 214 208	752 419	593 178	98 778	259 346	48 936	5 540 107
<i>Rate (per 1000 population) (c)</i>									
Males									
Less than 15 years	78.5	na	176.5	181.8	184.9	180.3	216.8	126.4	136.6
15–24	440.0	na	353.5	311.3	365.8	212.6	1 097.0	284.6	398.2
25–34	794.3	na	483.1	388.3	596.9	306.7	975.6	349.2	617.0
35–44	763.9	na	424.9	387.0	620.6	225.7	977.9	330.6	586.7
45–54	485.4	na	289.7	310.5	439.4	161.3	613.7	185.1	392.2
55–64	263.5	na	183.0	237.3	252.0	69.6	378.5	121.3	231.1
65 years and over	152.2	na	133.3	238.1	160.5	117.4	394.8	59.4	161.2
Total males (a)	426.9	na	296.3	294.3	377.6	189.4	670.5	211.6	363.1
Females									
Less than 15 years	69.1	na	129.3	144.8	147.0	149.1	251.6	69.5	109.8
15–24	384.5	na	380.9	478.1	362.1	335.0	1 402.8	276.0	417.5
25–34	355.4	na	318.6	359.4	431.2	193.3	794.0	298.6	359.4
35–44	380.6	na	325.2	385.3	513.4	214.4	788.6	294.3	381.9

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
45–54	323.0	na	263.5	384.6	409.1	171.2	658.9	157.5	324.7
55–64	227.9	na	186.8	292.2	279.9	163.2	423.7	140.8	232.3
65 years and over	199.5	na	159.8	326.4	225.8	154.4	574.0	48.8	212.5
Total females (a)	272.0	na	251.7	332.0	334.9	196.6	709.6	183.2	287.6
Total people									
Less than 15 years	74.0	na	153.5	163.7	166.3	165.5	233.7	98.9	123.6
15–24	413.0	na	367.1	392.1	364.1	271.9	1 245.9	280.6	407.7
25–34	575.4	na	401.2	374.4	515.3	249.8	885.7	325.0	489.5
35–44	570.6	na	374.6	386.1	567.2	220.2	882.9	313.0	484.0
45–54	404.1	na	276.5	347.4	424.3	166.4	636.9	171.9	358.5
55–64	246.2	na	185.0	264.7	266.2	116.7	401.7	130.2	232.0
65 years and over	178.3	na	147.3	285.4	196.4	137.2	492.3	54.5	189.0
Total (b)	362.0	na	274.1	316.8	371.8	200.9	690.4	198.0	333.2
2012-13 (d), (e)									
<i>Number</i>									
Males									
Less than 15 years	54 886	na	101 393	40 319	32 198	6 017	4 694	4 444	243 951
15–24	252 340	na	140 155	57 807	42 579	4 780	32 991	6 750	537 402
25–34	427 303	na	179 352	78 313	67 864	5 547	31 878	10 433	800 690
35–44	390 035	na	167 225	70 617	71 895	4 614	24 683	8 337	737 406
45–54	256 661	na	110 105	51 691	54 143	3 711	17 538	3 360	497 209
55–64	120 294	na	54 708	31 928	27 278	1 548	6 794	1 616	244 166
65 years and over	94 464	na	47 018	33 355	21 324	3 659	7 452	709	207 981
Total males (a)	1 623 182	na	800 010	364 182	317 288	29 911	126 526	35 659	3 296 758
Females									
Less than 15 years	66 002	na	82 575	37 485	23 693	6 265	9 562	2 993	228 575

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
15–24	239 714	na	159 312	93 177	44 801	8 942	41 531	5 850	593 327
25–34	215 308	na	119 338	69 032	49 182	4 210	26 061	7 491	490 622
35–44	224 573	na	125 231	70 924	57 947	4 520	23 613	6 412	513 220
45–54	189 919	na	95 677	62 987	52 638	3 733	18 052	3 317	426 323
55–64	111 697	na	59 243	39 149	29 635	3 628	10 281	1 976	255 609
65 years and over	142 960	na	64 849	57 774	39 404	5 985	11 662	405	323 039
Total females (a)	1 202 344	na	706 340	430 817	297 348	37 348	141 357	28 452	2 844 006
People									
Less than 15 years	121 001	na	183 971	77 804	55 891	12 287	14 256	7 437	472 647
15–24	492 382	na	299 506	150 990	87 435	13 734	74 522	12 600	1 131 169
25–34	642 807	na	298 692	147 349	117 125	9 802	57 942	17 924	1 291 641
35–44	614 826	na	292 473	141 545	129 922	9 148	48 296	14 749	1 250 959
45–54	447 357	na	205 951	114 680	106 817	7 458	35 590	6 677	924 530
55–64	232 217	na	113 969	71 082	56 932	5 182	17 075	3 592	500 049
65 years and over	239 217	na	111 867	91 129	60 770	9 652	19 114	1 114	532 863
Total (b)	2 924 684	na	1 506 598	795 202	639 715	67 680	267 887	64 111	6 265 877
<i>Rate (per 1000 population) (c)</i>									
Males									
Less than 15 years	77.3	..	215.7	166.6	213.9	..	130.9	161.5	144.7
15–24	510.1	..	432.7	328.2	378.9	..	1 116.4	350.7	451.6
25–34	816.8	..	546.6	388.0	607.3	..	971.1	466.8	640.5
35–44	775.5	..	520.7	391.3	653.2	..	889.1	444.7	617.9
45–54	528.4	..	361.5	308.2	476.4	..	723.8	205.7	433.1
55–64	286.3	..	211.3	234.0	272.2	..	351.2	129.9	248.6
65 years and over	184.8	..	160.0	232.0	170.9	..	384.9	89.8	182.1

TABLE 12A.24

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total males (a)	456.6	..	355.9	293.4	400.7	..	649.7	269.9	391.8
Females									
Less than 15 years	98.2	..	185.5	161.4	164.9	..	281.9	116.3	143.0
15–24	507.8	..	507.3	562.6	418.7	..	1 488.8	361.3	523.1
25–34	411.6	..	366.9	370.1	452.5	..	805.8	365.9	400.1
35–44	437.3	..	383.4	406.7	528.2	..	847.2	365.5	426.7
45–54	383.1	..	307.3	381.0	456.7	..	717.6	221.4	366.1
55–64	260.9	..	227.7	287.2	285.3	..	503.4	183.3	257.1
65 years and over	239.9	..	197.8	352.1	261.6	..	506.7	61.1	245.8
Total females (a)	330.9	..	312.6	356.0	364.3	..	747.6	239.3	335.8
Total people									
Less than 15 years	87.5	..	201.0	164.1	190.0	..	204.3	139.7	143.9
15–24	509.3	..	469.5	441.8	398.6	..	1 297.2	355.5	486.6
25–34	614.4	..	457.2	379.4	531.3	..	889.1	418.5	521.6
35–44	604.9	..	451.5	398.9	591.2	..	868.1	406.4	522.0
45–54	455.8	..	334.4	344.4	466.6	..	720.6	213.2	399.8
55–64	273.7	..	219.5	260.6	279.0	..	429.4	154.7	253.0
65 years and over	216.1	..	179.9	296.0	220.7	..	451.1	76.7	216.9
Total (b)	406.8	..	334.2	324.6	398.2	..	698.5	255.1	371.1

(a) Includes service contacts for which age group was not reported.

(b) Includes service contacts for which sex and/or age group was not reported.

(c) Total rates for males, females and all were directly age-standardised up to data for 2012-13. Age rates are crude rates, as detailed in Technical information—see Technical notes section of *Mental Health Services in Australia* online.

Table 12A.24 **Community mental health service contacts, by sex and age group**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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(d) Data were not available for Victoria in 2011–12 or 2012-13 due to service level collection gaps resulting from protected industrial action during this period. Victoria required that data for 2011–12 and 2012-13 be excluded from all totals, with no proxy data to be included for Victoria when calculating national totals. Industrial action in Tasmania in 2011–12 and 2012-13 has affected the quality and quantity of Tasmania's data (see the online data source of the Community mental health care section).

(e) Totals include only those jurisdictions that provided data. Rates for 2011-12 and 2012-13 were calculated using a methodology which accounts for missing data, as detailed in the online technical information. Comparisons between jurisdictions and over time should be made with caution.

na Not available. – Nil or rounded to zero. **np** Not published.

Source: AIHW (various issues) *Mental Health Services in Australia* (various years), (available at <http://mhsa.aihw.gov.au/home/>).

TABLE 12A.25

Table 12A.25 **Specialised mental health care reported, by Indigenous status**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
<i>2005-06</i>										
<i>Episodes of community-based residential mental health care (a), (b), (c)</i>										
Number										
Aboriginal and Torres Strait Islander (d)	no.	23	11	..	np	8	16	np	..	64
Non-Indigenous	no.	403	778	..	172	130	565	48	..	2 096
Not reported	no.	10	2	..	–	2	160	11	..	185
Total	no.	436	791	..	177	140	741	60	..	2 345
Rate per 10 000 people (e)										
Aboriginal and Torres Strait Islander (d)	per 10 000 people	2.0	3.7	..	np	3.6	18.5	np	..	1.9
Non-Indigenous	per 10 000 people	0.6	1.6	..	0.9	0.9	15.4	1.8	..	1.1
Rate ratio (f)		3.3	2.3	..	0.8	4.0	1.2	1.2	..	1.7
Total	per 10 000 people	0.6	1.6	..	0.9	1.0	14.1	1.8	..	1.1
<i>Community-based ambulatory mental health service contacts (g)</i>										
Number										
Aboriginal	no.	97 430	21 682	49 225	23 006	11 255	950	5 275	10 654	219 477
Torres Strait Islander	no.	1 697	2 146	5 314	171	158	22	39	27	9 574
Both Aboriginal and Torres Strait Islander	no.	9 518	2 474	2 704	1 953	762	7	412	382	18 212
Aboriginal and Torres Strait Islander (d)	no.	108 645	26 302	57 243	25 130	12 175	979	5 726	11 063	247 263
Neither Aboriginal nor Torres Strait Islander	no.	1 040 517	1 800 406	832 841	440 820	271 101	47 412	135 872	24 807	4 593 776
Not reported	no.	683 015	6 497	2 309	26 518	19 124	17 185	69 235	486	824 369
Total	no.	1 832 177	1 833 205	892 393	492 468	302 400	65 576	210 833	36 356	5 665 408

TABLE 12A.25

Table 12A.25 **Specialised mental health care reported, by Indigenous status**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
Rate per 10 000 people (e)										
Aboriginal and Torres Strait Islander (d)	per 1 000 people	822.1	936.6	435.5	375.9	446.3	153.5	1138.6	187.2	531.7
Non-Indigenous (h)	per 1 000 people	254.2	356.4	216.6	239.5	191.4	133.0	612.6	168.4	270.3
Rate ratio (f)		3.2	2.6	2.0	1.6	2.3	1.2	1.9	1.1	2.0
Total	per 1 000 people	265.1	357.3	221.5	242.2	195.6	130.5	616.3	170.8	274.9
<i>Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)</i>										
Aboriginal and Torres Strait Islander (d)										
Separations	no.	1 709	316	1 007	623	328	np	np	np	4 478
Separation rate (e)	per 1 000 people	13.6	10.9	8.2	9.3	12.2	np	np	np	10.4
Patient days	no.	30 049	4506	22 285	14 339	4 641	np	np	np	80 616
Psychiatric care days	no.	29 549	4502	22 167	14 288	4 641	np	np	np	79 907
Average length of stay (overnight)	no.	18.0	14.5	22.5	23.3	15.0	np	np	np	18.5
Non-Indigenous (h)										
Separations	no.	36 704	25 380	25 438	10 976	9 990	np	np	np	109 139
Separation rate (e)	per 1 000 people	5.5	5.0	6.6	5.6	6.4	np	np	np	5.7
Patient days	no.	790 150	466 353	458 231	205 605	236 494	np	np	np	2 162 881
Psychiatric care days	no.	766 667	465 514	454 165	202 744	236 494	np	np	np	2 131 599
Average length of stay (overnight)	no.	23.0	19.4	21.3	19.9	27.2	np	np	np	21.7
Rate ratio (f)		2.5	2.2	1.2	1.7	1.9	np	np	np	1.8

TABLE 12A.25

Table 12A.25 **Specialised mental health care reported, by Indigenous status**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
<i>2006-07</i>										
<i>Episodes of community-based residential mental health care (a), (b), (c)</i>										
Number										
Aboriginal and Torres Strait Islander (d)	no.	15	26	..	np	2	10	np	np	60
Non-Indigenous	no.	377	968	..	178	115	627	73	6	2 344
Not reported	no.	1	9	..	np	4	106	7	np	127
Total	no.	393	1 003	..	181	121	743	81	9	2 531
Rate per 10 000 people										
Aboriginal and Torres Strait Islander (d)	per 10 000 people	1.8	10.3	..	np	0.8	15.4	1.6	np	1.8
Non-Indigenous	per 10 000 people	0.6	1.9	..	0.9	0.8	12.8	2.1	0.5	1.2
Rate ratio (f)		3.0	5.4	..	np	1.0	1.2	0.8	np	1.5
Total	per 10 000 people	0.6	2.0	..	0.9	0.8	14.7	2.3	0.5	1.2
<i>Community-based ambulatory mental health service contacts (g)</i>										
Number										
Aboriginal	no.	114 468	25 636	65 117	23 967	14 042	2 598	3 710	10 897	260 435
Torres Strait Islander	no.	2 402	1 681	7 514	123	166	31	8	62	11 987
Both Aboriginal and Torres Strait Islander	no.	12 137	1 760	4 299	1 335	763	23	199	297	20 813
Aboriginal and Torres Strait Islander (d)	no.	129 007	29 077	76 930	25 425	14 971	2 652	3 917	11 256	293 235
Neither Aboriginal nor Torres Strait Islander	no.	1 288 558	1 789 065	970 751	489 271	333 057	77 479	177 633	24 799	5 150 613
Not reported	no.	410 903	12 136	3 279	21 113	34 276	13 055	25 937	1 730	522 429
Total	no.	1 828 468	1 830 278	1 050 960	535 809	382 304	93 186	207 487	37 785	5 966 277

TABLE 12A.25

Table 12A.25 **Specialised mental health care reported, by Indigenous status**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
Rate per 1000 people (e)										
Aboriginal and Torres Strait Islander	per 1 000 people	996.3	1 022.1	595.3	359.7	528.9	181.3	902.5	180.8	629.3
Non-Indigenous (h)	per 1 000 people	255.4	349.3	245.8	253.3	243.1	189.4	596.8	167.2	279.8
Rate ratio (f)		3.9	2.9	2.4	1.4	2.2	1.0	1.5	1.1	2.2
Total	per 1 000 people	269.7	353.3	256.7	257.9	249.3	189.2	602.9	172.3	288.0
<i>Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)</i>										
Aboriginal and Torres Strait Islander (d)										
Separations	no.	1 915	361	1 219	607	362	np	np	440	4 904
Separation rate (e)	per 1 000 people	15.1	12.6	10.1	8.4	13.5	np	np	7.0	11.3
Patient days	no.	37 458	6 008	40 405	14 216	6 833	np	np	5 369	110 289
Psychiatric care days	no.	36 981	5 997	40 265	14 134	6 833	np	np	5 339	109 549
Average length of stay (overnight)	no.	19.7	16.7	34.9	23.6	19.5	np	np	12.8	23.0
Non-Indigenous (h)										
Separations	no.	37 344	27 095	24 791	11 389	10 775	np	np	544	111 938
Separation rate (e)	per 1 000 people	5.6	5.2	6.2	5.6	6.8	np	np	3.3	5.7
Patient days	no.	808 262	536 843	481 912	226 377	207 442	np	np	5 957	2 266 793
Psychiatric care days	no.	782 915	536 176	477 831	223 946	207 442	np	np	5 886	2 234 196
Average length of stay (overnight)	no.	22.6	20.6	23.4	21.3	22.3	np	np	11.2	22.0
Rate ratio (f)		2.7	2.4	1.6	1.5	2.0	np	np	2.1	1.8

TABLE 12A.25

Table 12A.25 **Specialised mental health care reported, by Indigenous status**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
<i>2007-08</i>										
<i>Episodes of community-based residential mental health care (a), (b), (c)</i>										
Number										
Aboriginal and Torres Strait Islander (d)	no.	np	np	..	np	np	np	np	np	87
Non-Indigenous	no.	np	np	..	np	np	np	np	np	2 962
Not reported	no.	np	np	..	np	np	np	np	np	np
Total	no.	305	1 498	..	240	192	907	75	5	3 222
Rate per 10 000 people										
Aboriginal and Torres Strait Islander (d)	per 10 000 people	np	np	..	np	np	np	np	np	1.9
Non-Indigenous (h)	per 10 000 people	np	np	..	np	np	np	np	np	1.4
Rate ratio (f)		np	np	..	np	np	np	np	np	1.4
Total	per 10 000 people	0.4	2.8	..	1.1	1.3	17.3	2.1	0.3	1.5
<i>Community-based ambulatory mental health service contacts (g)</i>										
Number										
Aboriginal	no.	154 648	25 248	81 047	27 339	19 616	3 371	4 399	10 788	326 456
Torres Strait Islander	no.	3 088	1 516	7 942	98	248	41	24	37	12 994
Both Aboriginal and Torres Strait Islander	no.	12 511	2 646	5 164	1 394	817	113	–	334	22 979
Aboriginal and Torres Strait Islander (d)	no.	170 247	29 410	94 153	28 831	20 681	3 525	4 423	11 159	362 429
Neither Aboriginal nor Torres Strait Islander	no.	1 602 002	1 691 539	1 066 035	508 389	388 682	120 633	179 059	21 081	5 577 420
Not reported	no.	300 191	15 507	2 369	17 338	47 579	23 543	23 985	3 906	434 418

TABLE 12A.25

Table 12A.25 **Specialised mental health care reported, by Indigenous status**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
Total		2 072 440	1 736 456	1 162 557	554 558	456 942	147 701	207 467	36 146	6 374 267
Rate per 1000 people (e)										
Aboriginal and Torres Strait Islander (d)	per 1 000 people	1228.5	940.5	678.2	412.4	729.0	193.7	1077.2	172.0	735.7
Non-Indigenous (h)	per 1 000 people	262.9	302.5	253.5	231.6	261.1	254.1	552.0	151.1	271.6
Rate ratio (f)		4.7	3.1	2.7	1.8	2.8	0.8	2.0	1.1	2.7
Total	per 1 000 people	289.8	327.1	276.7	256.6	279.4	280.9	591.8	158.6	295.7
<i>Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)</i>										
Aboriginal and Torres Strait Islander (d)										
Separations	no.	1 940	362	1 227	590	302	np	np	404	4 825
Separation rate (e)	per 1 000 people	14.1	11.9	9.3	8.3	11.3	np	np	5.9	10.5
Patient days	no.	38 573	6 463	45 785	14 307	4 984	np	np	5 074	115 186
Psychiatric care days	no.	37 795	6 351	45 011	14 171	4 984	np	np	5 050	113 362
Average length of stay (overnight)	no.	20.0	18.2	39.1	24.4	16.7	np	np	12.9	24.3
Non-Indigenous										
Separations	no.	38 256	28 910	24 429	12 494	9 549	np	np	553	114 191
Separation rate (e)	per 1 000 people	5.6	5.5	5.9	6.0	6.0	np	np	3.4	5.7
Patient days	no.	874 557	537 322	469 727	238 391	188 967	np	np	5 376	2 314 340
Psychiatric care days	no.	856 734	536 505	465 016	235 522	188 967	np	np	5 343	2 288 087
Average length of stay (overnight)	no.	24.0	19.5	22.7	21.9	22.7	np	np	10.2	22.2
Rate ratio (f)		2.5	2.2	1.6	1.4	1.9	np	np	1.7	1.8

TABLE 12A.25

Table 12A.25 **Specialised mental health care reported, by Indigenous status**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
<i>2008-09</i>										
<i>Episodes of community-based residential mental health care (a), (b), (c)</i>										
Number										
Aboriginal and Torres Strait Islander (d)	no.	13	34	..	5	11	9	–	9	81
Non-Indigenous	no.	200	1 685	..	249	219	822	45	40	3 260
Total	no.	213	1 730	..	254	237	968	46	49	3 497
Rate per 10 000 people (e)										
Aboriginal and Torres Strait Islander	per 10 000 people	np	np	..	np	np	np	np	np	1.7
Non-Indigenous	per 10 000 people	np	np	..	np	np	np	np	np	1.5
Rate ratio (f)		np	np	..	np	np	np	np	np	1.1
Total	per 10 000 people	0.3	3.2	..	1.1	1.6	18.4	1.3	2.2	1.6
<i>Community-based ambulatory mental health service contacts (g)</i>										
Number										
Aboriginal	no.	155 180	26 648	67 758	32 355	26 639	3 645	5 332	12 100	329 657
Torres Strait Islander	no.	3 647	1 755	7 181	81	417	48	33	70	13 232
Both Aboriginal and Torres Strait Islander	no.	12 899	2 570	4 419	1 469	890	641	–	348	23 236
Aboriginal and Torres Strait Islander (d)	no.	171 726	30 973	79 358	33 905	27 946	4 334	5 365	12 518	366 125
Neither Aboriginal nor Torres Strait Islander	no.	1 441 593	1 643 674	872 221	557 448	434 958	142 697	191 895	21 500	5 305 986
Not reported	no.	438 260	14 681	7 342	17 923	62 313	26 757	26 068	5 310	598 654
Total		2 051 579	1 689 328	958 921	609 276	525 217	173 788	223 328	39 328	6 270 765

TABLE 12A.25

Table 12A.25 **Specialised mental health care reported, by Indigenous status**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
Rate per 1000 people (e)										
Aboriginal and Torres Strait Islander (d)	per 1 000 people	1 224	975.0	556.7	482.7	943.6	269.5	1108.3	188.1	731.2
Non-Indigenous	per 1 000 people	211.5	308.8	212.1	264.5	283.8	300.5	549.2	131.3	254.0
Rate ratio (f)		5.8	3.2	2.6	1.8	3.3	0.9	2.0	1.4	2.9
Total	per 1 000 people	294.8	313.6	223.5	277.1	335.5	351.5	632.5	167.4	291.9
<i>Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)</i>										
Aboriginal and Torres Strait Islander (d)										
Separations	no.	np	np	np	np	np	np	np	np	4 951
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	10.6
Non-Indigenous (h)										
Separations	no.	np	np	np	np	np	np	np	np	122 255
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	6.0
Rate ratio (f)		np	np	np	np	np	np	np	np	1.8
2009-10										
<i>Episodes of community-based residential mental health care (a), (b), (c)</i>										
Number										
Aboriginal and Torres Strait Islander (d)	no.	18	27	..	8	19	16	–	33	121
Non-Indigenous	no.	196	2 200	..	215	190	780	55	49	3 685
Total	no.	214	2 240	..	223	219	929	57	82	3 964
Rate per 10 000 people (e)										
Aboriginal and Torres Strait Islander (d)	per 10 000 people	np	np	np	np	np	np	np	np	2.5
Non-Indigenous	per 10 000 people	np	np	np	np	np	np	np	np	1.7
Rate ratio (f)		np	np	np	np	np	np	np	np	1.5

TABLE 12A.25

Table 12A.25 **Specialised mental health care reported, by Indigenous status**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
Total	per 10 000 people	np	np	np	np	np	np	np	np	1.8
<i>Community-based ambulatory mental health service contacts (g)</i>										
Number										
Aboriginal	no.	190 299	25 973	67 059	38 366	27 363	18 496	7 632	14 483	389 671
Torres Strait Islander	no.	3 227	2 091	6 382	202	310	587	172	107	13 078
Both Aboriginal and Torres Strait Islander	no.	16 017	4 138	4 633	1 552	860	527	–	418	28 145
Aboriginal and Torres Strait Islander (d)	no.	209 543	32 202	78 074	40 120	28 533	19 610	7 804	15 008	430 894
Neither Aboriginal nor Torres Strait Islander	no.	1 604 984	1 681 351	803 254	617 936	446 762	178 757	226 842	23 514	5 583 400
Not reported	no.	427 507	22 457	2 130	22 078	68 053	14 232	22 851	462	579 770
Total		2 242 034	1 736 010	883 458	680 134	543 348	212 599	257 497	38 984	6 594 064
Rate per 1000 people (e)										
Aboriginal and Torres Strait Islander (d)	per 1 000 people	1 459.1	971.2	530.2	554.4	941.3	1211.1	1767.0	217.4	841.8
Non-Indigenous (h)	per 1 000 people	231.7	309.4	190.6	284.5	288.8	380.4	649.0	141.6	262.0
Rate ratio (f)		6.3	3.1	2.8	1.9	3.3	3.2	2.7	1.5	3.2
Total	per 1 000 people	315.5	314.4	200.5	300.5	343.1	434.2	724.8	161.9	299.9
<i>Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)</i>										
Aboriginal and Torres Strait Islander (d)										
Separations	no.	np	np	np	np	np	np	np	np	5 075
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	10.6
Non-Indigenous (h)										
Separations	no.	np	np	np	np	np	np	np	np	122 489

TABLE 12A.25

Table 12A.25 **Specialised mental health care reported, by Indigenous status**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	5.9
Rate ratio (f)		np	np	np	np	np	np	np	np	1.8
<i>2010-11</i>										
<i>Episodes of community-based residential mental health care (a), (b), (c)</i>										
Number										
Aboriginal and Torres Strait Islander (d)	no.	17	27	..	6	15	14	np	np	121
Non-Indigenous	no.	215	2 425	..	231	323	656	np	np	3 969
Total (h)	no.	232	2 475	..	237	369	760	75	86	4 234
Rate per 10 000 people (e)										
Aboriginal and Torres Strait Islander (d)	per 10 000 people	np	np	np	np	np	np	np	np	2.6
Non-Indigenous	per 10 000 people	np	np	np	np	np	np	np	np	1.8
Rate ratio (f)		np	np	np	np	np	np	np	np	1.4
Total	per 10 000 people	np	np	np	np	np	np	np	np	1.9
<i>Community-based ambulatory mental health service contacts (g)</i>										
Number										
Aboriginal	no.	200 879	26 355	82 921	49 083	28 886	3 580	9 173	16 098	416 975
Torres Strait Islander	no.	3 186	1 741	7 777	135	451	392	157	71	13 910
Both Aboriginal and Torres Strait Islander	no.	16 143	2 128	6 327	1 592	54	978	–	461	27 683
Aboriginal and Torres Strait Islander (d)	no.	220 208	30 224	97 025	50 810	29 391	4 950	9 330	16 630	458 568
Neither Aboriginal nor Torres Strait Islander	no.	1 755 783	1 731 303	924 592	679 170	461 470	121 216	211 748	24 296	5 909 578
Not reported	no.	432 497	233 225	1 885	22 206	69 637	24 523	21 779	295	806 047

TABLE 12A.25

Table 12A.25 **Specialised mental health care reported, by Indigenous status**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
Total		2 408 488	1 994 752	1 023 502	752 186	560 498	150 689	242 857	41 221	7 174 193
Rate per 1000 people (e)										
Aboriginal and Torres Strait Islander (d)	per 1 000 people	1 511.5	892.2	634.1	676.6	968.8	289.2	1807.5	242.4	870.9
Non-Indigenous (h)	per 1 000 people	254.4	317.5	220.2	306.1	297.7	251.3	587.8	142.9	276.7
Rate ratio (f)		5.9	2.8	2.9	2.2	3.3	1.2	3.1	1.7	3.1
Total	per 1 000 people	341.4	362.1	234.3	325.4	354.8	301.9	659.9	168.1	326.8
<i>Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)</i>										
Aboriginal and Torres Strait Islander (d)										
Separations	no.	np	np	np	np	np	np	np	np	6 109
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	12.9
Non-Indigenous (h)										
Separations	no.	np	np	np	np	np	np	np	np	122 610
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	5.8
Rate ratio (f)		np	np	np	np	np	np	np	np	2.2
2011-12 (m), (n)										
<i>Episodes of community-based residential mental health care (a), (b), (c)</i>										
Number										
Aboriginal and Torres Strait Islander (d)	no.	28	49	..	np	45	41	np	55	230
Non-Indigenous	no.	268	2 711	..	np	1 083	816	np	67	5 275
Total (h)	no.	296	2 794	..	277	1 223	949	66	122	5 727
Rate per 10 000 people (e)										
Aboriginal and Torres Strait Islander (d)	per 10 000 people	np	np	np	np	np	np	np	np	5.0
Non-Indigenous	per 10 000 people	np	np	np	np	np	np	np	np	2.4

TABLE 12A.25

Table 12A.25 Specialised mental health care reported, by Indigenous status

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
Rate ratio (f)		np	np	np	np	np	np	np	np	2.1
Total	per 10 000 people	0.4	5.0	..	1.2	7.7	18.4	1.7	4.9	2.6
<i>Community-based ambulatory mental health service contacts (g)</i>										
Number										
Aboriginal	no.	237 868	na	108 533	53 297	33 578	2 427	9 608	18 303	463 614
Torres Strait Islander	no.	3 353	na	11 029	190	700	179	45	131	15 627
Both Aboriginal and Torres Strait Islander	no.	18 724	na	6 884	1 755	31	1 209	–	465	29 068
Aboriginal and Torres Strait Islander (d)	no.	259 945	na	126 446	55 242	34 309	3 815	9 653	18 899	508 309
Neither Aboriginal nor Torres Strait Islander	no.	1 851 698	na	1 085 140	678 862	485 828	76 872	228 150	29 832	4 436 382
Not reported	no.	461 599	na	2 622	18 315	73 041	18 091	21 543	205	595 416
Total		2 573 242	na	1 214 208	752 419	593 178	98 778	259 346	48 936	5 540 107
Rate per 1000 people (e), (m), (n)										
Aboriginal and Torres Strait Islander (d)	per 1 000 people	1 756.7	na	797.9	713.7	1 126.2	193.5	2 045.1	265.7	1 007.7
Non-Indigenous (h)	per 1 000 people	261.8	na	249.8	300.0	307.6	164.1	625.2	178.2	272.8
Rate ratio (f)		6.7	na	3.2	2.4	3.7	1.2	3.3	1.5	3.7
Total	per 1 000 people	362.0	na	274.1	316.8	371.8	200.9	690.4	198.0	333.2
<i>Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)</i>										
Aboriginal and Torres Strait Islander (d)										
Separations	no.	np	np	np	np	np	np	np	np	6 749
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	13.9
Non-Indigenous (h)										

TABLE 12A.25

Table 12A.25 Specialised mental health care reported, by Indigenous status

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
Separations	no.	np	np	np	np	np	np	np	np	135 149
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	6.1
Rate ratio (f)		np	np	np	np	np	np	np	np	2.3
<i>2012-13 (m), (n)</i>										
<i>Episodes of community-based residential mental health care (a), (b), (c)</i>										
Number										
Aboriginal and Torres Strait Islander (d)	no.	27	44	..	13	73	34	np	np	228
Non-Indigenous	no.	271	2 912	..	255	1 518	1 024	np	np	6 114
Total (h)	no.	298	2 992	..	268	1 707	1 097	69	104	6 535
Rate per 10 000 people (e)										
Aboriginal and Torres Strait Islander (d)	per 10 000 people	np	np	np	np	np	np	np	np	4.1
Non-Indigenous	per 10 000 people	np	np	np	np	np	np	np	np	2.8
Rate ratio (f)		np	np	np	np	np	np	np	np	1.5
Total	per 10 000 people	0.4	5.3	..	1.1	10.7	20.9	1.8	4.2	2.9
<i>Community-based ambulatory mental health service contacts (g)</i>										
Number										
Aboriginal	no.	268 575	na	142 575	62 417	34 992	2 586	10 158	26 399	547 702
Torres Strait Islander	no.	3 401	na	14 983	309	345	70	226	158	19 492
Both Aboriginal and Torres Strait Islander	no.	17 345	na	9 426	1 887	260	339	239	585	30 081
Aboriginal and Torres Strait Islander (d)	no.	289 321	na	166 984	64 613	35 597	2 995	10 623	27 142	597 275
Neither Aboriginal nor Torres Strait Islander	no.	2 138 992	na	1 337 663	722 417	526 506	62 430	244 074	36 595	5 068 677

Table 12A.25 **Specialised mental health care reported, by Indigenous status**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
Not reported	no.	496 371	na	1 951	8 172	77 612	2 255	13 190	374	599 925
Total		2 924 684	na	1 506 598	795 202	639 715	67 680	267 887	64 111	6 265 877
Rate per 1000 people (e), (m), (n)										
Aboriginal and Torres Strait Islander (d)	per 1 000 people	1 558.9	..	890.5	725.9	930.8	..	1 711.4	374.5	998.8
Non-Indigenous (h)	per 1 000 people	306.6	..	312.1	309.6	335.3	..	652.2	214.9	313.1
Rate ratio (f)		5.1	..	2.9	2.3	2.8	..	2.6	1.7	3.2
Total	per 1 000 people	406.8	..	334.2	324.6	398.2	..	698.5	255.1	371.1
<i>Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)</i>										
Aboriginal and Torres Strait Islander (d)										
Separations	no.	np	np	np	np	np	np	np	np	7 209
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	12.7
Non-Indigenous (h)										
Separations	no.	np	np	np	np	np	np	np	np	139 726
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	6.3
Rate ratio (f)		np	np	np	np	np	np	np	np	2.0

- (a) Data for episodes of community residential care should be interpreted with caution due to the varying quality and completeness of Indigenous identification across jurisdictions.
- (b) Queensland does not have any government-operated residential mental health services. Tasmanian information contains data for government-funded residential units operated by the non-government sector in that state, being the only jurisdiction providing this level of reporting. The NT did not have any community residential units in 2005-06.
- (c) For NSW, Confused and Disturbed Elderly (CADE) residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007-08 onwards. Comparison of NSW data over time therefore should be approached with caution.
- (d) Includes patients identified as being either of Aboriginal but not Torres Strait Islander origin, Torres Strait Islander but not Aboriginal origin, Aboriginal and Torres Strait Islander origin and patients identified as of Aboriginal or Torres Strait Islander origin.

Table 12A.25 **Specialised mental health care reported, by Indigenous status**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
(e)	The rates were directly aged standardised against the Australian Estimated Resident Population as at 30 June 2001.									
(f)	The rate ratio is equal to the service use (episodes, contacts or separations) rate for Indigenous Australians divided by the service use rate for non-Indigenous Australians.									
(g)	Data for community mental health service contacts should be interpreted with caution. Across jurisdictions, the data quality and completeness of Indigenous identification varies or is unknown. See <i>Mental Health Services in Australia</i> (http://mhsa.aihw.gov.au/home) for further information.									
(h)	Includes data for people where Indigenous status was missing or not reported.									
(i)	Admitted patient separations refers to those non-ambulatory separations when a patient undergoes a hospital's formal admission process, completes an episode of care and 'separates' from the hospital, excluding ambulatory-equivalent separations. Separations for which care type was reported as Newborn with no qualified days and records for Hospital boarders and Posthumous organ procurement have been excluded. Comprises separations with and without mental health-related principal diagnoses but with specialised psychiatric care.									
(j)	Interpretation of differences between jurisdictions needs to be undertaken with care as they may reflect different service delivery and admission practices and/or differences in the types of establishments categorised as hospitals.									
(k)	Includes only public hospital separations for the NT.									
(l)	Indigenous status data for NSW, Victoria, Queensland, WA, SA and the NT public hospitals are considered to be of acceptable quality for analytical purposes. Indigenous identification is likely to be incomplete and to vary among jurisdictions. Total includes data for these jurisdictions only.									
(m)	Data were not available for Victoria in 2011–12 and 2012-13 due to service level collection gaps resulting from protected industrial action during this period. Victoria required that data for 2011–12 and 2012-13 be excluded from all totals, with no proxy data to be included for Victoria when calculating national totals. Industrial action in Tasmania in 2011–12 and 2012-13 has affected the quality and quantity of Tasmania's data (see the Mental Health Services in Australia online data source of the Community mental health care section).									
(n)	Totals include only those jurisdictions that provided data. Rates were calculated using a methodology which accounts for missing data, as detailed in the online technical information. Comparisons between jurisdictions and over time should be made with caution.									

na Not available. – Nil or rounded to zero. **np** Not published. .. Not applicable.

Source: AIHW (various issues) *Mental Health Services in Australia* (various years), (available at <http://mhsa.aihw.gov.au/home/>).

TABLE 12A.26

Table 12A.26 Available beds in specialised mental health services (a), (b), (c)

	NSW (d), (e)	Vic	Qld (f)	WA (g)	SA	Tas (h), (i)	ACT (i)	NT (i)	Aust
<i>No. of beds</i>									
Public psychiatric hospitals									
2005-06	1 072	116	375	245	455	..	..	..	2 263
2006-07	1 060	134	375	254	388	..	..	..	2 211
2007-08	1 024	154	376	245	357	..	..	..	2 156
2008-09	911	154	375	246	343	..	..	..	2 029
2009-10	967	150	375	243	267	..	..	..	2 002
2010-11	1 064	152	375	246	247	..	..	..	2 083
2011-12	902	150	345	246	230	..	..	..	1 873
2012-13	785	152	345	242	205	..	..	..	1 729
Public acute hospitals with psychiatric units or wards									
2005-06	1 151	1 048	1 014	403	188	125	50	32	4 011
2006-07	1 227	1 050	1 022	415	247	126	70	34	4 191
2007-08	1 400	1 062	1 033	425	243	128	70	34	4 395
2008-09	1 542	1 064	1 029	432	233	130	63	34	4 527
2009-10	1 558	1 082	1 033	452	246	128	63	34	4 597
2010-11	1 586	1 104	1 044	454	252	127	65	33	4 666
2011-12	1 747	1 091	1 057	463	250	131	65	32	4 836
2012-13	1 884	1 113	1 110	479	247	131	70	40	5 074
Community-based residential units (public)									
2005-06	440	1 319	..	80	43	174	80	10	2 146
2006-07	437	1 359	..	85	63	176	75	5	2 200
2007-08	251	1 404	..	130	71	176	77	5	2 114
2008-09	196	1 456	..	178	99	165	83	13	2 190
2009-10	195	1 430	..	260	89	169	83	13	2 239
2010-11	185	1 448	..	283	97	170	83	15	2 281
2011-12	176	1 476	..	303	138	162	82	15	2 352
2012-13	157	1 497	..	298	137	156	95	16	2 356
<i>Proportion of all beds in different settings (%)</i>									
Public psychiatric hospitals									
2005-06	40.3	4.7	27.0	33.7	66.3	..	..	..	26.9
2006-07	38.9	5.3	26.8	33.7	55.6	..	..	..	25.7
2007-08	38.3	5.9	26.7	30.6	53.2	..	..	..	24.9
2008-09	34.4	5.8	26.7	28.7	50.8	..	..	..	23.2
2009-10	35.6	5.6	26.6	25.4	44.3	..	..	..	22.7
2010-11	37.5	5.6	26.4	25.0	41.4	..	..	..	23.1
2011-12	31.9	5.5	24.6	24.3	37.2	..	..	..	20.7
2012-13	27.8	5.5	23.7	23.7	34.8	..	..	..	18.9
Public acute hospitals with psychiatric units or wards									
2005-06	43.2	42.2	73.0	55.4	27.4	41.8	38.5	76.2	47.6
2006-07	45.0	41.3	73.2	55.0	35.4	41.7	48.3	87.2	48.7

Table 12A.26 Available beds in specialised mental health services (a), (b), (c)

	NSW (d), (e)	Vic	Qld (f)	WA (g)	SA	Tas (h), (i)	ACT (i)	NT (i)	Aust
2007-08	52.3	40.5	73.3	53.1	36.2	42.1	47.6	87.2	50.7
2008-09	58.2	39.8	73.3	50.5	34.5	44.1	43.2	72.3	51.8
2009-10	57.3	40.6	73.4	47.3	40.9	43.1	43.2	72.3	52.0
2010-11	55.9	40.8	73.6	46.2	42.3	42.8	43.9	68.9	51.7
2011-12	61.8	40.2	75.4	45.8	40.5	44.7	44.2	68.1	53.4
2012-13	66.7	40.3	76.3	47.0	41.8	45.6	42.4	71.4	55.4
Community-based residential units (public)									
2005-06	16.5	53.1	..	11.0	6.3	58.2	61.5	23.8	25.5
2006-07	16.0	53.4	..	11.3	9.0	58.3	51.7	12.8	25.6
2007-08	9.4	53.6	..	16.3	10.6	57.9	52.4	12.8	24.4
2008-09	7.4	54.5	..	20.8	14.7	55.9	56.8	27.7	25.0
2009-10	7.2	53.7	..	27.2	14.8	56.9	56.8	27.7	25.3
2010-11	6.5	53.6	..	28.8	16.3	57.2	56.1	31.1	25.3
2011-12	6.2	54.3	..	29.9	22.3	55.3	55.8	31.9	26.0
2012-13	5.6	54.2	..	29.3	23.3	54.4	57.6	28.6	25.7
<i>Beds per 100 000 people</i>									
Public psychiatric hospitals									
2005-06	16.0	2.3	9.5	12.1	29.5	..	..	..	11.1
2006-07	15.6	2.6	9.2	12.2	24.9	..	..	..	10.7
2007-08	14.9	3.0	9.0	11.5	22.6	..	..	..	10.3
2008-09	13.0	2.9	8.8	11.1	21.5	..	..	..	9.4
2009-10	13.6	2.8	8.6	10.7	16.5	..	..	..	9.2
2010-11	14.8	2.8	8.5	10.6	15.1	..	..	..	9.4
2011-12	12.4	2.7	7.6	10.3	14.0	..	..	..	8.3
2012-13	10.7	2.7	7.5	9.8	12.4	..	..	..	7.5
Public acute hospitals with psychiatric units or wards									
2005-06	17.1	20.9	25.6	19.9	12.2	25.6	15.0	15.4	19.7
2006-07	18.1	20.6	25.2	20.0	15.8	25.6	20.7	16.1	20.3
2007-08	20.3	20.4	24.8	19.9	15.4	25.8	20.3	15.7	20.9
2008-09	22.0	20.0	24.1	19.6	14.6	25.9	17.9	15.3	21.1
2009-10	21.9	20.0	23.7	20.0	15.2	25.3	17.6	14.9	21.0
2010-11	22.1	20.1	23.5	19.6	15.4	24.9	17.8	14.5	21.0
2011-12	24.1	19.6	23.4	19.4	15.2	25.6	17.5	13.8	21.5
2012-13	25.6	19.6	24.1	19.4	14.8	25.6	18.4	16.9	22.2
Publicly funded community-based residential units									
2005-06	6.5	26.3	..	3.9	2.8	35.6	24.0	4.8	10.6
2006-07	6.4	26.6	..	4.1	4.0	35.8	22.2	2.4	10.7
2007-08	3.6	27.0	..	6.1	4.5	35.5	22.4	2.3	10.1
2008-09	2.8	27.4	..	8.1	6.2	32.9	23.6	5.8	10.2
2009-10	2.7	26.4	..	11.5	5.5	33.3	23.2	5.7	10.2
2010-11	2.6	26.3	..	12.2	6.0	33.3	22.8	6.5	10.3

Table 12A.26 Available beds in specialised mental health services (a), (b), (c)

	NSW (d), (e)	Vic	Qld (f)	WA (g)	SA	Tas (h), (i)	ACT (i)	NT (i)	Aust
2011-12	2.4	26.5	..	12.7	8.4	31.7	22.1	6.5	10.5
2012-13	2.1	26.4	..	12.1	8.3	30.4	25.0	6.8	10.3
Total									
2005-06	39.6	49.4	35.0	35.9	44.4	61.3	39.0	20.3	41.5
2006-07	40.1	49.8	34.4	36.3	44.7	61.4	42.9	18.5	41.7
2007-08	38.9	50.4	33.9	37.5	42.5	61.3	42.7	18.0	41.2
2008-09	37.8	50.3	32.8	38.8	42.2	58.8	41.6	21.1	40.7
2009-10	38.3	49.1	32.2	42.2	37.2	58.6	40.8	20.6	40.4
2010-11	39.5	49.2	32.0	42.4	36.5	58.2	40.6	21.0	40.7
2011-12	39.0	48.7	31.1	42.4	37.6	57.3	39.7	20.2	40.3
2012-13	38.5	48.6	31.6	41.2	35.5	56.0	43.5	23.6	40.0

- (a) Bed numbers represent the average number of beds which are immediately available for use by an admitted patient or resident within the establishment. See AIHW *Mental Health Services in Australia* on-line publication (<http://mhsa.aihw.gov.au/resources/expenditure/data-source/>) for a full description of the bed estimates. Available beds are counted as the average of monthly available bed numbers. Available beds counts exclude beds in wards that were closed for any reason (except weekend closures for beds/wards staffed and available on weekdays only).
- (b) Due to the ongoing validation of NMDS, data could differ from previous reports.
- (c) Hospital bed can include government funded beds managed and operated by private and non-government entities.
- (d) Caution is required when interpreting NSW data. Seven residential mental health services in 2006–07 were reclassified as non-acute older person specialised hospital services in 2007–08, reflecting a change in function of those units.
- (e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.
- (f) Queensland does not fund community residential services, however, it funds a number of campus based and non-campus based extended treatment services. These services are reported either as wards of public acute hospitals or beds in public psychiatric hospitals. Furthermore, limiting the classification of all inpatient beds to either co-located or standalone results in the reporting of some psychogeriatric beds co-located with nursing homes being reported as 'standalone' which results in the reporting of these beds as psychiatric hospital beds in this report. In 2005-06, there was temporary closure of acute beds in one Queensland hospital and some transitional extended treatment beds were permanently closed. In addition, Queensland did not change its method for counting beds until 2007-08 (see 2011 Report for details of previous method).
- (g) Beds numbers in WA include publicly funded mental health beds in private hospitals for all years. Bed numbers in WA include emergency department observation beds in one hospital for all years prior to 2010-11.
- (h) In Tasmania, for 2005-06, non-government organisations' residential beds funded by government were included for the first time in the publicly funded community residential facilities category.
- (i) Tasmania, the ACT and the NT do not have public psychiatric hospitals.
.. Not applicable.

Source: AIHW (unpublished) MHE NMDS; ABS (various issues), *Australian Demographic Statistics*, December (various years), Cat. no. 3101.0.

TABLE 12A.27

Table 12A.27 Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people) (a), (b), (c)

	NSW (d)	Vic	Qld (e)	WA	SA	Tas	ACT	NT	Aust
2005-06									
Medical									
Consultant psychiatrist	5.5	4.6	4.3	4.9	5.1	5.0	3.2	3.7	4.9
Psychiatry registrar	4.7	4.7	5.0	4.4	5.7	3.0	5.1	3.1	4.8
Other medical officers	0.8	1.9	0.8	2.9	1.6	0.8	1.3	2.7	1.4
Total	11.0	11.2	10.1	12.2	12.4	8.8	9.7	9.5	11.0
Nursing									
Registered nursing	53.1	53.7	47.8	63.2	56.9	60.4	37.8	40.6	53.3
Non-registered	8.3	12.0	7.6	7.9	14.5	10.3	7.0	3.9	9.5
Total	61.4	65.7	55.4	71.1	71.4	70.7	44.8	44.4	62.8
Allied health									
Occupation therapist	3.2	4.4	3.6	5.9	3.0	1.8	2.1	0.5	3.8
Social worker	5.3	7.9	6.9	8.4	12.5	4.0	7.4	2.4	7.1
Psychologist	8.5	7.8	7.7	7.1	5.4	5.6	21.9	5.8	7.9
Other allied health staff	5.1	2.2	2.9	5.7	3.6	5.9	4.1	8.2	3.9
Total	22.1	22.3	21.1	27.2	24.6	17.3	35.5	16.9	22.7
Other personal care	1.8	5.1	4.7	4.4	0.9	27.7	8.9	2.4	4.1
Total	96.2	104.3	91.4	114.9	109.3	124.5	98.9	73.2	100.6
2006-07									
Medical									
Consultant psychiatrist	5.5	4.6	4.6	4.8	5.8	4.5	3.8	3.9	5.0
Psychiatry registrar	5.4	4.5	5.6	4.8	6.1	2.8	4.5	4.0	5.1
Other medical officers	0.7	1.6	0.8	3.4	1.6	1.0	0.5	2.2	1.3
Total	11.6	10.7	11.1	12.9	13.5	8.4	8.8	10.1	11.4
Nursing									
Registered nursing	54.4	52.0	50.1	61.6	61.1	65.0	41.7	41.8	54.1
Non-registered	8.2	14.1	7.5	8.7	13.8	10.6	8.4	4.5	10.0
Total	62.5	66.1	57.6	70.3	74.9	75.6	50.1	46.3	64.1
Allied health									
Occupation therapist	3.3	4.7	3.5	6.3	3.6	3.0	1.8	0.5	3.9
Social worker	5.2	8.2	7.0	9.5	12.7	6.1	5.9	3.4	7.3
Psychologist	8.3	8.3	8.1	8.1	5.1	5.5	17.9	5.9	8.1
Other allied health staff	5.4	1.7	2.9	5.3	3.9	5.8	2.0	5.7	3.8
Total	22.2	22.9	21.6	29.3	25.3	20.3	27.7	15.4	23.2
Other personal care	2.4	4.2	5.0	4.3	1.5	29.2	8.5	3.3	4.2
Total	98.7	103.9	95.3	116.8	115.2	133.5	95.1	75.1	102.9
2007-08									
Medical									
Consultant psychiatrist	5.6	4.3	5.7	4.8	6.1	5.4	4.3	4.0	5.2

TABLE 12A.27

Table 12A.27 **Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people) (a), (b), (c)**

	<i>NSW (d)</i>	<i>Vic</i>	<i>Qld (e)</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Psychiatry registrar	5.4	4.8	5.6	4.8	6.6	3.2	4.8	4.1	5.2
Other medical officers	1.2	2.2	0.9	3.6	1.1	0.2	0.4	2.3	1.6
Total	12.1	11.3	12.1	13.2	13.8	8.9	9.5	10.4	12.0
Nursing									
Registered nursing	54.4	51.0	52.2	61.1	63.8	59.2	40.6	42.7	54.3
Non-registered	8.1	14.4	8.3	8.8	15.0	11.0	8.6	4.2	10.3
Total	62.5	65.4	60.4	70.0	78.7	70.2	49.2	46.9	64.6
Allied health									
Occupation therapist	3.3	4.5	3.9	6.8	4.4	2.2	2.2	0.8	4.1
Social worker	4.7	8.4	7.7	9.5	14.3	5.6	6.8	3.8	7.4
Psychologist	8.7	7.5	9.5	7.4	6.9	5.0	14.2	5.8	8.3
Other allied health staff	5.6	2.2	3.1	5.7	4.4	5.9	0.2	6.1	4.1
Total	22.3	22.6	24.2	29.5	30.0	18.7	23.4	16.5	23.9
Other personal care	1.0	4.7	4.8	6.2	1.5	31.2	9.4	3.6	4.1
Total	97.9	104.0	101.5	118.8	124.0	129.0	91.4	77.3	104.6
2008-09									
Medical									
Consultant psychiatrist	6.2	4.8	5.7	5.3	6.1	4.6	5.8	5.8	5.6
Psychiatry registrar	5.8	5.1	5.9	4.7	7.1	2.8	4.5	4.3	5.5
Other medical officers	0.9	1.5	0.5	3.5	0.2	2.7	0.8	2.7	1.3
Total	12.9	11.4	12.1	13.5	13.4	10.1	11.1	12.8	12.4
Nursing									
Registered nursing	56.0	50.9	52.7	61.9	62.3	60.2	37.4	46.6	54.9
Non-registered	8.2	15.4	8.4	9.3	15.3	11.0	9.3	2.4	10.7
Total	64.2	66.2	61.1	71.2	77.6	71.2	46.6	48.9	65.5
Allied health									
Occupation therapist	3.9	4.6	4.5	6.8	4.2	3.3	4.2	1.0	4.5
Social worker	5.7	8.8	7.8	9.2	14.7	5.9	5.9	5.2	7.9
Psychologist	8.3	7.8	9.3	7.9	5.6	4.6	13.5	4.5	8.1
Other allied health staff	4.0	1.7	3.7	6.2	3.0	4.5	0.4	5.0	3.5
Total	22.0	22.9	25.3	30.0	27.5	18.3	24.0	15.7	24.0
Other personal care	0.8	4.8	4.1	6.0	4.7	30.2	7.7	9.4	4.2
Total	99.9	105.5	102.7	120.7	123.2	129.9	89.4	86.9	106.1
2009-10									
Medical									
Consultant psychiatrist	6.1	5.4	5.6	5.6	6.2	5.4	6.8	5.8	5.8
Psychiatry registrar	6.6	4.7	5.8	4.5	6.8	2.8	5.2	4.6	5.6
Other medical officers	0.4	1.7	0.7	3.5	0.4	2.2	0.5	2.3	1.1
Total	13.1	11.9	12.1	13.7	13.4	10.4	12.5	12.7	12.6

TABLE 12A.27

Table 12A.27 **Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people) (a), (b), (c)**

	<i>NSW (d)</i>	<i>Vic Qld (e)</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Nursing									
Registered nursing	59.3	50.3	50.0	60.5	62.9	58.3	40.9	45.5	55.1
Non-registered	7.3	15.3	7.5	9.7	14.6	11.1	8.5	3.3	10.2
Total	66.6	65.6	57.5	70.3	77.6	69.4	49.4	48.8	65.3
Allied health									
Occupation therapist	4.1	4.8	4.1	6.4	4.7	2.9	3.2	1.4	4.5
Social worker	6.0	8.6	8.6	8.8	15.0	6.2	6.0	4.2	8.1
Psychologist	8.4	7.6	8.7	7.2	5.6	4.7	14.4	4.7	7.9
Other allied health staff	4.1	1.6	3.6	6.4	2.5	6.6	0.4	5.7	3.5
Total	22.5	22.5	25.1	28.8	27.8	20.4	24.0	16.0	24.0
Other personal care	0.9	4.6	4.8	7.4	5.9	34.3	7.6	8.7	4.6
Total	103.1	104.6	99.4	120.1	124.7	134.5	93.5	86.2	106.5
<i>2010-11</i>									
Medical									
Consultant psychiatrist	6.3	5.5	6.0	6.0	7.6	6.4	6.0	4.5	6.1
Psychiatry registrar	6.8	5.0	5.8	4.3	5.8	2.5	5.1	5.6	5.7
Other medical officers	0.5	1.5	1.0	3.8	0.3	1.9	0.2	2.1	1.2
Total	13.6	12.0	12.9	14.1	13.7	10.7	11.3	12.2	13.0
Nursing									
Registered nursing	61.0	51.7	53.2	59.6	65.7	59.1	40.4	45.1	56.8
Non-registered	6.6	15.3	7.3	9.7	14.9	10.5	7.6	3.3	9.9
Total	67.6	67.0	60.5	69.3	80.6	69.6	48.0	48.3	66.7
Allied health									
Occupation therapist	4.2	5.2	4.5	6.4	4.7	3.0	3.3	1.2	4.7
Social worker	6.4	8.7	8.9	9.0	14.6	6.4	6.1	5.9	8.3
Psychologist	8.8	7.7	9.2	7.4	5.8	4.3	16.8	7.2	8.3
Other allied health staff	4.7	1.9	3.9	6.1	2.5	7.2	0.2	4.2	3.8
Total	24.1	23.4	26.6	28.9	27.6	20.9	26.4	18.5	25.1
Other personal care	0.6	4.5	5.3	10.7	7.2	33.2	7.1	10.1	5.0
Total	105.9	106.9	105.3	123.0	129.1	134.5	92.8	89.1	109.8
<i>2011-12</i>									
Medical									
Consultant psychiatrist	5.9	5.2	6.2	6.2	7.1	5.8	8.2	6.7	6.0
Psychiatry registrar	6.0	5.3	6.6	4.8	6.2	3.0	4.6	6.3	5.8
Other medical officers	1.3	1.7	0.8	3.6	0.3	1.1	0.2	0.4	1.4
Total	13.2	12.3	13.6	14.6	13.6	10.0	13.0	13.4	13.2
Nursing									
Registered nursing	62.2	52.0	56.0	60.5	63.1	56.8	38.7	47.7	57.7
Non-registered	8.2	15.6	8.0	10.0	13.4	9.2	7.6	3.7	10.5

Table 12A.27 Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people) (a), (b), (c)

	NSW (d)	Vic	Qld (e)	WA	SA	Tas	ACT	NT	Aust
Total	70.5	67.5	64.0	70.5	76.5	66.0	46.4	51.3	68.2
Allied health									
Occupation therapist	3.8	5.6	4.5	5.9	4.5	2.5	3.6	1.6	4.6
Social worker	6.2	8.6	9.2	9.0	14.8	6.1	6.8	6.9	8.4
Psychologist	8.7	7.6	9.7	7.4	5.9	3.9	16.1	5.7	8.3
Other allied health staff	5.3	1.9	3.9	7.2	0.9	6.0	0.2	4.6	4.0
Total	24.1	23.6	27.4	29.6	26.0	18.5	26.6	18.7	25.2
Other personal care	0.6	4.4	5.0	11.5	7.4	31.6	7.0	9.5	5.0
Total	108.4	107.8	110.0	126.3	123.6	126.0	93.1	93.0	111.6
<i>2012-13</i>									
Medical									
Consultant psychiatrist	5.7	4.9	6.1	6.1	7.0	5.5	8.4	6.4	5.8
Psychiatry registrar	7.3	5.8	6.7	3.9	6.0	4.1	4.8	5.3	6.2
Other medical officers	0.9	1.7	0.7	5.2	0.4	1.2	0.2	1.1	1.5
Total	14.0	12.4	13.5	15.1	13.4	10.7	13.4	12.7	13.5
Nursing									
Registered nursing	64.1	51.4	54.8	62.4	60.6	55.3	39.6	52.5	57.9
Non-registered	6.1	14.2	8.0	9.8	12.3	9.2	7.9	4.4	9.4
Total	70.2	65.6	62.8	72.1	72.9	64.5	47.6	56.9	67.3
Allied health									
Occupation therapist	4.0	5.3	4.6	6.6	4.5	2.6	3.5	0.6	4.7
Social worker	6.3	8.8	8.9	10.0	14.5	5.5	6.5	6.3	8.4
Psychologist	8.1	7.3	9.4	7.4	5.8	5.7	16.4	5.4	8.0
Other allied health staff	5.9	2.3	5.6	5.6	1.0	5.8	0.2	5.9	4.4
Total	24.3	23.6	28.5	29.6	25.8	19.6	26.5	18.2	25.5
Other personal care	0.5	4.7	5.2	10.1	7.0	27.7	11.4	17.4	4.9
Total	109.0	106.3	109.9	127.1	119.0	122.5	98.9	105.2	111.3

(a) Professional categories are defined by profession rather than role. See AIHW *Mental Health Services in Australia* on-line publication (<http://mhsa.aihw.gov.au/resources/expenditure/data-source/>) for a full description of the derivation of staffing estimates.

(b) Total FTE figures presented in this table can differ from those in table 12A.28.

(c) Due to the ongoing validation of NMDS, data could differ from previous reports.

(d) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(e) Queensland implemented a new method to calculate FTE from the 2009-10 data. The new method is associated with the reduction in reported FTE so caution should be exercised when conducting time series analysis.

Source: AIHW (unpublished) derived from the MHE NMDS; ABS (various issues), Australian Demographic Statistics, December (various years), Cat. no. 3101.0.

TABLE 12A.28

Table 12A.28 **FTE direct care staff employed in specialised mental health services, by service setting (per 100 000 people) (a), (b), (c), (d)**

	<i>NSW (e), (f)</i>	<i>Vic Qld (g), (h)</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
2005-06									
Inpatient services	53.5	37.0	55.5	62.5	62.9	48.8	25.4	30.6	50.6
Ambulatory mental health services	38.7	44.1	35.9	49.5	45.0	40.9	50.0	40.6	41.3
Community residential services	4.0	22.9	..	2.9	1.4	34.6	19.2	1.9	8.6
Total	96.2	103.9	91.4	114.9	109.3	124.3	94.5	73.2	100.4
2006-07									
Inpatient services	55.6	37.3	54.7	63.9	67.4	58.6	28.2	32.3	52.0
Ambulatory mental health services	38.8	44.7	40.6	49.7	46.4	40.2	50.5	41.3	42.5
Community residential services	4.3	21.9	..	3.3	1.4	32.3	16.4	1.4	8.3
Total	98.7	103.9	95.3	116.8	115.2	131.1	95.1	75.0	102.9
2007-08									
Inpatient services	55.8	37.5	57.0	63.9	70.1	56.5	28.3	31.9	52.7
Ambulatory mental health services	39.9	44.2	44.5	49.4	50.9	38.9	49.0	43.8	43.8
Community residential services	2.3	22.2	..	5.5	3.0	31.6	14.0	1.7	8.0
Total	97.9	104.0	101.5	118.8	124.0	126.9	91.4	77.4	104.6
2008-09									
Inpatient services	57.9	38.6	55.8	64.8	67.1	56.6	26.4	38.0	53.4
Ambulatory mental health services	40.1	44.6	46.9	49.6	51.2	40.9	48.7	42.8	44.6
Community residential services	1.8	22.2	..	6.4	5.0	30.3	14.2	6.1	8.1
Total	99.9	105.5	102.7	120.7	123.2	127.8	89.4	86.9	106.0
2009-10									
Inpatient services	59.8	38.5	51.8	63.8	64.2	57.6	28.5	36.6	52.9
Ambulatory mental health services	41.7	44.6	47.6	49.4	55.5	42.2	50.1	43.1	45.6
Community residential services	1.6	21.5	..	6.9	5.0	32.9	14.9	6.4	8.0
Total	103.1	104.6	99.4	120.1	124.7	132.6	93.5	86.1	106.4
2010-11									
Inpatient services	61.2	39.4	53.6	64.1	62.5	58.3	29.8	38.0	53.8
Ambulatory mental health services	43.4	46.2	51.6	50.9	60.6	42.3	48.9	44.2	47.9
Community residential services	1.2	21.3	..	8.1	6.0	31.6	14.1	6.8	8.0
Total	105.9	106.9	105.3	123.0	129.1	132.2	92.7	89.1	109.7
2011-12									
Inpatient services	64.8	39.9	56.2	65.7	55.5	54.9	26.9	37.2	55.2

Table 12A.28 FTE direct care staff employed in specialised mental health services, by service setting (per 100 000 people) (a), (b), (c), (d)

	NSW (e), (f)	Vic	Qld (g), (h)	WA	SA	Tas	ACT	NT	Aust
Ambulatory mental health services	42.2	46.9	53.9	51.8	58.2	40.1	51.6	49.2	48.1
Community residential services	1.3	21.0	..	8.8	9.9	26.8	14.1	6.6	8.2
Total	108.4	107.8	110.0	126.2	123.6	121.8	92.6	93.0	111.5
2012-13 (d)									
Inpatient services	61.8	39.1	55.0	65.6	50.9	47.4	29.4	48.4	53.4
Ambulatory mental health services	39.4	46.6	51.6	49.7	57.1	42.9	51.9	49.5	46.4
Community residential services	0.7	20.6	..	7.6	9.4	28.3	17.6	7.8	7.8
Total	101.8	106.3	106.6	122.9	117.4	118.7	98.8	105.6	107.6

(a) See AIHW *Mental Health Services in Australia* on-line publication (<http://mhsa.aihw.gov.au/resources/expenditure/data-source/>) for a full description of the derivation of staffing estimates.

(b) Total FTE figures in this table can differ from those in table 12A.27. Data for 2012-13 differ more than other years due to a new organisational overhead setting for reporting FTE that has led to a decreased FTE by service setting for some jurisdictions. In addition, totals may not add due to rounding.

(c) Due to the ongoing validation of NMDS, data could differ from previous reports.

(d) A new organisational overhead setting for reporting FTE was implemented from the 2012–13 collection period, which may result in decreased FTE in the service setting category for some jurisdictions. Time series analyses should be approached with caution.

(e) Caution is required when interpreting NSW data. Seven residential mental health services in 2006–07 were reclassified as non-acute older person specialised hospital services in 2007–08, reflecting a change in function of those units.

(f) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(g) The apparent absence of community residential services in Queensland reflects Queensland's preference to describe such facilities as 'extended inpatient care'.

(h) Queensland implemented a new method to calculate FTE from the 2009–10 data. The new method is associated with the reduction in reported FTE so caution should be exercised when conducting time series analysis.

.. Not applicable.

Source: AIHW (unpublished) derived from the MHE NMDS.

Table 12A.29 Targeted Community Care (Mental Health) DSS Program participants (number), 2012-13

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Personal Helpers and Mentors	4 325	3 319	3 173	1 410	1 781	458	266	334	15 066
Family Mental Health Support Services	9 693	12 190	11 701	13 323	8 989	3 337	5 484	3 689	68 406
Mental Health Respite: Carer Support	11 760	8 915	4 179	3 003	4 254	1 163	333	714	34 321

Source: DSS (2013) *Targeted Community Care (Mental Health) Program – Summary Data 2012-13*, (available at www.dss.gov.au/our-responsibilities/mental-health/publications-articles)

Table 12A.30 Admitted patient mental health-related separations without specialised psychiatric care, by principal diagnosis in ICD-10-AM groupings, 2012-13

<i>ICD-10</i>		<i>Public acute and public psychiatric hospital</i>	<i>Per cent</i>
		<i>no.</i>	<i>%</i>
F00–F03	Dementia	4 077	4.8
F04–F09	Other organic mental disorders	9 465	11.1
F10	Mental and behavioural disorders due to use of alcohol	16 623	19.4
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	5 981	7.0
F20	Schizophrenia	4 157	4.9
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 034	1.2
F22	Persistent delusional disorders	532	0.6
F23	Acute and transient psychotic disorders	814	1.0
F25	Schizoaffective disorders	1 628	1.9
F30	Manic episode	329	0.4
F31	Bipolar affective disorders	2 750	3.2
F32	Depressive episode	10 170	11.9
F33	Recurrent depressive disorders	1 634	1.9
F34	Persistent mood (affective) disorders	119	0.1
F38–F39	Other and unspecified mood (affective) disorders	68	0.1
F40	Phobic anxiety disorders	36	–
F41	Other anxiety disorders	4 639	5.4
F42	Obsessive-compulsive disorders	51	0.1
F43	Reaction to severe stress and adjustment disorders	5 659	6.6
F44	Dissociative (conversion) disorders	1 301	1.5
F45, F48	Somatoform and other neurotic disorders	398	0.5
F50	Eating disorders	1 373	1.6
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	737	0.9
F60	Specific personality disorders	1 182	1.4
F61–F69	Disorders of adult personality and behaviour	100	0.1
F70–F79	Mental retardation	146	0.2
F80–F89	Disorders of psychological development	550	0.6

Table 12A.30 **Admitted patient mental health-related separations without specialised psychiatric care, by principal diagnosis in ICD-10-AM groupings, 2012-13**

<i>ICD-10</i>		<i>Public acute and public psychiatric hospital</i>	<i>Per cent</i>
F90	Hyperkinetic disorders	23	–
F91	Conduct disorders	502	0.6
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	349	0.4
F99	Mental disorder not otherwise specified	202	0.2
G30	Alzheimer's disease	2 493	2.9
	Other factors related to mental and behavioural disorders and substance use (a)	354	0.4
	Other specified mental health-related principal diagnosis (b)	6 081	7.1
	Total	85 557	100.0

(a) Includes ICD-10-AM codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z54.3, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.

(b) Includes separations for which the principal diagnosis was any other mental health-related principal diagnosis as listed in the online technical information.

– Nil or rounded to zero.

Source: AIHW (2014) *Mental Health Services in Australia*, (available at <http://mhsa.aihw.gov.au/home/>).

Table 12A.31 Ambulatory-equivalent mental health-related separations without specialised psychiatric care, by principal diagnosis and hospital type, 2009-10

ICD-10		Public acute hospitals	Public psychiatric hospitals	Total	Per cent
<i>Without specialised psychiatric care</i>					
F00-F09	Organic, including symptomatic, mental disorders	218	–	218	1.2
F10-F19	Mental and behavioural disorders due to psychoactive substance use	6 778	6	6 784	37.4
F20-F29	Schizophrenia, schizotypal and delusional disorders	1 062	np	1 062	5.8
F30-F39	Mood (affective) disorders	3 336	np	3 336	18.4
F40-F48	Neurotic, stress-related and somatoform disorders	4 751	6	4 757	26.2
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors	155	–	155	0.9
F60-F69	Disorders of adult personality and behaviour	363	np	363	2.0
F70-F79	Mental retardation	44	–	44	0.2
F80-F89	Disorders of psychological development	36	–	36	0.2
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	243	np	243	1.3
F99	Mental disorder not otherwise specified	36	–	36	0.2
G30	Alzheimer's disease	38	np	38	0.2
	Other factors related to mental and behavioural disorders and substance use (a)	128	–	128	0.7
	Other specified mental health-related principal diagnosis (b)	951	–	951	5.2
Total		18 139	16	18 155	100.0

(a) Includes ICD-10-AM codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z54.3, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.

(b) Includes separations for which the principal diagnosis was any other mental health-related principal diagnosis.

– Nil or rounded to zero. **np** Not published.

Source: AIHW (2014) *Mental Health Services in Australia*, (available at <http://mhsa.aihw.gov.au/home/>).

TABLE 12A.32

Table 12A.32 **Mental health-related emergency department occasions of service in public hospitals, by episode end status, 2011–12 (a)**

	<i>NSW</i>	<i>Vic (b)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Episode end status (number)									
Admitted to this hospital (c)	18 341	18 953	11 746	7 944	5 927	1 724	1 174	1 971	67 780
Non-admitted patient emergency department service episode completed (d)	27 266	21 838	32 614	10 742	8 775	2 586	2 306	2 514	108 641
Referred to another hospital for admission	783	293	948	733	773	38	116	3	3 687
Did not wait to be attended by a health care professional	966	..	390	86	43	3	3	14	1 505
Left at own risk (e)	1 433	1 100	1 191	300	297	54	39	105	4 519
Principal diagnosis (f)									
Organic, including symptomatic, mental disorders	2 816	2 345	3 035	1 806	1 008	336	197	112	11 655
Mental and behavioural disorders due to psychoactive substance use	11 073	10 655	12 214	5 519	3 938	970	610	2 317	47 296
Schizophrenia, schizotypal and delusional disorders	5 562	5 674	5 618	1 727	2 316	639	789	724	23 049
Mood (affective) disorders	7 537	7 791	5 988	2 539	1 534	985	841	336	27 551
Neurotic, stress-related and somatoform disorders	14 681	10 092	12 457	7 013	5 452	899	853	1 006	52 453
Behavioural syndromes associated with physiological disturbances and physical factors	414	390	542	85	171	35	36	13	1 686
Disorders of adult personality and behaviour	1 484	3 251	1 365	359	438	212	186	16	7 311

TABLE 12A.32

Table 12A.32 **Mental health-related emergency department occasions of service in public hospitals, by episode end status, 2011–12 (a)**

	NSW	Vic (b)	Qld	WA	SA	Tas	ACT	NT	Aust
Mental retardation	19	25	9	1	10	–	1	–	65
Disorders of psychological development	56	–	27	22	30	3	21	2	161
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	1 432	939	1 197	593	771	76	30	81	5 119
Unspecified mental disorder	6 280	1 022	4 443	145	176	253	74	–	12 393
Total (g)	51 354	42 184	46 895	19 809	15 844	4 408	3 638	4 607	188 739
Rates (per 10 000 population) (h)	70.8	75.6	103.8	82.9	96.2	86.1	98.1	198.0	83.8

(a) Emergency department occasions of service included are those that had a principal diagnosis that fell within the Mental and behavioural disorders chapter (Chapter 5) of ICD-10-AM (codes F00–F99) or the equivalent ICD-9-CM codes.

(b) Victoria does not record a diagnosis for occasions of service with an episode end status of *Did not wait to be attended by a health care professional*.

(c) Includes admissions to beds or units within the emergency department.

(d) Patient departed without being admitted or referred to another hospital.

(e) Patient left at own risk after being attended by a health care professional but before the non-admitted patient emergency department occasion of service was completed.

(f) NSW and SA used a combination of ICD-9-CM and ICD-10-AM.

(g) The number of occasions of service may not sum to the total due to missing or not reported data. Also included in the total are 6 occasions of service with an episode end status of *Died in emergency department as a non-admitted patient* and 1 occasion of service with an episode end status of *Dead on arrival, not treated in emergency department*.

(h) Crude rate is based on the preliminary Australian estimated resident population as at 31 December 2010 and is expressed per 10 000 population as detailed in the online technical information.

– Nil or rounded to zero.

Source: AIHW (2014) *Mental Health Services in Australia*, (available at <http://mhsa.aihw.gov.au/home/>).

TABLE 12A.33

Table 12A.33 **New clients as a proportion of total clients under the care of State or Territory specialised public mental health services (a), (b)**

	<i>Unit</i>	<i>NSW (c), (d), (e)</i>	<i>Vic (f)</i>	<i>Qld (g)</i>	<i>WA (h)</i>	<i>SA (i)</i>	<i>Tas (j)</i>	<i>ACT</i>	<i>NT (k)</i>	<i>Aust (f)</i>
<i>2009-10</i>										
New clients	no.	46 323	14 985	32 301	17 059	13 206	1 369	3 210	2 652	131 105
Total clients	no.	116 276	61 636	73 903	41 928	31 186	6 209	7 661	5 552	344 351
Proportion of total clients who are new	%	39.8	24.3	43.7	40.7	42.3	22.0	41.9	47.8	38.1
<i>2010-11</i>										
New clients	no.	48 506	15 015	34 440	18 749	13 302	1 691	3 305	2 815	137 823
Total clients	no.	119 380	61 687	78 129	44 980	31 689	7 845	8 093	5 834	357 637
Proportion of total clients who are new	%	40.6	24.3	44.1	41.7	42.0	21.6	40.8	48.3	38.5
<i>2011-12</i>										
New clients	no.	49 590	na	36 655	19 772	14 557	1 204	3 470	3 263	128 511
Total clients	no.	123 341	na	82 179	47 296	34 092	6 390	8 412	6 607	308 317
Proportion of total clients who are new	%	40.2	na	44.6	41.8	42.7	18.8	41.3	49.4	41.7
<i>2012-13</i>										
New clients	no.	51 651	na	39 293	21 403	15 693	3 880	3 751	3 453	139 124
Total clients	no.	129 183	na	86 671	50 234	35 992	6 678	9 046	7 212	325 016
Proportion of total clients who are new	%	40.0	na	45.3	42.6	43.6	58.1	41.5	47.9	42.8

- (a) Clients in receipt of services include all people who received one or more community service contacts or had one or more days of inpatient or residential care in the data period.
- (b) A new client is defined as a consumer who has not been seen in the five years preceding the first contact with a State or Territory specialised public mental health service in the data period.
- (c) NSW has implemented a Statewide Unique Patient Identifier (SUPI) for mental health care. The identification of prior contacts for MH clients is dependent upon the SUPI, both in coverage (all clients having a SUPI) and in the resolution of possible duplicates. There are differences in the completeness of coverage between the Local Health Districts/Networks and over time. The average SUPI coverage at a State level for 2012-13 is 99.9 per cent. The numbers provided are a distinct count of individuals using the SUPI (majority) and a count of individuals at the facility level for a small percentage of clients without a SUPI in the reporting period (which may include some duplicates of those who attended multiple facilities).

Table 12A.33 New clients as a proportion of total clients under the care of State or Territory specialised public mental health services (a), (b)

	<i>Unit</i>	<i>NSW (c), (d), (e)</i>	<i>Vic (f)</i>	<i>Qld (g)</i>	<i>WA (h)</i>	<i>SA (i)</i>	<i>Tas (j)</i>	<i>ACT</i>	<i>NT (k)</i>	<i>Aust (f)</i>
(d)		For NSW, residential clients are not included because their data are manually collected without SUPI assigned, thus making the unique counts of the residential clients together with the inpatient and ambulatory clients not possible. The client base of the NSW MH residential is very small which will have minimal effect on the final result (total residential MH clients in 2010-11 is 185 with 59 potential new clients, 243 total residential MH clients with 130 potential new clients in 2011-12 and and 237 total residential MH clients with 131 potential new clients in 2012-13).								
(e)		For NSW, all historical data has been updated to fix coverage issues with previously submitted figures.								
(f)		Victorian 2011-12 and 2012-13 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data.								
(g)		For Qld, a linkage program is utilised to link between admitted and community activity and patients.								
(h)		For WA, the matching of mental health community contacts to inpatient episodes is done for 2012-13 between two separate data systems and requires the use of record linkage to be able to identify the same person in both systems. There are delays associated in the use of record linkage and these delays can result in not getting a match between a community contact and a separation when there should be one. The number of unique consumers (both total and new) could be over estimated as a result. Data before 2012-13 are based on data submitted for the National Minimum Data Set (NMDS) and have not been revised.								
(i)		For SA, the new client (numerator) count is not unique: it is an aggregation of three separate databases with no linkage between them. Similarly, the total client (denominator) count is not unique: it is an aggregation of three separate databases with no linkage between them. However, impact on the result should be minimal due to populations being relatively stable within the three respective catchments.								
(j)		For Tasmania, information for years before 2012-13 were extracted from three different data sources and linked together with a Statistical Linkage Key (SLK) for each individual present in the extracts for the reporting period. While every attempt has been made to reduce any duplication of identified clients, using an SLK will lead to some duplication and can wrongly identify clients as new clients. Industrial action in Tasmania has limited the available data quality and quantity of data for 2011-12 and 2012-13. Tasmania has been progressively implementing a state-wide patient identification system. Data for 2012-13 is considered to be the first collection period with this system fully implemented. It is likely that an improved patient identification system will increase the percentage of post-discharge community care reported by Tasmania. Therefore, Tasmanian data are not comparable across years.								
(k)		For the NT, for 2009-10, the count of all clients will not be exactly the same as provided in other reported collections due to non-availability of 'snapshot' or archived annual data sets.								

na Not available.

Source: AIHW (unpublished) derived from data provided by State and Territory governments.

TABLE 12A.34

Table 12A.34 **New clients as a proportion of total clients under the care of State or Territory specialised public mental health services, by selected characteristics, 2012-13 (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust (d), (e)</i>
<i>Age group</i>										
Less than 15 years	%	52.8	na	54.7	54.4	47.4	73.3	65.4	50.1	53.3
15–24 years	%	44.8	na	47.8	47.7	52.4	63.0	43.7	54.5	47.4
25–34 years	%	37.5	na	42.4	42.0	42.9	50.9	40.2	45.7	40.7
35–44 years	%	32.9	na	39.1	35.9	36.2	50.0	34.8	41.0	35.9
45–54 years	%	32.3	na	39.8	33.0	36.0	50.8	34.6	44.9	35.4
55–64 years	%	34.2	na	42.4	34.9	38.2	52.2	36.7	47.8	37.5
65–74 years	%	39.4	na	47.3	42.8	44.1	53.6	39.9	49.4	42.9
75 years or over	%	52.0	na	57.5	53.3	51.8	71.7	51.8	74.4	53.9
<i>Gender</i>										
Male	%	37.8	na	42.9	41.5	41.4	58.0	39.0	45.6	40.7
Female	%	42.2	na	47.8	43.3	45.4	57.8	43.6	50.7	44.8
<i>SEIFA quintiles</i>										
Quintile 1 (most disadvantaged)	%	39.4	na	41.3	40.2	43.3	56.7	51.9	45.0	41.5
Quintile 2	%	39.0	na	45.6	39.4	41.7	57.2	42.1	44.4	41.3
Quintile 3	%	40.0	na	46.0	41.2	43.8	59.0	45.1	46.7	42.9
Quintile 4	%	39.4	na	46.8	41.1	42.9	60.8	39.0	49.8	42.9
Quintile 5 (least disadvantaged)	%	41.9	na	49.7	44.0	45.8	59.1	42.8	55.3	44.2
<i>Indigenous status</i>										
Aboriginal and Torres Strait Islander	%	32.0	na	37.8	39.9	35.8	56.7	33.4	41.7	36.6
Non-Indigenous	%	39.5	na	46.0	41.4	41.4	56.6	40.2	51.6	42.4
<i>Remoteness</i>										
Major cities	%	39.8	na	44.3	40.0	40.3	70.6	40.5	83.0	41.0

Table 12A.34 New clients as a proportion of total clients under the care of State or Territory specialised public mental health services, by selected characteristics, 2012-13 (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust (d), (e)</i>
Inner regional	%	40.3	na	44.8	42.0	48.1	56.7	61.3	76.5	43.5
Outer regional	%	38.8	na	46.0	40.8	49.1	60.1	76.4	48.2	44.7
Remote	%	39.5	na	46.0	48.1	49.3	59.1	50.3	45.1	46.5
Very remote	%	27.6	na	45.2	48.8	40.7	66.7	–	45.3	44.5

- (a) Clients in receipt of services include all people who received one or more community service contacts or had one or more days of inpatient or residential care in the data period.
- (b) A new client is defined as a consumer who has not been seen in the five years preceding the first contact with a State or Territory specialised public mental health service in the data period.
- (c) See table 12A.33 and the DQI for specific footnotes regarding each State or Territory.
- (d) Victorian 2011-12 and 2012-13 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data.
- (e) Remoteness and socioeconomic status have been allocated using the client's usual residence, not the location of the service provider. State/territory is reported for the state/territory of the service provider.

na Not available. – Nil or rounded to zero.

Source: AIHW (unpublished) derived from data provided by State and Territory governments.

TABLE 12A.35

Table 12A.35 Proportion of total clients of MBS subsidised mental health services who are new (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>2012-13</i>										
New clients	no.	207 960	170 407	133 195	54 418	43 974	13 192	9 417	4 006	636 569
Total clients	no.	573 571	488 817	345 030	141 797	124 333	34 636	23 954	8 184	1 740 323
Proportion of total clients who are new	%	36.3	34.9	38.6	38.4	35.4	38.1	39.3	48.9	36.6
<i>2013-14</i>										
New clients	no.	218 557	180 249	143 620	62 527	45 769	13 889	10 246	4 292	679 149
Total clients	no.	621 804	534 906	385 502	160 831	133 684	37 694	26 454	8 837	1 909 712
Proportion of total clients who are new	%	35.1	33.7	37.3	38.9	34.2	36.8	38.7	48.6	35.6

(a) Data are calculated based on date of processing of specified MBS mental health items.

(b) State/Territory is allocated based on the postcode recorded for the person at the first service event within each reference period year.

(c) A new client is defined as a patient who has not previously used a MBS mental health item in the five years preceding the first use of a MBS mental health item in the reference period.

Source: Department of Health (unpublished).

TABLE 12A.36

Table 12A.36 **Proportion of people receiving clinical mental health services by service type and Indigenous status**

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>		
		Age standardised proportion (%) (a)										no.
<i>2007-08</i>												
Public (b), (c)												
Aboriginal and Torres Strait Islander		3.6	2.6	3.5	3.1	4.3	1.3	4.8	2.9	3.3	19 187	
Non-Indigenous		1.2	1.1	1.8	1.6	1.5	2.0	1.6	1.9	1.4	276 005	
Private (d)												
Aboriginal and Torres Strait Islander		na	na	na	na	na	na	na	..	na	na	
Non-Indigenous		na	na	na	na	na	na	na	..	na	na	
MBS and DVA (e)												
Aboriginal and Torres Strait Islander		np	np	np	np	np	np	np	np	np	np	
Non-Indigenous		np	np	np	np	np	np	np	np	np	np	
<i>2008-09</i>												
Public (b), (c)												
Aboriginal and Torres Strait Islander		3.9	2.6	3.4	3.4	4.8	1.1	4.8	3.0	3.4	20 616	
Non-Indigenous		1.2	1.1	1.6	1.7	1.6	1.3	1.7	1.9	1.4	277 321	
Private (d)												
Aboriginal and Torres Strait Islander		na	na	na	na	na	na	na	..	na	na	
Non-Indigenous		na	na	na	na	na	na	na	..	na	na	
MBS and DVA (e)												
Aboriginal and Torres Strait Islander		5.9	7.6	3.9	2.4	4.7	5.6	6.7	1.0	4.4	24 603	

TABLE 12A.36

Table 12A.36 Proportion of people receiving clinical mental health services by service type and Indigenous status

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Non-Indigenous	6.0	6.5	5.5	4.9	5.7	5.0	4.6	2.7	5.8	1 200 337
<i>2009-10</i>										
Public (b), (c)										
Aboriginal and Torres Strait Islander	4.0	2.6	3.5	3.8	4.8	3.0	4.8	3.7	3.7	22 930
Non-Indigenous	1.2	1.1	1.6	1.7	1.6	1.4	1.7	2.0	1.4	282 620
Private (d)										
Aboriginal and Torres Strait Islander	na	na	na	na	na	na	na	..	na	na
Non-Indigenous	na	na	na	na	na	na	na	..	na	na
MBS and DVA (e)										
Aboriginal and Torres Strait Islander	6.6	8.3	4.2	2.7	5.1	6.2	7.2	1.3	4.8	28 303
Non-Indigenous	6.5	7.1	6.1	5.3	6.4	5.6	5.0	3.2	6.4	1 337 882
<i>2010-11</i>										
Public (b), (c)										
Aboriginal and Torres Strait Islander	3.9	2.5	3.9	4.3	4.9	1.6	5.3	3.7	3.8	24 250
Non-Indigenous	1.2	1.1	1.7	1.8	1.6	1.6	1.8	2.0	1.4	291 381
Private (d)										
Aboriginal and Torres Strait Islander	na	na	na	na	na	na	na	..	na	na
Non-Indigenous	na	na	na	na	na	na	na	..	na	na
MBS and DVA (e)										
Aboriginal and Torres Strait Islander	8.2	9.2	5.2	3.6	6.5	7.6	9.7	1.5	6.0	36 044

TABLE 12A.36

Table 12A.36 Proportion of people receiving clinical mental health services by service type and Indigenous status

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Non-Indigenous	7.1	7.8	6.8	5.7	7.0	6.3	5.5	3.4	7.0	1 486 676
<i>2011-12</i>										
Public (b), (c)										
Aboriginal and Torres Strait Islander	4.5	na	4.2	4.9	5.7	1.0	6.4	3.9	4.3	26 133
Non-Indigenous	1.2	na	1.7	1.8	1.7	0.8	1.9	2.3	1.5	240 556
Private (d)										
Aboriginal and Torres Strait Islander	na	na	na	na	na	na	na	..	na	na
Non-Indigenous	na	na	na	na	na	na	na	..	na	na
MBS and DVA (e)										
Aboriginal and Torres Strait Islander	9.7	11.4	6.4	3.7	7.5	7.6	10.7	1.4	7.0	43 634
Non-Indigenous	7.3	8.1	7.1	5.7	7.3	6.4	5.6	3.7	7.2	1 559 298
<i>2012-13 (f)</i>										
Public (b), (c)										
Aboriginal and Torres Strait Islander	4.9	na	4.5	5.3	5.9	1.4	6.3	4.1	4.7	29 378
Non-Indigenous	1.5	na	1.8	1.9	1.8	1.2	2.2	2.4	1.7	269 525
Private (d)										
Aboriginal and Torres Strait Islander	na	na	na	na	na	na	na	..	na	na
Non-Indigenous	na	na	na	na	na	na	na	..	na	na
MBS and DVA (e)										
Aboriginal and Torres Strait Islander	10.7	12.0	7.1	4.0	8.2	8.8	11.4	1.4	7.7	49 787

TABLE 12A.36

Table 12A.36 **Proportion of people receiving clinical mental health services by service type and Indigenous status**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Non-Indigenous	7.9	8.7	7.7	5.9	7.6	7.0	6.2	4.1	7.7	1 690 537

- (a) Rates are age-standardised to the Australian population as at 30 June 2001.
- (b) Excludes people for whom Indigenous status was missing or not reported. The Indigenous status rates should be interpreted with caution due to the varying and, in some instances, unknown quality of Indigenous identification across jurisdictions. All historical data has been recalculated using the revised Indigenous population data.
- (c) Caution should be taken when making inter-jurisdictional comparisons for public data. South Australia submitted data that were not based on unique patient identifier or data matching approaches. This was also the case for data submitted by Tasmania prior to 2012-13. Victorian 2011-12 and 2012-13 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. Industrial action during 2011-12 and 2012-13 in Tasmania has limited the available data quality and quantity of the community mental health care data; which represents a large proportion of the overall figures. Australian totals for 2011-12 and 2012-13 only include available data and should therefore be interpreted with caution. Australian totals for 2011-12 and 2012-13 should not be compared to previous years.
- (d) Indigenous information is not collected for private psychiatric hospitals.
- (e) DVA data not available by Indigenous status. MBS data are not published for 2007-08. Medicare data presented by Indigenous status have been adjusted for under-identification in the Department of Human Services (DHS) Voluntary Indigenous Identifier (VII) database. Indigenous rates are therefore modelled and should be interpreted with caution. These statistics are not derived from the total Australian Indigenous population, but from those Aboriginal and Torres Strait Islander people who have voluntarily identified as Indigenous to DHS. The statistics have been adjusted to reflect demographic characteristics of the overall Indigenous population, but this adjustment may not address all the differences in the service use patterns of the enrolled population relative to the total Indigenous population. The level of VII enrolment (61 per cent nationally as at August 2012) varies across age-sex-remoteness-State/Territory sub-groups and over time which means that the extent of adjustment required varies across jurisdictions and over time. Indigenous rates should also be interpreted with caution due to small population numbers in some jurisdictions. MBS data for 2011-12 has been updated since the 2014 Report.
- (f) A change in scope for 'public data' implemented for the 2012-13 collection period means that comparison of rates for years up to and including 2011-12 with years 2012-13 and beyond should not be made. See data quality information for additional information.

na Not available. **..** Not applicable. **np** Not published.

Source: State and territory (unpublished) specialised mental health services data; Private Mental Health Alliance (unpublished); Centralised Data Management Service data; Department of Health (unpublished) and DVA (unpublished), MBS Statistics; ABS (unpublished) Estimated Residential Population, 30 June (prior to relevant period).

TABLE 12A.37

Table 12A.37 Proportion of people receiving clinical mental health services by service type and remoteness area (a)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	no.
	Age standardised proportion (%) (b)									
<i>2007-08</i>										
Public (c), (d)										
Major cities	1.2	0.9	1.5	1.3	1.6	..	1.8	..	1.2	173 288
Inner regional	2.6	1.7	2.5	3.9	1.7	np	np	..	2.2	85 003
Outer regional	3.5	2.2	2.2	2.2	2.6	np	..	2.0	2.3	43 447
Remote	4.4	4.3	1.9	0.9	2.0	np	..	2.2	1.9	5 744
Very remote	13.0	..	3.9	4.8	2.1	np	..	2.2	3.6	6 297
Private (c), (e)										
Major cities	0.1	0.1	0.1	0.1	np	..	np	..	0.1	19 261
Inner regional	0.1	–	0.1	0.1	np	np	np	..	0.1	2 973
Outer regional	–	–	–	–	np	np	..	..	–	579
Remote	–	–	–	–	np	np	..	..	–	69
Very remote	–	..	–	–	np	np	..	..	–	30
MBS and DVA (c)										
Major cities	5.3	5.8	5.1	4.6	5.2	..	4.0	..	5.3	764 089
Inner regional	5.1	5.3	4.6	3.7	4.5	4.8	4.6	..	4.9	192 134
Outer regional	3.7	3.7	3.1	3.6	3.2	3.4	..	2.4	3.3	62 986
Remote	2.5	4.7	1.9	1.4	2.5	2.1	..	0.9	1.8	5 668
Very remote	2.6	..	1.2	0.7	2.7	5.5	..	1.2	1.3	2 070
<i>2008-09</i>										
Public (c), (d)										
Major cities	1.2	0.9	1.4	1.3	1.9	..	1.9	..	1.2	180 087
Inner regional	2.7	1.5	2.4	4.0	2.0	np	np	..	2.2	85 135
Outer regional	4.0	2.1	2.2	2.3	2.6	np	..	2.0	2.4	44 963

TABLE 12A.37

Table 12A.37 Proportion of people receiving clinical mental health services by service type and remoteness area (a)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Remote	5.8	1.5	1.6	0.9	2.5	np	..	2.5	2.0	6 193
Very remote	16.2	..	3.1	5.1	2.3	np	..	2.2	3.7	6 544
Private (c), (e)										
Major cities	0.1	0.1	0.2	0.1	np	..	np	..	0.1	20 251
Inner regional	0.1	–	0.1	0.1	np	np	np	..	0.1	3 205
Outer regional	–	–	–	–	np	np	..	..	–	645
Remote	0.1	–	–	–	np	np	..	..	–	98
Very remote	–	..	–	–	np	np	..	..	–	30
MBS and DVA (c)										
Major cities	6.2	6.7	6.1	5.3	6.3	..	4.8	..	6.2	916 074
Inner regional	6.2	6.6	5.7	4.7	5.5	5.6	5.7	..	6.0	239 453
Outer regional	4.7	4.5	4.0	4.4	4.1	4.2	..	3.0	4.2	80 394
Remote	3.0	6.1	2.5	1.9	3.4	2.7	..	1.3	2.4	7 460
Very remote	4.3	..	1.6	0.8	2.4	6.3	..	1.6	1.5	2 557
2009-10										
Public (c), (d)										
Major cities	1.4	0.9	1.6	1.3	1.8	..	2.0	..	1.3	198 917
Inner regional	2.2	1.6	1.8	4.3	2.1	1.4	np	..	2.0	81 749
Outer regional	2.6	2.1	1.8	2.3	2.5	1.2	..	2.0	2.1	39 579
Remote	3.8	1.0	1.5	1.0	2.6	–	..	2.8	1.9	5 798
Very remote	5.5	..	2.4	5.8	2.1	0.7	..	2.6	3.5	6 416
Private (c), (e)										
Major cities	0.1	0.1	0.2	0.2	np	..	np	..	0.1	21 149
Inner regional	0.1	0.1	0.1	0.1	np	np	np	..	0.1	3 416
Outer regional	–	–	–	–	np	np	..	..	–	674

TABLE 12A.37

Table 12A.37 Proportion of people receiving clinical mental health services by service type and remoteness area (a)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Remote	0.1	0.1	–	–	np	np	..	..	–	105
Very remote	–	..	–	–	np	np	..	..	–	31
MBS and DVA (c)										
Major cities	6.6	7.3	6.7	5.7	6.9	..	5.2	..	6.7	1 011 181
Inner regional	6.8	7.4	6.3	5.2	6.5	6.3	6.4	..	6.7	270 641
Outer regional	5.2	5.4	4.7	4.9	4.6	4.8	..	3.4	4.8	93 109
Remote	3.2	6.3	2.8	2.3	4.4	2.8	..	1.6	2.7	8 759
Very remote	4.9	..	1.7	1.0	2.3	4.9	..	2.0	1.7	2 963
2010-11										
Public (c), (d)										
Major cities	1.4	0.9	1.7	1.8	1.8	..	2.1	..	1.4	214 072
Inner regional	2.2	1.6	1.8	1.6	2.1	1.9	np	..	1.9	76 427
Outer regional	2.5	2.0	1.9	2.5	2.4	1.6	..	2.0	2.1	40 932
Remote	3.5	1.2	1.9	3.0	2.6	0.6	..	2.7	2.6	8 115
Very remote	5.1	..	2.9	2.0	2.5	0.7	..	3.1	2.5	4 820
Private (c), (e)										
Major cities	0.1	0.2	0.2	0.2	np	..	np	..	0.1	22 910
Inner regional	0.1	0.1	0.1	0.1	np	np	np	..	0.1	3 950
Outer regional	–	–	–	–	np	np	..	..	–	858
Remote	0.1	0.1	–	0.1	np	np	..	..	–	115
Very remote	–	..	–	–	np	np	..	..	–	45
MBS and DVA (c)										
Major cities	7.3	7.9	7.4	6.1	7.6	..	5.6	..	7.3	1 124 293
Inner regional	7.6	8.1	6.9	5.9	7.1	6.9	6.4	..	7.4	301 981
Outer regional	5.7	6.3	5.3	5.5	5.1	5.5	..	3.6	5.4	104 578

TABLE 12A.37

Table 12A.37 Proportion of people receiving clinical mental health services by service type and remoteness area (a)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Remote	3.2	5.8	3.6	2.6	4.0	3.4	..	1.8	3.0	9 668
Very remote	4.4	..	1.9	1.2	2.3	7.4	..	2.0	1.8	3 314
<i>2011-12</i>										
Public (c), (d)										
Major cities	1.4	na	1.6	1.8	1.9	..	2.1	..	1.6	181 124
Inner regional	2.2	na	2.1	2.0	2.1	1.7	np	..	2.1	59 145
Outer regional	2.6	na	2.2	2.8	2.8	1.4	..	2.3	2.3	39 567
Remote	3.3	na	2.1	2.8	2.7	1.5	..	2.8	2.6	7 915
Very remote	5.2	..	3.0	2.9	2.4	0.9	..	3.3	3.0	6 164
Private (c), (e)										
Major cities	0.1	0.2	0.2	0.2	np	..	np	..	0.2	25 188
Inner regional	0.1	0.1	0.1	0.1	np	np	np	..	0.1	4 112
Outer regional	–	–	0.1	0.1	np	np	..	..	0.1	1 104
Remote	0.1	0.2	–	0.1	np	np	..	..	–	122
Very remote	–	..	0.1	–	np	np	..	..	–	75
MBS and DVA (c), (f)										
Major cities	7.5	8.3	7.9	5.9	7.9	..	5.8	..	7.6	1 191 781
Inner regional	7.9	8.2	7.0	5.8	7.4	6.8	6.4	..	7.6	297 015
Outer regional	6.1	6.3	5.5	4.7	5.4	6.0	..	3.0	5.4	106 181
Remote	3.7	5.7	3.4	2.5	4.1	4.3	..	1.8	3.0	9 465
Very remote	3.1	..	1.9	1.3	2.2	6.5	..	0.6	1.5	2 892
<i>2012-13</i>										
Public (c), (d)										
Major cities	1.5	na	1.6	1.8	2.0	..	2.2	..	1.7	194 311
Inner regional	2.4	na	2.1	2.1	2.3	1.4	np	..	2.2	62 368

TABLE 12A.37

Table 12A.37 **Proportion of people receiving clinical mental health services by service type and remoteness area (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Outer regional	2.8	na	2.2	2.8	3.0	1.2	..	2.4	2.4	41 323
Remote	3.5	na	2.5	3.4	2.8	1.6	..	3.5	3.1	9 401
Very remote	5.4	na	2.6	2.5	4.2	0.7	..	2.9	2.8	5 816
Private (c), (e)										
Major cities	0.2	0.2	0.2	0.2	np	..	np	..	0.2	26 968
Inner regional	0.1	0.1	0.1	0.1	np	np	np	..	0.1	4 610
Outer regional	–	0.1	0.1	0.1	np	np	..	..	0.1	1 133
Remote	0.1	0.1	–	0.1	np	np	..	..	–	137
Very remote	–	..	–	–	np	np	..	..	–	49
MBS and DVA (c)										
Major cities	8.0	8.8	8.5	6.1	8.2	..	6.3	..	8.1	1 289 439
Inner regional	8.7	9.0	7.5	6.2	8.0	7.4	5.1	..	8.2	325 303
Outer regional	6.6	6.7	6.0	4.7	5.8	6.6	..	3.4	5.9	116 157
Remote	4.0	6.8	3.5	2.5	4.4	4.8	..	1.9	3.2	10 102
Very remote	2.9	..	1.8	1.3	2.7	5.8	..	0.6	1.5	3 003

- (a) Not all remoteness areas are represented in each State or Territory. Where a state/territory does not have a particular remoteness category a rate cannot be calculated. Excludes contacts for which demographic information was missing and/or not reported.
- (b) Rates are age-standardised to the Australian population as at 30 June 2001.
- (c) For 2007-08 and 2008-09, disaggregation by remoteness area is based on a person's usual residence, the location of the service provider or a combination of both. For these years, the public data should be interpreted with caution as the methodology used to allocate remoteness area varied across jurisdictions. For 2009-10 data onwards, disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider, except for public data for the NT, for which the majority of the data was based on the location of the service. State/territory is the state/territory of the service provider.

Table 12A.37 **Proportion of people receiving clinical mental health services by service type and remoteness area (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(d)	Caution should be taken when making inter-jurisdictional comparisons for public data. South Australia submitted data that were not based on unique patient identifier or data matching approaches. This was also the case for data submitted by Tasmania prior to 2012-13. Victorian 2011-12 and 2012-13 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. Industrial action during 2011-12 and 2012-13 in Tasmania has limited the available data quality and quantity of the community mental health care data; which represents a large proportion of the overall figures. Australian totals for 2011-12 and 2012-13 only include available data and should therefore be interpreted with caution. A change in scope for public data implemented for the 2012-13 collection period means that comparison of rates for years up to and including 2011-12 with years 2012-13 and beyond should not be made. See the quality statement for additional information.								
(e)	Private psychiatric hospital figures are not published for SA, Tasmania, and the ACT due to confidentiality reasons, but are included in the Australia figures.								
(f)	MBS data for 2011-12 has been updated since the 2014 Report.								
	na Not available. .. Not applicable. – Nil or rounded to zero. np Not published.								

Source: AIHW (unpublished) derived from data provided by State and Territory governments; State and territory (unpublished) specialised mental health services data; Private Mental Health Alliance (unpublished) Centralised Data Management Service data; Department of Health (unpublished) and DVA (unpublished), MBS Statistics; ABS (unpublished) Estimated Residential Population, 30 June (prior to relevant period).

TABLE 12A.38

Table 12A.38 Proportion of people receiving clinical mental health services by service type and SEIFA (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
	Age standardised proportion (c)									no.
<i>2007-08</i>										
Public (d), (e), (f)										
Quintile 1 (most disadvantaged)	1.8	1.5	1.9	2.0	2.9	2.0	np	1.5	1.9	76 635
Quintile 2	1.9	1.4	2.6	1.4	1.2	2.9	4.3	6.1	1.8	74 505
Quintile 3	1.5	1.2	2.0	2.1	1.0	1.3	3.7	3.8	1.6	67 420
Quintile 4	1.4	0.9	1.7	2.0	1.3	0.9	2.3	0.6	1.4	55 904
Quintile 5 (least disadvantaged)	1.2	0.7	1.2	1.4	2.0	..	1.5	2.5	1.2	48 530
Private (d), (g)										
Quintile 1 (most disadvantaged)	–	0.1	–	0.1	np	np	np	np	0.1	2 556
Quintile 2	–	–	0.1	–	np	np	np	np	0.1	2 351
Quintile 3	0.1	–	0.1	0.1	np	np	np	np	0.1	3 572
Quintile 4	0.1	0.1	0.2	0.1	np	np	np	np	0.1	5 383
Quintile 5 (least disadvantaged)	0.2	0.2	0.2	0.2	np	..	np	np	0.2	9 074
MBS and DVA										
Quintile 1 (most disadvantaged)	4.4	4.9	4.3	2.3	4.5	3.8	3.7	0.7	4.3	176 364
Quintile 2	5.3	5.2	4.1	3.9	4.8	3.9	4.2	2.0	4.9	200 248
Quintile 3	5.2	5.4	4.6	3.9	4.5	4.2	3.9	1.6	4.8	202 268
Quintile 4	5.3	5.5	4.9	3.9	5.0	6.1	4.0	1.7	5.0	206 586
Quintile 5 (least disadvantaged)	5.4	6.3	4.9	4.8	5.4	..	3.9	1.4	5.4	231 002
<i>2008-09</i>										
Public (d), (e), (f)										
Quintile 1 (most disadvantaged)	1.9	1.5	1.7	2.2	2.7	np	np	1.6	1.8	72 356
Quintile 2	2.0	1.4	2.7	1.5	1.3	np	4.6	6.2	1.9	77 089
Quintile 3	1.5	1.2	2.3	2.1	1.3	np	3.8	4.0	1.7	71 113

TABLE 12A.38

Table 12A.38 Proportion of people receiving clinical mental health services by service type and SEIFA (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Quintile 4	1.4	0.8	1.3	2.0	0.8	np	2.4	0.6	1.2	51 399
Quintile 5 (least disadvantaged)	1.2	0.7	1.0	1.4	3.5	..	1.6	2.4	1.2	50 798
Private (d), (g)										
Quintile 1 (most disadvantaged)	–	0.1	–	0.1	np	np	np	np	–	2 036
Quintile 2	–	–	0.1	0.1	np	np	np	np	0.1	2 578
Quintile 3	0.1	0.1	0.1	0.1	np	np	np	np	0.1	3 888
Quintile 4	0.1	0.2	0.2	0.1	np	np	np	np	0.1	6 212
Quintile 5 (least disadvantaged)	0.2	0.2	0.2	0.2	np	..	np	np	0.2	9 553
MBS and DVA										
Quintile 1 (most disadvantaged)	5.3	5.8	5.4	2.7	5.6	4.6	4.6	0.9	5.2	218 084
Quintile 2	6.3	6.2	5.1	4.7	5.9	4.7	4.8	2.5	5.9	244 695
Quintile 3	6.1	6.5	5.7	4.8	5.7	4.9	4.8	2.2	5.8	247 895
Quintile 4	6.1	6.5	5.8	4.5	5.7	6.7	4.9	2.0	5.9	250 106
Quintile 5 (least disadvantaged)	6.3	7.2	5.6	5.5	6.3	..	4.6	1.8	6.2	270 901
2009-10										
Public (d), (e), (f)										
Quintile 1 (most disadvantaged)	1.9	1.5	2.6	2.2	2.7	1.0	np	2.6	2.0	85 633
Quintile 2	1.9	1.4	1.8	1.5	2.1	4.2	4.8	2.4	1.8	75 384
Quintile 3	1.5	1.2	1.7	2.2	1.7	1.3	3.8	3.3	1.6	69 386
Quintile 4	1.4	0.8	1.4	2.1	1.2	1.0	2.5	1.6	1.3	56 689
Quintile 5 (least disadvantaged)	1.1	0.7	1.0	1.4	1.0	..	1.7	1.7	1.0	45 247
Private (d), (g)										
Quintile 1 (most disadvantaged)	0.0	0.1	0.0	0.1	np	np	np	np	–	1 939
Quintile 2	0.1	0.1	0.1	0.1	np	np	np	np	0.1	2 864
Quintile 3	0.1	0.1	0.1	0.1	np	np	np	np	0.1	4 121

TABLE 12A.38

Table 12A.38 Proportion of people receiving clinical mental health services by service type and SEIFA (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Quintile 4	0.1	0.1	0.2	0.2	np	np	np	np	0.1	5 993
Quintile 5 (least disadvantaged)	0.2	0.2	0.2	0.3	np	..	np	np	0.2	10 565
MBS and DVA										
Quintile 1 (most disadvantaged)	5.9	6.5	6.0	3.1	6.4	5.2	5.2	1.1	5.8	246 684
Quintile 2	6.8	6.9	5.7	5.1	6.6	5.1	5.3	3.0	6.5	274 627
Quintile 3	6.6	7.2	6.4	5.2	6.2	5.6	5.2	2.5	6.4	277 661
Quintile 4	6.5	7.1	6.4	4.9	6.2	7.5	5.3	2.3	6.4	278 258
Quintile 5 (least disadvantaged)	6.7	7.6	6.1	5.8	6.9	..	5.0	2.1	6.6	293 715
2010-11										
Public (d), (e), (f)										
Quintile 1 (most disadvantaged)	1.9	1.5	2.9	3.5	2.7	2.0	np	2.9	2.2	93 565
Quintile 2	1.9	1.4	1.9	2.2	2.1	1.4	4.4	2.5	1.9	79 324
Quintile 3	1.6	1.2	1.7	1.9	1.7	1.2	3.7	3.0	1.6	69 526
Quintile 4	1.4	0.8	1.3	1.6	1.3	1.7	2.6	1.7	1.3	55 664
Quintile 5 (least disadvantaged)	1.1	0.7	1.0	1.4	1.0	..	1.7	1.8	1.0	45 973
Private (d), (g)										
Quintile 1 (most disadvantaged)	–	0.1	–	0.1	np	np	np	np	–	2 179.0
Quintile 2	0.1	0.1	0.1	0.1	np	np	np	np	0.1	3 217.0
Quintile 3	0.1	0.1	0.1	0.1	np	np	np	np	0.1	4 752.0
Quintile 4	0.1	0.1	0.2	0.2	np	np	np	np	0.1	6 743.0
Quintile 5 (least disadvantaged)	0.2	0.3	0.2	0.3	np	..	np	np	0.2	10 987.0
MBS and DVA										
Quintile 1 (most disadvantaged)	6.5	7.2	6.6	3.7	7.0	5.9	5.8	1.2	6.5	277 164
Quintile 2	7.6	7.6	6.5	5.5	7.3	5.6	5.9	3.4	7.2	309 010
Quintile 3	7.1	7.9	7.2	5.5	6.7	6.3	5.4	2.8	7.0	307 839

TABLE 12A.38

Table 12A.38 Proportion of people receiving clinical mental health services by service type and SEIFA (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Quintile 4	7.2	7.7	7.2	5.3	6.9	8.0	5.7	2.4	7.0	312 702
Quintile 5 (least disadvantaged)	7.2	8.1	6.6	6.2	7.6	..	5.5	2.2	7.1	319 001
<i>2011-12</i>										
Public (d), (e), (f)										
Quintile 1 (most disadvantaged)	1.9	na	2.8	4.1	3.1	1.7	np	2.9	2.3	81 894
Quintile 2	1.9	na	2.0	2.4	2.1	1.3	3.5	2.9	2.0	64 732
Quintile 3	1.5	na	1.8	2.1	1.7	1.4	3.3	2.9	1.7	58 780
Quintile 4	1.5	na	1.4	1.7	1.5	1.3	2.9	2.6	1.6	46 849
Quintile 5 (least disadvantaged)	1.1	na	1.1	1.5	1.1	..	1.8	2.2	1.3	41 555
Private (d)										
Quintile 1 (most disadvantaged)	na	na	na	na	na	na	na	na	0.1	2 394
Quintile 2	na	na	na	na	na	na	na	na	0.1	3 524
Quintile 3	na	na	na	na	na	na	na	na	0.1	5 461
Quintile 4	na	na	na	na	na	na	na	na	0.2	7 354
Quintile 5 (least disadvantaged)	na	na	na	na	na	..	na	na	0.3	11 868
MBS and DVA (h)										
Quintile 1 (most disadvantaged)	na	na	na	na	na	na	na	na	6.9	306 636
Quintile 2	na	na	na	na	na	na	na	na	7.0	311 718
Quintile 3	na	na	na	na	na	na	na	na	7.0	322 463
Quintile 4	na	na	na	na	na	na	na	na	7.1	328 411
Quintile 5 (least disadvantaged)	na	na	na	na	na	..	na	na	6.9	320 535
<i>2012-13</i>										
Public (d), (e), (f), (i)										
Quintile 1 (most disadvantaged)	2.2	na	3.5	3.2	3.2	1.7	np	3.2	2.7	92 603
Quintile 2	2.1	na	2.2	2.8	2.4	1.2	7.1	2.4	2.2	76 043

TABLE 12A.38

Table 12A.38 Proportion of people receiving clinical mental health services by service type and SEIFA (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Quintile 3	1.7	na	1.6	2.1	1.9	1.0	4.4	3.9	1.8	57 740
Quintile 4	1.6	na	1.4	1.7	1.4	1.0	2.7	2.6	1.5	48 216
Quintile 5 (least disadvantaged)	1.2	na	1.0	1.3	1.0	0.9	1.8	2.1	1.2	41 979
Private (d)										
Quintile 1 (most disadvantaged)	na	na	na	na	na	na	na	na	0.1	2 411
Quintile 2	na	na	na	na	na	na	na	na	0.1	3 998
Quintile 3	na	na	na	na	na	na	na	na	0.1	5 506
Quintile 4	na	na	na	na	na	na	na	na	0.2	7 835
Quintile 5 (least disadvantaged)	na	na	na	na	na	na	na	na	0.3	13 147
MBS and DVA										
Quintile 1 (most disadvantaged)	na	na	na	na	na	na	na	na	7.5	336 345
Quintile 2	na	na	na	na	na	na	na	na	7.5	340 118
Quintile 3	na	na	na	na	na	na	na	na	7.6	351 587
Quintile 4	na	na	na	na	na	na	na	na	7.6	355 720
Quintile 5 (least disadvantaged)	na	na	na	na	na	na	na	na	7.3	343 452

- (a) Socio-Economic Indexes for Areas (SEIFA) quintiles are based on the ABS Index of Relative Socio-economic Disadvantage, with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. SEIFA quintiles represent approximately 20 per cent of the national population, but do not necessarily represent 20 per cent of the population in each State or Territory. Excludes people for whom demographic information was missing and/or not reported.
- (b) Disaggregation by SEIFA is based on a person's usual residence, not the location of the service provider.
- (c) Rates are age-standardised to the Australian population as at 30 June 2001.
- (d) For 2007-08 and 2008-09, disaggregation by SEIFA is based on a person's usual residence, the location of the service provider or a combination of both. For these years, the public data should be interpreted with caution as the methodology used to allocate SEIFA varied across jurisdictions. From 2009-10 onwards, disaggregation by SEIFA is based on a person's usual residence, not the location of the service provider, except for public data for the NT, for which the majority of the data was based on the location of the service. Due to system-related issues impacting data quality, Tasmania was unable to provide data by SEIFA for 2008-09.

Table 12A.38 **Proportion of people receiving clinical mental health services by service type and SEIFA (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(e)	SA submitted data that were not based on unique patient identifier or data matching approaches. This was also the case for data submitted by Tasmania before 2012-13. Therefore caution should be taken when making inter-jurisdictional comparisons.								
(f)	Victorian 2011-12 and 2012-13 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. Industrial action during 2011-12 and 2012-13 in Tasmania has limited the available data quality and quantity of the community mental health care data; which represents a large proportion of the overall figures. Australian totals for 2011-12 and 2012-13 only include available data and should therefore be interpreted with caution.								
(g)	Private psychiatric hospital figures are not published for SA, Tasmania, and the ACT due to confidentiality reasons but are included in the Australia figures.								
(h)	MBS data for 2011-12 has been updated since the 2014 Report.								
(i)	A change in scope for public data implemented for the 2012-13 collection period means that comparison of rates for years up to and including 2011-12 with years 2012-13 and beyond should not be made. See the quality statement for additional information.								

na Not available. .. Not applicable. – Nil or rounded to zero. **np** Not published.

Source: AIHW (unpublished) derived from data provided by State and Territory governments. State and Territory (unpublished) community mental health care data; Private Mental Health Alliance (unpublished) Centralised Data Management Service data; Department of Health (unpublished) and DVA (unpublished), MBS Statistics; ABS (unpublished) Estimated Residential Population, 30 June (prior to relevant period).

TABLE 12A.39

Table 12A.39 Proportion of people receiving clinical public mental health services, by age group and gender, 2012-13 (a)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
Age groups					%					<i>no.</i>
Less than 15 years	1.0	na	1.4	1.2	1.9	0.8	0.9	1.7	1.2	40 207
15–24 years	2.8	na	3.1	2.9	3.1	2.2	3.9	4.9	3.0	68 852
25–34 years	2.2	na	2.5	2.6	2.7	1.7	3.0	4.0	2.4	59 355
35–44 years	2.2	na	2.3	2.5	2.7	1.7	2.9	3.8	2.4	56 153
45–54 years	1.8	na	1.7	1.9	2.1	1.2	2.4	2.4	1.8	41 753
55–64 years	1.2	na	1.2	1.4	1.4	0.8	1.7	1.7	1.2	24 234
65+ years	1.4	na	1.2	2.1	1.3	1.2	2.2	1.4	1.4	33 914
Gender (b)										
Male	1.8	na	2.0	1.9	2.3	1.3	2.2	3.0	1.9	161 976
Female	1.8	na	1.9	2.2	2.2	1.4	2.6	2.7	1.9	162 240
Total (b)	1.8	na	1.9	2.1	2.3	1.3	2.4	2.9	1.9	324 867

(a) Caution should be taken when making inter-jurisdictional comparisons for public data. SA submitted data that were not based on unique patient identifier or data matching approaches. Victorian data are unavailable due to service level collection gaps resulting from protected industrial action during this period. Industrial action in Tasmania has limited the available data quality and quantity of the data; which represents a large proportion of the overall figures. Australian totals only include available data and should therefore be interpreted with caution.

(b) Rates are age-standardised to the Australian population as at 30 June 2001.

na Not available.

Source: AIHW (unpublished) derived from data provided by State and Territory governments; State and Territory governments (unpublished) specialised mental health services data; ABS (unpublished) Estimated Residential Population, 30 June (prior to relevant period).

TABLE 12A.40

Table 12A.40 **Proportion of people receiving clinical mental health services, by service type and SEIFA IRSD deciles (age-standardised rate) (a), (b), (c)**

	<i>Public (d)</i>	<i>Private</i>	<i>MBS and DVA</i>
<i>2007-08</i>			
Decile 1	1.9	0.1	4.1
Decile 2	1.9	–	4.5
Decile 3	1.9	0.1	4.8
Decile 4	1.8	0.1	5.0
Decile 5	1.6	0.1	4.8
Decile 6	1.6	0.1	4.9
Decile 7	1.3	0.1	4.9
Decile 8	1.5	0.1	5.1
Decile 9	1.2	0.2	5.5
Decile 10	1.1	0.2	5.3
<i>2008-09</i>			
Decile 1	1.7	–	5.0
Decile 2	1.8	–	5.5
Decile 3	1.8	0.1	5.8
Decile 4	1.9	0.1	5.9
Decile 5	1.7	0.1	5.8
Decile 6	1.6	0.1	5.9
Decile 7	1.2	0.1	5.7
Decile 8	1.2	0.1	6.0
Decile 9	1.2	0.2	6.4
Decile 10	1.2	0.2	6.0
<i>2009-10</i>			
Decile 1	2.1	–	5.6
Decile 2	2.0	–	6.1

TABLE 12A.40

Table 12A.40 **Proportion of people receiving clinical mental health services, by service type and SEIFA IRSD deciles (age-standardised rate) (a), (b), (c)**

	<i>Public (d)</i>	<i>Private</i>	<i>MBS and DVA</i>
Decile 3	1.8	0.1	6.4
Decile 4	1.7	0.1	6.5
Decile 5	1.6	0.1	6.3
Decile 6	1.6	0.1	6.4
Decile 7	1.4	0.1	6.2
Decile 8	1.2	0.1	6.5
Decile 9	1.1	0.2	6.8
Decile 10	1.0	0.2	6.5
<i>2010-11</i>			
Decile 1	2.2	–	6.3
Decile 2	2.2	0.1	6.7
Decile 3	1.8	0.1	7.2
Decile 4	1.9	0.1	7.2
Decile 5	1.7	0.1	6.9
Decile 6	1.4	0.1	7.0
Decile 7	1.3	0.1	6.9
Decile 8	1.2	0.2	7.1
Decile 9	1.1	0.2	7.3
Decile 10	1.0	0.3	6.9
<i>2011-12 (e)</i>			
Decile 1	1.9	–	6.9
Decile 2	1.9	0.1	7.2
Decile 3	1.5	0.1	7.2
Decile 4	1.5	0.1	6.9
Decile 5	1.3	0.1	7.1

TABLE 12A.40

Table 12A.40 **Proportion of people receiving clinical mental health services, by service type and SEIFA IRSD deciles (age-standardised rate) (a), (b), (c)**

	<i>Public (d)</i>	<i>Private</i>	<i>MBS and DVA</i>
Decile 6	1.3	0.1	7.2
Decile 7	1.1	0.1	7.1
Decile 8	1.0	0.2	7.3
Decile 9	1.0	0.2	7.0
Decile 10	0.8	0.3	7.0
<i>2012-13 (f)</i>			
Decile 1	2.2	–	7.6
Decile 2	2.1	0.1	7.9
Decile 3	1.8	0.1	7.9
Decile 4	1.6	0.1	7.5
Decile 5	1.3	0.1	7.8
Decile 6	1.3	0.1	7.9
Decile 7	1.2	0.2	7.8
Decile 8	0.9	0.2	7.9
Decile 9	1.0	0.3	7.6
Decile 10	0.9	0.3	7.6

(a) SEIFA deciles are based on the ABS Index of Relative Socio-economic Disadvantage (IRSD), with decile 1 being the most disadvantaged and decile 10 being the least disadvantaged. SEIFA deciles represent approximately 10 per cent of the national population, but do not necessarily represent 10 per cent of the population in each State or Territory. Excludes people for whom information was missing and/or not reported.

(b) Disaggregation by SEIFA is based on a person's usual residence, not the location of the service provider, except for public data for the NT, for which the majority of the data was based on the location of the service.

(c) Rates are age-standardised to the Australian population as at 30 June 2001.

Table 12A.40 Proportion of people receiving clinical mental health services, by service type and SEIFA IRSD deciles (age-standardised rate) (a), (b), (c)

	<i>Public (d)</i>	<i>Private</i>	<i>MBS and DVA</i>
(d)	For 2007-08 and 2008-09, disaggregation by SEIFA is based on a person's usual residence, the location of the service provider or a combination of both. For these years, the public data should be interpreted with caution as the methodology used to allocate SEIFA varied across jurisdictions. From 2009-10 onwards, disaggregation by SEIFA is based on a person's usual residence, not the location of the service provider. Due to system-related issues impacting data quality, Tasmania was unable to provide data by SEIFA for 2008-09. Victorian 2011-12 and 2012-13 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. Industrial action during 2011-12 and 2012-13 in Tasmania has limited the available data quality and quantity of the community mental health care data; which represents a large proportion of the overall figures. Australian totals for 2011-12 and 2012-13 only include available data and should therefore be interpreted with caution. Public 2012-13 data are considered a break in series due to a change of scope between 2011-12 and 2012-13. Historical SEIFA data was not re-supplied due to this change in scope. Therefore, changes in public data from 2012-13 onwards with years prior to 2012-13 should not be made.		
(e)	MBS data for 2011-12 has been updated since the 2014 Report.		
(f)	A change in scope for public data implemented for the 2012-13 collection period means that comparison of rates for years up to and including 2011-12 with years 2012-13 and beyond should not be made. See the quality statement for additional information.		
	– Nil or rounded to zero.		

Source: AIHW (unpublished) derived from data provided by State and Territory governments; State and Territory governments (unpublished) specialised mental health services data; Private Mental Health Alliance (unpublished) Centralised Data Management Service data; Department of Health (unpublished) and DVA (unpublished), MBS Statistics; ABS (unpublished) Estimated Residential Population, 30 June (prior to relevant period).

TABLE 12A.41

Table 12A.41 Proportion of people receiving clinical mental health services by service type (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>2007-08</i>										
Public (b)										
Number	no.	109 250	59 352	76 227	37 862	28 400	9 499	6 832	4 559	331 981
Rate	%	1.6	1.1	1.9	1.8	1.9	2.0	2.0	2.1	1.6
Private (c)										
Number	no.	7 256	6 170	4 791	2 183	np	np	np	..	23 044
Rate	%	0.1	0.1	0.1	0.1	np	np	np	..	0.1
MBS and DVA										
Number: Total MBS and DVA (d)	no.	349 679	287 210	189 005	87 638	75 116	20 527	14 163	3 981	1 027 330
Rate: Total MBS and DVA (d)	%	5.1	5.5	4.6	4.1	4.8	4.3	4.0	1.8	4.9
Rate: Psychiatrist (e)	%	1.4	1.5	1.3	1.1	1.6	1.0	1.1	0.4	1.4
Rate: Clinical psychologist (f)	%	0.6	0.6	0.4	1.0	0.7	0.9	0.6	0.1	0.6
Rate: GP (g)	%	3.7	4.0	3.2	3.0	3.2	3.2	2.8	1.4	3.5
Rate: Other allied health (h)	%	1.4	1.8	1.4	0.6	0.9	1.1	1.2	0.4	1.3
<i>2008-09</i>										
Public (b)										
Number	no.	112 751	60 034	74 168	39 886	30 777	9 362	7 371	4 930	339 279
Rate	%	1.6	1.1	1.8	1.8	2.0	1.9	2.1	2.2	1.6
Private (c)										
Number	no.	7 575	6 308	5 270	2 629	np	np	np	..	24 348
Rate	%	0.1	0.1	0.1	0.1	np	np	np	..	0.1
MBS and DVA										
Number: Total MBS and DVA (d)	no.	419 027	346 064	235 222	107 077	91 841	24 501	17 119	5 104	1 247 142
Rate: Total MBS and DVA (d)	%	6.0	6.6	5.6	4.9	5.8	5.1	4.8	2.3	5.9
Rate: Psychiatrist (e)	%	1.4	1.5	1.3	1.1	1.6	1.0	1.1	0.4	1.4

TABLE 12A.41

Table 12A.41 Proportion of people receiving clinical mental health services by service type (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Rate: Clinical psychologist (f)	%	0.8	0.8	0.6	1.2	1.1	1.2	0.7	0.2	0.8
Rate: GP (g)	%	4.6	4.9	4.2	3.7	4.2	3.9	3.4	1.9	4.4
Rate: Other allied health (h)	%	1.7	2.3	1.8	0.8	1.1	1.3	1.5	0.5	1.7
<i>2009-10</i>										
Public (b)										
Number	no.	116 276	61 130	73 903	41 928	31 208	6 209	7 670	5 450	343 774
Rate	%	1.7	1.1	1.7	1.9	2.0	1.3	2.1	2.3	1.6
Private (c)										
Number	no.	8 145	6 544	5 392	3 047	np	np	np	..	25 536
Rate	%	0.1	0.1	0.1	0.1	np	np	np	..	0.1
MBS										
Number: Total MBS and DVA (d)		460 708	385 085	265 357	119 533	103 225	27 741	18 871	6 146	1 387 297
Rate: Total MBS and DVA (d)		6.6	7.2	6.1	5.3	6.5	5.7	5.2	2.7	6.4
Rate: Psychiatrist (e)		1.4	1.5	1.3	1.1	1.7	1.1	1.1	0.4	1.4
Rate: Clinical psychologist (f)		1.0	1.0	0.7	1.4	1.3	1.3	0.9	0.3	1.0
Rate: GP (g)		5.0	5.4	4.7	4.0	4.7	4.3	3.7	2.2	4.8
Rate: Other allied health (h)		2.0	2.6	2.1	1.0	1.2	1.5	1.7	0.7	2.0
<i>2010-11</i>										
Public (b)										
Number	no.	119 380	61 686	78 129	44 980	32 063	7 845	8 101	5 730	357 914
Rate	%	1.7	1.1	1.8	2.0	2.0	1.6	2.2	2.4	1.6
Private (c)										
Number	no.	8 354	7 692	5 673	3 250	np	np	np	..	27 924
Rate	%	0.1	0.1	0.1	0.1	np	np	np	..	0.1
MBS										
Number: Total MBS and DVA (d)		511 672	426 982	300 311	131 892	115 088	31 175	20 838	6 775	1 544 744

TABLE 12A.41

Table 12A.41 Proportion of people receiving clinical mental health services by service type (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Rate: Total MBS and DVA (d)		7.2	7.8	6.8	5.7	7.1	6.4	5.6	2.9	7.0
Rate: Psychiatrist (e)		1.4	1.5	1.3	1.1	1.6	1.1	1.2	0.4	1.4
Rate: Clinical psychologist (f)		1.1	1.1	0.9	1.4	1.7	1.4	1.2	0.3	1.1
Rate: GP (g)		5.6	6.1	5.4	4.4	5.4	5.0	4.2	2.4	5.5
Rate: Other allied health (h)		2.3	2.8	2.3	1.2	1.4	1.9	1.7	0.7	2.2
<i>2011-12</i>										
Public (b)										
Number	no.	123 341	na	82 179	47 296	34 090	6 390	8 427	6 437	308 160
Rate	%	1.7	na	1.9	2.0	2.2	1.3	2.3	2.7	1.9
Private (c)										
Number	no.	9 537	8 301	6 578	3 616	np	np	np	..	30 640
Rate	%	0.1	0.1	0.1	0.2	np	np	np	..	0.1
MBS										
Number: Total MBS and DVA (d)		536 353	453 347	320 397	134 105	119 613	32 031	21 926	7 307	1 625 098
Rate: Total MBS and DVA (d)		7.5	8.2	7.2	5.7	7.4	6.5	5.8	3.1	7.3
Rate: Psychiatrist (e)		1.4	1.5	1.4	1.1	1.6	1.1	1.1	0.4	1.4
Rate: Clinical psychologist (f)		1.2	1.3	1.0	1.5	1.9	1.5	1.5	0.4	1.3
Rate: GP (g)		5.8	6.4	5.6	4.3	5.6	5.1	4.4	2.6	5.7
Rate: Other allied health (h)		2.3	2.9	2.4	1.2	1.5	2.0	1.6	0.7	2.3
<i>2012-13</i>										
Public (b)										
Number	no.	129 183	na	86 671	50 234	35 992	6 678	9 058	7 051	324 867
Rate	%	1.8	na	1.9	2.1	2.3	1.3	2.4	2.9	1.9
Private (c)										
Number	no.	10 539	8 642	7 241	3 785	np	np	np	..	32 944
Rate	%	0.1	0.1	0.2	0.2	np	np	np	..	0.1

TABLE 12A.41

Table 12A.41 **Proportion of people receiving clinical mental health services by service type (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
MBS										
Number: Total MBS and DVA (d)		580 047	492 618	353 147	143 637	126 345	34 848	24 275	8 097	1 763 028
Rate: Total MBS and DVA (d)		8.0	8.8	7.8	5.9	7.8	7.1	6.3	3.4	7.8
Rate: Psychiatrist (e)		1.5	1.6	1.5	1.1	1.7	1.2	1.0	0.3	1.5
Rate: Clinical psychologist (f)		1.4	1.6	1.2	1.5	2.0	1.9	1.7	0.4	1.5
Rate: GP (g)		6.3	6.9	6.1	4.5	5.9	5.6	4.9	2.9	6.1
Rate: Other allied health (h)		2.5	3.1	2.5	1.2	1.7	2.0	1.8	0.7	2.4

(a) Rates are age-standardised to the Australian population as at 30 June 2001.

(b) All public historical data has been updated since the 2014 Report due to a change of scope. See the data quality statement for more information. Caution should be taken when making inter-jurisdictional comparisons for public data. South Australia submitted data that were not based on unique patient identifier or data matching approaches. This was also the case for data submitted by Tasmania prior to 2012-13. Tasmania 2007-08 and 2008-09 data have been provided using the old scope for this indicator, but the remaining years have been provided using the new scope for this indicator. See the data quality information for more information. Victorian 2011-12 and 2012-13 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. Industrial action during 2011-12 and 2012-13 in Tasmania has limited the available data quality and quantity of the community mental health care data; which represents a large proportion of the overall figures. Australian totals for 2011-12 and 2012-13 only include available data and should therefore be interpreted with caution. Australian totals for 2011-12 and 2012-13 should not be compared to previous years.

(c) Private psychiatric hospital figures are not published for SA, Tasmania, and the ACT due to confidentiality reasons but are included in the Australia totals.

(d) MBS and DVA services are those provided under any of the Medicare/DVA-funded service types described at (e) to (h). People seen by more than one provider type are counted only once in the total. MBS data for 2011-12 has been updated since the 2014 Report.

(e) Consultant psychiatrist services are MBS items 134, 136, 138, 140, 142, 289, 291, 293, 296, 297, 299, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 320, 322, 324, 326, 328, 330, 332, 334, 336, 338, 342, 344, 346, 348, 350, 352, 353, 355, 356, 357, 358, 359, 361, 364, 366, 367, 369, 370, 855, 857, 858, 861, 864, 866, 14224 (as relevant across years).

(f) Clinical psychologist services are MBS items: 80000, 80005, 80010, 80015, 80020 and DVA items US01, US02, US03, US04, US05, US06, US07, US08, US50, US51, US99 (as relevant across years).

(g) GP services are MBS items 170, 171, 172, 2574, 2575, 2577, 2578, 2700, 2701, 2702, 2704, 2705, 2707, 2708, 2710, 2712, 2713, 2715, 2717, 2719, 2721, 2723, 2725, 2727, 20104 (as relevant across years).

Table 12A.41 **Proportion of people receiving clinical mental health services by service type (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(h)	Other allied health services are MBS items 10956, 10968, 80100, 80105, 80110, 80115, 80120, 80125, 80130, 80135, 80140, 80145, 80150, 80155, 80160, 80165, 80170, 81325, 81355, 82000, 82015 and DVA items CL20, CL25, CL30, US11, US12, US13, US14, US15, US16, US17, US18, US21, US22, US23, US24, US25, US26, US27, US31, US32, US33, US34, US35, US36, US37, US52, US53, US96, US97, US98 (as relevant across years).									

na Not available. .. Not applicable. **np** Not published.

Source: AIHW (unpublished) derived from data provided by Australian, State and Territory governments; State and Territory governments (unpublished) specialised mental health services data; Private Mental Health Alliance (unpublished) Centralised Data Management Service data; Department of Health (unpublished) and DVA (unpublished), MBS Statistics; ABS (unpublished) Estimated Residential Population, 30 June (prior to relevant period).

TABLE 12A.42

Table 12A.42 Services used for mental health problems, Australia, 2007 (per cent) (a), (b)

	With lifetime mental disorder		No lifetime mental disorder (e)	Total
	Symptoms in previous 12 months (c)	No symptoms in previous 12 months (d)		
GP	24.7 ± 2.4	6.2 ± 1.5	2.8 ± 0.9	8.1 ± 0.7
Psychiatrist	7.9 ± 2.7	1.4 ± 0.7	0.6 ± 0.3	2.3 ± 0.6
Psychologist	13.2 ± 2.1	1.8 ± 0.6	0.8 ± 0.3	3.5 ± 0.5
Other mental health professional	7.7 ± 1.6	1.5 ± 0.5	np	2.2 ± 0.4
Other health professional	6.6 ± 1.6	2.1 ± 1.0	1.0 ± 0.4	2.4 ± 0.5
Hospitalisation	2.6 ± 1.1	np	np	0.7 ± 0.3
Total who used health services	34.9 ± 3.1	9.2 ± 1.8	4.7 ± 1.1	11.9 ± 0.9
Total who did not use services for mental health	65.1 ± 3.1	90.8 ± 1.8	95.2 ± 1.1	88.1 ± 0.9

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(e) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source: ABS (unpublished) 2007 Survey of Mental Health and Wellbeing, Cat. no. 4326.0.

TABLE 12A.43

Table 12A.43 Services used for mental health, by mental disorder status, 2007 (per cent) (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total who used services for mental health in previous 12 months (c)									
Any 12-month mental disorder (d)	32.5 ± 6.4	37.0 ± 7.1	34.4 ± 7.0	35.8 ± 10.5	35.2 ± 9.1	np	np	np	34.9 ± 3.1
Lifetime mental disorder, with no 12-month symptoms (e)	7.6 ± 2.0	11.5 ± 4.0	9.0 ± 3.3	7.4 ± 3.6	np	np	np	np	9.2 ± 1.8
No lifetime mental disorder (f)	np	4.6 ± 1.8	5.6 ± 1.8	4.8 ± 2.3	np	np	np	np	4.7 ± 1.1
Total	10.9 ± 1.8	13.1 ± 2.2	12.1 ± 2.0	12.0 ± 2.5	11.0 ± 2.7	np	np	np	11.9 ± 0.9
Total who did not use services for mental health in previous 12 months									
Any 12-month mental disorder (d)	67.5 ± 6.4	63.0 ± 7.1	65.6 ± 7.0	64.2 ± 10.5	64.8 ± 9.1	65.5 ± 23.2	np	np	65.1 ± 3.1
Lifetime mental disorder, with no 12-month symptoms (e)	92.4 ± 2.0	88.5 ± 4.0	91.0 ± 3.3	92.6 ± 3.6	90.3 ± 5.7	87.8 ± 13.3	np	np	90.8 ± 1.8
No lifetime mental disorder (f)	95.4 ± 2.3	95.4 ± 1.8	94.4 ± 1.8	95.2 ± 2.3	96.1 ± 2.8	95.2 ± 7.1	np	np	95.2 ± 1.1
Total	89.1 ± 1.8	86.9 ± 2.2	87.9 ± 2.0	88.0 ± 2.5	88.6 ± 2.8	88.7 ± 6.9	81.6 ± 12.2	95.3 ± 6.2	88.1 ± 0.9

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.

(c) Includes hospitalisations.

(d) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(f) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source: ABS (unpublished) 2007 Survey of Mental Health and Wellbeing, Cat. no. 4326.0.

TABLE 12A.44

Table 12A.44 **Young people who had contact with MBS subsidised primary mental health care services, by age group (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (h)</i>
<i>2010-11</i>										
<i>Number of children or young adults who have had contact</i>										
Pre-school (0-<5 years)	no.	2 868	2 527	1 326	645	760	114	76	25	8 341
Primary school (5-<12 years)	no.	21 250	18 890	12 749	5 106	5 037	1 180	803	225	65 242
Secondary school (12-<18 years)	no.	29 381	24 940	17 697	7 392	6 685	2 059	1 384	359	89 900
Youth/young adult (18-<25 years)	no.	49 576	42 417	30 564	14 091	11 699	3 693	2 538	758	155 338
All children and young people aged <25 years	no.	103 075	88 774	62 335	27 235	24 181	7 045	4 800	1 366	318 819
<i>Number of people (g)</i>										
Pre-school (0-<5 years)	no.	474 241	349 577	304 196	153 515	97 277	32 467	23 833	18 771	1 454 012
Primary school (5-<12 years)	no.	618 550	456 156	402 390	201 872	133 082	44 149	29 527	24 188	1 910 177
Secondary school (12-<18 years)	no.	542 416	407 825	355 513	179 698	122 489	40 735	26 535	19 688	1 695 155
Youth/young adult (18-<25 years)	no.	689 605	561 825	440 994	236 395	158 803	45 886	44 290	26 288	2 204 456
All children and young people aged <25 years	no.	2 324 812	1 775 383	1 503 093	771 480	511 651	163 237	124 185	88 935	7 263 800
<i>Proportion of population who had contact with MBS-subsidised primary mental health services</i>										
Pre-school (0-<5 years)	%	0.6	0.7	0.4	0.4	0.8	0.4	0.3	0.1	0.6
Primary school (5-<12 years)	%	3.4	4.1	3.2	2.5	3.8	2.7	2.7	0.9	3.4
Secondary school (12-<18 years)	%	5.4	6.1	5.0	4.1	5.5	5.1	5.2	1.8	5.3
Youth/young adult (18-<25 years)	%	7.2	7.5	6.9	6.0	7.4	8.0	5.7	2.9	7.0
All children and young people aged <25 years	%	4.4	5.0	4.1	3.5	4.7	4.3	3.9	1.5	4.4
<i>2011-12</i>										
<i>Number of children or young adults who have had contact</i>										
Pre-school (0-<5 years)	no.	3 249	2 783	1 485	724	765	129	97	33	9 266
Primary school (5-<12 years)	no.	23 830	22 469	14 868	5 618	5 510	1 383	866	283	74 830
Secondary school (12-<18 years)	no.	32 882	28 198	19 921	8 282	7 399	2 311	1 515	439	100 950

TABLE 12A.44

Table 12A.44 Young people who had contact with MBS subsidised primary mental health care services, by age group (a), (b), (c), (d), (e), (f), (g)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (h)</i>
Youth/young adult (18-<25 years)	no.	53 901	46 621	33 628	14 626	12 716	3 782	2 790	870	168 937
All children and young people aged <25 years	no.	113 861	100 072	69 902	29 250	26 391	7 605	5 268	1 624	353 982
<i>Number of people (g)</i>										
Pre-school (0-<5 years)	no.	473 405	351 951	304 330	156 415	97 426	31 821	24 132	18 492	1 458 114
Primary school (5-<12 years)	no.	626 129	463 563	411 006	206 638	133 583	44 076	30 095	24 417	1 939 761
Secondary school (12-<18 years)	no.	541 943	407 320	357 235	181 723	121 992	40 659	26 204	19 428	1 696 713
Youth/young adult (18-<25 years)	no.	685 985	558 932	443 898	240 030	158 518	45 657	44 989	25 772	2 204 147
All children and young people aged <25 years	no.	2 327 462	1 781 766	1 516 469	784 806	511 519	162 213	125 420	88 109	7 298 735
<i>Proportion of population who had contact with MBS-subsidised primary mental health services</i>										
Pre-school (0-<5 years)	%	0.7	0.8	0.5	0.5	0.8	0.4	0.4	0.2	0.6
Primary school (5-<12 years)	%	3.8	4.8	3.6	2.7	4.1	3.1	2.9	1.2	3.9
Secondary school (12-<18 years)	%	6.1	6.9	5.6	4.6	6.1	5.7	5.8	2.3	5.9
Youth/young adult (18-<25 years)	%	7.9	8.3	7.6	6.1	8.0	8.3	6.2	3.4	7.7
All children and young people aged <25 years	%	4.9	5.6	4.6	3.7	5.2	4.7	4.2	1.8	4.8
<i>2012-13</i>										
<i>Number of children or young adults who have had contact</i>										
Pre-school (0-<5 years)	no.	3 778	3 279	1 914	763	841	119	83	28	10 805
Primary school (5-<12 years)	no.	27 396	26 535	17 774	6 551	6 195	1 586	983	302	87 325
Secondary school (12-<18 years)	no.	38 242	33 217	24 143	10 293	8 528	2 703	1 985	427	119 542
Youth/young adult (18-<25 years)	no.	60 739	52 016	38 351	16 055	13 774	4 285	3 220	992	189 438
All children and young people aged <25 years	no.	130 155	115 047	82 181	33 662	29 337	8 693	6 272	1 749	407 110
<i>Number of people (g)</i>										
Pre-school (0-<5 years)	no.	475 077	359 465	309 885	162 286	99 326	31 787	25 003	18 793	1 481 769
Primary school (5-<12 years)	no.	626 137	466 682	415 281	211 475	133 270	43 335	30 437	24 385	1 951 242

TABLE 12A.44

Table 12A.44 Young people who had contact with MBS subsidised primary mental health care services, by age group (a), (b), (c), (d), (e), (f), (g)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (h)
Secondary school (12-<18 years)	no.	541 187	406 537	359 285	184 029	121 486	40 255	26 028	19 431	1 698 453
Youth/young adult (18-<25 years)	no.	689 385	559 692	451 421	245 385	158 004	45 092	44 379	25 665	2 219 344
All children and young people aged <25 years	no.	2 331 786	1 792 376	1 535 872	803 175	512 086	160 469	125 847	88 274	7 350 808
<i>Proportion of population who had contact with MBS-subsidised primary mental health services</i>										
Pre-school (0-<5 years)	%	0.8	0.9	0.6	0.5	0.8	0.4	0.3	0.1	0.7
Primary school (5-<12 years)	%	4.4	5.7	4.3	3.1	4.6	3.7	3.2	1.2	4.5
Secondary school (12-<18 years)	%	7.1	8.2	6.7	5.6	7.0	6.7	7.6	2.2	7.0
Youth/young adult (18-<25 years)	%	8.8	9.3	8.5	6.5	8.7	9.5	7.3	3.9	8.5
All children and young people aged <25 years	%	5.6	6.4	5.4	4.2	5.7	5.4	5.0	2.0	5.5
<i>2013-14</i>										
<i>Number of children or young adults who have had contact</i>										
Pre-school (0-<5 years)	no.	4 191	3 417	2 292	840	971	159	98	51	12 019
Primary school (5-<12 years)	no.	30 859	29 925	21 884	7 784	7 342	1 948	1 163	357	101 264
Secondary school (12-<18 years)	no.	42 464	35 174	27 742	11 273	9 259	3 024	2 246	469	131 657
Youth/young adult (18-<25 years)	no.	66 526	56 911	43 070	18 648	15 051	4 736	3 588	1 054	209 589
All children and young people aged <25 years	no.	144 040	125 428	94 988	38 545	32 624	9 866	7 095	1 930	454 528
<i>Number of people (g)</i>										
Pre-school (0-<5 years)	no.	487 532	368 787	316 233	168 543	100 127	31 362	26 079	18 969	1 517 791
Primary school (5-<12 years)	no.	641 973	482 009	428 422	221 074	136 050	43 964	31 761	24 549	2 010 039
Secondary school (12-<18 years)	no.	542 315	406 991	362 507	186 749	120 521	39 690	26 118	19 643	1 704 753
Youth/young adult (18-<25 years)	no.	698 022	563 614	460 170	251 609	158 289	45 187	43 808	26 002	2 246 989
All children and young people aged <25 years	no.	2 369 842	1 821 401	1 567 332	827 975	514 987	160 203	127 766	89 163	7 479 572
<i>Proportion of population who had contact with MBS-subsidised primary mental health services</i>										
Pre-school (0-<5 years)	%	0.9	0.9	0.7	0.5	1.0	0.5	0.4	0.3	0.8

TABLE 12A.44

Table 12A.44 **Young people who had contact with MBS subsidised primary mental health care services, by age group (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (h)</i>
Primary school (5-<12 years)	%	4.8	6.2	5.1	3.5	5.4	4.4	3.7	1.5	5.0
Secondary school (12-<18 years)	%	7.8	8.6	7.7	6.0	7.7	7.6	8.6	2.4	7.7
Youth/young adult (18-<25 years)	%	9.5	10.1	9.4	7.4	9.5	10.5	8.2	4.1	9.3
All children and young people aged <25 years	%	6.1	6.9	6.1	4.7	6.3	6.2	5.6	2.2	6.1

- (a) Totals do not equal the sum of all mental health providers as data excludes psychiatrists. MBS items included for this indicator are as follows:
 – Clinical psychologist services: MBS items 80000, 80005, 80010, 80015, 80020
 – GP services: MBS items 170, 171, 172, 2574, 2575, 2577, 2578, 2700, 2701, 2702, 2704, 2705, 2707, 2708, 2710, 2712, 2713, 2715, 2717, 2719, 2721, 2723, 2725, 2727
 – Other allied health services: MBS items 10956, 10968, 80100, 80105, 80110, 80115, 80120, 80125, 80130, 80135, 80140, 80145, 80150, 80155, 80160, 80165, 80170, 81325, 81355, 82000, 82015.
- (b) Data are based on the date the claim was processed.
- (c) Age of the patient is based on age at last service during the reporting period. Note that in previous years, data supplied for this indicator calculated each patient's age at 30 June of each reference year. The derived rates may differ to those published in previous reports.
- (d) A person is counted if any of the specified mental health item has been used in the reference period
- (e) A patient is allocated to a state/territory based on their location as at the last service in the reference period.
- (f) The allocation to the state or territory uses a concordance (ABS ASGS 2011 Postcode to Remoteness Area/State) and splits a person where the postcode covers more than one state/territory, therefore the totals may not equal the sum of the individual cells due to rounding.
- (g) The population data used in this table have been revised from December mid-point estimates to the June estimate before the the relevant financial year. For 2012-13 data, the estimate is June 2012. The derived rates may differ to those published in previous reports.
- (h) The sum of the states and territories may not add to the Australian totals as the Australian totals include young people who could not be allocated to a State or Territory.

Source: Department of Health (unpublished); ABS (unpublished) *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE 12A.45

Table 12A.45 **Proportion of young people (aged < 25 years) who had contact with MBS subsidised primary mental health care services, by selected characteristics (per cent) (a), (b), (c), (d), (e), (f), (g), (h)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (i)</i>
<i>2011-12</i>									
Gender									
Male	4.2	4.8	3.9	3.0	4.4	3.8	3.2	1.4	4.1
Female	5.6	6.5	5.4	4.5	6.0	5.7	5.3	2.3	5.6
Remoteness areas (h)									
Major cities	4.7	5.5	5.0	3.8	5.5	..	4.2	..	4.9
Inner regional	5.6	6.2	4.8	4.1	5.5	4.9	–	..	5.4
Outer regional	4.1	5.0	3.6	3.0	3.7	4.2	..	2.0	3.7
Remote	2.4	3.6	1.9	1.4	2.6	2.6	..	1.2	1.8
Very Remote	1.6	..	0.9	0.8	0.8	3.6	..	0.3	0.7
Unallocated	–	–	–	0.1	–	–	–	0.5	–
SEIFA quintiles (h)									
Quintile 1 (most disadvantaged)	4.5	5.0	4.5	3.0	5.0	4.3	5.4	0.5	4.4
Quintile 2	4.9	5.5	4.7	3.4	5.1	4.7	4.0	1.9	4.8
Quintile 3	5.1	5.9	4.8	3.7	5.0	4.8	4.2	1.8	5.0
Quintile 4	5.0	5.7	4.5	3.6	5.4	5.3	4.4	1.9	4.9
Quintile 5 (least disadvantaged)	5.0	5.7	4.4	3.9	5.2	5.7	4.1	1.7	4.8
Unallocated	–	–	–	0.1	–	–	0.1	0.5	–
Indigenous status									
Indigenous	6.1	7.9	3.8	2.2	4.5	6.2	6.5	0.8	4.5
Non-Indigenous	4.8	5.6	4.7	3.8	5.2	4.6	4.1	2.6	4.9

TABLE 12A.45

Table 12A.45 **Proportion of young people (aged < 25 years) who had contact with MBS subsidised primary mental health care services, by selected characteristics (per cent) (a), (b), (c), (d), (e), (f), (g), (h)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (i)</i>
<i>2012-13</i>									
Gender									
Male	4.8	5.5	4.5	3.3	4.8	4.3	3.8	1.6	4.7
Female	6.4	7.4	6.3	5.1	6.7	6.6	6.2	2.5	6.5
Remoteness areas (h)									
Major cities	5.4	6.2	5.8	4.3	6.0	..	4.9	..	5.6
Inner regional	6.5	7.2	5.4	4.8	6.3	5.6	–	..	6.2
Outer regional	4.7	5.4	4.2	3.3	4.1	5.0	..	2.2	4.3
Remote	2.7	4.0	1.9	1.7	3.1	3.3	..	1.3	2.0
Very Remote	1.5	..	0.9	0.9	1.3	3.6	..	0.3	0.8
Unallocated	–	–	–	0.1	–	–	0.1	0.5	–
SEIFA quintiles (h)									
Quintile 1 (most disadvantaged)	5.1	5.8	5.3	3.4	5.6	5.1	5.8	0.5	5.1
Quintile 2	5.6	6.4	5.5	3.9	5.7	5.4	5.1	2.1	5.5
Quintile 3	5.9	6.7	5.5	4.1	5.6	5.4	5.0	2.0	5.7
Quintile 4	5.6	6.4	5.2	4.1	5.9	5.9	5.2	2.1	5.6
Quintile 5 (least disadvantaged)	5.6	6.3	5.1	4.3	5.7	6.2	4.8	2.0	5.4
Unallocated	–	–	–	0.1	–	–	0.1	0.5	–
Indigenous status									
Indigenous	7.1	9.1	4.6	2.4	5.3	6.6	8.1	0.8	5.2
Non-Indigenous	5.5	6.4	5.4	4.3	5.7	5.3	4.9	2.8	5.6

TABLE 12A.45

Table 12A.45 **Proportion of young people (aged < 25 years) who had contact with MBS subsidised primary mental health care services, by selected characteristics (per cent) (a), (b), (c), (d), (e), (f), (g), (h)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (i)</i>
<i>2013-14</i>									
Gender									
Male	5.2	5.9	5.2	3.8	5.4	4.9	4.3	1.7	5.2
Female	7.0	7.9	7.0	5.6	7.3	7.5	6.9	2.7	7.0
Remoteness areas (h)									
Major cities	5.8	6.6	6.4	4.7	6.6	..	5.5	..	6.0
Inner regional	7.3	7.9	6.3	5.5	7.1	6.4	–	..	7.1
Outer regional	5.5	6.0	5.0	4.0	4.6	5.6	..	2.5	4.9
Remote	3.7	5.3	2.5	2.0	3.6	3.7	..	1.1	2.4
Very Remote	2.3	..	1.1	1.3	1.6	4.4	..	0.3	1.0
Unallocated	–	–	–	0.1	–	–	0.1	0.5	–
SEIFA quintiles (h)									
Quintile 1 (most disadvantaged)	5.7	6.2	6.0	3.7	6.2	5.6	6.3	0.5	5.7
Quintile 2	6.1	7.0	6.4	4.4	6.4	6.3	5.8	2.3	6.2
Quintile 3	6.4	7.2	6.2	4.7	6.2	6.2	5.9	1.9	6.3
Quintile 4	6.0	6.9	6.0	4.5	6.6	6.8	5.9	2.4	6.1
Quintile 5 (least disadvantaged)	6.1	6.7	5.7	4.7	6.3	7.2	5.3	2.2	5.9
Unallocated	0.9	3.1	0.1	2.1	0.4	0.5	3.8	1.4	1.0
Indigenous status									
Aboriginal and Torres Strait Islander	7.7	10.4	5.7	2.9	5.7	6.7	8.6	0.9	5.9
Non-Indigenous	6.0	6.8	6.1	4.8	6.4	6.1	5.5	3.0	6.1

Table 12A.45 Proportion of young people (aged < 25 years) who had contact with MBS subsidised primary mental health care services, by selected characteristics (per cent) (a), (b), (c), (d), (e), (f), (g), (h)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (i)</i>
(a) Totals do not equal the sum of all mental health providers as data excludes psychiatrists. MBS items included for this indicator are as follows:									
– Clinical psychologist services: MBS items 80000, 80005, 80010, 80015, 80020									
– GP services: MBS items 170, 171, 172, 2574, 2575, 2577, 2578, 2700, 2701,2702, 2704, 2705, 2707, 2708, 2710, 2712, 2713, 2715, 2717, 2719, 2721, 2723, 2725, 2727									
– Other allied health services:MBS items 10956, 10968, 80100, 80105, 80110, 80115, 80120, 80125, 80130, 80135, 80140, 80145, 80150, 80155, 80160, 80165, 80170, 81325, 81355, 82000, 82015.									
(b) Data are based on the date the claim was processed.									
(c) Age of the patient is based on age at last service during the reporting period. Note that in previous years, data supplied for this indicator calculated each patient's age at 30 June of each reference year.									
(d) A person is counted if any of the specified mental health item has been used in the reference period									
(e) A patient is allocated to a state/territory based on their location as at the last service in the reference period.									
(f) The allocation to the state or territory uses a concordance (ABS ASGS 2011 Postcode to Remoteness Area/State) and splits a person where the postcode covers more than one state/territory, therefore the totals may not equal the sum of the individual cells due to rounding.									
(g) The population data used in this table are the June estimate before the the relevant financial year. For 2012-13 data, the estimate is June 2012.									
(h) Remoteness Areas and State are based on ABS ASGS 2011. State for SEIFA data are derived from the SEIFA concordance: poa11_seifa_erp2012.									
(i) The Australian total rates include young people who could not be allocated to a State or Territory.									
– Nil or rounded to zero. .. Not applicable.									

Source: Department of Health (unpublished); ABS (unpublished) *Australian Demographic Statistics*, Cat. no. 3101.0; ABS (2014) *Australian Demographic Statistics*, Cat. no. 3101.0.

Table 12A.46 Proportion of young people (aged < 25 years) who had contact with MBS-subsidised primary mental health care services, by service type (per cent) (a), (b), (c), (d), (e), (f), (g)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (h)
2011-12									
GP and other services	4.2	4.7	4.0	3.2	4.4	3.9	3.6	1.6	4.1
Clinical psychologist services	1.0	1.1	0.9	1.2	1.9	1.2	1.3	0.2	1.1
Other allied health services	2.0	2.5	1.9	1.0	1.3	1.8	1.4	0.7	1.9
2012-13									
GP and other services	4.8	5.5	4.7	3.6	4.9	4.5	4.2	1.7	4.8
Clinical psychologist services	1.2	1.3	1.0	1.3	2.0	1.6	1.5	0.2	1.3
Other allied health services	2.2	2.8	2.2	1.1	1.5	1.9	1.7	0.6	2.2
2013-14									
GP and other services	5.3	5.9	5.3	4.0	5.4	5.1	4.7	1.9	5.2
Clinical psychologist services	1.4	1.5	1.2	1.4	2.3	2.0	1.7	0.2	1.5
Other allied health services	2.3	3.0	2.5	1.3	1.7	2.0	1.8	0.7	2.3

- (a) Data excludes psychiatrists. MBS items included for this indicator are as follows:
 – Clinical psychologist services: MBS items 80000, 80005, 80010, 80015, 80020
 – GP services: MBS items 170, 171, 172, 2574, 2575, 2577, 2578, 2700, 2701, 2702, 2704, 2705, 2707, 2708, 2710, 2712, 2713, 2715, 2717, 2719, 2721, 2723, 2725, 2727
 – Other allied health services: MBS items 10956, 10968, 80100, 80105, 80110, 80115, 80120, 80125, 80130, 80135, 80140, 80145, 80150, 80155, 80160, 80165, 80170, 81325, 81355, 82000, 82015.
- (b) Data are based on the date the claim was processed.
- (c) Age of the patient is based on age at last service during the reporting period. Note that in previous years, data supplied for this indicator calculated each patient's age at 30 June of each reference year.
- (d) A person is counted if any of the specified mental health item has been used in the reference period
- (e) A patient is allocated to a state/territory based on their location as at the last service in the reference period.
- (f) The allocation to the state or territory uses a concordance (ABS ASGS 2011 Postcode to Remoteness Area/State) and splits a person where the postcode covers more than one state/territory, therefore the totals may not equal the sum of the individual cells due to rounding.
- (g) The population data used in this table are the June estimate before the the relevant financial year. For 2012-13 data, the estimate is June 2012.
- (h) The Australian total rates include young people who could not be allocated to a State or Territory.

Source: Department of Health (unpublished); ABS (unpublished) *Australian Demographic Statistics*, Cat. no. 3101.0; ABS (2014) *Australian Demographic Statistics*, Cat. no. 3101.0.

Table 12A.47 Specialised public mental health services reviewed against National Standards for Mental Health Services, 30 June (a)

		<i>NSW (b)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Expenditure on services assessed at level 1										
2006	\$'000	641 641	574 931	380 642	129 288	153 479	32 236	36 950	22 820	1 971 986
2007	\$'000	556 183	586 248	410 814	95 750	190 360	33 997	46 838	25 537	1 945 727
2008	\$'000	770 511	635 893	526 682	134 530	104 592	42 635	48 458	28 062	2 291 362
2009	\$'000	880 733	681 385	586 763	187 961	100 433	50 559	54 558	30 202	2 572 592
2010	\$'000	851 044	714 515	611 262	178 483	270 545	16 252	54 835	32 326	2 729 262
2011	\$'000	921 406	762 949	699 580	212 630	276 680	45 469	57 536	35 230	3 011 479
2012	\$'000	900 151	525 579	759 987	299 748	124 058	–	62 122	39 291	2 710 936
2013	\$'000	1 053 960	667 682	766 324	432 525	127 752	8 272	64 666	–	3 121 181
Expenditure on services assessed at level 2										
2006	\$'000	–	–	602	12 993	2 013	11 126	–	–	26 734
2007	\$'000	18 413	–	236	168 105	1 409	3 363	–	–	191 526
2008	\$'000	33 962	190	1 770	170 831	1 594	–	–	–	208 347
2009	\$'000	44 946	70	1 234	171 349	1 175	6 171	–	–	224 946
2010	\$'000	217 392	4 117	1 671	174 807	–	–	–	–	397 987
2011	\$'000	236 712	86	–	–	–	49 232	–	–	286 030
2012	\$'000	60 110	272	1 330	53 701	157 099	–	–	–	272 511
2013	\$'000	2 766	103	–	10 096	81 609	–	–	41 329	135 903
Expenditure on services assessed at level 3										
2006	\$'000	94 363	18 628	14 377	147 659	42 422	14 212	–	–	331 661
2007	\$'000	220 311	13 383	51 891	45 173	31 781	8 970	–	–	371 509
2008	\$'000	63 334	148	16 771	38 271	135 413	18 753	–	–	272 689
2009	\$'000	71 549	21 630	1 772	16 283	164 555	21 880	–	–	297 669
2010	\$'000	486	23 010	52 296	38 423	2 116	74 572	–	–	190 903
2011	\$'000	490	16 128	3 692	124 290	10 518	–	–	–	155 119
2012	\$'000	174 141	15 709	–	84 463	–	88 003	–	–	362 317
2013	\$'000	162 070	61 161	1 492	54 206	78 580	5 165	–	–	362 672
Expenditure on services assessed at level 4										
2006	\$'000	46 246	1 073	4 326	–	1 418	2 328	–	–	55 391
2007	\$'000	61 105	1 107	3 694	–	2 180	24 165	–	–	92 252
2008	\$'000	37 887	4 911	462	2 220	3 507	16 235	–	–	65 223
2009	\$'000	3 107	4 143	655	6 304	2 220	2 653	–	–	19 082
2010	\$'000	12 602	8 940	815	7 927	6 611	–	–	–	36 895
2011	\$'000	12 122	15 616	1 971	98 024	1 124	–	–	–	128 858
2012	\$'000	101 544	287 982	926	38 667	16 194	–	–	–	445 313
2013	\$'000	56 800	123 350	940	7 041	15 526	76 378	–	572	280 608
Expenditure on specialised public mental health services										
2006	\$'000	782 250	594 633	399 947	289 939	199 332	59 901	36 950	22 820	2 385 771
2007	\$'000	856 012	600 739	466 636	309 027	225 730	70 494	46 838	25 537	2 601 014
2008	\$'000	905 693	641 143	545 686	345 852	245 106	77 623	48 458	28 062	2 837 621

TABLE 12A.47

Table 12A.47 **Specialised public mental health services reviewed against National Standards for Mental Health Services, 30 June (a)**

		<i>NSW (b)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2009	\$'000	1 000 336	707 227	590 424	381 897	268 383	81 263	54 558	30 202	3 114 289
2010	\$'000	1 081 524	750 582	666 043	399 640	279 273	90 824	54 835	32 326	3 355 046
2011	\$'000	1 170 730	794 780	705 243	434 944	288 323	94 701	57 536	35 230	3 581 486
2012	\$'000	1 235 946	829 543	762 243	476 579	297 351	88 003	62 122	39 291	3 791 078
2013	\$'000	1 275 596	852 296	768 756	503 868	303 467	89 815	64 666	41 901	3 900 364
Per cent of expenditure on services assessed at level 1										
2006	%	82.0	96.7	95.2	44.6	77.0	53.8	100.0	100.0	82.7
2007	%	65.0	97.6	88.0	31.0	84.3	48.2	100.0	100.0	74.8
2008	%	85.1	99.2	96.5	38.9	42.7	54.9	100.0	100.0	80.7
2009	%	88.0	96.3	99.4	49.2	37.4	62.2	100.0	100.0	82.6
2010	%	78.7	95.2	91.8	44.7	96.9	17.9	100.0	100.0	81.3
2011	%	78.7	96.0	99.2	48.9	96.0	48.0	100.0	100.0	84.1
2012	%	72.8	63.4	99.7	62.9	41.7	–	100.0	100.0	71.5
2013	%	82.6	78.3	99.7	85.8	42.1	9.2	100.0	–	80.0
Per cent of expenditure on services assessed at level 2										
2006	%	–	–	0.2	4.5	1.0	18.6	–	–	1.1
2007	%	2.2	–	0.1	54.4	0.6	4.8	–	–	7.4
2008	%	3.7	–	0.3	49.4	0.7	–	–	–	7.3
2009	%	4.5	–	0.2	44.9	0.4	7.6	–	–	7.2
2010	%	20.1	0.5	0.3	43.7	–	–	–	–	11.9
2011	%	20.2	–	–	–	–	52.0	–	–	8.0
2012	%	4.9	–	0.2	11.3	52.8	–	–	–	7.2
2013	%	0.2	–	–	2.0	26.9	–	–	98.6	3.5
Per cent of expenditure on services assessed at level 3										
2006	%	12.1	3.1	3.6	50.9	21.3	23.7	–	–	13.9
2007	%	25.7	2.2	11.1	14.6	14.1	12.7	–	–	14.3
2008	%	7.0	–	3.1	11.1	55.2	24.2	–	–	9.6
2009	%	7.2	3.1	0.3	4.3	61.3	26.9	–	–	9.6
2010	%	–	3.1	7.9	9.6	0.8	82.1	–	–	5.7
2011	%	–	2.0	0.5	28.6	3.6	–	–	–	4.3
2012	%	14.1	1.9	–	17.7	–	100.0	–	–	9.6
2013	%	12.7	7.2	0.2	10.8	25.9	5.8	–	–	9.3
Per cent of expenditure on services assessed at level 4										
2006	%	5.9	0.2	1.1	–	0.7	3.9	–	–	2.3
2007	%	7.1	0.2	0.8	–	1.0	34.3	–	–	3.5
2008	%	4.2	0.8	0.1	0.6	1.4	20.9	–	–	2.3
2009	%	0.3	0.6	0.1	1.7	0.8	3.3	–	–	0.6
2010	%	1.2	1.2	0.1	2.0	2.4	–	–	–	1.1
2011	%	1.0	2.0	0.3	22.5	0.4	–	–	–	3.6
2012	%	8.2	34.7	0.1	8.1	5.4	–	–	–	11.7
2013	%	4.5	14.5	0.1	1.4	5.1	85.0	–	1.4	7.2

Table 12A.47 **Specialised public mental health services reviewed against National Standards for Mental Health Services, 30 June (a)**

	<i>NSW (b)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(a)	There is variation across jurisdictions in the method used to assign an assessment level (1, 2, 3 or 4) to service units. In some jurisdictions, if an organisation with multiple service units is assessed at a particular level all the expenditure on the organisation's units is 'counted' at that assessment level. In other jurisdictions, assessment levels are assigned at the service unit and this may or may not be consistent with the other units within the organisation. The approach can also vary across organisations within a single jurisdiction.								
(b)	The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.								
	– Nil or rounded to zero.								

Source: AIHW (unpublished) derived from the MHE NMDS.

Table 12A.48 Recurrent expenditure on community-based services as a proportion of total spending on mental health services (per cent) (a), (b), (c)

	<i>NSW</i> (d)	<i>Vic</i>	<i>Qld</i> (e)	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2005-06	43.5	63.5	43.3	51.3	45.1	62.4	79.2	60.4	51.0
2006-07	43.7	63.3	48.1	52.0	45.6	59.3	73.3	65.7	51.5
2007-08	46.1	62.6	49.1	53.1	47.9	57.8	71.5	64.0	52.4
2008-09	44.5	62.6	51.8	53.6	49.9	57.7	74.2	62.6	52.7
2009-10	44.6	62.8	54.0	54.4	52.4	54.8	74.7	65.4	53.4
2010-11	44.3	63.2	55.5	53.4	56.5	56.5	73.2	64.3	53.9
2011-12	43.8	64.2	56.3	53.4	58.8	56.8	74.4	63.9	54.2
2012-13	41.6	64.1	55.3	52.9	61.5	58.8	73.3	61.6	53.4

(a) See AIHW *Mental Health Services in Australia* on-line publication (<http://mhsa.aihw.gov.au/resources/expenditure/data-source/>) for a full description of the derivation of expenditure estimates.

(b) Due to the ongoing validation of NMDS, data could differ from previous reports.

(c) Recurrent expenditure exclude indirect and aged care residential expenditure.

(d) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(e) Queensland does not fund community-based residential services, but funds extended treatment (campus-based and non-campus-based) services that provide longer term inpatient treatment and rehabilitation services with clinical staffing for 24 hours a day, 7 days a week

Source: AIHW (unpublished) derived from the MHE NMDS.

TABLE 12A.49

Table 12A.49 Specialised public mental health services episodes with completed consumer outcomes measures collected (a), (b)

<i>Unit</i>	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>	
2007-08									
Group A: People discharged from hospital (d)									
no.	5 989	3 740	4 419	2 564	2 657	324	40	92	19 825
%	29.7	28.0	42.0	43.0	50.4	19.7	4.6	16.1	34.0
Group B: People discharged from community care (e)									
no.	2 126	3 938	6 065	1 196	1 457	366	np	51	15 199
%	12.0	33.9	39.5	21.5	30.4	22.3	np	6.2	25.7
Group C: People in ongoing community care (f)									
no.	5 073	5 307	5 917	2 760	3 097	705	159	305	23 323
%	16.5	27.4	31.5	26.1	39.7	19.3	5.6	23.3	24.8
2008-09									
Group A: People discharged from hospital (d)									
no.	5 605	6 350	2 205	2 944	2 360	321	46	104	19 935
%	27.8	47.8	20.6	47.9	46.3	20.2	4.9	18.2	34.0
Group B: People discharged from community care (e)									
no.	1 985	6 804	3 577	1 162	1 420	305	np	25	15 278
%	10.3	62.3	19.3	18.8	27.2	21.2	np	3.3	23.7
Group C: People in ongoing community care (f)									
no.	5 108	6 472	5 759	3 558	3 340	712	175	383	25 507
%	16.1	34.0	34.0	30.9	37.7	21.3	5.6	25.0	27.1
2009-10									
Group A: People discharged from hospital (d)									
no.	6 146	7 845	1 736	2 945	2 490	316	67	146	21 691
%	30.2	55.7	16.2	44.4	46.9	np	7.6	26.3	36.1
Group B: People discharged from community care (e)									
no.	2 024	8 618	2 706	1 329	1 510	291	np	48	16 526
%	9.9	77.3	17.7	20.6	28.9	24.0	np	6.0	27.0
Group C: People in ongoing community care (f)									
no.	5 943	7 895	6 544	4 064	3 201	685	335	396	29 063
%	17.5	44.1	32.0	35.0	36.3	30.1	10.0	23.8	29.4
2010-11									
Group A: People discharged from hospital (d)									
no.	5 937	8 249	2 515	3 236	2 288	443	87	200	22 955
%	30.1	57.1	22.6	45.3	39.3	30.8	8.9	34.6	37.5
Group B: People discharged from community care (e)									
no.	2 309	10 243	3 537	1 351	1 473	583	np	50	19 546
%	11.0	80.4	21.7	18.4	25.2	39.2	np	6.6	28.6
Group C: People in ongoing community care (f)									
no.	6 020	8 165	7 146	4 453	3 150	703	466	354	30 457
%	18.1	45.7	35.1	36.3	36.3	31.8	13.8	20.3	30.8

Table 12A.49 Specialised public mental health services episodes with completed consumer outcomes measures collected (a), (b)

<i>Unit</i>	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>	
2011-12 (c)									
Group A: People discharged from hospital (d)									
no.	6 095	na	3 377	3 614	2 307	774	33	223	16 423
%	29.4	na	28.8	49.5	42.5	52.8	3.3	36.2	34.0
Group B: People discharged from community care (e)									
no.	2 501	na	3 227	1 332	1 438	294	np	48	8 840
%	12.7	na	18.1	16.7	22.6	17.7	np	5.1	15.9
Group C: People in ongoing community care (f)									
no.	7 498	na	7 133	3 651	3 200	541	276	402	22 701
%	21.1	na	34.1	29.1	34.8	23.3	7.8	19.7	26.5
2012-13 (c)									
Group A: People discharged from hospital (d)									
no.	7 088	na	4 664	3 623	2 149	1 010	66	225	18 825
%	32.3	na	36.5	45.7	42.3	54.8	6.0	33.7	36.7
Group B: People discharged from community care (e)									
no.	2 403	na	4 521	1 404	1 396	392	26	64	10 206
%	12.3	na	25.0	16.7	21.2	28.0	5.0	6.0	18.0
Group C: People in ongoing community care (f)									
no.	6 460	na	8 254	3 855	3 409	618	302	412	23 310
%	19.4	na	41.2	31.4	37.6	26.8	8.7	19.6	28.3

- (a) These data were prepared by the Australian Mental Health Outcomes and Classification Network, using data submitted by State and Territory governments to the Australian Government Department of Health. To be counted as an episode for which consumer outcome measures are collected, data need to be completed correctly (a specified minimum number of items completed) and have a 'matching pair' — that is, a beginning and end rating are needed to enable an outcome score to be determined.
- (b) Estimates of the number of episodes with complete outcome data for state and territory mental health services for all years are based on a revised analytic approach that compares the number of episodes with 'matched pairs' outcomes data to data submitted for the various mental health National Minimum Data Sets. This approach provides more robust estimates than published in previous years.
- (c) Data are not available for Victoria for 2011-12 and 2012-13. All totals for 2011-12 and 2012-13 exclude Victoria. Industrial action in Tasmania has limited the available data quality and quantity of the 2011-12 and 2012-13 data.
- (d) Group A covers people who received a discrete episode of inpatient care within a state/territory designated psychiatric inpatient unit during the reference year. The defining characteristic of the group is that the episode of inpatient care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission and discharge. The analysis excludes episodes where length of stay was three days or less because it is not meaningful to compare admission and discharge ratings for short duration episodes.

Table 12A.49 **Specialised public mental health services episodes with completed consumer outcomes measures collected (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
(e)	Group B covers people who received relatively short term community care from a state/territory mental health service during the reference year. The defining characteristic of the group is that the episode of community care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission to, and discharge from, community care. A subgroup of people whose episode of community care completed because they were admitted to hospital is not included in this analysis.								
(f)	Group C covers people receiving relatively long term community care from a state/territory mental health service. It includes people who were receiving care for the whole of the reference year, and those who commenced community care sometime after 1 July who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June). Outcome scores were calculated as the difference between the total score recorded on the first occasion rated and the last occasion rated in the year.								

na Not available. – Nil or rounded to zero. **np** Not published.

Source: Australian Mental Health Outcomes and Classification Network, authorised by Australian Government Department of Health.

Table 12A.50 Rate of seclusion in public specialised mental health acute inpatient units (per 1000 bed days) (a), (b)

	<i>NSW</i> (c)	<i>Vic</i> (d)	<i>Qld</i> (e)	<i>WA</i> (f)	<i>SA</i> (g), (h)	<i>Tas</i> (i)	<i>ACT</i> (j), (k), (l)	<i>NT</i> (e), (m), (n)	<i>Aust</i>
2008-09	11.0	18.8	18.2	15.3	na	15.4	13.3	na	15.5
2009-10	11.5	19.4	15.0	11.6	7.6	11.5	1.7	23.0	13.5
2010-11	9.4	15.1	17.2	8.3	7.7	14.7	0.7	19.9	11.8
2011-12	9.2	13.3	13.3	4.7	10.1	11.9	1.3	25.9	10.4
2012-13	8.5	10.9	12.7	6.0	9.1	19.7	0.9	16.4	9.6
2013-14	7.4	9.2	11.1	5.0	4.5	15.2	1.1	21.6	8.0

- (a) Data are from a number of ad hoc seclusion data collections for specialised mental health public acute hospital services conducted by the Safety and Quality Partnership Standing Committee (SQPSC), of the Mental Health, Drug and Alcohol Principal Committee (MHDAPC), in partnership with the relevant state and territory authorities for presentation at benchmarking forums. State and Territory governments have agreed to the report these data because of their importance to the consumers, carers, policy makers, stakeholders and the general public (AIHW 2013).
- (b) Variation in jurisdictional legislation may result in differences in the definition of a seclusion event. Data reported by jurisdictions may therefore vary and comparisons should therefore be made with caution.
- (c) NSW does not have a centralised database for the collection of seclusion data. Services report seclusion rates regularly to the NSW Ministry of Health. Services are required to maintain local seclusion registers, which may be audited by NSW Official Visitors. Seclusion rates are a Key Performance Indicator (KPI) in regular performance reporting to NSW Local Health Districts.
- (d) For Victoria, both the National Beacon Projects and the Creating Safety Project supported Victorian services to review their use of seclusion and employ different strategies to support reduction, with targets set in the Statement of Priorities to support health services reduce seclusion events. Victoria has fewer beds per capita than other jurisdictions, and as such, it may be useful to view the rate of seclusion events in a broader population context (rates per capita).
- (e) Queensland and the NT do not report any acute forensic services, however forensic patients can and do access acute care through general units
- (f) For WA, it does not have a centralised data base for the collection of seclusion data. Services provided seclusion data from their own data bases.
- (g) For SA, data reporting improvements over the past few years will affect SA data. Importantly, the number of bed days is an estimate which affects the rate of seclusion reported for South Australia and fluctuations in bed numbers related to new infrastructure projects. During 2010-11, a substantial number of seclusion events in one particular hospital were for a single patient and over half of those were patient-requested events. This may have affected the overall seclusion rate reported for the state for 2010-11.
- (h) For 2008-09, SA was unable to supply seclusion data.
- (i) The increase in the state-wide Tasmanian seclusion rate for 2012–13 and 2013–14 data is due to a small number of clients having an above average number of seclusion events.
- (j) For the ACT, when interpreting these data, the relative small size of the ACT should be noted, with a total of between 60 and 65 acute inpatient beds reported between 2008-09 and 2011-12.

Table 12A.50 Rate of seclusion in public specialised mental health acute inpatient units (per 1000 bed days) (a), (b)

	<i>NSW</i> (c)	<i>Vic</i> (d)	<i>Qld</i> (e)	<i>WA</i> (f)	<i>SA</i> (g), (h)	<i>Tas</i> (i)	<i>ACT</i> (j), (k), (l)	<i>NT</i> (e), (m), (n)	<i>Aust</i>
(k)									ACT activities initiated as part of the Beacon Site project included the implementation of a clinical review committee inclusive of clinical staff, consumers and carer representation to review episodes of seclusion for systemic issues on a case-by-case basis. This has led to a number of reforms over several years that have had a direct impact on the use of seclusion and its reduction to the low levels now reported.
(l)									In the ACT, work is progressive and ongoing as part of a larger process of providing a place of improved safety and security, both for people experiencing an acute episode of mental ill health leading to an inpatient admission, visitors and for the staff who work in this challenging environment.
(m)									Due to the low ratio of beds per person in the NT compared with other jurisdictions, the apparent rate of seclusion is inflated when reporting seclusion per patient day compared with reporting on a population basis. Due to the low number of beds in the NT, high rates of seclusion for a few individuals has a disproportional effect on the rate of seclusion reported.
(n)									The NT, was unable to supply seclusion data for 2008-09.
									na Not available.

Source: AIHW (2014) *Mental Health Services in Australia* Online, mhsa.aihw.gov.au/home/ (accessed 17 December 2014).

Table 12A.51 Rate of seclusion in public specialised mental health acute inpatient units (per 1000 patient days), by target population (a)

	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
General	17.1	15.4	13.1	11.6	10.3	9.5
Child and adolescent	17.0	11.4	16.6	18.1	14.5	9.6
Older person	3.7	2.9	1.2	0.7	0.7	0.5
Mixed	15.1	13.3	12.3	10.3	10.0	..
Forensic (b)	10.8	6.9	5.2	6.8	8.9	5.3
Total	15.5	13.5	11.8	10.4	9.6	8.0

(a) See table 12A.50 for general caveats regarding seclusion data.

(b) Excludes some public sector acute forensic mental health hospital services operated in correctional facilities.

.. Not applicable.

Source: AIHW (2014) *Mental Health Services in Australia Online*, mhsa.aihw.gov.au/home/ (accessed 17 December 2014).

TABLE 12A.52

Table 12A.52 **Consumer and carer participation (a), (b), (c), (d)**

	NSW (e), (f)	Vic	Qld	WA (g)	SA	Tas	ACT (h)	NT (h)	Aust
<i>Number of consumer and carer consultants</i>									
Number of paid consumer workers (FTE)									
2005-06	27.3	19.6	9.8	0.5	2.8	–	1.3	–	61.3
2006-07	24.8	19.0	10.3	0.8	2.1	–	–	–	57.0
2007-08	27.9	20.0	9.7	1.2	4.7	–	–	–	63.5
2008-09	23.5	17.1	13.6	3.6	6.3	0.5	–	–	64.6
2009-10	21.5	17.7	14.1	5.1	5.7	0.5	–	–	64.6
2010-11	20.5	17.9	17.8	3.3	8.4	0.5	–	–	68.5
2011-12	23.9	19.1	19.5	2.0	8.2	1.5	–	–	74.2
2012-13	18.6	19.4	14.3	4.2	12.5	–	–	0.2	69.1
Number of paid carer workers (FTE)									
2005-06	2.7	11.7	0.4	–	–	–	–	–	14.8
2006-07	8.6	13.6	0.9	–	–	–	–	–	23.1
2007-08	7.0	15.5	1.5	0.8	1.8	–	–	–	26.6
2008-09	10.3	14.3	2.7	0.5	2.4	0.5	–	–	30.6
2009-10	13.7	15.8	4.8	1.0	1.5	0.5	–	–	37.3
2010-11	13.7	17.9	5.3	1.0	5.0	0.5	–	–	43.4
2011-12	15.9	18.5	6.4	0.2	4.2	0.6	–	–	45.8
2012-13	10.2	18.6	3.0	0.2	3.6	1.0	–	–	36.6
Number of paid direct care, consumer and carer worker positions (FTE)									
2005-06	6 494.5	5 270.0	3 633.8	2 332.3	1 691.3	607.7	331.3	151.9	20 512.8
2006-07	6 732.0	5 338.0	3 875.8	2 427.1	1 800.9	656.2	321.8	158.5	21 310.3
2007-08	6 777.3	5 440.8	4 233.4	2 537.7	1 963.3	639.7	314.7	167.5	22 074.4
2008-09	7 025.6	5 634.4	4 405.7	2 670.5	1 977.3	652.6	313.8	193.3	22 873.2
2009-10	7 357.2	5 703.9	4 361.7	2 724.8	2 025.3	682.5	334.5	196.3	23 386.1
2010-11	7 637.3	5 912.7	4 694.2	2 856.0	2 121.6	687.3	338.4	205.3	24 452.7

TABLE 12A.52

Table 12A.52 **Consumer and carer participation (a), (b), (c), (d)**

	NSW (e), (f)	Vic	Qld	WA (g)	SA	Tas	ACT (h)	NT (h)	Aust
2011-12	7 893.9	6 049.5	4 991.9	3 017.4	2 045.6	646.8	345.1	216.1	25 206.1
2012-13	8 035.6	6 075.3	5 086.1	3 146.3	1 994.0	628.9	375.5	249.4	25 591.0
Paid consumer workers (FTE) per 1000 paid direct care, consumer and carer staff (FTE) (h)									
2005-06	4.2	3.7	2.7	0.2	1.7	–	3.9	–	3.0
2006-07	3.7	3.6	2.7	0.3	1.2	–	–	–	2.7
2007-08	4.1	3.7	2.3	0.5	2.4	–	–	–	2.9
2008-09	3.3	3.0	3.1	1.4	3.2	0.8	–	–	2.8
2009-10	2.9	3.1	3.2	1.9	2.8	0.7	–	–	2.8
2010-11	2.7	3.0	3.8	1.2	4.0	0.7	–	–	2.8
2011-12	3.0	3.2	3.9	0.7	4.0	2.3	–	–	2.9
2012-13	2.3	3.2	2.8	1.3	6.3	–	–	0.7	2.7
Paid carer workers (FTE) per 1000 paid direct care, consumer and carer staff (FTE) (h)									
2005-06	0.4	2.2	0.1	–	–	–	–	–	0.7
2006-07	1.3	2.5	0.2	–	–	–	–	–	1.1
2007-08	1.0	2.9	0.4	0.3	0.9	–	–	–	1.2
2008-09	1.5	2.5	0.6	0.2	1.2	0.8	–	–	1.3
2009-10	1.9	2.8	1.1	0.4	0.8	0.7	–	–	1.6
2010-11	1.8	3.0	1.1	0.4	2.4	0.7	–	–	1.8
2011-12	2.0	3.1	1.3	0.1	2.1	0.9	–	–	1.8
2012-13	1.3	3.1	0.6	0.1	1.8	1.6	–	–	1.4

(a) Non-government organisations are included only where they provide staffed residential services.

(b) See AIHW *Mental Health Services in Australia* on-line publication (<http://mhsa.aihw.gov.au/resources/expenditure/data-source/>) for a full description of the derivation of relevant items.

(c) Due to the ongoing validation of NMDS, data could differ from previous reports.

Table 12A.52 **Consumer and carer participation (a), (b), (c), (d)**

	<i>NSW</i> (e), (f)	<i>Vic</i>	<i>Qld</i>	<i>WA</i> (g)	<i>SA</i>	<i>Tas</i>	<i>ACT</i> (h)	<i>NT</i> (h)	<i>Aust</i>
(d)	Data up to 2009-10 were restricted to consumer/carer consultants. In 2010-11, the definitions were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. These improved definitions should promote greater consistency between jurisdictions. Comparisons between data up to 2009-10 with data from 2010-11 should not be made.								
(e)	NSW advised that the government has no authority to require consumer participation in services delivered through the primary care program.								
(f)	The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.								
(g)	WA has advised that this information does not represent the full range of consumer and carer participation. Genuine engagement with consumers and carers is one of the key principles of the Mental Health Commission's Strategic Policy document Mental Health 2020. The Commission has allocated funding to establish and support Consumers of Mental Health WA Inc., a peak body that provides systemic advocacy and is run for and by consumers. Other examples include provision of funding to develop the capacity of non-government organisations to employ people with a lived experience of mental illness and awarding scholarships to people with a lived experience to complete approved university and polytechnic studies in mental health. Several key consumer and carer advisory groups are supported and provided with financial assistance and collectively, these groups provide advice and representations on consumer and carer issues. The Commission funds Carers Association of WA for the provision of systemic advocacy services and the Mental Health Carers ARAFMI (WA) for a range of services including individual advocacy.								
(h)	Consumer and carer workers are not employed in the ACT (except in 2005-06). The NT do not employ carer staff and employed consumer staff in 2012-13 only.								
	– Nil or rounded to zero.								

Source: AIHW (unpublished) derived from the MHE NMDS.

TABLE 12A.53

Table 12A.53 Rates of community follow-up for people within the first seven days of discharge from hospital

	<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (b)</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
2005-06										
Overnight separations from acute psychiatric inpatient services	no.	24 891	14 957	14 326	6 222	5 352	na	1 136	1 004	67 888
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	10 695	8 938	6 488	2 703	1 611	na	769	188	31 392
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	43.0	59.8	45.3	43.4	30.1	na	67.7	18.7	46.2
2006-07										
Overnight separations from acute psychiatric inpatient services	no.	26 656	15 602	13 534	5 994	5 430	na	1 100	888	69 204
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	11 539	9 303	6 833	2 756	1 532	na	759	342	33 064
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	43.3	59.6	50.5	46.0	28.2	na	69.0	38.5	47.8
2007-08										
Overnight separations from acute psychiatric inpatient services	no.	27 103	16 400	13 600	5 863	5 590	2 116	1 148	854	72 674
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	10 856	9 803	7 094	2 778	1 941	433	827	348	34 080

TABLE 12A.53

Table 12A.53 Rates of community follow-up for people within the first seven days of discharge from hospital

	<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (b)</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	40.1	59.8	52.2	47.4	34.7	20.5	72.0	40.7	46.9
2008-09										
Overnight separations from acute psychiatric inpatient services	no.	27 035	16 429	14 147	6 272	5 435	2 121	1 233	780	73 452
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	11 078	10 132	6 228	3 070	2 222	461	901	323	34 415
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	41.0	61.7	44.0	48.9	40.9	21.7	73.1	41.4	46.9
2009-10										
Overnight separations from acute psychiatric inpatient services	no.	26 403	16 552	14 061	6 439	5 509	1 758	1 184	742	72 648
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	11 864	10 591	6 417	3 227	2 301	456	873	289	36 018
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	44.9	64.0	45.6	50.1	41.8	25.9	73.7	38.9	49.6
2010-11										
Overnight separations from acute psychiatric inpatient services	no.	26 932	17 156	14 634	7 524	5 825	1 730	1 185	771	75 757

TABLE 12A.53

Table 12A.53 Rates of community follow-up for people within the first seven days of discharge from hospital

	<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (b)</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	12 811	11 730	7 696	3 683	2 662	505	932	308	40 327
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	47.6	68.4	52.6	49.0	45.7	29.2	78.6	39.9	53.2
2011-12										
Overnight separations from acute psychiatric inpatient services	no.	27 407	na	15 324	7 840	5 987	1 655	1 306	781	60 300
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	14 348	na	9 872	4 032	3 064	531	1 015	313	33 175
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	52.4	na	64.4	51.4	51.2	32.1	77.7	40.1	55.0
2012-13										
Overnight separations from acute psychiatric inpatient services	no.	28 297	na	16 093	8 697	5 436	1 667	1 307	889	62 386
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	16 828	na	11 722	4 639	2 935	347	966	414	37 851
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	59.5	na	72.8	53.3	54.0	20.8	73.9	46.6	60.7

(a) For public sector community mental health services, Victorian data are unavailable for 2011-12 and 2012-13 due to service level collection gaps resulting from protected industrial action during this period.

Table 12A.53 **Rates of community follow-up for people within the first seven days of discharge from hospital**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (b)</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
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- (b) SA submitted data that was not based on unique patient identifier or data matching approaches.
- (c) Industrial action in Tasmania limited the available data quality and quantity of 2011-12 and 2012-13 community data. Tasmanian data are not available for 2005-06 and 2006-07. Data submitted up to 2012-13 were not based on unique patient identifiers or data matching approaches.
- (d) Due to data supply issues, Australian totals for 2005-06, 2006-07, 2011-12 and 2012-13 should be interpreted with caution.
- na** Not available.

Source: AIHW (unpublished) from data provided by State and Territory health authorities from admitted patient and community mental health care data.

TABLE 12A.54

Table 12A.54 **Rate of community follow up within first seven days of discharge from a psychiatric admission, by State and Territory, by Indigenous status and remoteness (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (d)</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (f)</i>
<i>2011-12</i>										
Indigenous status										
Aboriginal and Torres Strait Islander	%	45.2	na	61.0	40.5	45.4	na	87.9	32.5	48.0
Non-Indigenous	%	53.0	na	65.0	52.5	52.6	na	78.2	47.9	56.0
Remoteness										
Major cities	%	52.5	na	62.8	53.2	53.5	na	79.5	50.0	55.9
Inner regional	%	54.6	na	69.7	50.7	41.3	na	51.9	25.0	58.4
Outer regional	%	52.8	na	67.1	44.3	41.4	na	100.0	48.9	56.6
Remote	%	39.5	na	65.7	48.2	31.0	na	..	43.1	46.2
Very remote	%	36.4	na	62.2	30.4	34.5	na	..	25.8	33.8
<i>2012-13</i>										
Indigenous status										
Aboriginal and Torres Strait Islander	%	53.9	na	72.1	46.9	39.4	15.1	68.3	40.2	55.2
Non-Indigenous	%	60.0	na	73.1	54.0	55.9	21.3	74.5	53.1	61.4
Remoteness										
Major cities	%	59.4	na	71.2	54.8	56.8	–	75.6	16.7	61.6
Inner regional	%	62.7	na	77.8	52.0	40.2	10.1	32.6	33.3	60.9
Outer regional	%	59.8	na	76.4	47.1	38.6	3.7	19.3	53.8	60.6
Remote	%	38.7	na	65.2	56.9	47.4	3.7	–	54.8	52.8
Very remote	%	60.9	na	72.2	39.2	39.2	22.2	–	33.1	41.4

(a) The Indigenous status rates should be interpreted with caution due to the varying and, in some instances, unknown quality of Indigenous identification across jurisdictions. Excludes people for whom demographic information was missing or not reported.

Table 12A.54 **Rate of community follow up within first seven days of discharge from a psychiatric admission, by State and Territory, by Indigenous status and remoteness (a), (b)**

<i>Unit</i>	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (d)</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (f)</i>
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(b) Disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider. State/territory is the state/territory of the service provider. Excludes people for whom demographic information was missing or not reported.

(c) For public sector community mental health services, Victorian data are unavailable due to service level collection gaps resulting from protected industrial action during this period.

(d) SA submitted data that was not based on unique patient identifier or data matching approaches.

(e) Industrial action in Tasmania limited the available data quality and quantity of 2011-12 and 2012-13 community data.

(f) Due to data supply issues, Australian totals should be interpreted with caution.

na Not available. – Nil or rounded to zero. .. Not applicable.

Source: AIHW (unpublished) from data provided by State and Territory health authorities from admitted patient and community mental health care data.

TABLE 12A.55

Table 12A.55 **Rate of community follow up within first seven days of discharge from a psychiatric admission, by age group, gender and SEIFA quintiles, 2012-13**

	<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (b)</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
<i>Age group</i>										
Less than 15 years	%	55.4	na	56.1	59.3	35.3	–	–	50.0	54.9
15–24 years	%	57.7	na	69.9	54.7	51.9	15.8	87.6	41.8	59.7
25–34 years	%	60.3	na	71.8	52.0	55.2	18.4	77.3	48.4	60.8
35–44 years	%	60.8	na	73.7	51.3	51.4	19.0	72.7	47.4	60.9
45–54 years	%	60.6	na	76.0	52.6	58.3	23.8	73.9	49.5	62.0
55–64 years	%	59.3	na	78.9	57.5	54.4	20.1	61.3	50.0	62.3
65+ years	%	55.3	na	78.7	54.7	55.8	36.7	53.2	50.0	59.5
<i>Gender</i>										
Male	%	57.8	na	71.9	50.5	54.6	17.4	75.6	46.8	59.3
Female	%	61.3	na	73.9	56.1	53.4	24.7	72.3	46.2	62.1
<i>SEIFA quintiles</i>										
Quintile 1 (most disadvantaged)	%	62.9	na	74.1	57.3	50.0	19.2	31.6	33.9	61.1
Quintile 2	%	59.0	na	75.3	53.9	52.4	26.5	64.2	61.5	60.6
Quintile 3	%	58.2	na	72.5	52.4	54.3	40.3	58.1	58.7	60.9
Quintile 4	%	62.0	na	72.0	53.8	60.4	7.0	76.8	49.7	62.5
Quintile 5 (least disadvantaged)	%	57.2	na	71.3	52.5	60.2	5.9	76.1	61.7	60.6

(a) For public sector community mental health services, Victorian data are unavailable due to service level collection gaps resulting from protected industrial action during this period.

(b) SA submitted data that was not based on unique patient identifier or data matching approaches.

(c) Industrial action during the collection period in Tasmania has limited the available data quality and quantity of community data.

(d) Due to data supply issues, Australian totals should be interpreted with caution.

na Not available. – Nil or rounded to zero.

Table 12A.55 **Rate of community follow up within first seven days of discharge from a psychiatric admission, by age group, gender and SEIFA quintiles, 2012-13**

<i>Unit</i>	<i>NSW</i>	<i>Vic (a)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (b)</i>	<i>Tas (c)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
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Source: AIHW (unpublished) from data provided by State and Territory health authorities from admitted patient and community mental health care data.

TABLE 12A.56

Table 12A.56 **Readmissions to hospital within 28 days of discharge (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (e)</i>	<i>WA</i>	<i>SA (b)</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2005-06										
Overnight separations from psychiatric acute inpatient services	no.	25 087	14 957	14 211	6 644	5 352	2 617	1 136	1 004	71 008
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 057	2 098	2 696	905	629	334	152	140	11 011
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	16.2	14.0	19.0	13.6	11.8	12.8	13.4	13.9	15.5
2006-07										
Overnight separations from psychiatric acute inpatient services	no.	26 767	15 602	13 432	6 476	5 430	1 901	1 100	888	71 596
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 526	2 309	2 110	795	491	126	123	123	10 603
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	16.9	14.8	15.7	12.3	9.0	6.6	11.2	13.9	14.8
2007-08										
Overnight separations from psychiatric acute inpatient services	no.	27 202	16 400	13 296	6 447	5 590	2 046	1 148	848	72 977

TABLE 12A.56

Table 12A.56 Readmissions to hospital within 28 days of discharge (a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (e)</i>	<i>WA</i>	<i>SA (b)</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 716	2 484	2 059	828	616	167	114	111	11 095
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	17.3	15.1	15.5	12.8	11.0	8.2	9.9	13.1	15.2
2008-09										
Overnight separations from psychiatric acute inpatient services	no.	27 101	16 429	13 827	6 890	5 431	1 823	1 233	780	73 514
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 344	2 317	2 124	926	507	113	68	86	10 485
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	16.0	14.1	15.4	13.4	9.3	6.2	5.5	11.0	14.3
2009-10										
Overnight separations from psychiatric acute inpatient services	no.	26 447	16 552	13 928	7 329	5 503	1 758	1 184	742	73 443
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 094	2 300	2 106	982	455	196	51	75	10 259

TABLE 12A.56

Table 12A.56 **Readmissions to hospital within 28 days of discharge (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (e)</i>	<i>WA</i>	<i>SA (b)</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	15.5	13.9	15.1	13.4	8.3	11.1	4.3	10.1	14.0
2010-11										
Overnight separations from psychiatric acute inpatient services	no.	27 083	17 156	14 457	8 446	5 825	1 730	1 185	771	76 653
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 274	2 427	2 207	1 177	523	242	63	105	11 018
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	15.8	14.1	15.3	13.9	9.0	14.0	5.3	13.6	14.4
2011-12										
Overnight separations from psychiatric acute inpatient services	no.	27 463	17 910	15 192	8 767	5 987	1 655	1 306	781	79 061
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 298	2 554	2 294	1 203	551	191	165	88	11 344
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	15.7	14.3	15.1	13.7	9.2	11.5	12.6	11.3	14.3

TABLE 12A.56

Table 12A.56 **Readmissions to hospital within 28 days of discharge (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (e)</i>	<i>WA</i>	<i>SA (b)</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2012-13										
Overnight separations from psychiatric acute inpatient services	no.	28 157	18 912	15 916	9 640	5 437	1 667	1 307	889	81 925
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 141	2 771	2 275	1 295	420	212	188	95	11 397
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	14.7	14.7	14.3	13.4	7.7	12.7	14.4	10.7	13.9

- (a) Data are based on all 'in scope' separations from State and Territory psychiatric inpatient units, defined as those for which it is meaningful to examine readmission rates. The following separations were excluded: same day separations; overnight separations that occur through discharge/transfer to another hospital; statistical discharge — type change; left against medical advice/discharge at own risk and death.
- (b) For the purposes of this indicator, a readmission for any of the separations identified as 'in-scope' is defined as an admission to any other public psychiatric acute unit within the jurisdiction that occurs within 28 days of the date of the original separation. For this to occur a system of unique client identifiers needs to be in place that allows individuals to be 'tracked' across units. Such systems have been available in all states/territories for the full period (2005-06 to 2012-13), with the exception of Tasmania (which introduced such a system in 2012-13) and SA (which has not yet introduced such a system). Undercounting of readmissions may have occurred in SA and Tasmania in the years that the system of unique identifiers is not in place. For SA therefore only readmissions to same hospital are identified, in all years' data, rather than readmissions to any hospital.
- (c) No distinction is made between planned and unplanned readmissions because data collection systems in most Australian mental health services do not include a reliable and consistent method to distinguish a planned from an unplanned admission to hospital.
- (d) For data before 2012-13, states and territories differed in the overnight separations that they count as 'in scope'. NSW and Queensland excluded separations where length of stay is one night only and the procedure code for ECT is recorded and the ACT excluded all overnight separations with the procedure code for ECT, whereas the others (Victoria, WA, SA, Tasmania and the NT) include all overnight separations for the procedure code for ECT. For 2012-13, the exclusion of overnight stays of one night with an ECT procedure code became a business rule for the calculation of data for this indicator. The change was considered likely to be minimal, therefore, historical data updates were not considered mandatory. The change is also unlikely to alter the interpretability of long term data trends.
- (e) For Qld, inpatient identifiers are unique at a hospital level. A routine linkage program is utilised to create a unique identifier for reporting purposes.

Table 12A.56 **Readmissions to hospital within 28 days of discharge (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (e)</i>	<i>WA</i>	<i>SA (b)</i>	<i>Tas (b)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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Source: AIHW (unpublished) from data provided by State and Territory health authorities.

TABLE 12A.57

Table 12A.57 Readmissions to hospital within 28 days of discharge, by selected characteristics, 2012-13 (a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (e)</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Age group</i>										
Less than 15 years	%	15.7	19.9	8.8	8.1	14.7	na	na	–	13.8
15–24 years	%	14.0	19.8	16.5	14.6	11.7	14.9	18.6	12.2	15.9
25–34 years	%	16.6	15.9	15.2	14.0	7.0	14.5	15.5	10.2	15.1
35–44 years	%	15.6	13.9	13.9	14.7	7.3	12.3	14.1	11.9	14.2
45–54 years	%	14.0	11.9	13.6	14.2	6.4	14.4	11.1	9.5	12.9
55–64 years	%	11.8	11.2	14.0	10.8	6.3	5.7	13.2	–	11.3
65–74 years	%	13.1	9.6	9.5	9.8	5.6	10.2	8.8	8.3	10.2
75 years or over	%	9.1	5.0	8.7	5.9	6.1	–	12.5	na	6.9
<i>Gender</i>										
Male	%	13.9	13.2	14.1	12.6	7.0	12.3	13.8	11.2	13.1
Female	%	15.6	16.1	14.5	14.2	8.5	13.1	14.9	10.0	14.7
<i>SEIFA quintiles (d)</i>										
Quintile 1 (most disadvantaged)	%	13.6	16.0	14.3	14.0	7.0	13.1	–	11.2	13.7
Quintile 2	%	15.1	13.1	12.8	14.5	6.1	21.4	15.1	12.5	13.4
Quintile 3	%	14.9	14.7	13.6	13.0	10.0	6.6	20.3	9.8	13.9
Quintile 4	%	15.3	14.4	15.0	14.2	10.8	10.4	15.2	10.5	14.4
Quintile 5 (least disadvantaged)	%	15.7	15.1	15.6	10.9	6.3	–	13.9	8.6	14.4
<i>Indigenous status</i>										
Aboriginal and Torres Strait Islander	%	18.1	17.7	15.6	14.4	6.6	10.8	12.7	14.3	16.0
Non-Indigenous	%	14.4	14.7	14.3	13.3	8.2	12.9	14.8	7.0	13.9
<i>Remoteness (d)</i>										
Major cities	%	14.9	15.4	14.9	13.5	8.3	10.0	14.9	8.3	14.3
Inner regional	%	14.6	13.1	13.2	12.6	6.1	11.8	–	–	13.4

TABLE 12A.57

Table 12A.57 Readmissions to hospital within 28 days of discharge, by selected characteristics, 2012-13 (a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (e)</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Outer regional	%	12.6	11.1	12.6	13.8	4.1	15.5	10.0	9.9	12.1
Remote	%	19.4	11.5	6.7	11.9	5.5	11.1	na	10.6	11.4
Very remote	%	17.4	–	8.9	7.5	15.4	11.1	na	12.3	11.0

- (a) Data are based on all 'in scope' separations from State and Territory psychiatric inpatient units, defined as those for which it is meaningful to examine readmission rates. The following separations were excluded: same day separations; overnight separations that occur through discharge/transfer to another hospital; statistical discharge — type change; left against medical advice/discharge at own risk and death.
- (b) For the purposes of this indicator, a readmission for any of the separations identified as 'in-scope' is defined as an admission to any other public psychiatric acute unit within the jurisdiction that occurs within 28 days of the date of the original separation. For this to occur a system of unique client identifiers needs to be in place that allows individuals to be 'tracked' across units. Such systems have been available in all states/territories for the full period (2005-06 to 2012-13), with the exception of Tasmania (which introduced such a system in 2012-13) and SA (which has not yet introduced such a system). Undercounting of readmissions may have occurred in SA and Tasmania in the years that the system of unique identifiers is not in place.
- (c) No distinction is made between planned and unplanned readmissions because data collection systems in most Australian mental health services do not include a reliable and consistent method to distinguish a planned from an unplanned admission to hospital.
- (d) Remoteness and socioeconomic status have been allocated using the client's usual residence, not the location of the service provider. State/territory is reported for the state/territory of the service provider.
- (e) For Qld, inpatient identifiers are unique at a hospital level. A routine linkage program is utilised to create a unique identifier for reporting purposes.
- na Not available. – Nil or rounded to zero.

Source: AIHW (unpublished) from data provided by State and Territory health authorities.

TABLE 12A.58

Table 12A.58 **Average recurrent costs per inpatient bed day, public hospitals, by target population (2012-13 dollars) (a), (b), (c), (d), (e)**

	<i>NSW (f)</i>	<i>Vic</i>	<i>Qld (g), (h)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT (i), (j)</i>	<i>NT (i)</i>	<i>Aust</i>
General mental health services									
2005-06	776.70	669.20	671.12	930.28	746.68	717.32	728.00	1 113.93	749.21
2006-07	785.25	686.53	686.00	943.66	849.97	890.56	955.69	1 013.91	774.69
2007-08	774.28	738.01	762.92	997.92	880.89	918.30	994.07	1 211.97	806.31
2008-09	812.22	775.56	756.13	1 041.14	968.44	867.92	891.20	1 238.99	835.04
2009-10	816.33	789.31	799.28	1 032.60	957.42	1 065.37	882.53	1 266.25	849.77
2010-11	863.51	802.34	798.42	1 140.29	915.81	1 039.85	925.80	1 309.70	879.37
2011-12	913.14	815.38	831.36	1 141.47	922.18	895.59	944.44	1 567.55	908.86
2012-13	930.17	812.55	818.20	1 201.83	872.55	907.18	868.26	1 376.80	914.22
Child and adolescent mental health services									
2005-06	1 411.66	1 432.23	1 418.77	1 286.49	1 236.69	..	..	..	1 399.77
2006-07	1 440.11	1 434.74	1 518.45	1 572.71	1 564.15	..	..	..	1 476.18
2007-08	1 448.52	1 446.71	1 601.04	1 183.36	2 092.55	..	..	..	1 471.69
2008-09	1 423.25	1 581.44	1 691.78	1 589.06	1 880.79	..	..	..	1 548.35
2009-10	1 663.32	1 545.25	1 625.15	1 580.93	2 032.37	..	..	..	1 629.14
2010-11	1 950.70	1 542.20	1 624.36	2 052.03	1 822.52	..	..	..	1 771.36
2011-12	1 773.65	1 449.80	1 641.58	2 214.30	1 825.17	..	..	..	1 707.61
2012-13	1 540.26	1 359.14	1 313.48	2 055.41	2 099.93	..	..	..	1 490.58
Older people's mental health services									
2005-06	635.75	580.33	507.38	797.91	550.26	..	..	..	605.71
2006-07	656.20	609.57	554.90	784.78	583.66	..	2 650.93	..	634.98
2007-08	646.38	652.08	593.95	788.46	630.56	..	1 003.93	..	656.15
2008-09	697.29	659.65	598.22	847.26	714.94	..	1 047.41	..	697.85
2009-10	704.41	668.16	610.69	819.44	727.89	..	641.51	..	698.20
2010-11	769.65	696.46	623.96	839.41	678.74	..	641.19	..	723.44

TABLE 12A.58

Table 12A.58 **Average recurrent costs per inpatient bed day, public hospitals, by target population (2012-13 dollars) (a), (b), (c), (d), (e)**

	NSW (f)	Vic	Qld (g), (h)	WA	SA	Tas (i)	ACT (i), (j)	NT (i)	Aust
2011-12	788.92	696.55	632.69	938.46	696.85	..	626.35	..	747.03
2012-13	860.27	717.44	600.17	987.31	733.56	..	748.93	..	782.44
Forensic mental health services									
2005-06	596.35	853.03	886.19	1 187.50	945.47	532.87	..	1 041.45	802.71
2006-07	532.80	863.25	909.67	1 060.86	1 055.99	1 065.24	..	715.96	797.14
2007-08	542.34	872.65	1 029.92	1 017.90	1 086.46	1 536.63	..	..	842.14
2008-09	800.53	774.40	1 009.86	1 212.30	1 021.64	1 567.63	..	..	909.23
2009-10	864.60	905.11	1 063.03	1 126.11	1 020.73	1 996.41	..	..	963.84
2010-11	955.13	860.54	1 162.15	1 030.89	998.44	2 338.31	..	..	996.32
2011-12	893.19	813.13	1 292.29	1 198.09	997.72	1 441.31	..	..	963.32
2012-13	981.92	800.75	1 284.69	1 168.55	871.45	2 382.33	..	..	1 006.51

- (a) Constant price expenditure expressed in 2012-13 prices, using the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 12A.96).
- (b) Depreciation is excluded for all years.
- (c) See AIHW *Mental Health Services in Australia* on-line publication (<http://mhsa.aihw.gov.au/resources/expenditure/data-source/>) for a full description of the derivation of expenditure items.
- (d) Due to the ongoing validation of NMDS, data could differ from previous reports.
- (e) Includes government expenditure and funded patients days in services managed and operated by private and non-government entities.
- (f) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.
- (g) Queensland Government has advised that it provides older people's mental health inpatient services using a number of different service models including campus and noncampus based options. All service types are reported as older people's mental health services, which may have the effect of lowering the average patient day costs compared to jurisdictions who report 'older people's care units' separately.
- (h) Data for a small number of *Youth* services have been rolled into the General services category at the request of Queensland Government.

Table 12A.58 Average recurrent costs per inpatient bed day, public hospitals, by target population (2012-13 dollars) (a), (b), (c), (d), (e)

	<i>NSW (f)</i>	<i>Vic</i>	<i>Qld (g), (h)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT (i), (j)</i>	<i>NT (i)</i>	<i>Aust</i>
(i)	Child and adolescent mental health services were not available, or could not be separately identified, in Tasmania, the ACT and the NT. Older People's Mental Health Services programs were not available, or could not be separately identified, in Tasmania and the ACT for 2005-06, and the NT. Tasmanian figures include child and adolescent mental health services within the general mental health services category. Forensic mental health services were not provided separately in the ACT and in the NT from 2007-08.								
(j)	ACT average costs for older person's mental health services are based on a new 20 bed unit opened in March 2007. During 2006-07, only 6–10 beds operated due to issues related to staffing resources. This has artificially inflated the average cost of older people's mental health services relative to other jurisdictions and other years.								
	.. Not applicable.								

Source: AIHW (unpublished) derived from the MHE NMDS.

TABLE 12A.59

Table 12A.59 **Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2012-13 dollars) (a), (b), (c), (d)**

	NSW (e), (f)	Vic (g)	Qld (h), (i), (j)	WA (k)	SA (g)	Tas (g)	ACT (g), (l)	NT (g)	Aust
General mental health services									
<i>Acute</i>									
2005-06	879.77	693.29	754.74	933.79	823.58	709.73	728.00	1 113.93	815.60
2006-07	896.36	705.67	765.40	942.26	929.51	951.81	955.69	1 013.91	844.71
2007-08	876.33	768.99	877.55	989.70	929.97	911.99	994.07	1 211.97	879.35
2008-09	889.53	802.22	860.97	1 043.33	1 010.25	909.27	891.20	1 238.99	899.51
2009-10	901.50	815.81	870.89	1 045.56	995.87	1 141.03	882.53	1 266.25	912.58
2010-11	941.85	823.62	873.53	1 185.47	935.24	1 152.58	925.80	1 309.70	939.57
2011-12	983.97	818.96	885.84	1 165.78	889.28	956.25	944.44	1 567.55	951.07
2012-13	1 013.22	843.83	921.38	1 238.68	899.55	895.20	868.26	1 376.80	981.17
<i>Non-acute</i>									
2005-06	543.14	510.43	538.91	916.80	562.06	737.82	..	..	574.05
2006-07	519.70	557.09	558.89	948.76	605.74	750.41	..	..	582.40
2007-08	537.49	544.00	575.79	1 051.75	699.49	940.27	..	..	596.18
2008-09	621.97	601.96	588.92	1 028.11	787.52	754.43	..	..	646.00
2009-10	624.07	618.90	701.55	958.54	784.58	851.95	..	..	681.99
2010-11	686.14	660.61	697.73	1 007.58	830.93	757.87	..	..	726.86
2011-12	743.92	788.58	752.73	1 054.88	1 123.50	743.99	..	..	792.18
2012-13	727.70	635.85	678.53	1 059.97	701.94	944.33	..	..	733.16
Child and adolescent mental health services									
<i>Acute</i>									
2005-06	1 590.24	1 432.23	1 430.64	1 286.49	1 236.69	..	..	..	1 452.39
2006-07	1 378.28	1 434.74	1 615.31	1 515.05	1 564.15	..	..	..	1 471.65
2007-08	1 494.81	1 446.71	1 609.32	1 074.34	2 092.55	..	..	..	1 471.80
2008-09	1 527.97	1 581.44	1 662.75	1 486.29	1 880.79	..	..	..	1 583.51

TABLE 12A.59

Table 12A.59 **Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2012-13 dollars) (a), (b), (c), (d)**

	NSW (e), (f)	Vic (g)	Qld (h), (i), (j)	WA (k)	SA (g)	Tas (g)	ACT (g), (l)	NT (g)	Aust
2009-10	1 758.44	1 545.25	1 498.81	1 368.14	2 032.37	..	..	..	1 608.13
2010-11	1 912.33	1 542.20	1 538.97	1 851.80	1 822.52	..	..	..	1 709.35
2011-12	1 834.67	1 449.80	1 493.21	2 099.60	1 825.17	..	..	..	1 678.82
2012-13	1 788.63	1 359.14	1 257.26	2 055.41	2 099.93	..	..	..	1 577.03
<i>Non-acute</i>									
2005-06	1 101.86	..	1 369.85	..	..	..	..	..	1 178.00
2006-07	1 592.14	..	1 232.03	1 822.71	..	..	..	..	1 494.96
2007-08	1 347.60	..	1 574.48	1 995.96	..	..	..	..	1 471.27
2008-09	1 204.43	..	1 806.15	2 083.36	..	..	..	..	1 412.56
2009-10	1 410.61	..	2 163.95	3 080.44	..	..	..	..	1 731.62
2010-11	2 118.89	..	2 024.79	4 628.10	..	..	..	..	2 215.57
2011-12	1 595.20	..	2 448.20	4 632.38	..	..	..	..	1 867.07
2012-13	716.70	..	1 597.59	..	..	..	..	..	975.18
Older people's mental health services									
<i>Acute</i>									
2005-06	679.50	580.33	733.75	827.55	706.57	..	..	..	681.00
2006-07	710.41	609.57	820.84	825.76	809.23	..	2 650.93	..	723.23
2007-08	726.07	652.08	901.83	813.77	819.91	..	1 003.93	..	746.30
2008-09	758.08	659.65	819.89	875.55	800.06	..	1 047.41	..	758.89
2009-10	753.15	668.16	852.18	912.20	886.16	..	641.51	..	772.68
2010-11	829.53	696.46	847.95	902.27	802.41	..	641.19	..	794.46
2011-12	814.63	696.55	872.74	1 019.95	828.69	..	626.35	..	817.54
2012-13	911.94	717.44	863.61	1 058.95	832.19	..	748.93	..	863.00
<i>Non-acute</i>									
2005-06	577.33	..	430.94	652.91	463.70	..	..	..	495.86

TABLE 12A.59

Table 12A.59 **Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2012-13 dollars) (a), (b), (c), (d)**

	NSW (e), (f)	Vic (g)	Qld (h), (i), (j)	WA (k)	SA (g)	Tas (g)	ACT (g), (l)	NT (g)	Aust
2006-07	578.88	..	460.86	647.46	464.12	..	..	..	508.06
2007-08	577.32	..	484.94	702.24	520.53	..	..	..	543.36
2008-09	638.03	..	510.47	750.88	654.33	..	..	..	611.15
2009-10	651.62	..	519.93	523.56	598.00	..	..	..	588.24
2010-11	706.81	..	539.89	462.97	554.97	..	..	..	609.35
2011-12	759.85	..	544.29	451.88	534.07	..	..	..	627.29
2012-13	800.72	..	511.46	511.14	616.87	..	..	..	644.99
Forensic mental health services									
<i>Acute</i>									
2005-06	429.07	945.27	..	1 213.00	1 115.21	532.87	..	1 041.45	765.38
2006-07	480.01	1 031.32	..	1 073.32	1 202.50	1 065.24	..	715.96	807.72
2007-08	457.81	929.62	..	1 017.99	1 146.21	1 536.63	..	..	790.73
2008-09	724.78	843.73	..	1 212.30	1 268.16	1 567.63	..	..	900.82
2009-10	871.81	962.06	..	1 126.12	1 343.39	1 996.41	..	..	1 017.49
2010-11	1 002.37	916.28	..	1 120.85	1 341.95	2 338.31	..	..	1 067.21
2011-12	912.38	792.70	..	1 302.69	1 380.40	1 441.31	..	..	969.55
2012-13	1 017.18	791.09	..	1 286.93	883.49	2 382.33	..	..	1 033.23
<i>Non-acute</i>									
2005-06	672.64	767.54	886.19	1 161.07	901.91	..	..	..	817.67
2006-07	570.90	715.74	909.67	1 047.94	1 016.27	..	..	..	792.00
2007-08	611.91	826.67	1 029.92	1 017.76	1 070.48	..	..	..	869.53
2008-09	875.32	667.45	1 009.86	1 212.31	958.03	..	..	..	914.97
2009-10	857.89	810.98	1 063.03	1 126.11	940.51	..	..	..	917.06
2010-11	909.84	768.00	1 162.15	670.65	910.17	..	..	..	929.60
2011-12	877.72	844.93	1 292.29	779.31	901.08	..	..	..	957.97

Table 12A.59 Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2012-13 dollars) (a), (b), (c), (d)

	NSW (e), (f)	Vic (g)	Qld (h), (i), (j)	WA (k)	SA (g)	Tas (g)	ACT (g), (l)	NT (g)	Aust
2012-13	955.15	815.58	1 284.69	723.30	868.28	..	..	..	985.16

- (a) Constant price expenditure expressed in 2012-13 prices, using the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 12A.96).
- (b) Depreciation is excluded for all years.
- (c) See AIHW *Mental Health Services in Australia* on-line publication (<http://mhsa.aihw.gov.au/resources/expenditure/data-source/>) for a full description of the derivation of expenditure items.
- (d) Includes government expenditure and funded patients days in services managed and operated by private and non-government entities.
- (e) Caution is required when interpreting NSW data. Seven residential mental health services in 2006-07 were reclassified as non-acute older person specialised hospital services in 2007-08, reflecting a change in function of those units.
- (f) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.
- (g) Child and adolescent mental health services were not available, or could not be separately identified, in Tasmania, the ACT and the NT. Tasmanian figures include child and adolescent mental health services within the general mental health services category. Victoria and SA did not have non-acute child and adolescent mental health services units. Older People's Mental Health Services programs were not available, or could not be separately identified, in Tasmania and the NT. Older People's Mental Health Services in non-acute units were not available in Victoria and the ACT. Forensic mental health services were not provided separately in the ACT and in the NT from 2007-08.
- (h) Queensland Government has advised that it provides older people's mental health inpatient services using a number of different service models including campus and noncampus based options. All service types are reported as older people's mental health services, which may have the effect of lowering the average patient day costs compared to jurisdictions who report 'older people's care units' separately.
- (i) Caution is required when interpreting Queensland data. Several Forensic services reported in 2008-09 were reclassified as General services in 2009-10 to more accurately reflect the function of these services. Forensic mental health services in acute units were not provided separately in Queensland.
- (j) Expenditure for a small number of hospital beds reported by Queensland as youth specialised mental health hospital beds were included in the General category at the request of Queensland Government.
- (k) Caution is required when interpreting WA data. A review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010-11 collection, to more accurately reflect the function of these services. In addition, during 2010-11, the child and adolescent non acute inpatient service initiated the closure of beds in order to carry out a complete refurbishment. The service ceased operating in late 2011.

Table 12A.59 Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2012-13 dollars) (a), (b), (c), (d)

	<i>NSW (e), (f)</i>	<i>Vic (g)</i>	<i>Qld (h), (i), (j)</i>	<i>WA (k)</i>	<i>SA (g)</i>	<i>Tas (g)</i>	<i>ACT (g), (l)</i>	<i>NT (g)</i>	<i>Aust</i>
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(l) ACT average costs for older people's mental health services are based on a new 20 bed unit opened in March 2007. During 2006-07, only 6–10 beds operated due to issues related to staffing resources. This has artificially inflated the average cost of older people's mental health services relative to other jurisdictions and other years.

.. Not applicable.

Source: AIHW (unpublished) derived from the MHE NMDS.

TABLE 12A.60

Table 12A.60 **Average length of stay, public hospitals acute units, by target population (no. of days) (a), (b)**

	NSW (c)	Vic	Qld (d)	WA	SA	Tas (e)	ACT (e)	NT (e)	Aust
<i>2010-11</i>									
General mental health services	14.8	14.5	11.4	14.9	13.4	12.0	15.2	12.6	13.8
Child and adolescent mental health services	21.7	10.4	11.2	8.0	4.2	..	..	..	11.8
Older people's mental health services	35.4	32.6	20.7	51.3	45.6	..	36.3	..	35.5
Total	16.0	16.1	11.8	17.3	15.2	12.0	17.5	12.6	15.1
<i>2011-12</i>									
General mental health services	14.6	14.4	11.6	13.8	12.2	12.6	14.5	10.7	13.5
Child and adolescent mental health services	22.1	7.3	11.5	7.2	3.1	..	..	..	10.5
Older people's mental health services	41.2	30.5	11.3	49.8	41.2	..	36.8	..	31.9
Total	16.0	15.4	11.6	16.0	13.8	12.6	16.9	10.7	14.6
<i>2012-13</i>									
General mental health services	14.0	13.8	10.2	15.2	15.0	12.9	15.9	11.8	13.3
Child and adolescent mental health services	20.9	8.1	11.1	6.4	3.6	..	..	..	10.9
Older people's mental health services	42.1	29.7	21.9	50.3	39.1	..	40.3	..	35.7
Total	15.4	14.9	10.7	17.3	16.4	12.9	18.2	11.8	14.5

(a) The quality of the separations data used to derive the results in this table is variable across jurisdictions. Until recently, these separations data were not subject to in depth scrutiny. It is expected that the quality of these data will improve over time.

Table 12A.60 **Average length of stay, public hospitals acute units, by target population (no. of days) (a), (b)**

	<i>NSW (c)</i>	<i>Vic</i>	<i>Qld (d)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (e)</i>	<i>NT (e)</i>	<i>Aust</i>
(b)	There is a mismatch between the inpatient bed days and the separations used to derive this indicator for the relevant reference periods.								
	– Patients days for clients who separated in the reference period (for example, 2012-13) that were during the previous period (2011-12) are excluded.								
	– Patient days for clients who remain in hospital (that is, are not included in the separations data) are included.								
(c)	The quality of the NSW 2010-11 MHE NMDS data has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.								
(d)	Separations for a small number of hospital beds reported by Queensland as youth specialised mental health hospital beds were included in the general category at the request of Queensland Government.								
(e)	Child and adolescent mental health services were not available, or could not be separately identified, in Tasmania, the ACT and the NT. Tasmanian figures include child and adolescent mental health services within the general mental health services category. Older People's Mental Health Services programs were not available, or could not be separately identified, in Tasmania and the NT.								
	.. Not applicable.								

Source: AIHW (unpublished) derived from the MHE NMDS.

TABLE 12A.61

Table 12A.61 **Average recurrent cost per inpatient bed day, by public hospital type (2012-13 dollars) (a), (b), (c), (d), (e)**

	<i>NSW</i> (f), (g)	<i>Vic</i> (h)	<i>Qld</i> (i)	<i>WA</i> (j)	<i>SA</i> (k)	<i>Tas</i> (l)	<i>ACT</i> (k), (l)	<i>NT</i> (k), (l)	<i>Aust</i>
Psychiatric hospitals (acute units)									
2005-06	830.34	945.27	..	935.24	920.86	..	..	..	881.09
2006-07	796.31	1 031.32	..	967.74	1 046.34	..	..	..	899.02
2007-08	745.06	929.62	..	947.80	1 131.18	..	..	..	877.64
2008-09	757.49	843.73	..	1 013.95	1 094.10	..	..	..	902.95
2009-10	981.65	962.06	..	1 011.40	1 139.31	..	..	..	1 009.56
2010-11	962.16	916.28	..	1 190.61	955.76	..	..	..	1 002.17
2011-12	1 065.30	792.70	..	1 228.57	914.18	..	..	..	1 037.99
2012-13	1 214.13	791.09	..	1 288.12	1 025.44	..	..	..	1 128.48
Psychiatric hospitals (non-acute units)									
2005-06	583.32	767.54	711.93	957.92	558.06	..	..	..	645.52
2006-07	549.21	715.74	724.94	962.32	581.77	..	..	..	637.27
2007-08	562.92	826.67	798.00	949.83	651.54	..	..	..	673.03
2008-09	647.35	667.45	783.77	1 015.99	745.80	..	..	..	718.91
2009-10	638.28	810.98	804.44	1 001.41	723.98	..	..	..	719.14
2010-11	704.51	768.00	822.39	955.42	725.28	..	..	..	760.41
2011-12	741.72	844.93	907.54	990.55	805.68	..	..	..	821.11
2012-13	732.63	815.58	880.01	1 030.52	707.72	..	..	..	800.26
Psychiatric hospitals (all units)									
2005-06	668.19	853.03	711.93	945.19	694.80	..	..	..	722.82
2006-07	636.16	863.25	724.94	965.34	740.83	..	..	..	721.96
2007-08	625.08	872.65	798.00	948.39	806.41	..	..	..	741.44
2008-09	677.61	774.40	783.77	1 014.53	871.56	..	..	..	778.20
2009-10	734.42	905.11	804.44	1 008.51	863.30	..	..	..	811.40
2010-11	779.43	860.54	822.39	1 077.53	807.74	..	..	..	833.54

TABLE 12A.61

Table 12A.61 **Average recurrent cost per inpatient bed day, by public hospital type (2012-13 dollars) (a), (b), (c), (d), (e)**

	<i>NSW</i> (f), (g)	<i>Vic</i> (h)	<i>Qld</i> (i)	<i>WA</i> (j)	<i>SA</i> (k)	<i>Tas</i> (l)	<i>ACT</i> (k), (l)	<i>NT</i> (k), (l)	<i>Aust</i>
2011-12	848.34	813.13	907.54	1 127.81	849.56	..	..	..	893.97
2012-13	864.29	800.75	880.01	1 180.19	827.27	..	..	..	900.92
Public acute hospital with a psychiatric unit or ward (acute units)									
2006-07	890.86	713.02	810.72	925.26	854.56	978.02	1 031.58	1 010.85	834.98
2007-08	882.50	769.10	915.65	968.99	837.91	1 035.61	995.95	1 211.97	874.81
2008-09	911.92	801.17	899.49	1 036.75	932.12	1 040.64	918.55	1 238.99	902.55
2009-10	897.22	815.65	902.21	1 042.91	944.23	1 301.36	831.97	1 266.25	907.97
2010-11	966.17	827.79	907.41	1 120.57	921.33	1 346.64	861.35	1 309.70	944.78
2011-12	978.73	821.71	918.38	1 145.95	896.17	1 063.80	870.63	1 567.55	947.62
2012-13	1 013.25	843.60	940.69	1 204.42	864.21	1 123.84	843.75	1 376.80	975.73
Public acute hospital with a psychiatric unit or ward (non-acute units)									
2006-07	669.73	557.09	532.36	784.84	..	750.41	..	..	586.42
2007-08	617.98	544.00	547.45	1 028.50	..	940.27	..	..	606.87
2008-09	781.14	601.96	564.08	985.74	..	754.43	..	..	662.20
2009-10	854.63	618.90	615.81	761.84	..	851.95	..	..	699.42
2010-11	910.05	660.61	614.20	923.14	..	757.87	..	..	721.24
2011-12	895.57	788.58	646.51	921.86	..	743.99	..	..	777.70
2012-13	866.76	635.85	567.19	772.52	..	944.33	..	..	712.62
Public acute hospital with a psychiatric unit or ward (all units)									
2006-07	875.14	697.79	720.02	911.02	854.56	920.77	1 031.58	1 010.85	799.93
2007-08	845.19	745.50	797.84	974.49	837.91	1 017.75	995.95	1 211.97	832.13
2008-09	898.19	781.04	796.64	1 031.28	932.12	976.02	918.55	1 238.99	867.73
2009-10	892.52	795.45	816.70	1 009.98	944.23	1 200.86	831.97	1 266.25	877.68
2010-11	960.13	810.97	818.08	1 104.28	921.33	1 199.11	861.35	1 309.70	912.97
2011-12	964.10	818.73	836.41	1 127.86	896.17	987.86	870.63	1 567.55	920.05
2012-13	986.70	819.71	817.97	1 172.54	864.21	1 085.37	843.75	1 376.80	929.91

Table 12A.61 **Average recurrent cost per inpatient bed day, by public hospital type (2012-13 dollars) (a), (b), (c), (d), (e)**

	NSW (f), (g)	Vic (h)	Qld (i)	WA (j)	SA (k)	Tas (l)	ACT (k), (l)	NT (k), (l)	Aust
(a)	Constant price expenditure expressed in 2012-13 prices, using the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 12A.96).								
(b)	Depreciation is excluded for all years.								
(c)	See AIHW <i>Mental Health Services in Australia</i> on-line publication (http://mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of expenditure items.								
(d)	Due to the ongoing validation of NMDS, data could differ from previous reports.								
(e)	Includes government expenditure and funded patients days in services managed and operated by private and non-government entities.								
(f)	Caution is required when interpreting NSW data. Seven residential mental health services in 2006-07 were reclassified as non-acute older person specialised hospital services in 2007-08, reflecting a change in function of those units.								
(g)	The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.								
(h)	Mainstreaming has occurred at different rates in different jurisdictions. In Victoria's case, the data for psychiatric hospitals comprises mainly forensic services, since nearly all general psychiatric treatment occurs in mainstreamed units in general acute hospitals. This means that the client profile and service costs are very different from those of a jurisdiction where general psychiatric treatment still occurs mostly in psychiatric hospitals.								
(i)	Queensland data for public acute hospitals include costs associated with extended treatment services (campus-based and non-campus-based) that report through general acute hospitals. Queensland does not provide acute services in psychiatric hospitals.								
(j)	Caution is required when interpreting WA data. A review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010-11 collection, to more accurately reflect the function of these services.								
(k)	SA, the ACT and the NT do not have non-acute units in public acute hospitals with a psychiatric unit or ward.								
(l)	Tasmania, the ACT and the NT do not have public psychiatric hospitals.								
	.. Not applicable.								

Source: AIHW (unpublished) derived from the MHE NMDS.

TABLE 12A.62

Table 12A.62 **Average recurrent cost per patient day for community residential services (2012-13 dollars) (a), (b), (c), (d), (e)**

	<i>NSW</i> (f), (g), (h)	<i>Vic</i> (h)	<i>Qld</i> (i)	<i>WA</i> (j), (k), (h)	<i>SA</i> (k)	<i>Tas</i> (l), (m)	<i>ACT</i> (h), (m)	<i>NT</i> (k), (n)	<i>Aust</i>
General adult units									
2005-06									
24-hour staffed units	300.79	481.90	..	373.87	265.41	445.70	545.98	..	433.80
non-24-hour staffed units	98.01	169.51	..	138.56	309.10	351.16	86.81	127.36	153.34
2006-07									
24-hour staffed units	297.30	467.93	..	486.63	262.68	464.62	602.56	..	437.60
non-24-hour staffed units	94.46	154.17	..	156.11	315.22	233.19	120.62	293.79	146.72
2007-08									
24-hour staffed units	275.27	453.92	..	522.24	410.34	532.80	609.86	299.81	440.15
non-24-hour staffed units	181.33	151.10	..	193.45	503.70	235.77	112.88	..	169.81
2008-09									
24-hour staffed units	310.95	485.99	..	443.56	413.53	567.03	743.54	271.62	468.03
non-24-hour staffed units	234.76	150.54	..	176.34	305.27	265.81	107.82	..	174.36
2009-10									
24-hour staffed units	267.14	517.40	..	344.10	401.46	436.78	706.73	352.57	458.47
non-24-hour staffed units	202.04	156.13	..	161.04	271.56	241.22	121.87	..	171.03
2010-11									
24-hour staffed units	307.04	552.75	..	549.56	476.10	493.28	677.62	371.12	515.71
non-24-hour staffed units	188.85	161.54	..	144.38	276.94	231.29	114.75	..	165.55
2011-12									
24-hour staffed units	264.17	500.03	..	382.19	497.89	503.12	674.33	316.26	463.75
non-24-hour staffed units	180.28	162.06	..	153.16	340.55	203.72	137.96	..	167.23
2012-13									
24-hour staffed units	183.97	514.54	..	408.18	456.02	641.44	671.96	353.46	468.79
non-24-hour staffed units	107.87	156.12	..	161.16	227.65	248.16	119.76	..	164.74

TABLE 12A.62

Table 12A.62 **Average recurrent cost per patient day for community residential services (2012-13 dollars) (a), (b), (c), (d), (e)**

	<i>NSW</i> (f), (g), (h)	<i>Vic</i> (h)	<i>Qld</i> (i)	<i>WA</i> (j), (k), (h)	<i>SA</i> (k)	<i>Tas</i> (l), (m)	<i>ACT</i> (h), (m)	<i>NT</i> (k), (n)	<i>Aust</i>
Older people's care units									
2005-06									
24-hour staffed units	331.28	348.61	..	..	..	493.58	176.30	..	350.99
non-24-hour staffed units	124.15	..	..	..	..	..	..	..	124.15
2006-07									
24-hour staffed units	391.47	324.80	..	..	..	520.41	185.42	..	342.21
non-24-hour staffed units	322.08	..	..	..	..	..	..	..	322.08
2007-08									
24-hour staffed units	216.86	322.82	..	..	..	817.46	190.49	..	336.64
non-24-hour staffed units	173.09	..	..	..	..	..	..	..	173.09
2008-09									
24-hour staffed units	193.24	351.52	..	..	..	542.32	253.73	..	357.49
non-24-hour staffed units	229.67	..	..	..	..	..	..	..	229.67
2009-10									
24-hour staffed units	224.19	345.40	..	..	..	776.76	204.53	..	359.63
non-24-hour staffed units	222.36	..	..	..	..	..	..	..	222.36
2010-11									
24-hour staffed units	238.02	357.88	..	..	..	721.09	218.74	..	369.42
non-24-hour staffed units	292.22	..	..	..	..	..	..	..	292.22
2011-12									
24-hour staffed units	240.96	355.13	..	..	..	700.73	257.93	..	367.03
non-24-hour staffed units	..	..	..	..	..	..	..	..	..
2012-13									
24-hour staffed units	237.28	366.60	..	..	..	828.85	256.55	..	381.89

Table 12A.62 **Average recurrent cost per patient day for community residential services (2012-13 dollars) (a), (b), (c), (d), (e)**

	NSW (f), (g), (h)	Vic (h)	Qld (i)	WA (j), (k), (h)	SA (k)	Tas (l), (m)	ACT (h), (m)	NT (k), (n)	Aust
non-24-hour staffed units

- (a) Depreciation is excluded for all years.
- (b) Unit costs are not casemix adjusted.
- (c) Constant price expenditure expressed in 2012-13 prices, using the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 12A.96).
- (d) See AIHW *Mental Health Services in Australia* on-line publication (<http://mhsa.aihw.gov.au/resources/expenditure/data-source/>) for a full description of the derivation of expenditure items.
- (e) Due to the ongoing validation of NMDS, data could differ from previous reports.
- (f) Caution is required when interpreting NSW data. Seven residential mental health services in 2006–07 were reclassified as non-acute older person specialised hospital services in 2007–08, reflecting a change in function of those units.
- (g) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.
- (h) A small number of residential beds reported by NSW and the ACT as child and adolescent residential mental health service beds were included in the general category at the request of these jurisdictions. Expenditure for a small number of residential beds reported by Victoria, WA and the ACT as youth specialised mental health residential beds were included in the general category at the request of these jurisdictions.
- (i) Queensland does not fund community residential services, however, it funds a number of extended treatment services, both campus and non-campus based, which provide longer term inpatient treatment and rehabilitation services with a full clinical staffing 24 hours a day 7 days a week. Queensland does not report these beds as community residential beds as it considers these beds to be substantially different to beds described as such in other states and territories.
- (j) Caution is required when interpreting WA data. Several residential services reported as 24-hour staffed services in 2009-10 transitioned to a non-24-hour staffed model of care as of 1 July 2010.
- (k) WA, SA and the NT do not have any community residential services that are aged care units.
- (l) Tasmanian services include both acute and rehabilitation units which have higher unit costs than extended care units.
- (m) Tasmania and the ACT do not have any community-based residential services that are non-24 hour staffed older people's units. From 2011-12, NSW no longer has non-24 hour staffed older people's units.
- (n) General adult 24-hour residential services were not provided in the NT until 2007-08. From 2007-08, general non-24-hour staffed units are not provided.
.. Not applicable.

Table 12A.62 **Average recurrent cost per patient day for community residential services (2012-13 dollars) (a), (b), (c), (d), (e)**

	<i>NSW</i> (f), (g), (h)	<i>Vic</i> (h)	<i>Qld</i> (i)	<i>WA</i> (j), (k), (h)	<i>SA</i> (k)	<i>Tas</i> (l), (m)	<i>ACT</i> (h), (m)	<i>NT</i> (k), (n)	<i>Aust</i>
<i>Source:</i>	AIHW (unpublished) derived from the MHE NMDS.								

Table 12A.63 Average cost, and treatment days per episode, of ambulatory care (a), (b), (c)

	NSW (d)	Vic (e)	Qld	WA	SA	Tas (f)	ACT	NT	Aust
<i>Average treatment days per episode of ambulatory care</i>									
2005-06	6.7	7.8	4.9	4.5	4.8	4.7	8.2	4.0	6.0
2006-07	6.8	7.7	5.2	4.5	5.0	4.1	8.0	4.0	6.1
2007-08	8.0	7.7	5.4	4.6	5.2	5.9	8.0	3.9	6.5
2008-09	7.2	7.6	4.5	4.8	5.3	6.0	8.0	3.9	6.1
2009-10	7.6	7.6	4.9	4.9	5.3	5.2	8.2	3.5	6.3
2010-11	7.5	7.7	5.2	5.0	5.5	5.5	8.2	3.6	6.4
2011-12	8.0	na	5.8	5.0	5.4	4.5	8.6	3.6	6.4
2012-13	7.8	na	6.4	4.9	5.4	3.9	8.4	4.0	6.5
<i>Average cost per treatment day of ambulatory care (2012-13 \$) (g)</i>									
2005-06	256.23	271.54	298.71	458.88	419.05	653.56	279.90	463.32	306.10
2006-07	267.67	274.75	331.84	453.29	362.64	576.36	306.53	531.42	315.92
2007-08	258.78	294.97	356.27	483.89	324.31	445.58	286.96	597.07	319.80
2008-09	270.82	307.11	443.79	470.03	313.19	414.22	298.00	549.78	338.68
2009-10	257.74	310.25	509.09	440.54	320.42	401.92	261.47	602.60	339.79
2010-11	266.57	333.57	468.46	430.62	338.35	343.86	260.48	608.32	343.83
2011-12	252.60	na	436.63	447.24	332.97	479.74	258.04	557.42	336.51
2012-13	223.84	na	362.05	428.58	332.35	665.90	234.40	439.27	303.28

- (a) Non-uniquely identifiable consumers' have been excluded from the episodes of ambulatory care and treatment days data.
- (b) Recurrent expenditure data used to derive this measure have been adjusted (that is, reduced) to account for proportion of clients in the CMHC NMDS that were defined as 'non-uniquely identifiable consumers'. Therefore, it does not match recurrent expenditure on ambulatory care reported elsewhere.
- (c) Due to the ongoing validation of NMDS, data could differ from previous reports.
- (d) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.
- (e) Victorian 2011-12 and 2012-13 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data.
- (f) Industrial action in Tasmania has limited the available data quality and quantity of the 2011-12 and 2012-13 data.
- (g) Constant price expenditure expressed in 2012-13 prices, using the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 12A.96).

na Not available.

Source: AIHW (unpublished) derived from CMHC NMDS and MHE NMDS.

Table 12A.64 Risk status recent drinkers (in last 12 months) aged 14 years or over, 2013 (per cent)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Lifetime status</i>									
Abstainers (a)	24.3	23.5	19.9	18.3	20.6	16.9	17.5	16.7	22.0
Low risk (b)	58.9	60.4	60.0	60.0	60.9	64.4	60.5	53.6	59.9
Risky (c)	16.7	16.1	20.2	21.6	18.5	18.6	22.0	29.7	18.2
<i>Single occasion</i>									
Abstainers (a)	24.3	23.5	19.9	18.3	20.6	16.9	17.5	16.7	22.0
Low risk (d)	41.2	40.8	39.5	38.2	39.5	42.4	38.3	31.4	40.2
Risky									
At least yearly (e)	10.7	10.8	12.4	12.1	12.1	11.2	15.0	12.2	11.4
At least monthly (f)	11.3	11.8	12.8	13.6	12.9	14.3	13.1	14.0	12.2
At least weekly (g)	12.4	13.1	15.4	17.8	14.9	15.2	16.1	25.7	14.2
Total risky	34.5	35.7	40.6	43.5	39.9	40.7	44.2	51.9	37.8

(a) Not consumed alcohol in the previous 12 months.

(b) On average, had no more than 2 standard drinks per day.

(c) On average, had more than 2 standard drinks per day.

(d) Never had more than 4 standard drinks on any occasion.

(e) Had more than 4 standard drinks at least once a year, but not as often as monthly.

(f) Had more than 4 standard drinks at least once a month, but not as often as weekly.

(g) Had more than 4 standard drinks at least once a week.

Source: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra.

TABLE 12A.65

Table 12A.65 **Recent drinkers lifetime and single occasion risk, people aged 14 years or older, by social characteristics, 2013 (per cent)**

	Abstainers (a)	Lifetime risk		Single occasion risk		
		Low risk (b)	Risky (c)	Low risk (d)	At least yearly (e)	At least weekly (f)
<i>Socioeconomic status</i>						
Quintile 1 (lowest)	31.1	53.0	15.9	36.3	19.5	13.0
Quintile 2	24.4	57.6	18.0	39.6	21.5	14.6
Quintile 3	20.9	59.9	19.2	39.9	24.3	15.0
Quintile 4	18.6	62.4	19.0	42.3	24.4	14.7
Quintile 5 (highest)	16.7	65.0	18.4	42.1	27.6	13.6
<i>Geography</i>						
Major cities	23.1	60.2	16.7	40.4	23.5	13.0
Inner regional	18.9	62.0	19.1	41.8	24.4	14.9
Outer regional	20.5	56.9	22.6	38.1	23.6	17.8
Remote/Very remote	17.5	47.6	34.9	30.8	22.8	28.9
<i>Indigenous status</i>						
Aboriginal and/or Torres Strait Islander	27.9	49.4	22.7	22.4	29.8	19.9
Non-Indigenous	21.7	60.2	18.1	40.6	23.5	14.1

(a) Not consumed alcohol in the previous 12 months.

(b) On average, had no more than 2 standard drinks per day.

(c) On average, had more than 2 standard drinks per day.

(d) Never had more than 4 standard drinks on any occasion.

(e) Had more than 4 standard drinks at least once a year but not as often as weekly.

(f) Had more than 4 standard drinks at least once a week.

Source: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra.

Table 12A.66 Recent alcohol and illicit drug use, people aged 14 years or over, by substance, 2013 (per cent) (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Alcohol	75.8	76.7	80.4	81.8	79.5	83.2	82.6	83.6	78.2
Illicit drugs									
Cannabis	9.5	9.1	11.1	11.3	11.0	11.8	10.1	17.1	10.2
Ecstasy	2.4	2.4	2.4	2.6	2.8	*2.9	2.9	3.7	2.5
Meth/amphetamines (c)	1.4	1.9	2.3	3.8	2.2	*3.0	2.2	*2.8	2.1
Cocaine	2.7	2.0	2.0	1.6	*1.2	**1.2	2.8	*2.4	2.1
Hallucinogens	1.0	1.3	1.2	1.9	*1.6	*1.1	*1.7	*1.8	1.3
Inhalants	0.8	0.9	0.8	*0.5	*0.4	*1.7	*1.1	*0.8	0.8
Heroin	*<0.1	*0.1	**<0.1	*0.3	**<0.1	–	**0.3	**<0.1	0.1
Ketamine	*0.3	*0.3	**0.2	–	**0.3	*0.8	**0.2	**0.4	0.3
GHB	*<0.1	**<0.1	**<0.1	**0.1	–	**0.7	–	**<0.1	*<0.1
Synthetic Cannabinoids	1.0	1.0	1.5	*2.5	*0.9	*0.9	*0.8	2.8	1.2
New and Emerging Psychoactive Substances	*0.2	*0.5	*0.5	*0.5	*0.4	**1.1	**0.5	*0.6	0.4
Injected drugs	*0.3	*0.2	*0.3	*0.6	*0.3	*0.9	**0.2	*0.3	0.3
<i>Any illicit (d)</i>	11.4	11.0	12.6	13.7	12.5	13.3	12.4	19.0	12.0

(a) Recent means used in the previous 12 months. For alcohol 'recent use' includes daily, weekly and less than weekly drinkers.

(b) Results subject to RSEs of between 25 per cent and 50 per cent should be considered with caution and those with relative standard errors greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " ** " and those with RSEs of between 25 per cent and 50 per cent are marked with " * ".

(c) Use for non-medical purposes.

(d) Illicit use of at least 1 of 12 drugs (excluding pharmaceuticals) in the previous 12 months in 2013.

– Nil or rounded to zero.

Source: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra.

Table 12A.67 Use of cannabis, by age group, 2013 (per cent) (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Cannabis</i>									
14–19 years	14.6	12.5	14.7	19.1	*12.3	*19.2	*22.2	24.9	14.8
20–29 years	20.8	20.4	21.6	18.3	22.3	26.7	19.3	23.9	20.8
30–39 years	10.7	10.6	14.0	15.9	13.8	16.7	8.7	18.3	12.3
40–49 years	8.3	7.2	12.0	10.3	13.8	*10.1	8.6	13.1	9.5
50–59 years	6.6	7.0	8.1	6.9	9.3	9.1	*4.1	12.7	7.3
60 years or over	*1.6	*0.7	*0.7	*1.7	*0.9	*1.5	**1.4	*7.0	1.2
14 years or over	9.5	9.1	11.1	11.3	11.0	11.8	10.1	17.1	10.2

(a) Recent use means used in the previous 12 months.

(b) Results subject to RSEs of between 25 per cent and 50 per cent should be considered with caution and those with relative standard errors greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " ** " and those with RSEs of between 25 per cent and 50 per cent are marked with " * ".

Source: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra.

Table 12A.68 Risk status recent drinkers (in last 12 months) aged 14 years or over, 2010 (per cent)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Lifetime status</i>									
Abstainers (a)	22.2	21.3	17.1	17.3	19.3	14.6	13.7	13.9	19.9
Low risk (b)	58.8	59.9	59.1	59.6	60.9	65.7	66.5	56.2	59.6
Risky (c)	19.0	18.8	23.7	23.0	19.7	19.7	19.8	29.8	20.5
<i>Single occasion</i>									
Abstainers (a)	22.2	21.3	17.1	17.3	19.3	14.6	13.7	13.9	19.9
Low risk (d)	40.5	39.9	37.0	38.6	41.6	44.3	41.1	34.5	39.6
Risky									
At least yearly (e)	10.8	11.6	12.0	12.5	11.2	11.7	15.3	11.4	11.6
At least monthly (f)	11.2	12.5	15.3	13.4	11.4	13.3	16.1	15.1	12.8
At least weekly (g)	15.3	14.6	18.5	18.2	16.5	16.0	13.8	25.1	16.2
Total risky	37.3	38.8	45.9	44.0	39.1	41.0	45.2	51.6	40.6

- (a) Not consumed alcohol in the previous 12 months.
 (b) On average, had no more than 2 standard drinks per day.
 (c) On average, had more than 2 standard drinks per day.
 (d) Never had more than 4 standard drinks on any occasion.
 (e) Had more than 4 standard drinks at least once a year, but not as often as monthly.
 (f) Had more than 4 standard drinks at least once a month, but not as often as weekly.
 (g) Had more than 4 standard drinks at least once a week.

Source: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra.

Table 12A.69 Recent alcohol and illicit drug use, people aged 14 years or over, by substance, 2010 (per cent) (a), (b)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Alcohol	78.2	79.1	83.2	83.0	81.0	85.6	86.5	86.3	80.5
Illicit drugs									
Cannabis	9.3	9.4	11.0	13.4	11.3	8.6	9.5	16.5	10.3
Ecstasy	2.9	3.1	2.7	3.7	3.3	*1.7	*2.3	3.2	3.0
Meth/amphetamines (c)	1.6	2.3	1.9	3.4	2.5	*1.1	*1.2	*2.1	2.1
Cocaine	2.7	2.3	1.3	2.2	1.7	*0.8	*1.8	**0.5	2.1
Hallucinogens	0.8	1.8	1.4	1.9	1.0	*1.0	*1.5	*2.6	1.4
Inhalants	0.6	0.6	0.6	*0.4	*0.6	*0.8	**0.6	*1.5	0.6
Heroin	*0.2	*0.3	*0.1	*0.3	*0.2	**0.1	**0.3	**0.1	0.2
GHB	*0.2	*0.2	*0.1	**0.1	**0.1	–	**<0.1	–	0.1
<i>Any illicit (d)</i>	11.4	11.0	12.3	15.4	12.7	9.6	11.4	18.8	12.0

(a) Recent means used in the previous 12 months. For alcohol 'recent use' includes daily, weekly and less than weekly drinkers.

(b) Results subject to RSEs of between 25 per cent and 50 per cent should be considered with caution and those with relative standard errors greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " ** " and those with RSEs of between 25 per cent and 50 per cent are marked with " * ".

(c) Use for non-medical purposes.

(d) Includes ketamine and injected drugs, but excludes pharmaceuticals.

– Nil or rounded to zero.

Source: AIHW (2011) *2010 National Drug Strategy Household Survey Report*, Drug statistics series no. 25, Cat. no. PHE 145, Canberra.

TABLE 12A.70

Table 12A.70 **Lifetime risk status recent drinkers (in last 12 months) aged 14 years or over, by age group (per cent)**

	<i>Abstainers (a)</i>			<i>Low risk (b)</i>			<i>Risky (c)</i>		
	<i>2007</i>	<i>2010</i>	<i>2013</i>	<i>2007</i>	<i>2010</i>	<i>2013</i>	<i>2007</i>	<i>2010</i>	<i>2013</i>
<i>Males</i>									
14–19 years	30.4	36.9	47.3	51.7	43.6	43.1	17.8	19.5	9.6
20–29 years	11.2	14.1	14.2	49.5	49.1	54.5	39.2	36.8	31.2
18–24 years	12.1	14.9	16.5	49.2	46.0	55.9	38.6	39.1	27.6
25–34 years	10.9	13.6	14.5	55.5	53.1	55.1	33.5	33.3	30.4
35–44 years	10.9	12.3	14.1	58.0	55.6	55.7	31.0	32.1	30.2
45–54 years	10.0	12.1	15.6	58.5	55.5	56.5	31.4	32.3	27.8
55–64 years	12.0	14.2	15.3	58.1	57.2	55.2	29.7	28.6	29.6
65–74 years	16.9	17.1	19.1	57.2	57.9	54.9	25.8	25.0	26
75+ years	22.8	23.7	25.9	59.2	59.6	58.6	17.9	16.7	15.5
Total	14.2	16.7	19.1	56.0	53.8	54.5	29.7	29.6	26.5
<i>Females</i>									
14–19 years	29.3	36.6	46.1	59.3	52.5	47.5	11.2	10.9	6.4
20–29 years	14.9	15.9	19.4	67.5	66.4	68.4	17.5	17.7	12.2
18–24 years	14.5	14.1	18.0	65.2	63.8	67.5	20.2	22.1	14.6
25–34 years	13.8	18.5	21.3	72.8	69.0	69.0	13.2	12.4	9.7
35–44 years	13.5	16.3	18.3	73.3	71.9	70.5	13.1	11.9	11.2
45–54 years	15.6	18.9	18.1	71.7	68.4	68.6	12.5	12.7	13.2
55–64 years	22.2	22.6	20.4	67.9	67.5	69.0	9.8	10.0	10.5
65–74 years	33.9	31.0	29.6	59.1	62.8	63.1	6.9	6.2	7.3
75+ years	40.2	41.8	44.8	55.3	53.4	52.4	4.4	4.7	2.8
Total	20.5	23.0	24.8	67.5	65.4	65.2	11.8	11.6	10
<i>All people</i>									
14–19 years	29.9	36.7	46.7	55.4	48.0	45.2	14.5	15.3	8.1
20–29 years	13.0	15.0	16.8	58.4	57.6	61.3	28.5	27.4	21.9
18–24 years	13.3	14.6	17.2	56.9	54.4	61.5	29.7	31.0	21.3
25–34 years	12.4	16.1	17.9	64.3	61.1	62.1	23.2	22.8	20.0
35–44 years	12.2	14.3	16.2	65.7	63.9	63.2	22.0	21.7	20.6
45–54 years	12.7	15.5	16.9	65.0	62.0	62.7	22.1	22.5	20.4
55–64 years	17.4	18.4	17.8	63.3	62.3	62.1	19.2	19.3	20.1
65–74 years	25.5	24.1	24.3	58.2	60.3	59.0	16.2	15.5	16.6
75+ years	32.4	34.3	36.6	57.0	56.0	55.1	10.5	9.7	8.3
Total	17.4	19.9	22.0	61.8	59.6	59.9	20.6	20.5	18.2

(a) Not consumed alcohol in the previous 12 months.

(b) On average, had no more than 2 standard drinks per day.

(c) On average, had more than 2 standard drinks per day.

Source: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra.

TABLE 12A.71

Table 12A.71 **Single occasion risk status recent drinkers (in last 12 months) aged 14 years or over, by age group (per cent) (a), (b)**

	<i>Low risk (c)</i>			<i>Single occasion risky</i>											
				<i>At least yearly (d)</i>			<i>At least monthly (e)</i>			<i>At least weekly (f)</i>			<i>Every day/most days (g)</i>		
	<i>2007</i>	<i>2010</i>	<i>2013</i>	<i>2007</i>	<i>2010</i>	<i>2013</i>	<i>2007</i>	<i>2010</i>	<i>2013</i>	<i>2007</i>	<i>2010</i>	<i>2013</i>	<i>2007</i>	<i>2010</i>	<i>2013</i>
<i>Males</i>															
14–19 years	21.2	18.0	17.3	10.8	7.87	7.3	16.4	17.8	16.4	18.4	16.9	11.3	2.6	2.5	**0.5
20–29 years	15.8	18.5	19.7	11.7	11.4	14.7	22.5	22.4	22.2	32.2	27.6	25.2	6.4	5.9	4.1
18–24 years	14.4	15.8	17.2	12.3	9.2	13.1	18.8	22.5	25.4	36.5	32.6	25.7	5.7	5.0	2.1
25–34 years	20.0	21.0	21.7	16.3	14.9	15.3	23.2	22.4	21.5	23.0	20.9	21.8	6.3	7.2	5.3
35–44 years	28.6	28.0	27.7	16.3	16.6	16.6	17.4	16.3	17.3	17.5	17.7	15.0	9.1	9.1	9.3
45–54 years	35.1	34.6	34.9	15.4	13.7	12.9	16.9	14.4	14.6	12.5	14.0	13.6	9.9	11.3	8.4
55–64 years	44.1	42.6	42.3	12.5	11.8	10.6	11.6	11.0	12.1	8.4	10.0	10.0	11.3	10.4	9.7
65–74 years	55.2	56.8	53.5	7.8	7.0	6.6	6.2	6.0	6.9	5.0	5.2	4.9	8.8	7.9	9.0
75+ years	62.0	63.1	61.9	5.7	3.6	3.9	3.4	3.0	2.1	2.1	2.3	2.1	3.8	4.4	4.2
Total	32.8	32.5	32.7	13.1	12.0	12.1	15.7	15.2	15.4	16.2	15.8	14.1	7.9	7.9	6.7
<i>Females</i>															
14–19 years	27.7	23.4	22.1	11.5	8.8	10.2	18.0	19.0	14.6	11.8	11.6	6.4	1.4	*0.6	**0.6
20–29 years	27.3	28.6	31.6	19.1	17.7	17.5	19.9	19.1	18.8	16.6	17.1	11.0	1.9	1.7	1.8
18–24 years	21.8	25.2	26.0	17.7	13.5	15.8	22.6	22.5	24.3	21.7	22.8	14.4	1.4	1.9	*1.6
25–34 years	38.9	35.0	40.6	19.7	18.2	16.6	15.4	16.7	12.5	9.7	9.8	7.1	2.2	1.8	1.8
35–44 years	47.4	46.9	47.9	18.5	16.1	15.1	11.2	11.4	9.5	6.6	7.3	6.6	2.7	2.0	2.7
45–54 years	58.0	55.6	53.8	13.0	10.9	10.5	6.4	7.0	7.6	4.2	4.7	6.9	2.8	2.9	3.1
55–64 years	62.1	62.1	63.5	7.5	7.1	7.3	4.0	4.3	4.1	2.4	1.9	1.7	1.7	2.1	2.9
65–74 years	59.9	63.8	63.0	3.0	1.92	2.7	1.7	1.8	2.1	0.3	*0.5	*1.1	1.1	1.1	1.5
75+ years	56.2	54.3	52.3	0.8	*1.4	*1.3	1.1	*0.8	*1.0	0.5	**0.5	**0.2	1.1	*1.2	*0.5
Total	47.7	46.6	47.6	12.8	11.1	10.8	10.0	10.3	9.1	6.8	7.1	5.7	2.0	1.9	2.1

TABLE 12A.71

Table 12A.71 **Single occasion risk status recent drinkers (in last 12 months) aged 14 years or over, by age group (per cent) (a), (b)**

	Low risk (c)			Single occasion risky											
				At least yearly (d)			At least monthly (e)			At least weekly (f)			Every day/most days (g)		
	2007	2010	2013	2007	2010	2013	2007	2010	2013	2007	2010	2013	2007	2010	2013
<i>All people</i>															
14–19 years	24.4	20.6	19.6	11.1	8.3	8.7	17.2	18.4	15.5	15.1	14.3	8.9	2.0	1.6	*0.5
20–29 years	21.4	23.5	25.5	15.3	14.5	16.0	21.2	20.8	20.5	24.6	22.4	18.2	4.2	3.9	3.0
18–24 years	18.0	20.2	21.4	14.9	11.3	14.4	20.6	22.5	24.9	29.3	27.9	20.3	3.7	3.6	1.8
25–34 years	29.6	28.0	31.2	18.0	16.5	15.9	19.3	19.5	17.0	16.2	15.4	14.4	4.3	4.5	3.5
35–44 years	38.1	37.7	37.9	17.4	16.3	15.8	14.2	13.8	13.4	12.0	12.4	10.7	5.9	5.5	5.9
45–54 years	46.4	45.1	44.5	14.2	12.3	11.7	11.7	10.7	11.0	8.4	9.4	10.2	6.4	7.1	5.7
55–64 years	53.6	52.3	52.9	9.9	9.5	9.0	7.6	7.6	8.2	5.2	6.0	5.9	6.2	6.3	6.3
65–74 years	57.6	60.3	58.3	5.4	4.5	4.7	3.9	3.9	4.5	2.6	2.8	3.0	4.9	4.4	5.2
75+ years	58.8	57.9	56.4	3.0	2.3	2.4	2.1	1.7	1.5	1.2	1.2	1.0	2.3	2.5	2.1
Total	40.3	39.6	40.2	12.9	11.6	11.4	12.8	12.8	12.2	11.4	11.4	9.9	4.9	4.8	4.4

(a) Data on abstainers is in table 12A.70.

(b) Results subject to RSEs of between 25 per cent and 50 per cent should be considered with caution and those with relative standard errors greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " ** " and those with RSEs of between 25 per cent and 50 per cent are marked with " * ".

(c) Never had more than 4 standard drinks on any occasion.

(d) Had more than 4 standard drinks at least once a year but not as often as monthly.

(e) Had more than 4 standard drinks at least once a month but not as often as weekly.

(f) Had more than 4 standard drinks at least once a week but not as often as most days.

(g) Had more than 4 standard drinks on most days or every day.

Source: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra.

TABLE 12A.72

Table 12A.72 **Selected illicit drug use, by substance and age group (per cent)**
(a), (b)

	1995	1998	2001	2004	2007	2010	2013
<i>Cannabis</i>							
14–19 years	29.2	35.1	24.6	17.9	12.9	15.7	14.8
20–29 years	33.5	36.9	29.3	26.0	20.8	21.3	20.8
30–39 years	13.4	20.3	16.1	15.9	12.1	13.6	12.3
40–49 years	5.2	11.5	8.7	8.7	8.3	9.4	9.5
50–59 years	1.5	6.3	3.3	3.2	3.8	5.5	7.3
60 years or over	0.3	1.2	0.5	0.3	0.5	0.5	1.2
14 years or over	13.1	17.9	12.9	11.3	9.1	10.3	10.2
<i>Ecstasy</i>							
14–19 years	0.6	3.1	5.0	4.3	5.0	2.8	3.0
20–29 years	4.0	8.4	10.4	12.0	11.2	9.9	8.6
30–39 years	0.5	1.3	2.4	4.0	4.7	3.9	2.6
40 years or over	–	0.4	0.2	0.3	0.6	0.5	0.5
14 years or over	0.9	2.4	2.9	3.4	3.5	3.0	2.5
<i>Meth/amphetamines</i>							
14–19 years	2.7	5.9	6.2	4.4	1.6	1.6	*2.0
20–29 years	8.4	12.0	11.2	10.7	7.3	5.9	5.8
30–39 years	1.3	2.6	3.1	4.1	3.9	3.4	3.1
40 years or over	0.2	0.5	0.4	0.4	0.4	0.5	0.6
14 years or over	2.1	3.7	3.4	3.2	2.3	2.1	2.1
<i>Cocaine</i>							
14–19 years	1.1	0.8	1.5	1.0	1.1	1.3	*1.1
20–29 years	4.0	3.9	4.3	3.0	5.1	6.5	5.9
30–39 years	0.8	1.8	1.5	1.8	2.9	3.7	3.5
40 years or over	–	0.3	0.3	0.2	0.3	0.4	0.7
14 years or over	1.0	1.4	1.3	1.0	1.6	2.1	2.1

(a) Used in the previous 12 months.

(b) Results subject to RSEs of between 25 per cent and 50 per cent are marked with " * " and should be considered with caution.

Source: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra.

TABLE 12A.73

Table 12A.73 **Selected illicit drug use by people aged 18 years or over, by level of psychological distress and self-reported health conditions (per cent) (a), (b)**

	<i>Not used drug in last 12 months</i>			<i>Used drug in last 12 months</i>			<i>All people (18+)</i>
	<i>2007</i>	<i>2010</i>	<i>2013</i>	<i>2007</i>	<i>2010</i>	<i>2013</i>	<i>2013</i>
<i>Any illicit drug</i>							
<i>Level of psychological distress</i>							
Low	71.7	71.8	71.6	52.7	57.3	56.7	69.3
Moderate	19.9	19.6	19.7	29.2	25.8	25.9	20.6
High	6.6	6.5	6.5	13.4	12.8	11.1	7.2
Very high	1.7	2.1	2.1	4.7	4.1	6.4	2.8
<i>Self-reported health condition (c)</i>							
Diabetes	5.9	5.7	6.7	2.8	3.3	3.6	6.3
Heart diseases (d)	19.6	20.4	21.7	8.8	10.1	11.6	20.4
Asthma	8.2	8.3	9.2	10.5	10.3	10.9	9.5
Cancer	2.9	3.0	3.1	1.1	1.4	2.0	2.9
Mental illness (e)	10.3	10.8	12.6	16.1	18.7	20.7	13.9
<i>Cannabis</i>							
<i>Level of psychological distress</i>							
Low	70.1	71.1	70.7	52.8	56.7	57.1	69.3
Moderate	20.8	19.8	20.1	28.0	27.0	25.9	20.6
High	7.2	6.8	6.8	14.6	12.7	11.0	7.2
Very high	1.9	2.3	2.4	4.6	3.6	5.9	2.8
<i>Self-reported health condition (c)</i>							
Diabetes	5.8	5.8	6.8	1.4	2.0	1.4	6.3
Heart diseases (d)	19.0	20.5	21.8	5.8	5.9	7.2	20.4
Asthma	8.4	8.5	9.5	10.5	10.0	9.8	9.5
Cancer	2.8	3.0	3.2	0.8	0.9	1.1	2.9
Mental illness (e)	10.8	11.3	13.0	15.7	18.7	21.2	13.9
<i>Ecstasy</i>							
<i>Level of psychological distress</i>							
Low	69.9	70.1	70.0	49.5	55.9	51.4	69.3
Moderate	20.7	20.2	20.4	31.3	28.9	30.7	20.6
High	7.3	7.3	7.0	16.0	12.1	12.0	7.2
Very high	2.1	2.4	2.6	3.2	3.0	6.0	2.8
<i>Self-reported health condition (c)</i>							
Diabetes	5.7	5.5	6.5	1.1	**1.0	**0.8	6.3
Heart diseases (d)	18.9	19.5	20.9	3.2	*1.2	*1.7	20.4
Asthma	8.4	8.6	9.5	11.2	11.0	9.8	9.5
Cancer	2.8	2.9	3.0	0.3	**0.2	**0.6	2.9
Mental illness (e)	10.9	11.9	13.6	16.0	16.2	17.9	13.9

TABLE 12A.73

Table 12A.73 **Selected illicit drug use by people aged 18 years or over, by level of psychological distress and self-reported health conditions (per cent) (a), (b)**

	<i>Not used drug in last 12 months</i>			<i>Used drug in last 12 months</i>			<i>All people (18+)</i>
	<i>2007</i>	<i>2010</i>	<i>2013</i>	<i>2007</i>	<i>2010</i>	<i>2013</i>	<i>2013</i>
<i>Meth/amphetamines</i>							
<i>Level of psychological distress</i>							
Low	69.9	70.1	70.0	44.7	51.2	41.7	69.3
Moderate	20.9	20.3	20.4	31.7	28.0	31.8	20.6
High	7.2	7.3	7.0	19.0	13.3	15.6	7.2
Very high	2.0	2.3	2.6	4.6	7.5	10.9	2.8
<i>Self-reported health condition (c)</i>							
Diabetes	5.7	5.5	6.4	0.9	*1.5	*1.4	6.3
Heart diseases (d)	18.8	19.3	20.7	3.7	4.5	5.2	20.4
Asthma	8.4	8.6	9.5	11.4	11.2	11.5	9.5
Cancer	2.8	2.9	3.0	0.1	*0.7	*1.9	2.9
Mental illness (e)	10.9	11.7	13.5	20.3	25.6	29.0	13.9
<i>Cocaine</i>							
<i>Level of psychological distress</i>							
Low	69.6	70.0	69.8	45.8	55.0	55.3	69.3
Moderate	20.9	20.3	20.4	35.8	27.4	27.4	20.6
High	7.4	7.3	7.1	14.4	14.1	11.7	7.2
Very high	2.1	2.4	2.7	3.9	3.4	5.6	2.8
<i>Self-reported health condition (c)</i>							
Diabetes	5.6	5.5	6.4	0.9	**0.5	**0.8	6.3
Heart diseases (d)	18.6	19.4	20.7	4.4	*2.3	*3.5	20.4
Asthma	8.4	8.7	9.6	12.1	6.7	7.8	9.5
Cancer	2.7	2.9	3.0	0.2	**0.4	**1.0	2.9
Mental illness (e)	11.1	11.9	13.7	15.2	17.4	17.4	13.9

(a) Recent use means used in the previous 12 months.

(b) Results subject to RSEs of between 25 per cent and 50 per cent should be considered with caution and those with relative standard errors greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " ** " and those with RSEs of between 25 per cent and 50 per cent are marked with " * ".

(c) Respondents could select more than one condition in response to the question 'In the last 12 months have you been diagnosed or treated for...?'.
(d) Includes heart disease and hypertension (high blood pressure).

(e) Includes depression, anxiety disorder, schizophrenia, bipolar disorder, an eating disorder and other form of psychosis.

Source: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra.

TABLE 12A.74

Table 12A.74 **Illicit drug use, people aged 14 years or older, by social characteristics (per cent) (a)**

	<i>Never used</i>			<i>Ex-users (b)</i>			<i>Recent users (c)</i>		
	2007	2010	2013	2007	2010	2013	2007	2010	2013
<i>All illicit drugs</i>									
<i>Socioeconomic status</i>									
Quintile 1 (lowest)	65.1	64.0	61.6	21.1	20.9	22.5	13.8	15.1	15.9
Quintile 2	65.3	61.8	59.7	23.4	22.7	25.4	11.4	15.5	15.0
Quintile 3	64.2	60.4	57.4	22.2	26.0	27.7	13.6	13.6	14.9
Quintile 4	60.5	59.5	57.5	26.2	26.5	27.9	13.3	14.0	14.6
Quintile 5 (highest)	59.5	57.1	56.3	26.0	27.7	28.7	14.5	15.2	15.0
<i>Geography</i>									
Major cities	62.5	60.6	59.1	23.7	24.6	26.0	13.8	14.8	14.9
Inner regional	64.4	61.2	58.0	23.8	24.9	27.9	11.8	13.9	14.1
Outer regional	61.0	59.9	55.9	26.2	25.0	27.4	12.8	15.0	16.7
Remote/Very remote	51.8	50.8	49.9	27.6	31.9	31.4	20.6	17.2	18.7
<i>Indigenous status</i>									
Aboriginal and/or Torres Strait Islander	47.1	46.5	47.4	28.5	28.5	28.5	24.4	25.0	24.1
Non-Indigenous	62.7	60.8	58.6	24.2	25.1	26.6	13.1	14.2	14.8
<i>Cannabis</i>									
<i>Socioeconomic status</i>									
Quintile 1 (lowest)	70.9	68.7	69.7	20.0	21.0	20.0	9.0	10.3	10.3
Quintile 2	70.6	66.5	67.0	22.3	22.8	22.9	7.2	10.7	10.1
Quintile 3	69.1	64.5	63.1	21.9	25.4	26.2	8.9	10.1	10.7
Quintile 4	65.0	63.8	64.2	26.0	26.8	25.9	9.0	9.4	9.9
Quintile 5 (highest)	64.0	60.6	63.1	26.4	28.4	26.9	9.5	11.1	10.0
<i>Geography</i>									
Major cities	67.5	64.8	66.0	23.6	24.8	24.2	8.9	10.4	9.8
Inner regional	69.1	65.5	65.0	23.0	24.7	24.9	7.9	9.8	10.1
Outer regional	66.1	64.2	63.1	24.9	25.4	24.9	9.0	10.4	12.0
Remote/Very remote	58.3	55.2	56.1	27.6	33.4	30.3	14.1	11.4	13.6
<i>Indigenous status</i>									
Aboriginal and/or Torres Strait Islander	57.6	52.0	54.4	26.9	29.5	26.6	15.5	18.5	19.0
Non-Indigenous	67.4	64.8	65.4	23.8	25.2	24.6	8.7	10.0	10.0
<i>Ecstasy</i>									
<i>Socioeconomic status</i>									
Quintile 1 (lowest)	93.4	92.0	91.8	4.1	6.2	6.6	2.5	1.9	1.6
Quintile 2	93.8	90.8	91.5	4.0	6.6	6.6	2.3	2.5	2.0
Quintile 3	91.9	90.1	89.1	4.5	7.3	8.0	3.7	2.7	3.0
Quintile 4	90.6	88.7	88.9	5.8	8.1	8.3	3.6	3.1	2.8

TABLE 12A.74

Table 12A.74 **Illicit drug use, people aged 14 years or older, by social characteristics (per cent) (a)**

	<i>Never used</i>			<i>Ex-users (b)</i>			<i>Recent users (c)</i>		
	2007	2010	2013	2007	2010	2013	2007	2010	2013
Quintile 5 (highest)	88.7	87.6	88.6	6.7	8.0	8.5	4.6	4.4	2.9
<i>Geography</i>									
Major cities	90.4	88.9	89.3	5.7	7.8	7.9	3.9	3.3	2.9
Inner regional	93.8	91.9	91.9	3.8	6.1	6.6	2.5	2.0	1.5
Outer regional	93.7	91.9	91.7	4.5	5.9	6.7	1.8	2.2	1.6
Remote/Very remote	88.8	86.4	87.1	6.6	9.5	11.1	4.6	*4.1	*1.8
<i>Indigenous status</i>									
Aboriginal and/or Torres Strait Islander	90.2	89.9	89.3	6.1	*7.0	9.7	3.7	*3.0	**1.1
Non-Indigenous	91.4	89.7	89.9	5.2	7.3	7.6	3.4	3.0	2.5
<i>Meth/amphetamines</i>									
<i>Socioeconomic status</i>									
Quintile 1 (lowest)	93.8	92.9	93.4	3.9	4.7	4.4	2.3	2.4	2.2
Quintile 2	95.0	92.9	93.7	3.1	5.0	4.1	1.8	2.1	2.1
Quintile 3	94.3	93.4	92.3	3.2	4.5	5.3	2.5	2.1	2.4
Quintile 4	93.5	92.8	94.1	4.2	5.4	4.1	2.2	1.8	1.8
Quintile 5 (highest)	93.5	93.2	94.3	4.3	4.8	3.9	2.2	2.0	1.8
<i>Geography</i>									
Major cities	93.6	92.8	93.6	3.9	5.1	4.3	2.5	2.0	2.1
Inner regional	95.1	93.8	94.3	3.2	4.1	4.1	1.7	2.0	1.6
Outer regional	94.3	94.1	94.0	4.1	4.4	4.0	1.6	1.5	2.0
Remote/Very remote	91.3	88.8	87.0	5.7	7.2	8.6	3.0	*4.0	*4.4
<i>Indigenous status</i>									
Aboriginal and/or Torres Strait Islander	92.2	92.4	89.8	5.5	*4.0	7.0	2.3	*3.6	*3.1
Non-Indigenous	94.0	93.1	93.7	3.8	5.0	4.3	2.2	2.0	2.0
<i>Cocaine</i>									
<i>Socioeconomic status</i>									
Quintile 1 (lowest)	96.4	95.0	94.2	3.2	4.0	4.6	0.5	1.0	1.2
Quintile 2	96.1	94.7	94.2	3.2	3.9	4.4	0.7	1.4	1.4
Quintile 3	95.1	93.0	92.7	3.7	5.5	5.4	1.2	1.5	1.9
Quintile 4	93.8	92.2	91.2	4.4	5.6	6.3	1.8	2.2	2.5
Quintile 5 (highest)	90.7	89.5	90.0	6.0	6.2	6.5	3.3	4.3	3.5
<i>Geography</i>									
Major cities	93.1	91.8	91.6	4.8	5.6	5.8	2.1	2.6	2.6
Inner regional	96.8	94.7	94.7	2.6	4.3	4.5	0.6	1.0	0.8
Outer regional	95.3	95.7	94.1	4.3	3.4	4.8	0.4	*0.9	*1.1
Remote/Very remote	95.0	92.6	92.0	2.7	5.3	5.6	2.3	**2.0	*2.5

Table 12A.74 **Illicit drug use, people aged 14 years or older, by social characteristics (per cent) (a)**

	<i>Never used</i>			<i>Ex-users (b)</i>			<i>Recent users (c)</i>		
	2007	2010	2013	2007	2010	2013	2007	2010	2013
<i>Indigenous status</i>									
Aboriginal and/or Torres Strait Islander	92.4	95.9	93.4	6.3	*3.2	4.8	1.3	**0.9	*1.9
Non-Indigenous	94.2	92.7	92.3	4.2	5.2	5.5	1.6	2.1	2.2

(a) Results subject to RSEs of between 25 per cent and 50 per cent should be considered with caution and those with relative standard errors greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " ** " and those with RSEs of between 25 per cent and 50 per cent are marked with " * ".

(b) Used, but not in the previous 12 months.

(c) Used in the previous 12 months.

Source: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra.

TABLE 12A.75

Table 12A.75 **Prevalence of lifetime mental disorders among adults aged 16–85 years, 2007 (per cent) (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Any 12-month mental disorder (c)									
Anxiety disorders	14.4 ± 1.7	15.4 ± 2.0	13.1 ± 2.5	15.1 ± 3.7	14.4 ± 3.3	np	np	np	14.4 ± 0.9
Affective disorders	6.4 ± 1.2	6.6 ± 1.7	6.1 ± 1.6	6.2 ± 1.8	6.3 ± 2.3	np	np	np	6.2 ± 0.7
Substance use disorders	4.2 ± 1.1	5.5 ± 1.3	5.8 ± 1.8	6.0 ± 2.2	5.5 ± 2.0	np	np	np	5.1 ± 0.7
Any 12-month mental disorder (c), (d)	20.1 ± 2.2	20.7 ± 2.3	19.2 ± 2.6	21.4 ± 4.1	19.1 ± 3.4	14.1 ± 5.4	np	np	20.0 ± 1.1
Lifetime mental disorder, with no 12-month symptoms (e)	23.2 ± 1.9	26.3 ± 2.9	28.1 ± 3.4	23.6 ± 4.1	26.3 ± 4.1	30.7 ± 6.9	np	33.3 ± 12.9	25.5 ± 1.4
Without lifetime mental disorders (f)	56.7 ± 2.2	53.0 ± 3.6	52.6 ± 3.8	55.1 ± 5.2	54.6 ± 4.5	55.2 ± 8.2	53.1 ± 11.9	49.0 ± 18.8	54.5 ± 1.4

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) A person can have had more than one 12-month mental disorder. Therefore, the components may not add to the total.

(e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(f) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source: ABS (unpublished) *2007 Survey of Mental Health and Wellbeing*, Cat. no. 4326.0.

Table 12A.76 Prevalence of lifetime mental disorders among adults aged 16–85 years, by sex, 2007 (per cent) (a)

	<i>Males</i>	<i>Females</i>	<i>People</i>
Any 12-month mental disorder (b), (c)			
Anxiety disorders			
Panic disorders	2.3 ± 0.7	2.8 ± 0.6	2.6 ± 0.5
Agoraphobia	2.1 ± 0.7	3.5 ± 0.7	2.8 ± 0.5
Social phobia	3.8 ± 1.0	5.7 ± 0.8	4.7 ± 0.6
Generalised anxiety disorder	2.0 ± 0.7	3.5 ± 0.8	2.7 ± 0.6
Obsessive compulsive disorder	1.6 ± 0.6	2.2 ± 0.5	1.9 ± 0.4
Post traumatic stress disorder	4.6 ± 1.0	8.3 ± 1.0	6.4 ± 0.6
<i>Any anxiety disorder (c)</i>	10.8 ± 1.4	17.9 ± 1.3	14.4 ± 0.9
Affective disorders			
Depression (d)	3.1 ± 0.8	5.1 ± 0.8	4.1 ± 0.6
Dysthymia	1.0 ± 0.4	1.5 ± 0.5	1.3 ± 0.3
Bipolar	1.8 ± 0.6	1.7 ± 0.4	1.8 ± 0.4
<i>Any affective disorder (c)</i>	5.3 ± 1.0	7.1 ± 1.0	6.2 ± 0.7
Substance use disorders			
Alcohol harmful use	3.8 ± 0.8	2.1 ± 0.6	2.9 ± 0.5
Alcohol dependence	2.2 ± 0.7	0.7 ± 0.2	1.4 ± 0.3
Drug use (e)	2.1 ± 0.6	0.8 ± 0.3	1.4 ± 0.3
<i>Any substance use disorder (c), (e)</i>	7.0 ± 1.2	3.3 ± 0.7	5.1 ± 0.7
Any 12-month mental disorder (c)	17.6 ± 1.9	22.3 ± 1.3	20.0 ± 1.1
Lifetime mental disorder, with no 12-month symptoms (f)	30.5 ± 2.2	20.7 ± 1.4	25.5 ± 1.4
No lifetime mental disorder (g)	51.9 ± 2.0	57.0 ± 1.7	54.5 ± 1.4

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(c) A person can have had more than one 12-month mental disorder. Therefore, the components may not add to the total.

(d) Includes severe depressive episode, moderate depressive episode and mild depressive episode.

(e) Includes harmful use and dependence.

(f) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(g) People who did not meet criteria for diagnosis of a lifetime mental disorder.

Source: ABS (unpublished) 2007 Survey of Mental Health and Wellbeing, Cat. no. 4326.0.

TABLE 12A.77

Table 12A.77 **Prevalence of lifetime mental disorders among adults, by age, 2007 (per cent) (a), (b)**

	16–24 years	25–34 years	35–44 years	45–54 years	55–64 years	65–74 years	75–85 years
Any 12-month mental disorder (c), (d)							
Anxiety disorders	15.4 ± 2.0	16.3 ± 2.8	18.1 ± 3.0	17.6 ± 3.0	11.3 ± 1.9	6.3 ± 1.5	4.0 ± 1.8
Affective disorders	6.3 ± 1.5	7.9 ± 2.1	8.3 ± 2.1	7.1 ± 2.2	4.2 ± 1.3	2.8 ± 1.2	np
Substance use disorders	12.7 ± 2.0	7.3 ± 2.2	4.6 ± 1.6	3.8 ± 1.6	np	np	np
Any 12-month mental disorder (c), (d)	26.4 ± 2.7	24.8 ± 3.2	23.3 ± 3.3	21.5 ± 3.5	13.6 ± 2.1	8.6 ± 1.6	5.9 ± 2.1
Lifetime mental disorder, with no 12-month symptoms (e)	13.2 ± 2.0	29.0 ± 4.4	30.7 ± 3.3	30.4 ± 4.2	27.6 ± 3.6	23.1 ± 2.6	16.2 ± 4.1
No lifetime mental disorder (f)	60.5 ± 3.0	46.2 ± 3.9	46.0 ± 3.3	48.2 ± 4.6	58.8 ± 4.1	68.3 ± 3.0	77.8 ± 4.6

(a) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.

(b) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) A person can have had more than one 12-month mental disorder. Therefore, the components may not add to the total.

(e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(f) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source: ABS (unpublished) *2007 Survey of Mental Health and Wellbeing*, Cat. no. 4326.0.

TABLE 12A.78

Table 12A.78 **Prevalence of lifetime mental disorders among adults, by disadvantage and section of state, 2007 (per cent) (a)**

	<i>Mental disorders with symptoms in last 12 months (b)</i>			<i>Total mental disorders with symptoms in last 12 months (b), (c)</i>	<i>Total without mental disorders with symptoms in last 12 months (d)</i>	<i>Total</i>
	<i>Anxiety disorders</i>	<i>Affective disorders</i>	<i>Substance use disorders</i>			
<i>Index of disadvantage</i>						
1st quintile	15.8 ± 2.6	7.5 ± 2.1	5.6 ± 1.8	21.5 ± 3.0	78.5 ± 2.9	100.0
5th quintile	10.9 ± 2.3	4.2 ± 1.1	4.0 ± 1.2	15.9 ± 2.7	84.1 ± 2.8	100.0
<i>Section of state</i>						
Major urban	14.6 ± 1.2	6.5 ± 0.8	5.5 ± 0.8	20.4 ± 1.4	79.6 ± 1.4	100.0
Other urban	13.3 ± 2.1	6.1 ± 1.4	4.8 ± 1.3	19.2 ± 2.7	80.8 ± 2.7	100.0
Balance of state	14.9 ± 2.7	5.1 ± 1.7	3.5 ± 1.2	19.2 ± 2.6	80.8 ± 2.7	100.0
All people aged 16–85 years	14.4 ± 0.9	6.2 ± 0.7	5.1 ± 0.6	20.0 ± 1.1	80.0 ± 1.1	100.0

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(c) A person can have had more than one 12-month mental disorder. Therefore, the components may not add to the total.

(d) People who did not meet criteria for diagnosis of a lifetime mental disorder and people who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

Source: ABS (2008) *2007 Survey of Mental Health and Wellbeing*, Cat. no. 4326.0.

Table 12A.79 Suicides and mortality rate, by sex, Australia (a), (b), (c)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Suicides (no.)										
Males	1 737	1 661	1 658	1 624	1 699	1 833	1 785	1 914	1 803	1 901
Females	477	437	444	494	530	508	552	566	577	634
People	2 214	2 098	2 102	2 118	2 229	2 341	2 337	2 480	2 380	2 535
Suicide death rate (per 100 000 people) (d)										
Males	17.7	16.8	16.5	16.0	16.4	17.3	16.5	17.5	16.2	16.8
Females	4.8	4.4	4.4	4.8	5.1	4.8	5.1	5.1	5.1	5.6
People	11.2	10.5	10.4	10.4	10.7	11.0	10.8	11.3	10.7	11.2

- (a) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide due to limitations of data. See ABS *Causes of Death, 2012* (Cat. no. 3303.0) Explanatory Notes 92–94.
- (b) By year of registration. Year-to-year variation can be influenced by coronial workloads.
- (c) Data for 2006 to 2010 have undergone revisions and are now considered final. Data for 2011 have been revised and are subject to further revisions. Data for 2012 are preliminary and subject to a revisions process. See ABS' *Causes of Death, Australia 2012*, publication for more information.
- (d) Crude death rate per 100 000 people using estimated resident populations (ERPs) for Australia (people) at 30 June of relevant year. Rates are derived using ERPs based on the *2006 Census* and cannot be compared with rates derived using ERPs based on the 2011 Census. Details are included in the relevant tables.

Source: ABS (2014) *Causes of Death, Australia 2012*, Cat. no. 3303.0, Canberra.

TABLE 12A.80

Table 12A.80 **Suicides and mortality rate, by age and sex, Australia (a), (b)**

	15–24 years	25–34 years	35–44 years	45–54 years	55–64 years	65–74 years	75–84 years	85 years +	All ages (c)
2012									
Suicides (no.)									
Males	214	348	400	385	246	147	99	56	1 901
Females	110	93	133	117	82	40	39	12	634
People	324	441	533	502	328	187	138	68	2 535
Suicide death rate (per 100 000 people) (d), (e)									
Males	13.6	21.0	25.2	25.4	19.2	16.7	21.6	37.6	16.8
Females	7.3	5.7	8.3	7.6	6.3	4.4	7.0	4.4	5.6
People	10.5	13.4	16.7	16.4	12.7	10.5	13.6	16.0	11.2
2008–2012									
Suicides (no.)									
Males	1 119	1 698	2 021	1 823	1 182	653	499	212	9 236
Females	410	469	591	572	374	183	142	67	2 837
People	1 529	2 167	2 612	2 395	1 556	836	641	279	12 073
Suicide death rate (per 100 000 people) (e)									
Males	14.2	21.5	26.0	24.4	19.0	16.4	22.7	32.2	16.8
Females	5.5	6.1	7.5	7.5	6.0	4.5	5.2	5.3	5.1
People	10.0	13.9	16.6	15.9	12.4	10.4	13.0	14.4	11.0

(a) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide due to limitations of data. See ABS *Causes of Death, 2011* (Cat. no. 3303.0) Explanatory Notes 92–94.

(b) Data for 2006–2010 have undergone revisions and are now considered final. Data for 2011 have been revised and are subject to further revisions. Data for 2012 are preliminary and subject to a revisions process. See ABS' *Causes of Death, Australia 2012*, publication for more information.

(c) All ages includes deaths of people aged under 15 years and age not stated.

(d) Crude death rate per 100 000 estimated resident population as at 30 June 2012 for each age group and sex. Rates are derived using ERPs based on the 2011 Census.

Table 12A.80 **Suicides and mortality rate, by age and sex, Australia (a), (b)**

	<i>15–24 years</i>	<i>25–34 years</i>	<i>35–44 years</i>	<i>45–54 years</i>	<i>55–64 years</i>	<i>65–74 years</i>	<i>75–84 years</i>	<i>85 years +</i>	<i>All ages (c)</i>
(e) Rate per 100 000 estimated resident population at 30 June of the relevant mid point year (for 2008–2012 it is 2010). Rates are derived using ERPs based on the 2011 Census. The total death rate per 100 000 people for 2008–2012 does not match that in table 12A.81 as it is a crude rate and the rate in table 12A.81 is age standardised.									

Source: ABS (2014) *Causes of Death, Australia 2012*, Cat. no. 3303.0, Canberra; ABS (2014) *Australian Demographic Statistics*, Cat. no. 3101.0.

Table 12A.81 **Suicide deaths and death rate (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i> (c)	<i>ACT</i> (c)	<i>NT</i> (c)	<i>Aust</i>
Suicide deaths (no.)									
2003	640	540	466	227	193	69	35	44	2 214
2004	587	521	453	194	178	88	26	51	2 098
2005	549	506	459	203	231	74	35	45	2 102
2006 (d)	577	485	494	245	180	72	32	33	2 118
2007 (d)	611	474	520	266	205	66	32	55	2 229
2008 (d)	620	545	553	300	175	73	36	38	2 341
2009 (d)	623	576	525	279	185	79	32	37	2 337
2010 (d)	674	558	588	313	197	64	41	45	2 480
2011 (e)	606	525	577	309	212	74	33	44	2 380
2012 (f)	707	502	621	366	197	70	24	48	2 535
2008–2012	3 230	2 706	2 864	1 567	966	360	166	212	12 073
Suicide death rate per 100 000 people (g), (h), (i)									
2003	9.6	11.0	12.3	11.6	12.6	14.5	10.8	21.2	11.1
2004	8.7	10.5	11.7	9.8	11.6	18.2	8.0	25.5	10.4
2005	8.0	9.8	11.6	10.1	14.9	15.8	10.5	21.7	10.3
2006 (d)	8.4	9.5	12.4	12.1	11.5	14.8	9.7	14.2	10.3
2007 (d)	8.8	9.0	12.5	12.6	12.9	14.1	9.1	26.5	10.5
2008 (d)	8.9	10.3	13.3	14.2	11.0	15.2	10.3	17.9	11.1
2009 (d)	8.7	10.5	12.1	12.3	11.5	15.4	8.9	17.4	10.7
2010 (d)	9.3	10.1	13.4	13.6	11.8	13.0	11.3	18.8	11.2
2011 (e)	8.2	9.2	12.9	12.9	12.9	14.1	9.3	18.5	10.5
2012 (f)	9.5	8.8	13.6	14.8	11.7	13.4	6.2	19.1	11.0
2008–2012 (g)	8.9	9.7	13.0	13.5	11.8	14.1	9.1	18.1	10.8

(a) By year of registration. Year-to-year variation can be influenced by coronial workloads.

(b) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide due to limitations of data.

(c) Low population results in small variations in the number of suicides appearing as large changes across the single year rates.

(d) Data for 2006 to 2010 have undergone revisions and are now considered final.

(e) Data for 2011 have been revised and are subject to further revisions.

(f) Data for 2012 are preliminary and subject to a revisions process.

(g) Rate per 100 000 estimated resident population at 30 June of the relevant single year or for five year average the mid-point year (2008–2012). 2008–2012 rate includes final 2008, 2009 and 2010 data, revised 2011 data and preliminary 2012 data.

(h) Death rates standardised to the mid-year 2001 population. The total death rate per 100 000 people for 2008–2012 does not match that in table 12A.80 as it reports the crude rate.

(i) The ERPs used to derived these rates differ across years. For data up to 2005 the rates are derived using ERPs based on the 2001 Census. For data up to 2008 the rates are derived using ERPs based on the 2006 Census. For data from 2009 (and for the five year averages 2008–2012) the rates are derived using the ERPs based on the 2011 Census. Rates derived using ERPs based on different Censuses are not comparable.

Table 12A.81 **Suicide deaths and death rate (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (c)</i>	<i>ACT (c)</i>	<i>NT (c)</i>	<i>Aust</i>
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Source: ABS (2014) *Causes of Death, Australia 2012*, Cat. no. 3303.0, Canberra; ABS (unpublished) *Causes of Death, Australia*, Cat. no. 3303.0.

Table 12A.82 Suicide deaths and death rate of people aged 15–24 years (a), (b), (c), (d), (e)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i> (f)	<i>ACT</i> (f)	<i>NT</i> (f)	<i>Aust</i> (g)
Number of suicide deaths of people aged 15–24 years									
2003	78	64	64	39	27	6	9	13	300
2004	75	66	54	23	22	np	3	np	265
2005	66	61	67	30	37	9	5	15	290
2006	74	61	74	41	25	9	6	8	298
2007	54	74	81	46	19	4	3	21	300
2008	62	63	80	44	21	np	6	9	288
2009	63	60	63	47	21	8	np	11	276
2010	65	79	76	37	22	7	3	11	299
2011	61	64	89	53	36	10	5	16	334
2012	75	64	78	56	20	10	3	18	324
2008–2012	326	330	386	237	120	35	17	65	1 521
Suicide death rate per 100 000 people aged 15–24 years (h), (i)									
2003	8.7	9.6	12.0	14.0	13.3	9.4	17.4	42.7	10.9
2004	8.3	9.7	9.9	8.2	10.8	np	5.8	np	9.5
2005	7.2	8.9	11.9	10.5	17.9	13.9	9.7	48.1	10.2
2006	8.0	8.5	12.8	13.8	11.7	13.8	11.1	24.5	10.3
2007	5.7	10.1	13.6	15.1	8.8	4.6	3.6	62.6	10.1
2008	6.4	8.3	13.0	14.0	9.6	np	11.0	26.1	9.5
2009	6.5	7.8	10.3	14.5	9.6	12.1	7.0	30.8	9.1
2010	6.7	10.3	12.2	11.3	9.9	10.5	np	30.4	9.8
2011	6.4	8.3	14.2	16.0	16.3	15.1	8.5	45.1	10.9
2012	7.8	8.3	12.3	16.6	9.1	15.2	np	50.9	10.5
2008–2012 (h)	6.8	8.6	12.4	14.5	10.8	11.4	6.5	36.0	9.9

- (a) By year of registration. Year-to-year variation can be influenced by coronial workloads.
- (b) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide. For further information, see Explanatory Notes 92-95 of Causes of Death, Australia, 2011 (cat. No. 3303.0).
- (c) From 2006 data onwards, data cells with small values have been randomly assigned to protect the confidentiality of individuals. As a result, some totals will not equal the sum of their components. Rates use the actual count and not the randomly assigned value. Cells with a zero value have not been affected by confidentialisation.
- (d) All footnotes and caveats, including this notice, must remain attached to data at all times.
- (e) All causes of death data from 2006 onward are subject to a revisions process — once data for a reference year are 'final', they are no longer revised. Revised data for this year's report are: 2010 (final), 2011 (revised) and the data for 2012 are preliminary.
- (f) Low population results in small variations in the number of suicides appearing as large changes across the single year rates.
- (g) Includes 'Other Territories'.
- (h) Rate per 100 000 ERP at 30 June of the relevant single year or for five year average the mid-point year (2008–2012). 2008–2012 rate includes final 2008, 2009 and 2010 data, revised 2011 data and preliminary 2011 data.

Table 12A.82 Suicide deaths and death rate of people aged 15–24 years (a), (b), (c), (d), (e)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT (f)</i>	<i>NT (f)</i>	<i>Aust (g)</i>
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(i) The ERPs used to derived these rates differ across years. For data up to 2005 the rates are derived using ERPs based on the 2001 Census. For data up to 2008 the rates are derived using ERPs based on the 2006 Census. For data from 2009 (and for the five year averages 2007–2011) the rates are derived using the ERPs based on the 2011 Census. Rates derived using ERPs based on different Censuses are not comparable.

np not published

Source: ABS (2014) *Causes of Death, Australia 2012*, Cat. no. 3303.0, Canberra; ABS (unpublished) *Causes of Death, Australia*, Cat. no. 3303.0.

Table 12A.83 Suicide deaths and suicide death rate, by area (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (l)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (m)</i>
<i>Number of suicide deaths by area</i>									
2003									
Capital city	379	372	220	164	137	27	35	20	1 354
Other urban	218	111	185	48	39	22	..	12	635
Rural	38	54	55	11	16	19	..	12	205
2004									
Capital city	358	345	194	141	125	29	26	22	1 240
Other urban	192	122	199	38	np	37	..	..	629
Rural	32	50	55	15	21	22	..	16	211
2005									
Capital city	342	332	179	142	173	29	35	23	1 255
Other urban	186	124	204	45	33	31	..	11	634
Rural	19	49	69	14	25	12	..	11	199
2006									
Capital city	340	330	187	157	133	28	32	14	1 221
Other urban	129	64	171	19	..	20	..	..	403
Rural	108	91	136	69	47	24	–	19	494
2007									
Capital city	393	327	189	180	148	22	32	27	1 318
Urban centres	140	63	191	20	–	25	–	..	439
Rural	76	84	137	65	57	18	–	27	464
2008									
Capital city	362	374	216	219	125	27	36	23	1 382
Urban centres	127	76	215	27	..	26	..	..	471
Rural	131	95	122	54	50	20	–	15	487
2009									
Capital city	326	385	198	194	145	35	32	15	1 330
Urban centres	208	107	198	35	18	22	..	2	591
Rural	87	81	124	44	20	22	–	19	398
2010									
Capital city	352	366	220	225	151	33	41	20	1 408
Urban centres	204	100	227	41	17	15	..	3	608
Rural	115	89	133	45	26	16	–	21	445
2011									
Capital city	317	354	251	196	155	31	32	12	1 348
Urban centres	201	87	213	47	18	25	..	4	595
Rural	82	82	111	65	38	18	3	27	424
2012									
Capital city	342	329	242	252	140	31	24	14	1 374
Urban centres	218	79	249	49	20	17	..	7	639

TABLE 12A.83

Table 12A.83 **Suicide deaths and suicide death rate, by area (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (l)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (m)</i>
Rural	144	89	124	60	37	20	–	24	498
2008–2012									
Capital city	1 657	1 797	1 132	1 089	721	156	165	81	6 798
Urban centres	1 014	471	1 110	203	93	99	..	22	3 012
Rural	539	421	598	258	146	103	2	105	2 171
<i>Suicide death rate per 100 000 people by area (n)</i>									
2003									
Capital city	9.0	10.5	12.7	11.5	12.2	13.5	10.8	18.5	10.7
Other urban	10.0	10.9	11.7	12.6	16.8	12.0	..	26.1	11.3
Rural	12.2	16.0	11.3	7.9	9.2	20.4	..	26.9	12.9
Total	9.6	11.0	12.3	11.6	12.6	14.5	10.8	21.2	11.1
2004									
Capital city	8.5	9.6	10.9	9.7	11.1	14.3	8.0	20.1	9.7
Other urban	8.8	11.8	12.3	9.9	np	19.9	..	np	11.1
Rural	10.2	14.7	11.1	10.9	12.0	23.4	–	37.1	13.2
Total	8.7	10.5	11.7	9.8	11.6	18.2	8.0	25.5	10.4
2005									
Capital city	7.8	8.9	9.8	9.5	15.0	14.5	10.5	19.6	9.5
Other urban	8.6	12.2	12.3	11.6	14.8	17.0	..	22.2	11.2
Rural	6.5	14.7	13.9	9.6	13.5	12.9	..	27.2	12.5
Total	8.0	9.8	11.6	10.1	14.9	15.8	10.5	21.7	10.3
2006									
Capital city	7.8	8.8	10.3	10.5	11.5	13.8	9.7	np	9.2
Other urban	10.0	11.0	12.8	np	..	10.9	..	..	11.3
Rural	9.3	11.7	16.6	20.9	11.5	23.8	..	np	13.2
Total	8.4	9.5	12.4	12.1	11.5	14.8	9.7	14.2	10.3
2007									
Capital city	8.8	8.3	10.1	11.4	12.5	10.7	9.1	22.8	9.6
Urban centres	10.8	10.7	12.9	10.3	..	13.9	..	..	11.7
Rural	6.4	10.9	17.0	18.9	13.8	18.5	..	29.1	12.5
Total	8.8	9.0	12.5	12.6	12.9	14.1	9.1	26.5	10.5
2008									
Capital city	8.3	9.5	11.5	14.0	10.6	13.3	10.3	20.2	10.2
Urban centres	9.8	12.9	14.4	13.9	..	13.6	..	..	12.6
Rural	10.9	11.9	15.2	16.5	12.6	22.4	..	np	13.2
Total	8.9	10.3	13.3	14.2	11.0	15.2	10.3	17.9	11.1
2009									
Capital city	7.8	9.6	9.9	11.2	11.9	17.0	8.9	np	9.6
Urban centres	11.1	13.8	12.3	13.7	np	13.9	..	np	12.2
Rural	9.2	12.0	17.5	15.6	8.1	14.7	–	np	12.8

Table 12A.83 Suicide deaths and suicide death rate, by area (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (l)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (m)</i>
Total	8.7	10.5	12.1	12.3	11.5	15.4	8.9	17.4	10.7
2010									
Capital city	8.3	9.1	10.9	12.9	11.9	16.5	11.4	17.7	10.0
Urban centres	10.6	12.6	14.1	15.7	np	np	..	np	12.4
Rural	11.9	12.6	17.9	15.5	10.0	np	–	21.1	14.1
Total	9.3	10.1	13.4	13.6	11.8	13.0	11.3	18.8	11.2
2011									
Capital city	7.3	8.5	12.1	10.8	12.4	14.4	9.0	np	9.4
Urban centres	10.4	10.5	12.9	17.2	np	16.1	..	np	11.9
Rural	8.5	11.5	15.3	22.0	14.7	np	np	30.7	13.6
Total	8.2	9.2	12.9	12.9	12.9	14.1	9.3	18.5	10.5
2012									
Capital city	7.8	7.9	11.5	13.4	10.9	14.9	6.2	np	9.4
Urban centres	11.3	9.6	14.7	17.4	16.8	np	..	np	12.6
Rural	14.7	13.0	16.8	20.3	13.4	12.3	–	24.3	15.6
Total	9.5	8.8	13.6	14.8	11.7	13.4	6.2	19.1	11.0
2008–2012									
Capital city	7.8	8.8	11.2	12.4	11.5	15.2	9.1	14.3	9.7
Urban centres	10.6	11.8	13.6	15.4	14.5	12.4	..	14.8	12.2
Rural	11.1	12.2	16.5	17.9	11.3	14.2	np	23.0	13.8
Total	8.9	9.7	13.0	13.5	11.8	14.1	9.1	18.1	10.8

- (a) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide. See Explanatory Notes 92-94, Causes of Death, Australia, 2012 (Cat. no. 3303.0).
- (b) The total for each state and territory includes deaths registered to that state but which had a usual address which was undefined, overseas, of no fixed abode or off-shore and migratory. Such 'special purpose' Statistical Area 2s are only included in the state total.
- (c) The Australian total includes the 'Other Territories' — Jervis Bay, Christmas Island and the Cocos (Keeling) Islands.
- (d) The capital city, urban centres and rural groupings are based on the ABS' Significant Urban Areas classification (Cat. no. 1270.0.55.004). Capital cities are comprised of those Statistical Area 2s classified as capital cities. Urban centres are comprised of all Statistical Area 2s within a state which are classified as having or contributing to an urban area with a population of 10,000 or greater, excluding capital cities. Rural areas are those Statistical Area 2s which are not within a capital city or urban centre. For further information, see Cat. no. 1270.0.55.004 - Australian Statistical Geography Standard (ASGS): Volume 4 – Significant Urban Areas, Urban Centres and Localities, Section of State, July 2011. Data supplied in previous years also appear in this table (2003–2008), and for these years the geographical breakdown was based on a different method, using the ASGC (see footnotes g and h in this table). For years prior to 2008, death rates data are based on the previous year's ERP (i.e. 2007 ERP data for 2008 causes of death).
- (e) All causes of death data from 2006 onward are subject to a revisions process — once data for a reference year are 'final', they are no longer revised. Revised data for this year's report are: 2010 (final), 2011 (revised) and the data for 2012 are preliminary.

Table 12A.83 Suicide deaths and suicide death rate, by area (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k)

	NSW	Vic	Qld	WA	SA	Tas (l)	ACT	NT	Aust (m)
(f)	For data from 2006, cells with small values have been randomly assigned to protect the confidentiality of individuals. As a result, some totals will not equal the sum of their components. Cells with a zero value have not been affected by confidentialisation.								
(g)	For single year data prior to 2006, the categories were as follows: 'capital city' comprises capital city statistical divisions; 'other urban' comprises centres with more than 20 000 people; 'rural' comprises all areas except capital cities and other urban. 'Other urban' comprises statistical local areas with 50 per cent or greater of their 2001 census enumerated population contained in urban centres, based on Australian Standard Geographical Classification (ASGC) 2001 boundaries. 'Rural' comprises statistical local areas with 50 per cent or greater of their 2001 census enumerated population contained in rural areas. Changes in the population within geographical areas may not be reflected in the rates provided. There is some risk that urban growth areas have been classified as rural as the geography was based on the population in those areas in 2001. Therefore, analysis of data should be undertaken with caution.								
(h)	For single year 2006, 2007 and 2008, the categories were derived as follows: 'capital cities' — comprising capital city statistical divisions, 'urban centres' — based on 'statistical districts' that are urban centres with population >25 000 people, excluding capital city statistical divisions, (three statistical districts cross state boundaries and have to be split across the relevant states/territories — Albany–Wodonga, Canberra–Queanbeyan and Gold Coast–Tweed); 'rural' — balance of state, that is all areas other than capital cities and urban centres.								
(i)	For the single years 2009, 2010, 2011 and the five year sum and averages (2007–2011), the capital city, urban centres and rural groupings are based on the ABS' Significant Urban Areas classification (Cat. no. 1270.0.55.004). Capital cities are comprised of those Statistical Area 2s classified as capital cities. Urban centres are comprised of all Statistical Area 2s within a state which are classified as having or contributing to an urban area with a population of 10,000 or greater, excluding capital cities. Rural areas are those Statistical Area 2s which are not within a capital city or urban centre. For further information, see Cat. no. 1270.0.55.004 — Australian Statistical Geography Standard (ASGS): Volume 4 — Significant Urban Areas, Urban Centres and Localities, Section of State, July 2011. Some Significant Urban Areas cross state boundaries: Canberra - Queanbeyan (ACT/NSW); Albany - Wodonga (NSW/Vic); and Gold Coast - Tweed Heads (Qld/NSW). In these cases, deaths have been included in the Urban Centre category in the relevant state. The exception is Canberra - Queanbeyan: the Canberra portion forms the Capital City area for ACT, while the Queanbeyan portion has been included in the Urban Centres data for NSW.								
(j)	All footnotes and caveats, including this notice, must remain attached to data at all times.								
(k)	The total for each state and territory includes deaths registered to that state, but which had a usual address which was undefined, overseas, of no fixed abode or off-shore and migratory. Such 'special purpose' Statistical Area 2s are only included in the state total.								
(l)	The three criteria for this data tend to distort the Tasmanian picture due to the low level of urbanisation.								
(m)	Australia includes 'Other Territories'.								
(n)	Age-standardised death rates per 100 000 are standardised to Australian 30 June 2001 population. Rates for 2008–2012 and 2012 are based on 2012 revised substate estimated resident population data.								

.. Not applicable. – Nil or rounded to zero. **np** Not published.

Source: ABS (unpublished) *Causes of Death, Australia*, Cat. no. 3303.0.

Table 12A.84 Suicide deaths, by Indigenous status, 2008–2012 (a), (b), (c), (d), (e), (f), (g)

	<i>NSW</i>	<i>Vic</i>	<i>Qld (h)</i>	<i>WA (i)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (j)</i>
<i>Number</i>									
Aboriginal and Torres Strait Islander	93	np	166	150	37	np	np	115	561
Non-Indigenous	3 087	np	2 606	1 331	908	np	np	96	8 028
Total	3 180	np	2 772	1 481	945	np	np	211	8 589
<i>Suicide rate per 100 000 (i), (j), (k)</i>									
Aboriginal and Torres Strait Islander	11.4	np	18.3	35.2	21.0	np	np	29.3	20.1
Non-Indigenous (l)	8.7	np	12.3	11.9	11.2	np	np	12.1	10.4

- (a) All causes of death data from 2006 onward are subject to a revisions process — once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2008-2010 (final), 2011 (revised), 2012 (preliminary). See Explanatory Notes 29-33 and Technical Notes, Causes of Death Revisions, 2006 in Causes of Death, Australia, 2010 (Cat. no. 3303.0) and Causes of Death Revisions, 2010 and 2011 in Causes of Death, Australia, 2012 (Cat. no. 3303.0).
- (b) Data are based on State or Territory of usual residence.
- (c) Intentional self-harm includes ICD-10 codes X60-X84 and Y87.0.
- (d) Data are presented in five-year groupings due to the volatility of small numbers each year.
- (e) Data based on reference year.
- (f) Data on deaths of Aboriginal and Torres Strait Islander Australians are affected by differing levels of coverage of deaths identified as Aboriginal and Torres Strait Islander Australians across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between the Aboriginal and Torres Strait Islander and non-Indigenous data.
- (g) Deaths where the Indigenous status of the deceased was not stated are excluded from analysis.
- (h) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See data quality statements for a more detailed explanation.
- (i) Aboriginal and Torres Strait Islander data for WA were not published in Causes of Death, Australia, 2010 (cat. no. 3303.0) due to investigations being undertaken regarding the volatility of this data. Subsequently, Aboriginal and Torres Strait Islander deaths data in WA for the years 2008 and 2009 were adjusted to correct for potential over-reporting in this period. This data was released on 22 June, 2012 in Causes of Death, Australia, 2010 (Cat. no. 3303.0). This adjusted data has been included in this table.
- (j) Total includes data for NSW, Queensland, WA, SA and the NT only. These five states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.
- (k) Denominators used in the calculation of rates for the Indigenous population are Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians (ABS Cat. no. 3238.0, series B, 2011 base). There are no comparable population data for the non-Indigenous population. Denominators used in the calculation of rates for comparison with the Indigenous population have been derived by subtracting Aboriginal and Torres Strait Islander population estimates/projections from total estimated resident population and should be used with care, as these data include population units for which Indigenous status were not stated.

Table 12A.84 **Suicide deaths, by Indigenous status, 2008–2012 (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (h)</i>	<i>WA (i)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (j)</i>
(l) Age-standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 100 000 persons. SDRs in this table have been calculated using the indirect method, age standardised by five year age group to 75 years and over. Rates calculated using the indirect method are not comparable to rates calculated using the direct method.									

np Not published.

Source: ABS (unpublished) *Causes of Death, Australia*, Cat. no. 3303.0; ABS (2014) *Estimates and Projections, Aboriginal and Torres Strait Islander Australians*, 2001 to 2026, cat. no. 3238.0.

TABLE 12A.85

Table 12A.85 **Age-standardised proportions of adults by health risk factors and mental illness status, 2011-12 (a), (b), (c)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
<i>Overweight/obese</i>									
People with mental or behavioural problems (d), (e)	64.7 ± 5.9	66.3 ± 5.9	65.4 ± 6.4	73.6 ± 5.3	69.9 ± 6.2	65.4 ± 8.4	61.8 ± 6.7	68.1 ± 13.3	67.0 ± 2.5
People without mental or behavioural problems	60.2 ± 2.4	61.0 ± 2.3	65.3 ± 2.5	64.7 ± 2.3	65.5 ± 2.5	63.5 ± 2.7	63.9 ± 4.2	63.1 ± 4.5	62.4 ± 1.2
All people	61.1 ± 2.1	61.9 ± 2.2	65.4 ± 2.3	66.0 ± 2.1	66.1 ± 2.2	64.1 ± 2.5	63.6 ± 3.9	63.7 ± 3.9	63.2 ± 1.1
<i>Daily smoker</i>									
People with mental or behavioural problems (d), (e)	23.6 ± 4.5	28.9 ± 6.4	25.7 ± 4.6	26.0 ± 5.8	26.7 ± 4.9	32.4 ± 5.7	20.0 ± 5.6	29.1 ± 10.1	26.1 ± 2.4
People without mental or behavioural problems	13.4 ± 1.5	14.7 ± 1.7	15.8 ± 2.1	15.0 ± 1.9	15.5 ± 2.1	21.5 ± 2.3	11.7 ± 2.7	21.8 ± 3.0	14.7 ± 0.8
All people	14.8 ± 1.4	16.8 ± 1.8	17.5 ± 1.9	16.9 ± 2.1	17.4 ± 1.8	23.2 ± 2.2	13.4 ± 2.6	22.6 ± 2.8	16.5 ± 0.7
<i>At risk of long term harm from alcohol (f)</i>									
People with mental or behavioural problems (d), (e)	21.7 ± 4.9	20.5 ± 3.8	20.4 ± 4.4	25.1 ± 4.7	17.8 ± 5.3	22.2 ± 6.0	22.4 ± 6.9	19.8 ± 9.0	21.3 ± 2.0
People without mental or behavioural problems	17.9 ± 1.7	17.0 ± 1.8	19.8 ± 2.0	25.2 ± 2.4	18.2 ± 1.9	23.0 ± 2.7	20.6 ± 2.3	25.0 ± 3.8	19.0 ± 0.9
All people	18.5 ± 1.5	17.5 ± 1.6	19.9 ± 1.8	25.3 ± 2.1	18.2 ± 1.8	22.8 ± 2.4	21.0 ± 2.4	24.2 ± 3.5	19.4 ± 0.8

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) Numerators — number of adults (aged 18 years or over) who are overweight or obese (by mental health status) or a daily smoker or at risk of long term harm from alcohol. Denominators — number of adults (aged 18 years or over) in the population (by mental health status).

(c) As State and Territory comparisons are affected by age, estimates have been age standardised to the 2001 estimated resident population.

(d) People with a mental or behavioural condition are defined as having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.

(e) Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions.

Table 12A.85 **Age-standardised proportions of adults by health risk factors and mental illness status, 2011-12 (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
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(f) 'At risk of long term harm' to be defined based on the 2009 NHMRC guidelines.

Source: ABS (unpublished) *Australian Health Survey 2011-13 (2011-12 NHS component)*, Cat. no. 4364.0.

TABLE 12A.86

Table 12A.86 **Age-standardised proportions of adults by long-term health conditions and mental illness status, 2011-12 (a), (b), (c)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
<i>Cancer</i>									
People with mental or behavioural problems (d), (e)	3.0* ± 1.9	3.9* ± 2.2	3.2* ± 1.8	6.6 ± 3.0	1.5* ± 1.2	4.4* ± 2.7	3.4* ± 2.7	13.4* ± 7.3	3.5 ± 0.9
People without mental or behavioural problems	1.1 ± 0.4	1.6 ± 0.5	2.1 ± 0.6	1.5 ± 0.5	1.4 ± 0.5	1.6 ± 0.7	2.1* ± 1.0	1.7* ± 0.9	1.5 ± 0.2
All people	1.4 ± 0.4	2.0 ± 0.6	2.2 ± 0.6	2.3 ± 0.6	1.4 ± 0.5	2.2 ± 0.7	2.3 ± 1.0	2.8 ± 1.3	1.8 ± 0.2
<i>Diabetes</i>									
People with mental or behavioural problems (d), (e)	7.5 ± 2.9	5.9 ± 2.1	7.2 ± 2.5	6.4 ± 2.5	6.1 ± 2.5	6.4 ± 3.0	3.4* ± 2.5	10.5* ± 9.9	6.6 ± 1.1
People without mental or behavioural problems	5.5 ± 0.8	5.0 ± 0.8	4.7 ± 1.0	5.5 ± 1.2	5.7 ± 1.2	5.3 ± 1.3	5.8 ± 1.6	6.9 ± 2.6	5.3 ± 0.4
All people	5.8 ± 0.8	5.2 ± 0.8	5.2 ± 1.0	5.6 ± 1.1	5.8 ± 1.0	5.6 ± 1.2	5.4 ± 1.3	7.5 ± 2.1	5.5 ± 0.4
<i>Arthritis</i>									
People with mental or behavioural problems (d), (e)	29.1 ± 5.5	25.4 ± 4.1	25.1 ± 4.2	24.2 ± 5.1	26.3 ± 4.2	29.4 ± 4.9	31.9 ± 4.6	26.2 ± 11.5	26.9 ± 2.4
People without mental or behavioural problems	17.0 ± 1.3	15.9 ± 1.4	16.1 ± 1.6	17.3 ± 1.8	17.7 ± 1.9	19.8 ± 2.0	16.8 ± 2.5	14.1 ± 3.2	16.7 ± 0.7
All people	18.9 ± 1.1	17.4 ± 1.4	17.6 ± 1.6	18.6 ± 1.8	19.2 ± 1.9	21.6 ± 2.0	19.3 ± 2.5	15.5 ± 3.2	18.3 ± 0.7
<i>Cardiovascular disease</i>									
People with mental or behavioural problems (d), (e)	7.6 ± 2.4	9.6 ± 2.9	12.9 ± 3.4	8.2 ± 2.8	9.9 ± 2.6	11.9 ± 4.0	15.6 ± 4.4	14.5* ± 10.7	9.5 ± 1.2
People without mental or behavioural problems	5.8 ± 0.9	4.3 ± 0.8	5.8 ± 0.9	4.6 ± 0.9	4.9 ± 1.0	6.2 ± 1.2	5.6 ± 1.4	4.3 ± 1.9	5.2 ± 0.4
All people	6.1 ± 0.9	5.1 ± 0.8	6.8 ± 0.9	5.2 ± 0.9	5.7 ± 0.9	7.0 ± 1.1	7.4 ± 1.4	5.5 ± 2.4	5.9 ± 0.4

Table 12A.86 Age-standardised proportions of adults by long-term health conditions and mental illness status, 2011-12 (a), (b), (c)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
<i>Asthma</i>									
People with mental or behavioural problems (d), (e)	16.5 ± 3.9	18.8 ± 4.0	15.5 ± 3.4	16.0 ± 5.0	14.7 ± 4.3	17.0 ± 5.6	18.8 ± 5.7	17.6* ± 10.9	16.7 ± 1.8
People without mental or behavioural problems	8.8 ± 1.5	9.4 ± 1.2	9.3 ± 1.3	9.7 ± 1.5	9.8 ± 1.7	9.8 ± 2.0	8.3 ± 1.7	7.7 ± 2.5	9.2 ± 0.7
All people	9.9 ± 1.5	10.8 ± 1.2	10.3 ± 1.3	10.8 ± 1.4	10.7 ± 1.6	11.1 ± 2.0	10.0 ± 1.7	8.7 ± 2.3	10.4 ± 0.7

- (a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a RSE of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.
- (b) Numerators — number of adults who have the specific long-term health condition (for example, cancer) (by mental health status). Denominators — number of adults in the population (by mental health status).
- (c) As State and Territory comparisons are affected by age, estimates have been age standardised to the 2001 estimated resident population.
- (d) People with a mental or behavioural condition are defined as having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.
- (e) Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions.

Source: ABS (unpublished) *Australian Health Survey 2011-13 (2011-12 NHS component)*, Cat. no. 4364.0.

TABLE 12A.87

Table 12A.87 **Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2011–12 (per cent) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
People aged 16–64 years who are employed									
People with mental or behavioural problems (d), (e)	65.2 ± 7.7	59.4 ± 6.4	57.7 ± 6.7	65.0 ± 5.9	61.2 ± 7.2	51.6 ± 8.7	72.5 ± 8.2	63.2 ± 10.3	61.7 ± 3.1
People without mental or behavioural problems	78.7 ± 1.7	81.0 ± 1.8	81.8 ± 2.0	81.5 ± 1.9	78.7 ± 2.4	76.1 ± 2.9	85.6 ± 2.1	84.8 ± 3.1	80.3 ± 0.9
All people	76.6 ± 2.0	77.7 ± 1.8	77.7 ± 2.1	78.7 ± 1.9	76.0 ± 2.5	71.8 ± 3.2	83.4 ± 2.3	81.9 ± 3.1	77.4 ± 1.0
People aged 16–64 years who are unemployed									
People with mental or behavioural problems (d), (e)	4.3* ± 2.7	6.0* ± 3.2	9.6 ± 3.3	5.5* ± 3.6	7.0* ± 3.6	8.7* ± 4.6	2.9* ± 2.7	5.6** ± 7.0	6.3 ± 1.4
People without mental or behavioural problems	2.8 ± 0.9	2.8 ± 1.0	3.2 ± 1.0	2.8 ± 1.1	3.8 ± 1.3	3.6 ± 1.2	1.4* ± 0.9	2.0* ± 1.2	3.0 ± 0.4
All people	3.0 ± 0.8	3.4 ± 1.0	4.3 ± 1.0	3.3 ± 1.0	4.3 ± 1.2	4.4 ± 1.3	1.8* ± 0.9	2.4* ± 1.2	3.5 ± 0.4
People aged 16–64 years who are in the labour force									
People with mental or behavioural problems (d), (e)	69.5 ± 7.3	65.4 ± 6.5	67.3 ± 6.6	70.6 ± 6.2	68.2 ± 7.2	60.3 ± 8.7	75.4 ± 7.9	68.7 ± 11.2	68.0 ± 3.2
People without mental or behavioural problems	81.5 ± 1.6	83.8 ± 1.7	85.1 ± 1.8	84.4 ± 1.8	82.5 ± 2.1	79.6 ± 2.9	87.0 ± 2.0	86.8 ± 2.7	83.3 ± 0.9
All people	79.7 ± 1.8	81.1 ± 1.7	82.0 ± 1.8	81.9 ± 1.6	80.3 ± 2.2	76.2 ± 3.0	85.1 ± 2.0	84.3 ± 2.7	80.8 ± 0.9
People aged 16–64 years who are not in the labour force									
People with mental or behavioural problems (d), (e)	30.5 ± 7.3	34.6 ± 6.5	32.7 ± 6.6	29.4 ± 6.2	31.8 ± 7.2	39.7 ± 8.8	24.6 ± 7.9	31.3 ± 11.1	32.0 ± 3.2
People without mental or behavioural problems	18.5 ± 1.6	16.2 ± 1.7	14.9 ± 1.8	15.6 ± 1.8	17.5 ± 2.1	20.4 ± 2.9	13.0 ± 2.0	13.2 ± 2.7	16.7 ± 0.9
All people	20.3 ± 1.8	18.9 ± 1.7	18.0 ± 1.8	18.1 ± 1.6	19.7 ± 2.2	23.8 ± 3.0	14.9 ± 2.0	15.7 ± 2.7	19.2 ± 0.9

Table 12A.87 Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2011-12 (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
(a)	The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a RSE of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution. A '***' indicates a RSE of greater than 50 per cent. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.								
(b)	Numerators — number of people aged 16–64 years who are employed/unemployed/in the labour force/not in the labour force (by mental health status). Denominators — number of people aged 16–64 years in the population (by mental health status).								
(c)	As State and Territory comparisons are affected by age, estimates have been age standardised to the 2001 estimated resident population.								
(d)	People with a mental or behavioural condition are defined as having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.								
(e)	Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions.								

Source: ABS (unpublished) *Australian Health Survey 2011-13 (2011-12 NHS component)*, Cat. no. 4364.0.

TABLE 12A.88

Table 12A.88 **Age standardised proportion of the population aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part-time), by mental health status, 2011-12 (per cent) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
People with mental or behavioural problems (d), (e)	80.8 ± 9.1	80.4 ± 12.2	79.4 ± 8.3	70.9 ± 11.9	84.2 ± 10.2	74.8 ± 11.0	82.2 ± 12.3	55.2* ± 27.9	79.2 ± 4.2
People without mental or behavioural problems	93.2 ± 2.4	90.5 ± 2.7	87.0 ± 3.4	88.7 ± 3.7	85.5 ± 4.7	86.6 ± 4.8	97.2 ± 2.1	87.5 ± 5.4	90.2 ± 1.2
All people	91.8 ± 2.3	89.2 ± 2.8	85.8 ± 3.3	85.7 ± 4.0	85.4 ± 4.4	84.5 ± 4.3	94.9 ± 2.6	83.2 ± 6.1	88.7 ± 1.1

- (a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a RSE of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution.
- (b) Numerators – number of people aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part-time), by mental health status. Denominators – number of people aged 16–30 years, by mental health status.
- (c) As State and Territory comparisons are affected by age, estimates have been age standardised to the 2001 estimated resident population.
- (d) People with a mental or behavioural condition are defined as having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.
- (e) Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions.

Source: ABS (unpublished) *Australian Health Survey 2011-13 (2011-12 NHS component)*, Cat. no. 4364.0.

TABLE 12A.89

Table 12A.89 **Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2007–08 (per cent) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
People aged 16–64 years who are employed									
People with mental or behavioural problems (d), (e)	59.3 ± 6.2	68.2 ± 5.8	65.4 ± 6.9	70.8 ± 7.5	48.6 ± 6.9	55.7 ± 8.3	75.4 ± 5.9	57.2 ± 23.7	63.8 ± 3.2
People without mental or behavioural problems	78.0 ± 2.3	79.8 ± 2.0	79.0 ± 2.3	83.1 ± 2.3	79.3 ± 2.6	74.2 ± 3.1	85.9 ± 2.1	83.4 ± 11.1	79.4 ± 1.0
All people	75.6 ± 2.2	78.4 ± 1.8	77.0 ± 2.2	81.3 ± 2.4	75.1 ± 2.6	71.6 ± 3.1	84.5 ± 2.0	83.9 ± 8.8	77.3 ± 1.0
People aged 16–64 years who are unemployed									
People with mental or behavioural problems (d), (e)	7.2 ± 3.3	4.2 ± 2.0	4.2* ± 3.2	3.1* ± 2.5	8.7 ± 3.5	6.6* ± 5.9	3.6* ± 3.5	–	5.3 ± 1.2
People without mental or behavioural problems	2.4 ± 0.8	2.3 ± 0.8	2.9 ± 1.1	2.3 ± 1.1	3.1 ± 1.0	4.1 ± 2.0	np	np	2.5 ± 0.4
All people	3.1 ± 0.8	2.5 ± 0.7	3.1 ± 1.0	2.4 ± 1.0	3.9 ± 1.0	4.3 ± 1.7	np	np	2.9 ± 0.4
People aged 16–64 years who are in the labour force									
People with mental or behavioural problems (d), (e)	66.4 ± 5.7	72.4 ± 6.1	69.6 ± 6.2	73.9 ± 7.2	57.3 ± 7.2	62.3 ± 9.5	79.1 ± 5.9	57.2 ± 23.7	69.1 ± 2.8
People without mental or behavioural problems	80.4 ± 2.2	82.1 ± 2.0	81.9 ± 2.1	85.4 ± 2.1	82.4 ± 2.2	78.3 ± 2.8	87.4 ± 2.0	85.1 ± 10.5	81.9 ± 1.0
All people	78.7 ± 2.1	80.9 ± 1.8	80.1 ± 1.9	83.7 ± 2.2	79.0 ± 2.1	75.9 ± 3.1	86.2 ± 1.9	85.6 ± 8.1	80.2 ± 1.0
People aged 16–64 years who are not in the labour force									
People with mental or behavioural problems (d), (e)	33.6 ± 5.7	27.6 ± 6.1	30.4 ± 6.2	26.1 ± 7.2	42.7 ± 7.2	37.7 ± 9.5	np	np	30.9 ± 2.8
People without mental or behavioural problems	19.6 ± 2.2	17.9 ± 2.0	18.1 ± 2.1	14.6 ± 2.1	17.6 ± 2.2	21.7 ± 2.8	np	np	18.1 ± 1.0
All people	21.3 ± 2.1	19.1 ± 1.8	19.9 ± 1.9	16.3 ± 2.2	21.0 ± 2.1	24.1 ± 3.1	13.8 ± 1.9	14.4* ± 8.1	19.8 ± 1.0

Table 12A.89 Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2007-08 (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
(a)	The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution. A '**' indicates a RSE of greater than 50 per cent. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.								
(b)	Numerators — number of people aged 16–64 years who are employed/unemployed/in the labour force/not in the labour force (by mental health status). Denominators — number of people aged 16–64 years in the population (by mental health status).								
(c)	As State and Territory comparisons are affected by age, estimates have been age standardised to the 2001 estimated resident population.								
(d)	People with a mental or behavioural condition are defined as having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.								
(e)	Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions. – Nil or rounded to zero. np Not published.								

Source: ABS (unpublished) *National Health Survey 2007-08*, Cat. no. 4364.0.

TABLE 12A.90

Table 12A.90 **Population aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part-time), by mental health status, 2007-08 (per cent) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
People with mental illness ^a	78.1 ± 11.8	80.7 ± 10.0	83.6 ± 11.3	84.0 ± 10.6	66.1 ± 9.8	63.0 ± 17.5	88.3 ± 7.2	np	79.6 ± 5.7
People without mental illness ^a	89.8 ± 2.9	91.8 ± 2.7	86.9 ± 4.4	89.8 ± 3.9	89.1 ± 3.1	87.0 ± 5.1	94.7 ± 2.3	88.0 ± 24.9	89.7 ± 1.7
All people	88.4 ± 2.8	90.3 ± 2.6	86.4 ± 3.9	88.9 ± 4.0	85.9 ± 3.3	83.3 ± 6.0	93.8 ± 2.1	88.0 ± 24.9	88.4 ± 1.6

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution.

(b) Numerators – number of people aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part-time), by mental health status. Denominators – number of people aged 16–30 years, by mental health status.

(c) As State and Territory comparisons are affected by age, estimates have been age standardised to the 2001 estimated resident population.

(d) People with a mental or behavioural condition are defined as having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.

(e) Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions.

np Not published.

Source: ABS (unpublished) 2007-08 National Health Survey, Cat. no. 4364.0.

TABLE 12A.91

Table 12A.91 **Labour force and employment participation among adults aged 16–64 years, by mental disorder status, 2007 (per cent) (a)**

	<i>Employed (b)</i>			<i>Unemployed (b)</i>	<i>In labour force</i>	<i>Not in the labour force</i>
	<i>Full-time</i>	<i>Part-time</i>	<i>Total</i>			
Any 12-month mental disorder (c)						
Anxiety disorders	59.9 ± 5.5	35.4 ± 5.3	95.3 ± 2.0	4.7 ± 2.0	71.0 ± 3.4	29.0 ± 3.4
Affective disorders	57.4 ± 6.8	32.6 ± 7.0	90.0 ± 4.3	10.0 ± 4.3	69.8 ± 4.3	30.2 ± 4.3
Substance use disorders	62.3 ± 6.9	30.8 ± 7.3	93.1 ± 3.3	6.9 ± 3.3	83.0 ± 5.4	17.0 ± 5.4
Any 12-month mental disorder (c), (d)	59.8 ± 4.7	34.7 ± 4.4	94.5 ± 1.7	5.5 ± 1.7	73.6 ± 2.7	26.4 ± 2.7
Lifetime mental disorder, with no 12-month symptoms (e)	68.7 ± 3.8	27.4 ± 3.7	96.1 ± 1.7	3.9 ± 1.7	80.9 ± 2.4	19.1 ± 2.4
No lifetime mental disorder (f)	63.7 ± 2.3	33.1 ± 2.3	96.8 ± 0.9	3.2 ± 0.9	78.4 ± 1.6	21.6 ± 1.6

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) The employed and unemployed rates are as a proportion of those in the labour force.

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) A person may have more than one mental disorder. Therefore the components may not add to the total.

(e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(f) People who did not meet criteria for diagnosis of a lifetime mental disorder.

Source: ABS (unpublished) 2007 *Survey of Mental Health and Wellbeing*, Cat. no. 4326.0.

Table 12A.92 Education, training and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent) (a), (b)

	Studying (c)		Not studying		Total
		Employed	Unemployed/Not in the labour force	Total	
Any 12-month mental disorder (d)	42.0 ± 4.9	44.3 ± 5.0	13.7 ± 3.0	58.0 ± 4.9	100.0
Lifetime mental disorder, with no 12-month symptoms (e)	29.5 ± 6.6	55.9 ± 7.3	np	70.5 ± 6.6	100.0
No lifetime mental disorder (f)	51.6 ± 3.8	39.2 ± 3.3	9.2 ± 2.2	48.4 ± 3.8	100.0

- (a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).
- (b) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.
- (c) Includes people studying full-time and part-time and people still at school.
- (d) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.
- (e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.
- (f) People who did not meet criteria for diagnosis of a lifetime mental disorder.
- np** Not published.

Source: ABS (unpublished) 2007 Survey of Mental Health and Wellbeing, Cat. no. 4326.0.

Table 12A.93 Labour force and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent) (a)

	<i>Employed (b)</i>	<i>Unemployed (b)</i>	<i>Not in the labour force</i>
Any 12-month mental disorder (c)	92.1 ± 3.2	7.9 ± 3.2	19.2 ± 3.4
Lifetime mental disorder, with no 12-month symptoms (d)	92.2 ± 9.0	np	17.6 ± 6.2
No lifetime mental disorder (e)	93.6 ± 1.9	6.4 ± 1.9	22.1 ± 2.9

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). Estimates with RSEs greater than 25 per cent are not published.

(b) The employed and unemployed rates are as a proportion of those in the labour force.

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(e) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source: ABS (unpublished) *2007 Survey of Mental Health and Wellbeing*, Cat. no. 4326.0.

TABLE 12A.94

Table 12A.94 Clinical outcomes of people receiving various types of mental health care provided by State and Territory public mental health services (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT (f)</i>	<i>Aust (d)</i>
<i>2007-08</i>									
Group A: People discharged from hospital (g)									
Significant improvement	75.6	76.1	71.3	74.8	66.7	72.2	np	np	73.3
No significant change	20.2	20.5	22.7	20.4	29.0	21.6	np	np	22.1
Significant deterioration	4.2	3.5	6.0	4.8	4.4	6.2	np	np	4.6
Group B: People discharged from community care (h)									
Significant improvement	55.6	53.6	55.1	47.7	47.4	47.0	np	np	53.3
No significant change	42.0	42.5	38.9	44.7	47.0	46.4	np	np	41.7
Significant deterioration	2.4	3.9	6.0	7.6	5.6	6.6	np	np	5.0
Group C: People in ongoing community care (i)									
Significant improvement	24.5	27.9	29.3	28.5	24.9	27.7	np	23.3	27.1
No significant change	60.7	58.0	52.2	56.4	58.7	51.8	np	56.4	56.8
Significant deterioration	14.8	14.0	18.5	15.1	16.4	20.6	np	20.3	16.1
<i>2008-09</i>									
Group A: People discharged from hospital (g)									
Significant improvement	74.7	76.2	73.9	75.8	70.3	76.9	np	np	74.7
No significant change	21.2	20.1	21.2	20.2	25.4	20.2	np	np	21.2
Significant deterioration	4.0	3.7	4.9	4.0	4.4	2.8	np	np	4.0
Group B: People discharged from community care (h)									
Significant improvement	55.9	50.3	57.8	52.9	46.3	45.9	np	np	52.6
No significant change	41.6	44.2	36.3	39.8	48.9	46.9	np	np	42.1
Significant deterioration	2.6	5.5	5.9	7.2	4.8	7.2	np	np	5.3
Group C: People in ongoing community care (i)									
Significant improvement	23.6	29.4	29.4	25.6	27.1	27.2	np	27.2	27.3
No significant change	61.9	56.2	53.3	58.7	57.7	58.0	np	49.9	57.2
Significant deterioration	14.5	14.4	17.3	15.7	15.2	14.7	np	23.0	15.5
<i>2009-10</i>									
Group A: People discharged from hospital (g)									
Significant improvement	68.7	73.5	74.1	72.9	70.0	77.2	np	np	71.7
No significant change	26.2	22.6	21.4	22.5	26.0	19.9	np	np	23.9
Significant deterioration	5.1	3.9	4.5	4.6	4.0	2.8	np	np	4.4
Group B: People discharged from community care (h)									
Significant improvement	54.6	50.0	58.3	52.7	47.7	47.4	np	np	52.0
No significant change	42.1	43.8	35.7	42.3	48.2	48.5	np	np	42.6
Significant deterioration	3.3	6.1	5.9	5.0	4.0	4.1	np	np	5.4
Group C: People in ongoing community care (i)									
Significant improvement	22.6	28.3	31.9	27.2	25.2	27.4	18.5	25.5	27.3
No significant change	61.8	56.8	52.7	58.2	58.7	56.6	68.7	52.0	57.4
Significant deterioration	15.5	14.9	15.4	14.5	16.1	15.9	12.8	22.5	15.3

Table 12A.94 Clinical outcomes of people receiving various types of mental health care provided by State and Territory public mental health services (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT (f)</i>	<i>Aust (d)</i>
<i>2010-11</i>									
Group A: People discharged from hospital (g)									
Significant improvement	69.4	73.5	73.8	74.7	72.2	75.6	np	77.0	72.5
No significant change	25.1	22.8	20.1	21.6	24.1	20.1	np	19.5	23.1
Significant deterioration	5.4	3.7	6.2	3.7	3.8	4.3	np	3.5	4.5
Group B: People discharged from community care (h)									
Significant improvement	56.6	45.5	59.2	51.7	46.0	52.7	np	np	50.0
No significant change	40.5	43.8	35.5	42.4	49.6	43.9	np	np	42.2
Significant deterioration	2.9	10.7	5.3	5.8	4.3	3.4	np	np	7.7
Group C: People in ongoing community care (i)									
Significant improvement	22.8	27.4	30.6	24.7	24.6	25.9	18.7	28.5	26.4
No significant change	62.2	57.3	53.5	59.3	61.1	57.3	67.8	50.3	58.1
Significant deterioration	15.0	15.3	15.9	16.0	14.3	16.8	13.5	21.2	15.4
<i>2011-12</i>									
Group A: People discharged from hospital (g)									
Significant improvement	68.1	na	73.4	72.1	71.3	73.0	np	77.6	70.8
No significant change	27.0	na	19.7	22.8	24.7	22.1	np	16.1	24.0
Significant deterioration	4.9	na	6.9	5.1	4.0	4.9	np	6.3	5.2
Group B: People discharged from community care (h)									
Significant improvement	54.3	na	54.5	45.7	47.1	43.2	np	np	51.5
No significant change	42.4	na	39.5	48.7	48.8	51.7	np	np	43.7
Significant deterioration	3.3	na	5.9	5.6	4.0	5.1	np	np	4.8
Group C: People in ongoing community care (i)									
Significant improvement	23.0	na	30.4	24.6	23.7	27.5	29.0	27.4	26.0
No significant change	61.1	na	54.0	60.4	60.9	50.8	56.5	53.5	58.3
Significant deterioration	15.8	na	15.6	15.0	15.3	21.6	14.5	19.2	15.7
<i>2012-13</i>									
Group A: People discharged from hospital (g)									
Significant improvement	70.0	na	72.7	74.3	72.6	76.4	np	77.3	72.1
No significant change	25.6	na	20.7	21.5	22.6	19.5	np	16.0	22.9
Significant deterioration	4.4	na	6.6	4.2	4.8	4.1	np	6.7	5.0
Group B: People discharged from community care (h)									
Significant improvement	51.7	na	53.7	47.3	42.9	51.3	np	np	50.8
No significant change	45.3	na	40.6	48.1	52.6	45.4	np	np	44.6
Significant deterioration	3.0	na	5.6	4.6	4.5	3.3	np	np	4.6
Group C: People in ongoing community care (i)									
Significant improvement	22.3	na	31.3	24.4	23.5	21.2	22.8	29.9	26.1
No significant change	61.8	na	53.5	59.3	61.2	59.9	61.9	51.9	58.1
Significant deterioration	15.9	na	15.2	16.3	15.3	18.9	15.2	18.2	15.7

Table 12A.94 Clinical outcomes of people receiving various types of mental health care provided by State and Territory public mental health services (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT (f)</i>	<i>Aust (d)</i>
(a)	<p>These data were prepared by the Australian Mental Health Outcomes and Classification Network, using data submitted by State and Territory governments to the Australian Government Department of Health. Assessment of clinical outcomes is based on the changes reported in a consumer's score on a rating scale known as the Health of the Nation Outcomes Scale (HoNOS), or in the case of children and adolescent consumers, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Developed originally in England in the 1990s, these ratings scales comprise standard items that are rated by a clinician to measure the severity of the consumer's symptoms or disability across a range of domains (for example, depressed mood, hallucinations, substance use, suicidality, overactivity, activities of daily living, cognitive impairment). The HoNOS/HoNOSCA form part of small suite of standardised rating scales used to monitor outcomes across state and territory public sector mental health services and private hospitals with a specialised psychiatric unit. To be considered valid, Health of the Nation Outcomes Scale (HoNOS), or for children and adolescents, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) data needs to be completed correctly (a specified minimum number of items completed) and have a "matching pair" — that is, a beginning and end rating are needed to enable an outcome score to be determined.</p>								
(b)	<p>Proportions may not add to 100 per cent due to rounding.</p>								
(c)	<p>For all consumer groups, outcome scores for each episode are classified as either 'significant improvement', 'significant deterioration' or 'no significant change', based on Effect Size. Effect size is a statistic used to assess the magnitude of a treatment effect. It is based on the ratio of the difference between pre- and post- scores to the standard deviation of the pre- score. As a rule of thumb, effect sizes of 0.2 are considered small, 0.5 considered medium and 0.8 considered large. Based on this rule, a medium effect size of 0.5 was used to assign outcome scores to the three outcome categories. Thus individual episodes were classified as either: 'significant improvement' if the Effect Size index was greater than or equal to positive 0.5; 'significant deterioration' if the Effect Size index was less than or equal to negative 0.5; or 'no change' if the index was between -0.5 and 0.5.</p>								
(d)	<p>Victorian 2011-12 and 2012-13 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. All national averages for 2011-12 and 2012-13 exclude Victoria.</p>								
(e)	<p>Industrial action in Tasmania has limited the available data quality and quantity of data for 2011-12 and 2012-13.</p>								
(f)	<p>Some data for the ACT and the NT are np (not published) due to insufficient observations. The number of observations of consumer outcomes for some care types is too low to publish because conclusions based on such low numbers are known to have high levels of unreliability. For the purposes of this indicator, the threshold for the minimum number of observations to be reached was set at 200.</p>								
(g)	<p>Group A covers people who received a discrete episode of inpatient care within a state/territory designated psychiatric inpatient unit during the reference year. The defining characteristic of the group is that the episode of inpatient care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission and discharge. The analysis excludes episodes where length of stay was three days or less because it is not meaningful to compare admission and discharge ratings for short duration episodes.</p>								

Table 12A.94 Clinical outcomes of people receiving various types of mental health care provided by State and Territory public mental health services (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT (f)</i>	<i>Aust (d)</i>
(h) Group B covers people who received relatively short term community care from a state/territory mental health service during the reference year. The defining characteristic of the group is that the episode of community care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission to, and discharge from, community care. A subgroup of people whose episode of community care completed because they were admitted to hospital is not included in this analysis.									
(i) Group C covers people receiving relatively long term community care from a state/territory mental health service. It includes people who were receiving care for the whole of the reference year, and those who commenced community care sometime after 1 July who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June). Outcome scores were calculated as the difference between the total score recorded on the first occasion rated and the last occasion rated in the year.									

na Not available. **np** Not published.

Source: Australian Mental Health Outcomes and Classification Network, authorised by Australian Government Department of Health.

TABLE 12A.95

Table 12A.95 People who received mental health care provided by State and Territory public mental health services and who significantly improved, by service type and age group (per cent) (a), (b), (c)

	NSW	Vic (d)	Qld	WA	SA	Tas (e)	ACT (f)	NT (f)	Aust (d)
<i>2007-08</i>									
Group A: People discharged from hospital who significantly improved (g)									
Aged 0–17 years	61.7	72.3	61.8	np	np	np	np	np	63.2
Aged 18–64 years	77.1	78.3	72.5	78.0	68.4	72.8	np	np	75.0
Aged 65 years or over	68.8	67.0	67.2	58.3	69.8	np	np	np	66.4
Group B: People discharged from community care who significantly improved (h)									
Aged 0–17 years	59.4	53.9	59.8	np	41.1	np	np	np	53.7
Aged 18–64 years	55.0	56.0	55.6	46.6	57.1	np	np	np	55.3
Aged 65 years or over	52.0	49.3	47.4	42.6	np	np	np	np	47.8
Group C: People in ongoing community care who significantly improved (i)									
Aged 0–17 years	36.3	37.7	41.1	39.8	28.7	np	np	np	35.8
Aged 18–64 years	23.2	26.6	27.3	28.4	23.0	28.4	np	23.0	25.8
Aged 65 years or over	23.1	26.2	26.3	20.7	22.0	np	np	np	23.7
<i>2008-09</i>									
Group A: People discharged from hospital who significantly improved (g)									
Aged 0–17 years	59.4	74.3	74.3	74.2	np	np	np	np	69.1
Aged 18–64 years	76.2	77.0	74.7	78.2	71.5	77.5	np	np	76.0
Aged 65 years or over	69.5	72.0	np	64.1	70.7	np	np	np	69.2
Group B: People discharged from community care who significantly improved (h)									
Aged 0–17 years	57.2	48.4	60.0	np	40.5	np	np	np	51.8
Aged 18–64 years	59.6	51.5	58.6	55.8	57.0	np	np	np	54.8
Aged 65 years or over	47.4	47.9	50.3	44.0	np	np	np	np	47.5
Group C: People in ongoing community care who significantly improved (i)									
Aged 0–17 years	37.7	41.5	40.3	38.7	28.9	np	np	np	36.9
Aged 18–64 years	22.6	27.6	27.7	24.0	26.1	24.5	np	27.0	25.8
Aged 65 years or over	19.4	29.1	25.0	21.2	26.6	np	np	np	24.2
<i>2009-10</i>									
Group A: People discharged from hospital who significantly improved (g)									
Aged 0–17 years	56.3	67.4	np	67.1	np	np	np	np	62.2
Aged 18–64 years	72.4	74.6	76.1	75.9	71.7	77.1	np	np	73.9
Aged 65 years or over	45.9	69.9	67.7	60.4	69.0	np	np	np	61.6
Group B: People discharged from community care who significantly improved (h)									
Aged 0–17 years	61.1	48.7	55.9	64.8	41.7	np	np	np	50.7
Aged 18–64 years	58.7	51.1	61.6	54.5	58.0	np	np	np	54.3
Aged 65 years or over	39.6	47.3	48.5	44.0	np	np	np	np	46.5
Group C: People in ongoing community care who significantly improved (i)									
Aged 0–17 years	32.9	38.2	41.5	39.3	28.4	np	np	np	36.4
Aged 18–64 years	21.6	26.9	30.2	26.5	24.5	27.4	16.4	24.7	26.1
Aged 65 years or over	22.6	25.9	25.6	20.4	20.2	np	np	np	23.1

TABLE 12A.95

Table 12A.95 People who received mental health care provided by State and Territory public mental health services and who significantly improved, by service type and age group (per cent) (a), (b), (c)

	NSW	Vic (d)	Qld	WA	SA	Tas (e)	ACT (f)	NT (f)	Aust (d)
2010-11									
Group A: People discharged from hospital who significantly improved (g)									
Aged 0–17 years	59.0	62.1	np	67.0	np	np	np	np	59.8
Aged 18–64 years	71.5	74.3	76.0	77.6	73.8	75.8	np	np	74.1
Aged 65 years or over	60.1	74.5	64.5	61.4	80.7	np	np	np	68.1
Group B: People discharged from community care who significantly improved (h)									
Aged 0–17 years	59.1	51.3	57.1	63.8	38.7	np	np	np	51.2
Aged 18–64 years	61.4	45.7	62.8	52.9	62.6	58.7	np	np	51.8
Aged 65 years or over	45.2	42.4	47.1	44.7	np	np	np	np	44.1
Group C: People in ongoing community care who significantly improved (i)									
Aged 0–17 years	37.8	38.4	46.0	39.4	25.2	np	np	np	37.0
Aged 18–64 years	20.6	24.9	28.0	23.1	25.2	24.3	15.4	27.3	24.4
Aged 65 years or over	22.0	28.6	24.3	20.0	19.7	np	np	np	23.8
2011-12									
Group A: People discharged from hospital who significantly improved (g)									
Aged 0–17 years	54.0	na	53.5	np	np	np	np	np	53.2
Aged 18–64 years	70.5	na	76.5	73.9	73.5	73.3	np	78.6	73.1
Aged 65 years or over	59.1	na	70.6	60.6	77.2	np	np	np	64.2
Group B: People discharged from community care who significantly improved (h)									
Aged 0–17 years	57.9	na	58.9	63.1	40.0	np	np	np	51.1
Aged 18–64 years	58.0	na	55.1	50.8	62.5	np	np	np	55.9
Aged 65 years or over	45.2	na	46.5	37.2	np	np	np	np	44.1
Group C: People in ongoing community care who significantly improved (i)									
Aged 0–17 years	38.1	na	43.0	36.6	27.4	np	np	np	36.5
Aged 18–64 years	21.0	na	27.1	23.5	21.0	22.5	np	25.9	23.6
Aged 65 years or over	20.6	na	30.4	20.4	23.9	np	np	np	23.5
2012-13									
Group A: People discharged from hospital who significantly improved (g)									
Aged 0–17 years	57.7	na	52.2	np	37.0	np	np	np	53.2
Aged 18–64 years	72.2	na	75.6	76.7	76.4	77.3	np	77.7	74.6
Aged 65 years or over	61.1	na	74.3	60.7	np	np	np	np	65.3
Group B: People discharged from community care who significantly improved (h)									
Aged 0–17 years	57.5	na	60.2	57.9	38.3	np	np	np	51.4
Aged 18–64 years	53.8	na	54.0	51.0	54.3	np	np	np	53.6
Aged 65 years or over	44.0	na	44.7	39.1	np	np	np	np	44.2
Group C: People in ongoing community care who significantly improved (i)									
Aged 0–17 years	34.5	na	42.0	38.7	29.2	np	np	np	36.3
Aged 18–64 years	20.5	na	28.4	23.1	18.8	17.7	np	27.7	23.7
Aged 65 years or over	19.4	na	27.1	19.3	23.8	np	np	np	22.2

Table 12A.95 People who received mental health care provided by State and Territory public mental health services and who significantly improved, by service type and age group (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT (f)</i>	<i>Aust (d)</i>
(a)	<p>These data were prepared by the Australian Mental Health Outcomes and Classification Network, using data submitted by State and Territory governments to the Australian Government Department of Health. Assessment of clinical outcomes is based on the changes reported in a consumer's score on a rating scale known as the Health of the Nation Outcomes Scale (HoNOS), or in the case of children and adolescent consumers, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Developed originally in England in the 1990s, these ratings scales comprise standard items that are rated by a clinician to measure the severity of the consumer's symptoms or disability across a range of domains (for example, depressed mood, hallucinations, substance use, suicidality, overactivity, activities of daily living, cognitive impairment). The HoNOS/HoNOSCA form part of small suite of standardised rating scales used to monitor outcomes across state and territory public sector mental health services and private hospitals with a specialised psychiatric unit. To be considered valid, Health of the Nation Outcomes Scale (HoNOS), or for children and adolescents, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) data needs to be completed correctly (a specified minimum number of items completed) and have a "matching pair" — that is, a beginning and end rating are needed to enable an outcome score to be determined.</p>								
(b)	Proportions may not add to 100 per cent due to rounding.								
(c)	<p>For all consumer groups, outcome scores for each episode are classified as either 'significant improvement', 'significant deterioration' or 'no significant change', based on Effect Size. Effect size is a statistic used to assess the magnitude of a treatment effect. It is based on the ratio of the difference between pre- and post- scores to the standard deviation of the pre- score. As a rule of thumb, effect sizes of 0.2 are considered small, 0.5 considered medium and 0.8 considered large. Based on this rule, a medium effect size of 0.5 was used to assign outcome scores to the three outcome categories. Thus individual episodes were classified as either: 'significant improvement' if the Effect Size index was greater than or equal to positive 0.5; 'significant deterioration' if the Effect Size index was less than or equal to negative 0.5; or 'no change' if the index was between -0.5 and 0.5.</p>								
(d)	Victorian 2011-12 and 2012-13 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. All national averages for 2011-12 and 2012-13 exclude Victoria.								
(e)	Industrial action in Tasmania has limited the available data quality and quantity of data for 2011-12 and 2012-13.								
(f)	Some data for the ACT and the NT are np (not published) due to insufficient observations. The number of observations of consumer outcomes for some care types is too low to publish because conclusions based on such low numbers are known to have high levels of unreliability. For the purposes of this indicator, the threshold for the minimum number of observations to be reached was set at 200.								
(g)	Group A covers people who received a discrete episode of inpatient care within a state/territory designated psychiatric inpatient unit during the reference year. The defining characteristic of the group is that the episode of inpatient care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission and discharge. The analysis excludes episodes where length of stay was three days or less because it is not meaningful to compare admission and discharge ratings for short duration episodes.								

Table 12A.95 People who received mental health care provided by State and Territory public mental health services and who significantly improved, by service type and age group (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT (f)</i>	<i>Aust (d)</i>
(h) Group B covers people who received relatively short term community care from a state/territory mental health service during the reference year. The defining characteristic of the group is that the episode of community care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission to, and discharge from, community care. A subgroup of people whose episode of community care completed because they were admitted to hospital is not included in this analysis.									
(i) Group C covers people receiving relatively long term community care from a state/territory mental health service. It includes people who were receiving care for the whole of the reference year, and those who commenced community care sometime after 1 July who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June). Outcome scores were calculated as the difference between the total score recorded on the first occasion rated and the last occasion rated in the year.									

np Not published.

Source: Australian Mental Health Outcomes and Classification Network, authorised by Australian Government Department of Health.

Table 12A.96 Deflators used to calculate real State and Territory mental health expenditure (a)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2005-06	82.7	83.8	78.5	79.2	80.9	82.3	80.8	82.8	81.5
2006-07	86.4	86.5	82.2	82.1	83.9	85.8	83.8	85.9	84.8
2007-08	88.8	88.7	85.0	84.9	86.9	88.3	86.7	87.6	87.4
2008-09	90.9	91.6	88.3	88.2	90.4	91.0	89.8	91.0	90.2
2009-10	94.0	94.6	92.5	92.0	93.9	94.1	93.1	93.9	93.6
2010-11	94.9	96.0	94.5	92.9	94.7	95.1	93.9	94.8	94.9
2011-12	97.1	97.6	97.0	96.3	97.2	97.4	96.4	97.3	97.1
2012-13	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) The deflators used are the State and Territory implicit price deflators for general government final consumption expenditure on hospital and nursing home services.

Source: ABS (unpublished) *Australian National Accounts: National Income, Expenditure and Product*, Cat. no. 5204.0.

TABLE 12A.97

Table 12A.97 **Estimated resident populations used in mental health per head calculations (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (b)</i>
2005-06	6 718 023	5 023 203	3 964 175	2 029 936	1 544 852	488 098	333 505	207 385	20 311 543
2006-07	6 786 160	5 103 965	4 055 845	2 076 867	1 561 300	491 515	338 381	211 029	20 627 547
2007-08	6 883 852	5 199 503	4 159 990	2 135 006	1 578 489	495 858	344 176	216 618	21 016 121
2008-09	7 001 782	5 313 285	4 275 551	2 208 928	1 597 880	501 774	351 101	222 526	21 475 625
2009-10	7 101 504	5 419 249	4 367 454	2 263 747	1 618 578	506 461	357 859	227 783	21 865 623
2010-11	7 179 891	5 495 711	4 436 882	2 319 063	1 632 482	510 219	364 833	230 299	22 172 469
2011-12	7 247 669	5 574 455	4 513 009	2 387 232	1 645 040	511 718	370 729	232 365	22 485 340
2012-13	7 348 899	5 679 633	4 610 932	2 472 717	1 662 169	512 422	379 554	236 869	22 906 352

(a) The data represent the mid-point of the relevant financial year. For 2011-12 data, the mid-point is 31 December 2011. Population data used to derive rates are revised to the ABS' final 2011 Census rebased estimates and projections. Population data for All Australians for all years are estimates. See chapter 2 (tables 2A.1-2 and 2A.12-13) for details

(b) Includes other territories.

Source: ABS (various issues), *Australian Demographic Statistics, December (various years)*, Cat. no. 3101.0; table 2A.2.

Data quality information — Mental health management, chapter 12

Data Quality Information

Data quality information (DQI) provides information against the seven Australian Bureau of Statistics (ABS) data quality framework dimensions, for a selection of performance indicators in the Aged care services chapter. DQI for additional indicators will be progressively introduced in future reports.

Technical DQI has been supplied or agreed by relevant data providers. Additional Steering Committee commentary does not necessarily reflect the views of data providers.

DQI Contents:

New client index	3
Mental health service use by special needs groups and total population	6
Primary mental health care for children and young people	12
Services reviewed against the National Standards	15
Services provided in an appropriate setting	18
Collection of outcomes information	21
Rate of seclusion — acute inpatient units	25
Consumer and carer involvement in decision making	30
Post discharge community care	32
Readmissions to hospital within 28 days of discharge	35
Cost of inpatient care — average recurrent cost per inpatient bed day	38
Cost of inpatient care — average length of inpatient stay	42
Cost of community-based residential care	45
Cost of ambulatory care	48
Rates of illicit and licit drug use	52
Prevalence of mental illness	56
Mortality due to suicide	58
Social and economic inclusion of people with a mental illness — participation in employment of working age population	61
Social and economic inclusion of people with a mental illness — participation in education and employment by young people	63

Mental health outcomes of consumers of specialised public
mental health services

65

New client index

DQI for this indicator has been sourced from the Australian Institute of Health and Welfare (AIHW) and State and Territory health authorities with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	New client index
Measure	<u>Description:</u>
(computation)	Proportion of total clients under the care of State or Territory specialised public mental health services who were new clients. A new client is a consumer who has not been seen by a specialised public mental health service in the five years preceding the initial contact with a service in the relevant reference period. <u>Numerator:</u> Number of new clients — clients who had not been seen by a public mental health service in the five years preceding the initial contact with a service in the relevant reference period. <u>Denominator:</u> Number of total clients under the care of State or Territory specialised public mental health services in the relevant reference period. <u>Computation:</u> Expressed as a proportion: (Numerator ÷ Denominator)*100.
Data source/s	The AIHW using data provided by State and Territory governments from the community mental health care (CMHC), residential mental health and admitted patients mental health collections.

Data Quality Framework Dimensions

Institutional environment	<p>The AIHW calculated the indicator based on data supplied by state and territory health authorities.</p> <p>The State and Territory health authorities provide these data according to specifications agreed under the <i>National Key Performance Indicators for Australian Public Mental Health Services</i>. State and Territory health authorities receive these data from specialised mental health organisations/units in psychiatric and acute hospitals, community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p>
Relevance	<p>Estimates are based on all 'in-scope' clients (new and total) who are in receipt of services from state and territory public psychiatric inpatient units, residential units and community mental health services. New clients are those who have not been seen by a public specialised mental health service in the five years preceding the initial contact with a service in the relevant reference period. A consumer is not considered to be 'new' client if they present with a new condition, but have previously received treatment for other conditions.</p> <p>Data for all years reflect full financial year activity — that is, all in scope clients from public specialised mental health services between the period 1 July and 30 June for each financial year.</p> <p>Only state and territory specialised public mental health services are included. New clients may have been treated in the preceding five years outside the state/territory specialised public mental health system in the primary mental health care or the specialist private mental health sector.</p> <p>States and territories vary in their capacity to accurately track clients across organisations, due to the lack of unique patient identifiers or data matching systems. SA</p>

indicated that the data submitted were not based on unique patient identifier or data matching approaches.

Remoteness and socioeconomic status have been allocated using the client's usual residence, not the location of the service provider. State/territory is reported for the state/territory of the service provider.

For NSW, residential clients are not included because their data is manually collected without a Statewide Unique Patient Identifier (SUPI) assigned, thus making the unique counts of the residential clients together with the inpatient and ambulatory clients not possible.

For WA, the matching of mental health community contacts to inpatient episodes is done for 2012-13 between two separate data systems and requires the use of record linkage to be able to identify the same person in both systems. There are delays associated in the use of record linkage and these delays can result in not getting a match between a community contact and a separation when there should be one. The number of unique consumers (both total and new) could be over-estimated as a result. Data before 2012-13 are based on data submitted for the National Minimum Data Set (NMDS) and have not been revised.

Data are not available for Victoria for 2011-12 or 2012-13. All Australian totals for 2011-12 and 2012-13 exclude Victoria.

All states except Victoria count triage and referral patients, that is those who are assessed and referred on.

Industrial action in Tasmania in 2011-12 and 2012-13 has limited the quality and quantity of community data.

Timeliness

State and Territory governments provide data to the AIHW for national collation, approximately twelve months after the reference period. The reference period for the latest data is 2012-13.

Accuracy

State and Territory governments are primarily responsible for the quality of the data they provide. The AIHW analyses the data, but cannot independently verify them.

Data are subject to ongoing historical validation. Due to this ongoing validation, 2009-10 and 2011-12 data might differ from previous reports.

States and territories differ in their capacity to accurately track clients across organisations or service types, due to the lack of unique patient identifiers or data matching systems. This has led to over/undercounting of clients in some jurisdictions.

- NSW has implemented a SUPI for mental health care. The identification of prior contacts for mental health clients is dependent upon the SUPI, both in coverage (all clients having a SUPI) and in the resolution of possible duplicates. There are differences in the completeness of coverage between the Local Health Districts/Networks and over time. The average SUPI coverage at a State level is 99.9 per cent for 2012-13. The numbers provided are a distinct count of individuals using the SUPI (majority) and a count of individuals at the facility level for a small percentage of clients without a SUPI in the reporting period (which may include some duplicates of those who attended multiple facilities).
- For NSW, residential clients are not included because their data is manually collected without SUPI assigned, thus making the unique counts of the residential clients together with the inpatient and ambulatory clients not possible. The client base of the NSW mental health residential is very small which will have minimal effect on the final result (total residential MH clients in 2010-11 is 185 with 59 potential new clients, 243 total residential MH clients with 130 potential new clients in 2011-12) and 237 total residential MH clients with 131 potential new clients in 2012-13).
- For WA, the matching of mental health community contacts to inpatient episodes for 2012-13 is done between two separate data systems and requires the use of record linkage to be able to identify the same person in both systems. There are delays associated in the use of record linkage and these delays can result in not getting a match between a community contact and a separation when there should be one. The number of unique consumers (both total and new) could be over-estimated as a result.
- For SA, the client counts are not unique: they are an aggregation of three

separate databases with no linkage between them. The impact on the result should be minimal due to populations being relatively stable within the three respective catchments.

- For Tasmania, information for years before 2012-13 were extracted from three different data sources and linked together with a Statistical Linkage Key (SLK) for each individual present in the extracts for the reporting period. While every attempt has been made to reduce any duplication of identified clients, using an SLK will lead to some duplication and can wrongly identify clients as new clients. Tasmania has been progressively implementing a state-wide patient identification system. Data for 2012-13 is considered to be the first collection period with this system fully implemented.

Coherence

Data are reported for each year from 2009-10 to 2012-13. There has been no major change to the methodology used to collect the data across years except as outlined below for WA.

The Australian totals for 2011-12 and 2012-13 exclude Victoria and are not comparable to previous years.

Jurisdictions can differ in their approaches to counting clients under care. For example, people who are assessed for a mental health service but do not go on to be treated for a mental illness are included in the data by some jurisdictions but not others. Therefore, comparisons between jurisdictions should be made with caution.

States and territories differ in their capacity to accurately track clients across organisations or service types, this can affect the comparability of the results across jurisdictions (see the accuracy dimension).

For WA, data before 2012-13 are based on data submitted for the NMDS and have not been revised.

Accessibility

Data are also available for this indicator in the:

- National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data
- Key Performance Indicators for Australian Public Mental Health Services (available at mhsc.aihw.gov.au/indicators/nkpi/).

Interpretability

Information for understanding this indicator is available:

- the *Key Performance Indicators for Australian Public Mental Health Services, Second Edition* at [www.health.gov.au/internet/mhsc/publishing.nsf/Content/99A25CC5B3781660CA257A5D000235B3/\\$File/kpitech.pdf](http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/99A25CC5B3781660CA257A5D000235B3/$File/kpitech.pdf)
- in the *Key Performance Indicators for Australian Public Mental Health Services, Third Edition*
- from the *Key Performance Indicators for Australian Public Mental Health Services* (available at mhsc.aihw.gov.au/indicators/nkpi/).

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- States and territories vary in their capacity to accurately track clients across organisations, due to the lack of unique patient identifiers or data matching systems.
- Data are not available for Victoria for 2011-12 or 2012-13. All Australian totals for 2011-12 or 2012-13 exclude Victoria.
- Industrial action in Tasmania in 2011-12 and 2012-13 has limited the available data quality and quantity of community data.

Mental health service use by special needs groups and total population

DQI for this indicator has been sourced from the AIHW for the National Healthcare Agreement with additional Steering Committee comments.

Indicator definition and description

Elements	Equity — Access and Effectiveness — Access
Indicators	Mental health service use by special needs groups Mental health service use by total population
Measure (computation)	<p>The <i>numerator</i> is the number of people receiving mental health services, separately for three service types.</p> <p>The <i>denominator</i> is the Estimated Resident Population (ERP) as at 30 June.</p> <p><i>Calculation</i> is $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage and age-standardised to the Australian population as at 30 June 2001, using 5-year age groups to 84 years with ages over 84 years combined. Aboriginal and Torres Strait Islander population data are not available for all data sources for 5-year age groups beyond 64 years. Where data were not available, Aboriginal and Torres Strait Islander disaggregations were standardised to 64 years with ages over 64 years combined.</p> <p>These are calculated separately for public, private, Medicare Benefits Scheme- and Department of Veterans' Affairs (DVA)-funded services.</p>
Data source/s	<p><u>Numerators:</u></p> <p>For Public data: State/Territory data, including admitted specialised mental health hospital, residential mental health care and CMHC services.</p> <p>For Private data: Private Mental Health Alliance (PMHA) Centralised Data Management Service (CDMS) data.</p> <p>For MBS data: Australian Government Department of Health (Health) MBS Statistics.</p> <p>For DVA data: Australian Government DVA Statistical Services and Nominal Rolls using the Departmental Management Information System (DMIS). These data are known as Treatment Account System (TAS) data.</p> <p><u>Denominator:</u></p> <p>ABS ERP as at 30 June.</p> <p>ABS Aboriginal and Torres Strait Islander Estimates and Projections Series B.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The AIHW prepared the denominator and calculated the indicator based on numerators supplied by other data providers. The AIHW is an independent statutory authority within the Health portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.</p> <p>Numerators for this indicator were prepared by State and Territory health authorities, the PMHA, Health and DVA and quality-assessed by the AIHW.</p> <p>The AIHW drafted the initial data quality statement. The statement was finalised by AIHW following input from State and Territory health authorities, PMHA, Health and DVA. The AIHW does not hold the relevant mandated datasets required to independently verify the data tables for this indicator.</p> <p><u>Public data</u></p> <p>The State and Territory health authorities receive these data from public sector specialised mental health services. States and territories use these data for service</p>
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planning, monitoring and internal and public reporting.

Private data

The PMHA's CDMS provided data submitted by private hospitals with psychiatric beds. The data are used by hospitals for activities such as quality improvement.

Health MBS and DVA TAS data

The Department of Human Services (DHS) processes claims made under the *Medicare Australia Act 1973*. These data are then regularly provided to Health. DHS also processes claims for DVA Treatment Card holders made through the MBS under the *Veterans' Entitlements Act 1986*; *Military Rehabilitation and Compensation Act 2004* and *Medicare Australia Act 1973*. All claiming data is regularly provided to DVA as per the Memorandum of Understanding between DHS and DVA.

Relevance

Estimates are based on counts of individuals receiving care within the year, by each service type, where each individual is generally counted once regardless of the number of services received. Persons can receive services of more than one type within the year; a count of persons receiving services regardless of type is not available.

Persons receiving mental health treatment are not captured in these data sources include individuals receiving mental health services (other than as admitted patients in private hospitals) funded through other third party funders (eg transport accident insurers, workers compensation insurers) or out of pocket sources.

There is likely to be considerable overlap between the various data sources since it is likely that patients accessing public services and private hospital services would also access MBS services.

Remoteness and socioeconomic status have been allocated using the client's usual residence, not the location of the service provider. State/territory is reported for the state/territory of the service provider.

Public data

Person counts for State and Territory mental health services are counts of persons receiving one or more service contacts provided by public sector specialised mental health services, including admitted hospital, community and residential services. SA submitted data that were not based on unique patient identifier or data matching approaches.

Private data

Private hospital estimates are counts of individuals receiving admitted patient specialist psychiatric care in private hospitals.

Health MBS and DVA TAS data

Data are counts of individuals receiving mental health-specific MBS services for which DHS has processed a claim.

Analyses by state/territory, remoteness and socioeconomic status are based on postcode of residence of the client as recorded by DHS at the date of last service processed in the reference period. As clients may receive services in locations other than where they live, these data do not necessarily reflect the location in which services were received.

DVA clients comprised less than 2 per cent of people receiving Australian Government (Medicare Benefits Scheme- and DVA-funded) clinical mental health services.

Timeliness

The reference periods for these data are 2007-08, 2008-09, 2009-10, 2010-11, 2011-12 and 2012-13.

Accuracy

Cells have been suppressed to protect confidentiality (where the presentation could identify a patient or a single service provider).

Public data

State and Territory jurisdictions differ in their capacity to provide accurate estimates

of person receiving services (see above). Additionally, jurisdictions differ in their approaches to counting clients under care. For example, people who are assessed for a mental health service but do not go on to be treated for a mental illness are included in the data by some jurisdictions but not others. Therefore, comparisons between jurisdictions should be made with caution.

The Indigenous status data should be interpreted with caution due to the varying and, in some instances, unknown quality of Aboriginal and Torres Strait Islander identification across jurisdictions. Indigenous status was missing or not reported for around 8 per cent of all clients in 2012-13.

Private data

Coverage of private hospitals includes all private hospital with designated psychiatric beds and private psychiatric day hospitals.

The data provided are an estimate of overall activity. Actual counts are multiplied by a factor that accounts for the proportion of data missing from the CDMS collection. That adjustment is performed at the level of State and Territory and also financial year, since non-participation rates varied from state to state and financial year.

Patient counts are unique at the hospital level, therefore, duplication of persons in this data may be possible.

Indigenous status information is not collected for these data.

Health MBS and DVA TAS data

As with any administrative system a small degree of error may be present in the data captured.

Data used for statistical purposes are based on enrolment postcode of the patient. This postcode may not reflect the current postcode of the patient if an address change has not been notified to DHS.

The data provided are based on the date on which the claim was processed by DHS, not when the service was rendered. The use of data based on when the claim was processed, rather than when the service was rendered, produces little difference in the total number of persons included in the numerator for the reference period.

People who received more than one type of service are counted once only in the calculations for this indicator.

Health MBS data presented by Indigenous status have been adjusted for under-identification in the DHS Voluntary Indigenous Identifier (VII) database. Aboriginal and Torres Strait Islander rates are therefore modelled and should be interpreted with caution. These statistics are not derived from the total Australian Aboriginal and Torres Strait Islander population, but from those Aboriginal and Torres Strait Islander people who have voluntarily identified as Aboriginal and Torres Strait Islander to DHS. The statistics have been adjusted to reflect demographic characteristics of the overall Aboriginal and Torres Strait Islander population, but this adjustment may not address all the differences in the service use patterns of the enrolled population relative to the total Aboriginal and Torres Strait Islander population. The level of VII enrolment (61 per cent nationally as at August 2012) varies across age-sex-remoteness-State/Territory sub-groups and over time which means that the extent of adjustment required varies across jurisdictions and over time. The methodology for this adjustment was developed and verified by the AIHW and Health for assessment of MBS and PBS service use and expenditure for Aboriginal and Torres Strait Islander Australians. For an explanation of the methodology, see *Expenditure on health for Aboriginal and Torres Strait Islander people 2006-07*.

DVA TAS data are not available by Indigenous status.

Coherence

Following the 2011 Census of Population of Housing, the ABS has rebased the Australian population back to 1991. This rebasing had a significant impact on the population time series, therefore data were resupplied in the previous reporting cycle for previous years using the rebased ERP except for data presented by Indigenous status. Rebased Aboriginal and Torres Strait Islander population data is now available and have been used to re-calculate all historical data disaggregated

by Indigenous status.

In 2011, the ABS updated the standard geography used in Australia for most data collections from the Australian Standard Geographical Classification (ASGC) to the Australian Statistical Geography Standard (ASGS). Also updated at this time were remoteness areas and the Socio-Economic Indexes for Areas (SEIFA) based on the 2011 ABS Census of Population and Housing. The new remoteness areas will be referred to as RA 2011, and the previous remoteness areas as RA 2006. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006.

Data for 2007-08 through to 2010-11 reported by remoteness are reported for RA 2006. Data for 2011-12 and subsequent years are reported for RA 2011. The AIHW considers the change from RA 2006 to RA 2011 to be a series break when applied to data supplied for this indicator, therefore remoteness data for 2010-11 and previous years are not directly comparable to remoteness data for 2011-12 and subsequent years.

Data for 2007-08 through to 2010-11 reported for SEIFA deciles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011-12 are reported using SEIFA 2011 at the SLA level. Data for 2012-13 and subsequent years are reported using SEIFA 2011 at the Statistical Area (SA) 2 level. The AIHW considers the change from SEIFA 2006 to SEIFA 2011, and the change from SLA to SA2 to be series breaks when applied to data supplied for this indicator. Therefore SEIFA data for 2010-11 and previous years are not directly comparable with SEIFA data for 2011-12, and SEIFA data for 2011-12 and previous years are not directly comparable with SEIFA data for 2012-13 and subsequent years.

Public data

Public data for all collection periods were re-supplied by jurisdictions due to an expanded scope that includes all specialised public mental health services. Historical disaggregated data have not been re-supplied, therefore, comparisons with 2012-13 for any disaggregated data is not valid. As mentioned above, public historical Aboriginal and Torres Strait Islander data were re-calculated with the revised Aboriginal and Torres Strait Islander population data, however, as per this coherence issue, historical comparisons with 2012-13 data are not valid.

For public sector community mental health services, Victorian data is unavailable (for 2011-12 and 2012-13) due to service level collection gaps resulting from protected industrial action during this period. Industrial action during the 2011-12 and 2012-13 collection periods in Tasmania has limited the available data quality and quantity of data. Australian totals for 2011-12 and 2012-13 only include available data and should therefore be interpreted with caution. Australian totals for 2011-12 and 2012-13 should not be compared to previous years.

Tasmania has been progressively implementing a state-wide patient identification system. Data for 2012-13 is considered to be the first collection period with this system fully implemented. Tasmanian data for 2007-08 and 2008-09 include people who received a Helpline services. From 2009-10 onwards these have been excluded consistent with the indicator definitions. Data for 2007-08 and 2008-09 are also limited to people who accessed Community mental health services only. Therefore, Tasmanian data is not comparable across years.

In past years there has been variation in the underlying concept used to allocate remoteness and socioeconomic status across jurisdictions (i.e. location of service provider, location of client or a combination of both). In addition, the underlying concordances used by jurisdictions to allocate remoteness may vary. Since 2009-10, remoteness and socioeconomic status have been allocated using the SLA of the client at last contact. For 2011-12 data all jurisdictions have used the same concordance and proportionally allocated records to remoteness and SEIFA categories with the following exception:

- NSW and the NT used postcode concordance (rather than SLA concordance) to allocate records to remoteness and SEIFA.
- From 2009-10 onwards, disaggregation by SEIFA is based on a person's usual residence, not the location of the service provider, except for the NT for which the majority of the data were based on the location of the service. Due to system-related issues impacting data quality, Tasmania was unable to

provide data by SEIFA for 2008-09.

Comparisons over time for remoteness and socioeconomic status should therefore be interpreted with caution.

Private data

There has been no change to the methodology used to collect the data in 2012-13. Therefore, the data are comparable to previous reporting periods.

Health MBS and DVA TAS data

The same methodology to attribute demographic information to the data has been used in 2012-13 as in previous reporting periods.

For 2010-11 and previous years, remoteness and socioeconomic status for both Health MBS and DVA TAS data were allocated using a postcode concordance. For 2011-12 and beyond, DVA TAS data were allocated to remoteness using geocoding, and to socioeconomic status using an SLA/SA2 concordance.

MBS items 81325 and 81355 were added from 1 November 2008. These items relate to mental health or psychological services provided to a person who identified as being of Aboriginal or Torres Strait Islander descent.

On 1 January 2010, a new MBS item (2702) was introduced for patients of GPs who have not undertaken mental health skills training. Changes have been made to the existing MBS item 2710 to allow patients of GPs who have undertaken mental health skills training to access a higher rebate. Both of these items relate to the preparation of a GP mental health treatment plan.

On 1 November 2011, MBS items 2715 and 2717 were introduced to cover preparation of a GP mental health treatment plan by a GP who has undertaken mental health skills training. At the same time MBS items 2700 and 2701 were introduced to cover preparation of a GP mental health treatment plan by a GP who has not undertaken mental health skills training.

On 1 July 2011, MBS item 288 was introduced as a telehealth mental health related item.

MBS item 2719 existed from 1 November 2011 to 30 April 2012.

From 2011-12 MBS item 20104 is included to align with other national indicators.

Caution should be taken when interpreting Aboriginal and Torres Strait Islander rates over time. All other data can be meaningfully compared across reference periods.

Other publications

The AIHW publication series Mental health services in Australia contains data that is comparable in coverage (using different MBS item splits) and includes a summary of MBS mental health-related items.

The data used in this indicator is also published in the COAG National Action Plan on Mental Health — final progress report covering implementation to 2010-11. There may be some differences between the data published in these two sources as:

- rates may be calculated using different ERPs other than the June ERPs used for this indicator,
- MBS numbers are extracted using a different methodology. The COAG National Action Plan on Mental Health — final progress report covering implementation to 2010-11 counts a patient in each state they resided in during the reference period but only once in the total whereas this indicator counts a patient in only one State/Territory.

The indicator specifications and analysis methodology used for this report are equivalent to the Healthcare 2011-12: comparing performance across Australia.

Accessibility

MBS statistics are available at:

- www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1
- www.medicareaustralia.gov.au/statistics/mbs_item.shtml

Disaggregation of MBS data by SEIFA is not publicly available elsewhere.

Interpretability

Information is available for MBS data from:

- www.health.gov.au/internet/mbsonline/publishing.nsf/content/medicare-benefits-schedule-mbs-1

Data Gaps/Issues Analysis**Key data gaps/issues**

The Steering Committee notes the following issues:

- This is a proxy measure of access to appropriate care.
- State and Territory jurisdictions differ in their approaches to counting clients under care, including different thresholds for registering a client. Additionally, they differ in their capacity to provide accurate estimates of individual persons receiving mental health services. Therefore comparisons between jurisdictions need to be made with caution.
- The Indigenous status data should be interpreted with caution:
 - public sector community mental health services (Public) data: There is varying and, in some instances, unknown quality of Aboriginal and Torres Strait Islander identification among jurisdictional data sources.
 - Medicare Benefits Schedule (MBS) data: have been adjusted for under-identification of Indigenous status in the Medicare Australia Voluntary Indigenous Identifier (VII) database.
- Disaggregation of this indicator by Indigenous status for private patients and those recorded in DVA data is a priority.
- Remoteness data for 2010-11 and previous years are not directly comparable to remoteness data for 2011-12 and subsequent years.
- SEIFA data for 2010-11 and previous years are not directly comparable with SEIFA data for 2011-12, and SEIFA data for 2011-12 and previous years are not directly comparable with SEIFA data for 2012-13 and subsequent years.
- For public sector community mental health services, Victorian data is unavailable (for 2011-12 and 2012-13) due to service level collection gaps resulting from protected industrial action during this period. Industrial action during the 2011-12 and 2012-13 collection periods in Tasmania has limited the available data quality and quantity of data. Australian totals of public sector community mental health services for 2011-12 and 2012-13 only include available data and should therefore be interpreted with caution. Australian totals for 2011-12 and 2012-13 should not be compared to previous years.
- Public data for all collection periods has been re-supplied capturing a greater scope. Historical disaggregated data have not been re-supplied, therefore, comparisons between years for any disaggregated data is not valid.
- Historical Aboriginal and Torres Strait Islander data has been re-calculated with the revised Aboriginal and Torres Strait Islander population data.
- Data have been provided according to the State or Territory of service, but at the sub-state level (remoteness area) have been classified by the client's place of usual residence. For example, a person who usually resides in a very remote area of the NT and is treated by a service in a major city in Victoria would be classified at the sub-state level as a very remote area of Victoria (even though Victoria itself has no very remote areas under the ABS remoteness classification). Further work is required to determine whether geographic location for this indicator should be based on usual residence of the client (used for most indicators) or location of the service.
- Data linkage work is underway to obtain comprehensive and consistent data on people with mental illness across the full scope of service types.

Primary mental health care for children and young people

DQI for this indicator has been sourced from the Australian Government (Department of Health) with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Primary mental health care for children and young people
Measure	<u>Description:</u>
(computation)	Proportion of young people aged under 25 years who received a primary mental health care services subsidised through the MBS. Data are also reported by four age cohorts: pre-school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years). <u>Numerator:</u> Number of young people aged under 25 years who received a primary mental health care services subsidised through the MBS and by age cohort (pre-school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years)). <u>Denominator:</u> ERP aged under 25 years and by age cohort (pre-school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years)). <u>Computation:</u> Expressed as a proportion: (Numerator/s ÷ Denominator/s)*100. Calculated for all young people (aged under 25 years) and separately by age cohort, gender, Indigenous status, remoteness, SEIFA and service type.
Data source/s	Numerator: Department of Health MBS Statistics data. Denominator: ABS Australian Demographic Statistics.

Data Quality Framework Dimensions

Institutional environment	MBS data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> and regularly provides the data to Department of Health. The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i> . These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment at www.abs.gov.au .
Relevance	Includes primary mental health care covered by the MBS only. Other relevant forms of primary mental health care for young people are not incorporated due to a lack of available data, including community health centres, Aboriginal Community Controlled Health Services, school counsellors and health nurses, university and Technical and Further Education counselling services and a component of the mental health care provided by state/territory specialised public mental health services. MBS data are counts of young people receiving mental health-specific MBS services for which DHS has processed a claim, excluding those for psychiatrists. The relevant MBS items are as follows: <ul style="list-style-type: none">• GP and other services include MBS items 170, 171, 172, 2574, 2575, 2577, 2578, 2700, 2701, 2702, 2704, 2705, 2707, 2708, 2710, 2712, 2713, 2715, 2717,

2719, 2721, 2723, 2725, 2727.

- Clinical psychologist services include MBS items 80000, 80005, 80010, 80015, 80020.
- Other allied health services include MBS items 10956, 10968, 80100, 80105, 80110, 80115, 80120, 80125, 80130, 80135, 80140, 80145, 80150, 80155, 80160, 80165, 80170, 81325, 81355, 82000, 82015.

Analyses by state/territory of MBS data is based on postcode of residence of the client as recorded by DHS at the date of last service processed in the reference period. As clients may receive services in locations other than where they live, these data do not necessarily reflect the location in which services were received. The allocation to the state/territory uses a concordance and splits a person where the postcode covers more than one state/territory, therefore the totals may not equal the sum of the individual cells due to rounding.

MBS data are based on the date the claim was processed. Age of the patient is based on their age at the date of the service.

The population data are for the 30 June of the proceeding financial year. For 2013-14 data, it is June 2013. All ERP data are based on the *2011 Census of Population and Housing*.

Timeliness

MBS claims data are available within 14 days of the end of a month. The reference period for the latest data is 2013-14.

Accuracy

DVA TAS data are not available.

As with any administrative system a small degree of error may be present in the data captured.

For SEIFA and remoteness reporting, data are excluded for patients whose postcodes do not map to a SEIFA or remoteness area. These patients are reported in a 'not stated' category.

Data used for statistical purposes are based on enrolment postcode of the patient. This postcode may not reflect the current postcode of the patient if an address change has not been notified to DHS.

Analyses by age are based on the client's as recorded by DHS, Medicare at the date the last service that was received in the reference period.

The data provided are based on the date on which the claim was processed by DHS, not when the service was rendered. The use of data based on when the claim was processed, rather than when the service was rendered, produces little difference in the total number of persons included in the numerator for the reference period.

People who received more than one type of service are counted once only in the calculations for this indicator.

Health MBS data presented by Indigenous status have been adjusted for under-identification in the DHS Voluntary Indigenous Identifier (VII) database. Aboriginal and Torres Strait Islander rates are therefore modelled and should be interpreted with caution. These statistics are not derived from the total Australian Aboriginal and Torres Strait Islander population, but from those Aboriginal and Torres Strait Islander people who have voluntarily identified as Aboriginal and Torres Strait Islander to DHS. The statistics have been adjusted to reflect demographic characteristics of the overall Aboriginal and Torres Strait Islander population, but this adjustment may not address all the differences in the service use patterns of the enrolled population relative to the total Aboriginal and Torres Strait Islander population. The level of VII enrolment (61 per cent nationally as at August 2012) varies across age-sex-remoteness-State/Territory sub-groups and over time which means that the extent of adjustment required varies across jurisdictions and over time. The methodology for this adjustment was developed and verified by the AIHW and Health for assessment of MBS and PBS service use and expenditure for Aboriginal and Torres Strait Islander Australians. For an explanation of the methodology, see Expenditure on health for Aboriginal and Torres Strait Islander people 2006-07.

Coherence

Estimates are compiled the same way across jurisdictions and over time.

The MBS items included can change over time, for example 2700, 2701, 2715 and

	2719 were included for the later years of data.
Accessibility	MBS statistics are available at: <ul style="list-style-type: none"> • www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1 • www.medicareaustralia.gov.au/statistics/mbs_item.shtml
Interpretability	Information for understanding this indicator is available in the: <ul style="list-style-type: none"> • Fourth national mental health plan: measurement strategy, www.health.gov.au/internet/mhsc/publishing.nsf/Content/pub-plan4-meas • National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data.
<u>Data Gaps/Issues Analysis</u>	
Key data gaps/issues	The Steering Committee notes the following key data gaps/issues: <ul style="list-style-type: none"> • Not all relevant forms of primary mental health care for young people are not incorporated due to a lack of available data. • Annual data are available. The most recent data available are for 2013-14. • The data are consistent and comparable over time.

Services reviewed against the National Standards

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Services reviewed against the National Standards for Mental Health Services (<i>NSMHS</i>)
Measure	<u>Description:</u>
(computation)	Proportion of expenditure on specialised public mental health services that had completed a review by an external accreditation agency against the NSMHS. <u>Numerator/s:</u> Expenditure on service units, by assessed level (level 1, level 2, level 3, level 4). <u>Denominator:</u> Total expenditure on service units in scope for the NSMHS. <u>Computation:</u> Expressed as a proportion: (Numerator/s ÷ Denominator)*100. Calculated separately by assessed level.
Data source/s	AIHW from the Mental Health Establishments (MHE) NMDS

Data Quality Framework Dimensions

Institutional environment	<p>The AIHW has provided the data for this indicator.</p> <p>The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.</p> <p>The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p> <p>States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.</p>
Relevance	<p>The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS.</p> <p>The NSMHS were first introduced in 1996 and were adopted by all public specialised mental health services and private psychiatric hospitals. Most non-government community mental health services found it difficult to apply many of the NSMHS to the context within which they operated¹. Revised standards were endorsed in September 2010 and these are designed to be applied across the broad range of mental health services (where mental health is the main focus of care), including non-government organisations and private office based services (such as GPs). Coverage of all publicly</p>

¹ DoHA 2010, *National Standards for Mental Health Services: Implementation guidelines for Non-government Community Services*, Australian Government, Canberra.

funded mental health services to which the revised NSMHS now apply would improve the relevance of these data to measurement of this indicator for future reports.

Services were assessed as level 1, level 2, level 3, or level 4 where these levels are defined as:

- *Services at level 1* — the number of specialised public mental health services that have been reviewed by an external accreditation agency and judged to have met all NSMHS.
- *Services at level 2* — the number of specialised public mental health services that have been reviewed by an external accreditation agency and judged to have met some but not all NSMHS.
- *Services at level 3* — the number of specialised public mental health services that are (i) in the process of being reviewed by an external accreditation agency but the outcomes are not known, or (ii) booked for review by an external accreditation agency.
- *Services at level 4* — the number of specialised public mental health services that do not meet criteria detailed under levels 1 to 3, except those for whom the NSMHS do not apply — code 8 in the MHE NMDS.

Assessments against the NSMHS are based on periodic reviews, usually conducted every three to five years. Services assigned a level 1 for the 2011-12 data may have been assessed at this level in a review that was conducted in 2005-06 and therefore this assessed level may not necessarily reflect the quality of the actual services delivered in the 2011-12 reference period, nor the extent to which the NSMHS are used for ongoing quality improvement.

The data element '*National standards for mental health service review status*' is collected at the statistical unit of service unit (admitted patient, ambulatory and residential). Specialised mental health service units relate to units in public psychiatric hospitals, designated psychiatric units in acute care hospitals, public community-based ambulatory and residential services and publicly funded private hospital and non-government residential service units. Non-government operated community residential service units are excluded from the analysis. Aged care community residential services in receipt of funding under the *Aged Care Act 1997* are subject to residential aged care reporting and service standard requirements and are therefore excluded from the NSMHS analysis. Ambulatory services managed by non-government organisations are not defined as statistical units for the MHE NMDS and therefore data on this element are not available for these service types.

Timeliness

State and territory health authorities provide the MHE NMDS data to the AIHW for national collation, on an annual basis approximately nine months after the reference period. The reference period for the most recent data is 2012-13.

Accuracy

Coverage of the MHE NMDS in-scope services for the '*National standards for mental health service review status*' data element is complete across jurisdictions and years.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

Due to ongoing validation, 2005-06 to 2011-12 data could differ from previous reports.

Coherence

Data are reported for each year from 2005-06 to 2012-13.

The data reported from 2005-06 to 2009-10 all relate to specialised mental health services assessed against the old NSMHS. Data from 2010-11 will progressively include larger proportions of services assessed against the revised NSMHS that were endorsed in September 2010.

External accreditation agencies can undertake accreditation of a parent health organisation (for example, a hospital) that can cover a number of specialised mental health service units. Accreditation of the parent organisation does not currently require an individual service unit (for example, a community-based ambulatory service managed by the hospital) to be assessed separately against the NSMHS. Assessment against the NSMHS for a service unit must be specifically requested and involves a separate review process. This leads to variation across states and territories in the method used to assign an assessment level (1, 2, 3 or 4) to service units. In some states and territories, if an organisation with multiple service units is assessed at a particular level all the organisation's units are 'counted' at that assessment level. In other jurisdictions, assessments are conducted at the service unit level and the level assigned may or may not be consistent with the other units within the organisation. The approach can also vary across organisations within a single jurisdiction.

The external accreditation agencies such as Australian Council on Healthcare Standards (ACHS) and Quality Improvement Council (QIC) can use differing review methods. In addition, external review is a process of negotiation between a mental health service organisation and the accrediting agency. There may be differences in the extent to which all or some of the NSMHS are considered to be applicable to individual service units.

Accessibility

The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia's Health — a mental health chapter is included in this biennial publication
- National Mental Health Reports
- Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/).

Unpublished MHE NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incurred in gaining access. Cell sizes with small numbers may be suppressed.

Interpretability

Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Information for understanding this indicator is also available:

- in the Key Performance Indicators for Australian Public Mental Health Services, Third Edition
- from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/).

Data Gaps/Issues Analysis**Key data gaps/issues**

The Steering Committee notes the following key data gaps/issues:

- There is variation across and within states and territories in the method used to assign an assessment level (1, 2, 3 or 4) to service units. This may affect the comparability of the results across jurisdictions.
- Data are not provided for the latest reference period (2013-14). Further work is required to ensure availability of more timely data.

Services provided in an appropriate setting

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Services provided in an appropriate setting
Measure	<u>Description:</u>
(computation)	Recurrent expenditure on community-based services as a proportion of total expenditure on mental health services. <u>Numerator:</u> Governments' recurrent expenditure on community-based specialised mental health services. Community-based recurrent expenditure for this indicator includes expenditure on ambulatory care, non-government organisations and adult residential services. Aged residential care expenditure is excluded. <u>Denominator:</u> Total government recurrent expenditure on specialised mental health services, excluding aged residential care expenditure and unapportioned indirect expenditure. <u>Computation:</u> Expressed as a proportion: (Numerator/Denominator)*100.
Data source/s	Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional environment	<p>The AIHW has provided the data for this indicator.</p> <p>The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.</p> <p>The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p> <p>States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.</p>
Relevance	<p>The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS.</p> <p>The data elements on direct and indirect recurrent expenditure and grants to non-government organisations are collected at levels in the hierarchy used to capture jurisdiction-wide information on mental health services (state/territory, region, organisation and service units). Non-government grants are collected at the regional and state and territory levels. Direct recurrent expenditure comprises salaries and wages and non-salary expenditure, and is collected at the individual service unit level. Indirect recurrent expenditure is additional expenditure associated with the provision of mental health services not incurred or reported at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual</p>

service units. The estimates do not include residual indirect expenditure incurred at the state and territory level or that unapportioned from the organisational or regional level.

Certain categories of expenditure collected under the MHE NMDS are excluded to derive this indicator and improve the relevance of these data to its measurement.

- Community aged residential care expenditure is excluded from community-based expenditure to improve comparability across states and territories. A significant share of jurisdictions do not have this service type.
- Indirect expenditure at the State and Territory level and indirect expenditure at the organisational or regional level that cannot be apportioned to individual services is also excluded. This indicator is seeking to measure the service mix by showing the proportion of expenditure that is community-based relative to the other categories of service expenditure (admitted patients) and not relative to total expenditure, which includes indirect expenditure at the State or Territory level on areas such as program administration and property leasing costs.

Government expenditure on mental health services that are out of scope of the MHE NMDS, such as Medicare-subsidises for community-based services provided by GPs or the personal helpers and mentors program is not included in the analysis.

Timeliness

State and territory health authorities provide the MHE NMDS data to the AIHW for national collation, on an annual basis approximately nine months after the reference period. The reference period for the most recent data is 2012-13.

Accuracy

Coverage of the MHE NMDS in-scope mental health services' recurrent expenditure is essentially complete across jurisdictions and years.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2011-12 data could differ from previous reports.

Coherence

Data are reported for each year from 2005-06 to 2012-13. There has been no major change to the method used to collect the data or to derive the results across years for the majority of jurisdictions, therefore the data are largely comparable across most jurisdictions and years.

For NSW, Confused and Disturbed Elderly (CADE) residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007-08 onwards, including expenditure. Comparison of NSW data over time therefore should be approached with caution.

Accessibility

The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- National Mental Health Reports.

Unpublished MHE NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incurred in their provision. Cells may be suppressed for confidentiality reasons or where estimates are based on small numbers, resulting in low reliability.

Interpretability Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- Data are not provided for the latest reference period (2013-14). Further work is required to ensure availability of more timely data.

Collection of outcomes information

DQI for this indicator has been sourced from the Australian Mental Health Outcomes and Classification Network (AMHOCN), Department of Health, AIHW and State and Territory governments with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Collection of information on consumers' outcomes. This DQI should be considered in conjunction with the DQI for Mental health outcomes of consumers of specialised public mental health services
Measure (computation)	<p><u>Description:</u></p> <p>Proportion of specialised public mental health service episodes with completed clinical mental health outcome measures data, by consumer type (people in ongoing community-based care, people discharged from community-based care and people discharged from hospital).</p> <p><u>Numerator:</u></p> <p>Number of specialised public mental health service episodes with completed clinical mental health outcome measures data, by consumer type.</p> <p><u>Denominator:</u></p> <p>Estimated number of specialised public mental health service episodes, by consumer type.</p> <p><u>Computation:</u></p> <p>Expressed as a proportion: $(\text{Numerator/s} \div \text{Denominator}) * 100$. Calculated separately by consumer type.</p>
Data source/s	<p><u>Numerator:</u></p> <p>State and territory health authorities' data reported to the National Outcomes and Casemix Collection (NOCC) and analysed by the AMHOCN.</p> <p><u>Denominator:</u></p> <p>State and territory health authorities' data as reported to CMHC NMDS and the Admitted Patient Mental Health Care (APMHC) NMDS and analysed by the Department of Health.</p>

Data Quality Framework Dimensions

Institutional environment	<p>Health Ministers adopted the routine measurement of consumer outcomes as a priority under the <i>National Mental Health Strategy (1992)</i> and in all subsequent National Mental Health Plans. It is also compatible with State and Territory governments' documented policy emphasis on high quality health services and increased consumer and carer participation.</p> <p>The AMHOCN prepared this indicator using the NOCC data on the Health of the Nation Outcome Scales (HoNOS) family of measures. The Australian Government contracts AMHOCN to support the implementation of the NOCC as part of routine clinical practice by undertaking three functions 1) data bureau — receives and processes information 2) analysis and reporting — analyses and reports on the submitted data and 3) training and service development — supports training in the measures and their use for clinical practice, service management and development purposes.</p> <p>The NOCC was endorsed by all State and Territory governments in 2003, and all jurisdictions have reported data since 2004-05. The NOCC protocol prescribes a set of standard measures to be collected at particular times (collection occasions) in the clinical process. Under the NOCC protocol, collection of outcomes data is mandatory at admission, review and discharge. Data collected outside of NOCC protocols are excluded from the analysis.</p>
Relevance	The scope of the NOCC is all specialised public mental health services managed by, or

in receipt of funds from, state or territory health authorities. Australian Government funded aged residential services are excluded.

The purpose of the NOCC is to measure consumer outcomes. This indicator relates only to the collection of data for the HoNOS family of measures (HoNOS; HoNOS for Older People (HoNOS 65+) and HoNOS for Children and Adolescents (HoNOSCA). Other consumer outcomes measures are also collected, including those completed by consumers. For adults and older persons these include: Kessler 10 (K10+), Behavior and Symptom Identification Scales (BASIS-32); for children and adolescents, the parent and youth versions of the Strengths and Difficulties Questionnaire (SDQ). The uptake of these measures is not captured by this indicator.

For an episode to be counted as one for which consumer outcome measures are collected, a minimum of two data collection occasions with 'valid' measures within the reference period are required. 'Valid' measures are those with a correctly completed specified number of items, for the:

- HoNOS/HoNOS 65+ — a minimum of 10 of the 12 items
- HoNOSCA — a minimum of 11 of the first 13 items.

Brief ambulatory and inpatient care episodes (defined as follows) are excluded.

- inpatient care — episodes 3 days or less.
- ambulatory — episodes where the consumers had a treatment period between 1 and 14 days inclusive.

Ambulatory episodes of mental health care that end because of admission to hospital or residential mental health care are also excluded.

The completion of outcomes data are calculated for three consumer groups. Further, the calculation varies depending on the setting and the duration of the episode of care:

- people discharged from hospital, episodes for people who were admitted and discharged from inpatient care during the reference period (an individual can have two episodes of care so the data represent episode-counts, rather than person-counts) — measures need to be 'valid' for both the admission and discharge occasions rated during the reference period
- people in ongoing community-based care, episodes for people who received community care for the whole of the reference period or who commenced community care sometime after 1 July (beginning of the period) and continued to receive care for the rest of the reference period — measures need to be 'valid' for both the first (either an admission or a review) and last (either an admission or a review) occasions rated during the year
- people discharged from community-based care, episodes for people who were discharged from community care (not including those discharged to hospital) who received an episode of community care that started and ended in the reference period — measures need to be 'valid' for both the admission and discharge occasions rated during the reference period.

Outcomes are measured for consumers discharged from residential mental health care also, but there were too few public mental health service episodes with completed clinical mental health outcome measures data to derive coverage estimates.

The number of 'in-scope' specialised public mental health service episodes, for which outcomes data should be collected (the denominator) is not provided directly to the NOCC, but is an estimate based on the CMHC or APMHC NMDs. For determining the denominators for consumers in ongoing ambulatory care and those discharged from ambulatory care the following distinguishing definitions are used:

- ongoing — the estimated unique count of consumers with CMHC treatment periods of greater than 91 days (that is, from their first service contact date to their last service contact date); LESS the estimated number of consumers whose episodes of care were left censored (that is, commenced in an earlier reporting period by finished within the current reporting periods)
- discharged — the estimated unique count of consumers with CMHC treatment periods of 91 days or less (that is, from their first service contact date to their last service contact date); LESS the estimated number of consumers whose episodes of care resulted in a discharge to an inpatient setting.

Data are not available for Victoria for 2011-12 or 2012-13. All Australian totals for

	2011-12 and 2012-13 exclude Victoria. Industrial action in Tasmania in 2011-12 and 2012-13 has affected the quality and quantity of data.
Timeliness	<p>State and territory health authorities provide the CMHC and APMHC NMDS data to the AIHW for national collation, on an annual basis approximately six months after the reference period.</p> <p>State and territory health authorities provide the NOCC data to AMHOCN for national collation, on an annual basis and all data are to be submitted approximately six months after the reference period.</p> <p>The reference period for the latest data is 2012-13.</p>
Accuracy	<p>States and territories are primarily responsible for the quality of the NOCC data they provide. However, AMHOCN undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage, concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage, primarily concerned with identifying inconsistent, anomalous, and exceptional issues in relation to the NOCC protocol as well as flagging invalid domain values and/or missing data.</p> <p>Change in consumers' clinical outcomes is not presented for states and territories with less than 200 unique consumer outcomes identifiable within the reference period. States and territories excluded from individual publication are used to calculate the change in consumers' clinical outcomes for Australia.</p>
Coherence	<p>Data are available for 2007-08 to 2012-13.</p> <p>The numerator and denominator are sourced from different data sets. Estimates of the total number of episodes requiring outcomes assessment is not provided directly to the NOCC, so it is indirectly estimated from the NMDSs (CMHC and APMHC).</p> <p>The Australian totals for 2011-12 and 2012-13 are not comparable to other years as they exclude data for Victoria.</p>
Accessibility	<p>The AIHW and Department of Health provide a variety of products that draw upon the CMHC and APMHC NMDS. Published products available on the AIHW or Department of Health websites include:</p> <ul style="list-style-type: none"> • <i>Mental Health Services in Australia</i> — annual publication mhsa.aihw.gov.au/home/ • <i>Australia's Health</i> — a mental health chapter is included in this biennial publication aihw.gov.au/publication-detail/?id=10737422172 • National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data • the Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/). <p>Unpublished NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incurred in gaining access. Cell sizes with small numbers may be suppressed.</p> <p>NOCC data are available on the AMHOCN website amhocn.org/. The following on-line products are available:</p> <ul style="list-style-type: none"> • web decision support tool • NOCC Standard Reports • NOCC Volume and Percentage Clinical Ratings: Australia • NOCC data are also published in the National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data.
Interpretability	<p>Metadata information for the CMHC and APMHC NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.</p> <p>Metadata information for the NOCC are published on the AMHOCN website amhocn.org/.</p> <p>Information for understanding this indicator is also available:</p> <ul style="list-style-type: none"> • in the Key Performance Indicators for Australian Public Mental Health Services,

Third Edition

- from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/).

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- The numerator and denominator are sourced from different data sets. Estimates of the total number of episodes requiring outcomes assessment is not provided directly to the NOCC, so it is indirectly estimated from the NMDSs (CMHC and APMHC).

Rate of seclusion — acute inpatient units

DQI for this indicator has been sourced from the AIHW and State and Territory health authorities with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness—quality—safety
Indicator	Rate of seclusion — acute inpatient units
Measure (computation)	<p><u>Definition:</u></p> <p>Number of seclusion events per 1000 patient bed days in specialised public mental health acute inpatient units</p> <p><u>Numerator:</u></p> <p>Number of seclusion events in specialised public mental health acute inpatient units.</p> <p><u>Denominator:</u></p> <p>Number of accrued mental health care days in specialised public mental health acute inpatient units.</p> <p><u>Computation:</u></p> <p>Expressed as a rate. Calculation is: (Numerator ÷ Denominator) x 1000.</p>
Data source/s	<p>AIHW 2013, <i>Mental Health Services in Australia Online</i>, mhsa.aihw.gov.au/home/.</p> <p>AIHW publishes data provided by State and Territory governments from their adhoc seclusion data collections.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The AIHW is a major national agency set up by the Australian Government under the <i>Australian Institute of Health and Welfare Act 1987</i> to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent corporate Commonwealth entity established in 1987, governed by a management Board, and accountable to the Australian Parliament through the Health portfolio.</p> <p>The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.</p> <p>The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.</p> <p>One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.</p> <p>The <i>Australian Institute of Health and Welfare Act 1987</i>, in conjunction with compliance to the Privacy Act 1988, (Cth) ensures that the data collections managed by the AIHW are kept securely, under the strictest conditions with respect to privacy and confidentiality.</p> <p>For further information see the AIHW website www.aihw.gov.au</p> <p>At present there is no formal, routine nationally agreed collection and reporting framework for seclusion events in specialised mental health public acute hospital services. Data are sourced from state and territory seclusion data collections for specialised mental health public acute hospital services via Safety and Quality</p>
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Partnership Standing Committee (SQPSC) a subcommittee, of the Mental Health, Drug and Alcohol Principal Committee (MHDAPC).

The Australian Health Ministers Advisory Council (AHMAC) mental health committees are in the process of formalising the current 'ad hoc' SQPSC seclusion data collection arrangements. The Mental Health Information Strategy Standing Committee (MHISSC) is working with AIHW to develop an aggregate seclusion and restraint Data Set Specification (DSS) to standardise the national collection of both seclusion and restraint data (and provide a more detailed data set) from the 2015-16 collection period.

Relevance

Seclusion is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. A seclusion event commences when a clinical decision is made to seclude a mental health consumer and ceases when there is a clinical decision to cease seclusion. If a consumer re-enters seclusion within a short period of time this is considered a new seclusion event. The term 'seclusion event' is utilised to differentiate it from the different definitions of 'seclusion episodes' used across jurisdictions.

Data on seclusion events relates to all specialised mental health public hospital acute services. Wards or units other than specialised mental health services, such as emergency departments, are out of scope for this data collection. Specialised mental health acute forensic hospital services are in scope, regardless of which department manages the service, for example a health department versus a correctional services department.

Timeliness

State and Territory governments provide the data to the AIHW via SQPSC for national collation, approximately three months after the reference period.

At present, two reports have been published using the SQPSC 'ad hoc' seclusion data collection (see below for link to 2013 report). The first seclusion report was released on the Mental health services in Australia website in July 2013 with a reference period of 2011-12. A second report was released in November 2013 with a reference period of 2012-13.

It is anticipated that a third report will be published in December 2014 covering the 2013-14 reference period.

Accuracy

Estimated acute bed coverage for 2013-14 seclusion data was over 95 per cent based on acute beds reported to the MHE NMDS in 2012-13.

Data are reported as aggregate seclusion events at the hospital level.

Reported rates are derived from the included services combined total for number of seclusion events divided by their combined total for number of accrued mental health care days. This method provides an accurate indication of combined activity, ensuring that larger services are proportionally represented in the data. Previously, some reported rates were calculated from an average of the reported seclusion rates for each service, which may have utility for benchmarking purposes; however, anomalies from smaller services can disproportionately skew overall rates.

Occasionally, jurisdictions re-supply data for seclusion events or number of occupied bed days. Data re-submissions are highlighted in subsequent data supplies, with updated figures reported in the next annual publication. For 2013-14, historical data were re-supplied for 2 hospitals resulting in minimal changes.

Integrity of the supplied seclusion data is tested by AIHW via a series of 'logical' validation checks. Any missing or unusual data are clarified with the supplying jurisdiction.

Some outliers (i.e. a small number of clients who have an above average number of seclusion events) are apparent in the data and have not been removed, this has the effect of 'skewing' the rates of seclusion for some jurisdictions.

A new data element, average time in seclusion was collected for the first time for the 2013-14 collection period. As the average time in seclusion is significantly higher for forensic units, these units were excluded from average time in seclusion calculations to provide a more realistic estimation of seclusion duration.

The absence of unit record data limits the ability to undertake analysis to provide context around the incidence of seclusion events. For example, the analysis of consumer attributes which may indicate risk factors or a vulnerability to experiencing

seclusion and restraint events (i.e., legal status, gender, date of birth, indigenous status, country of birth etc).

In addition, identifying the timing of seclusion events within an episode of admitted patient mental health care may be informative in mitigating/pre-empting patterns in the use of restrictive practices. Some jurisdictions have the capacity to record and report this information but the lack of cross-jurisdictional consistency restricts the collection and reporting of unit record data at a national level.

Within the aggregate reporting framework, collection of service unit level data is currently not feasible. Although data are collected at target population, collection at the service unit level would improve consistency and comparability with other mental health collections such as the Mental Health Establishment NMDS.

The use of restrictive practices also includes restraint events. However, no national restraint data are currently reported representing a substantial data gap. The AIHW is currently working with the AHMAC mental health committees and jurisdictional representatives to develop national restraint data standards to facilitate the collection and reporting of national restraint event data.

Coherence

Variations in jurisdictional legislation may result in exceptions to the definition of a seclusion event. Data reported by jurisdictions may not be explicitly comparable, jurisdictional comparisons should therefore be made with caution.

Specific jurisdictional caveats are outlined below:

New South Wales

NSW does not have a centralised database for the collection of seclusion data. Services report seclusion rates regularly to the NSW Ministry of Health. Services are required to maintain local seclusion registers, which may be audited by NSW Official Visitors who function with legislative authority to raise issues in relation to patient safety, care or treatment. Seclusion rates are a Key Performance Indicator in regular performance reporting to NSW Local Health Districts. Importantly, NSW seclusion rates include bed days for some forensic services managed by correctional facilities.

Victoria

Both the National Beacon Projects and the Creating Safety Project supported Victorian services to review their use of seclusion and employ different strategies to support the reduction of seclusion, with targets set in the Statement of Priorities to support health services reduce seclusion events. From 2014-15 seclusion rates are included in the calculation of a Performance Assessment Score for each health service with a specialised mental health inpatient unit and ultimately the level of monitoring by the Department of Health. It is anticipated that variation between health services will improve over time following the increased emphasis on the target, introduction of a new Mental Health Act and a reduction in the use of restrictive practices.

Victoria has fewer beds per capita than other jurisdictions, and as such, it may be useful to view the rate of seclusion events in a broader population context (rates per capita).

Seclusion events per 10 000 population in Victoria were 7.2 in 2011-12, 5.8 in 2012-13 and 5.5 in 2013-14.

Queensland

Queensland do not report any acute forensic services to the collection, however forensic patients can and do access acute care through general units.

Western Australia

It should be noted that WA does not have a centralised data base for the collection of seclusion data. Services provided seclusion data from their own data bases. From 1 July 2014, the Chief Psychiatrist in WA has requested quarterly reporting of seclusion and restraint rates by all current reporting services.

WA reports occupied bed days rather than accrued mental health care days to the seclusion and restraint DSS. For the purpose of these analyses, occupied bed days are considered to be the same as accrued mental health care days for this jurisdiction.

South Australia

Recent data reporting improvements will impact on SA data. Importantly, bed days used to calculate SA's seclusion rates are estimated based on 100 per cent occupied bed numbers, which are fluctuating in relation to new infrastructure projects. During 2010-11, a substantial number of seclusion events in one particular hospital were for a small number of patients with over half of these patient-requested events. This may have impacted on the overall seclusion rate reported for the state for 2010-11.

SA was unable to supply seclusion data for 2008-09. Information on seclusion duration is only available in 4 hour blocks, therefore averages cannot be calculated and seclusion duration figures for SA are not included in national totals.

Tasmania

The increase in the state-wide Tasmanian seclusion rate for 2012-13 and 2013-14 data is due to a small number of clients having an above average number of seclusion events.

Australian Capital Territory

When interpreting these data, the relative small size of the ACT should be noted, with a total of between 60 and 70 acute inpatient beds reported between 2008-09 and 2013-14.

ACT was unable to provide the number of mental health-related admitted patient care episodes with a seclusion event in 2013-14. Therefore, the proportion of episodes with a seclusion event and the average number of seclusion events per episode could not be calculated for the ACT.

ACT activities initiated as part of the Beacon Site project included the implementation of a clinical review committee inclusive of clinical staff, consumers and carer representation to review episodes of seclusion for systemic issues on a case-by-case basis. This has led to a number of reforms over several years that have had a direct impact on the use of seclusion and its reduction to the low levels now reported.

Work is progressive and ongoing as part of a larger process of providing a place of improved safety and security, both for people experiencing an acute episode of mental ill health leading to an inpatient admission, visitors and for the staff who work in this challenging environment.

Northern Territory

The NT was unable to supply seclusion data for 2008-09.

The NT is unable to segregate Forensic Inpatient Episodes and Events from general events. Therefore all NT totals, wherever stated, are comprised of both General & Forensic Inpatient Episodes and Events. As this may artificially inflate NT data, caution should be used when comparing or interpreting this data.

Due to the low ratio of beds per person in the NT compared with other jurisdictions, the apparent rate of seclusion is inflated when reporting seclusion per patient day compared with reporting on a population basis.

Due to the low number of beds in the NT, high rates of seclusion for a few individuals have a disproportional effect on the rate of seclusion reported.

Due to these variations, NT seclusion data are not directly comparable with other jurisdictions.

At present there is no formal, routine nationally agreed collection and reporting framework for seclusion events in specialised mental health public acute hospital services. Data are sourced from state and territory seclusion data collections for specialised mental health public acute hospital services via SQPSC a subcommittee, of the MHDAPC.

Accessibility

Seclusion data are available at AIHW's Mental Health Services in Australia — annual publication (<https://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices>). Additional disaggregation of the seclusion data are in this AIHW publication.

Interpretability

Information is available for interpreting seclusion data from AIHW's Mental Health Services in Australia — annual publication

(mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices).

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- The absence of unit record data limits the ability to undertake analysis to provide context around the incidence of seclusion events. For example, the analysis of consumer attributes which may indicate risk factors or a vulnerability to experiencing seclusion and restraint events (for example, legal status, gender, date of birth, Indigenous status, and country of birth).
- In addition, identifying the timing of seclusion events within an episode of admitted patient mental health care may be informative in mitigating/pre-empting patterns in the use of restrictive practices. Some jurisdictions have the capacity to record and report this information but the lack of cross-jurisdictional consistency restricts the collection and reporting of unit record data at a national level.
- Within the aggregate reporting framework, collection of service unit level data is currently not feasible. Collection at this level would improve consistency and comparability with other mental health collections such as the Mental Health Establishment NMDS.
- The use of restrictive practices also includes restraint events. However, no national restraint data are currently reported representing a substantial data gap. The AIHW is currently working with the AHMAC mental health committees and jurisdictional representatives to develop national restraint data standards to facilitate the collection and reporting of national restraint event data.

Consumer and carer involvement in decision making

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — Quality — Responsiveness
Indicator	Consumer and carer involvement in decision making
Measure	<u>Description:</u>
(computation)	Number of paid full time equivalent (FTE) consumer OR carer staff per 1000 FTE direct care, carer and consumer staff
	<u>Numerator:</u>
	1) Number of paid FTE consumer staff.
	2) Number of paid FTE carer staff.
	<u>Denominator:</u>
	Number of paid FTE direct care, carer and consumer staff.
	<u>Computation:</u>
	Expressed as a proportion per 1000 FTE. Calculation is: (Numerator/Denominator*1000).
Data source/s	Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional environment	<p>The AIHW has provided the data for this indicator.</p> <p>The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.</p> <p>The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p> <p>States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.</p>
Relevance	<p>The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS.</p> <p>Direct care staff comprise consultant psychiatrists and psychiatrists, psychiatry registrars and trainees, other medical officers, registered nurses, enrolled nurses, occupational therapists, social workers, psychologists, other diagnostic and health professionals and other personal care staff. Other categories of staff who work in mental health services are collected under the MHE NMDS, such as administrative and clerical staff, but are not included.</p> <p>Mental health consumer and carer workers are individuals who are employed on a paid basis to represent the interests of consumers and carers, respectively, and advocate for their needs. The person must be employed for the expertise developed from their lived experience of mental illness. The person should also receive a salary or contract fee on a regular basis and it excludes individuals who only received reimbursement of</p>

	<p>expenses or occasional sitting fees for attendance at meetings.</p> <p>The MHE NMDS does not collect information on the staffing of, or consumer and carer participation in, specialised ambulatory mental health services managed by government-funded NGOs.</p>
Timeliness	<p>State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data are 2012-13.</p>
Accuracy	<p>Coverage of the MHE NMDS in-scope mental health services for direct care staff and consumer and carer workers may not be complete across jurisdictions and years due to the transition from a count of consumer/carer consultants up to 2009-10 to a count of mental health consumer/carer workers from 2010-11.</p> <p>States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.</p> <p>Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2011-12 data could differ from previous reports.</p> <p>The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.</p> <p>WA have advised that data on FTE consumer or carer workers per 1000 direct care, consumer and carer staff do not accurately represent consumer and carer participation strategies used in WA.</p>
Coherence	<p>Data are reported for each year from 2005-06 to 2012-13. Data up to 2009-10 were restricted to consumer/carer consultants. In 2010-11, the definitions were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. These improved definitions should promote greater consistency between jurisdictions. Comparisons between data up to 2009-10 and data from 2010-11 should not be made.</p>
Accessibility	<p>The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:</p> <ul style="list-style-type: none"> • Mental Health Services in Australia — annual publication • Australia's Health — a mental health chapter is included in this biennial publication • National Mental Health Reports.
Interpretability	<p>Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.</p>

Data Gaps/Issues Analysis

Key data gaps/issues	<p>The Steering Committee notes the following key data gaps/issues:</p> <ul style="list-style-type: none"> • From 2010-11, the definitions of consumer/carer workers were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. These improved definitions should promote greater consistency between jurisdictions. Comparisons between data up to 2009-10 and data from 2010-11 should not be made. • Data are not provided for the latest reference period (2013-14). Further work is required to ensure availability of more timely data.
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Post discharge community care

DQI for this indicator has been sourced from the AIHW for the National Healthcare Agreement with additional Steering Committee comments.

Indicator definition and description

Element	Quality – Continuity
Indicator	Post discharge care — rate of community follow up within first seven days of discharge from a psychiatric admission.
Measure (computation)	<p>Proportion of separations from the mental health service organisation's acute psychiatric inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated, was recorded in the seven days following that separation.</p> <p>The <i>numerator</i> is the number of in-scope separations from the mental health service organisation's acute psychiatric inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated, was recorded in the seven days following that separation.</p> <p>The <i>denominator</i> is the number of in-scope separations for the mental health service organisation's acute psychiatric inpatient unit(s).</p> <p>Calculation is $100 \times (\text{Numerator} \div \text{Denominator})$</p>
Data source/s	State/territory admitted patient and CMHC data.

Data Quality Framework Dimensions

Institutional environment	<p>The tables for this indicator were prepared by the AIHW based on data supplied by state and territory health authorities. The AIHW is an independent statutory authority within the Health portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.</p> <p>AIHW drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies) in consultation with State and Territory health authorities.</p> <p>The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities receive these data from public sector community mental health services and public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. The AIHW does not hold the relevant nationally mandated datasets required to independently verify the data tables for this indicator.</p> <p>Community mental health services and public hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p> <p>States and territories supplied these data for publication in the RoGS 2015 and for the indicators section of the AIHW's <i>Mental health services in Australia website</i>.</p>
Relevance	<p>Estimates are based on all 'in scope' separations from state and territory psychiatric acute inpatient units, where 'in scope' is defined as those separations for which it is meaningful to examine community follow-up rates. The following separations were excluded: same day separations; overnight separations that occur through discharge/transfer to another acute hospital; discharge to an(other) psychiatric hospital; statistical discharge – type change; left against medical advice/discharge at own risk; death; separations where the length of stay is one night and a procedure code for ECT is recorded and separations that end by transfer to community residential mental health services.</p> <p>Data for all years reflect full financial year activity – that is, all in scope separations from public sector acute psychiatric units between the period 1 July and 30 June for each financial year.</p> <p>Community mental health contacts counted for determining whether follow-up occurred are restricted to those in which the consumer participated. These may be face-to-face or 'indirect' (e.g., by telephone), but not contacts delivered 'on behalf of the client' in which</p>

they did not participate, with the exception of the NT which includes all contacts, but advised that the impact on the indicator is believed to be marginal. Contacts made on the day of discharge are also excluded for all jurisdictions.

Only community mental health contacts made by state and territory public mental health services are included. Where responsibility for clinical follow-up is managed outside the state/territory mental health system (e.g., by private psychiatrists, general practitioners), these contacts are not included.

States and territories vary in their capacity to accurately track post-discharge follow up between hospital and CMHC services, due to the lack of unique patient identifiers or data matching systems. SA was the only jurisdiction that indicated that the data submitted were not based on unique patient identifier or data matching approaches for 2012-13. This factor can contribute to a comparatively lower follow-up rate for SA.

Tasmania has been progressively implementing a state-wide patient identification system. Data for 2012-13 is considered to be the first collection period with this system fully implemented. It is likely that an improved patient identification system will increase the percentage post-discharge community care reported by Tasmania. Therefore, Tasmanian data are not comparable across years.

WA indicated that submitted data were not based on a unique state-wide patient identifier system. It is likely that this reduces the rate of post-discharge community care reported for WA.

In 2011, the ABS updated the standard geography used in Australia for most data collections from the ASGC to the ASGS. Also updated at this time were remoteness areas and the SEIFA. The new remoteness areas are referred to as RA 2011. The new SEIFA are referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006.

Data for 2011-12 and subsequent years are reported for RA 2011.

Data for 2011-12 are reported using SEIFA 2011 at the SLA level (an ASGC substate geographical unit). Data for 2012-13 are reported using SEIFA 2011 at the SA2 level (an ASGS substate geographical unit). The AIHW considers the change from SLA to SA2 to be a series break when applied to data supplied for this indicator. Therefore, SEIFA data for 2011-12 are not directly comparable with SEIFA data from 2012-13 and subsequent years.

Remoteness and socioeconomic status have been allocated using the SA2 of the client at last contact. For 2012-13 data all jurisdictions have used the same concordance and proportionally allocated records to remoteness and SEIFA categories with the following exception:

- NSW, Victoria and Tasmania used postcode concordance (rather than SA2 concordance) to allocate records to remoteness and SEIFA.

Remoteness and socioeconomic status have been allocated using the client's usual residence, not the location of the service provider except for the NT for which the majority of the data were based on the location of the service. State/territory is reported for the state/territory of the service provider.

Timeliness

The latest reference period for these data are 2012-13.

Accuracy

State and territory jurisdictions differ in their capacity to accurately track post-discharge follow up between hospital and community service organisations (see Relevance section above for further information).

Coherence

Specifications for this indicator were revised for the National Healthcare Agreement to align with specifications for the nationally agreed key performance indicators for public mental health services. Specifically, the revised indicator focuses on follow up care for people discharged from acute psychiatric units only, rather than discharges from all psychiatric units.

This indicator is currently reported in the RoGS and in the Indicators section of the AIHW's Mental health services in Australia website. It is also equivalent to the Key Performance Indicators for Australian Public Mental Health Services: MHS PI 12—Rates of post-discharge community care (which this new indicator is based on) and the Fourth National Mental Health Plan: NMHP PI 16—Rates of post-discharge community care.

Clarification of the scope of the separations data was made to the 2012-13 data specification, however, jurisdictions advised that the impact on the overall data is likely to be minimal. Therefore, data are considered comparable across years in terms of the definitions.

For public sector community mental health services, Victorian data are unavailable (for 2011-12 and 2012-13) due to service level collection gaps resulting from protected industrial action during this period.

Industrial action during the 2011-12 and 2012-13 collection periods in Tasmania has limited the available data quality and quantity of community data. Australian totals for 2011-12 and 2012-13 should therefore be interpreted with caution.

For 2012-13, the ACT has refined its calculation methodology and as such, comparisons to previous years' results should be viewed with caution.

All jurisdictions have used the same concordance and proportionally allocated records to remoteness and SEIFA categories.

Source systems vary in terms of whether location data for the patients usual address is SA2 versus postcode.

Accessibility

These data are published in the:

- RoGS available at: www.pc.gov.au/rogs.
- Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/).

Interpretability

Definitions for this indicator are published in the indicator specifications in METeOR.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- States and territories vary in their capacity to accurately track post-discharge follow up between hospital and community service organisations, due to the lack of unique patient identifiers or data matching systems.
- For public sector community mental health services, Victorian data are unavailable (for 2011-12 and 2012-13) due to service level collection gaps resulting from protected industrial action during this period. Industrial action during the 2011-12 and 2012-13 collection periods in Tasmania has limited the available data quality and quantity of community data. Australian totals for 2011-12 and 2012-13 should therefore be interpreted with caution.
- SEIFA data for 2011-12 are not directly comparable with SEIFA for 2012-13.

Readmissions to hospital within 28 days of discharge

DQI for this indicator has been sourced from state and territory health authorities and AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Quality— continuity
Indicator	Readmissions to hospital within 28 days of discharge
Measure (computation)	<p><u>Description:</u></p> <p>Proportion of 'in-scope' admitted patient overnight separations from public psychiatric acute inpatient services that were followed by readmission to public psychiatric acute inpatient services within 28 days of discharge.</p> <p><u>Numerator:</u></p> <p>Number of 'in-scope' admitted patient overnight separations from public psychiatric acute inpatient services that were followed by readmission to public psychiatric acute inpatient services within 28 days of discharge.</p> <p><u>Denominator:</u></p> <p>Number of 'in-scope' admitted patient overnight separations from public psychiatric acute inpatient services.</p> <p><u>Computation:</u></p> <p>Expressed as a proportion: (Numerator ÷ Denominator)*100.</p>
Data source/s	State and territory governments APMHC data set.

Data Quality Framework Dimensions

Institutional environment	<p>The AIHW calculated the indicator based on data supplied by state and territory health authorities. The state and territory health authorities receive these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting.</p> <p>Public hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p>
Relevance	<p>Estimates are based on all 'in scope' overnight separations from state and territory psychiatric acute inpatient units, where 'in scope' is defined as those separations for which it is meaningful to examine readmission after 28 days of discharge rates. The following separations were excluded: same day separations, including index separation and subsequent readmission; statistical and change of care type separations; separations that end by transfer to another acute or psychiatric hospital; separations that end by death, or instances where the person left against medical advice or discharged at own risk, separations where the length of stay is one night only and a procedure code for ECT is recorded.</p> <p>A readmission for any of the separations identified as 'in-scope' is an admission to any other public acute psychiatric unit within the jurisdiction. For this to occur a system of unique client identifiers needs to be in place that allows individuals to be 'tracked' across units. Such systems have been available in all states/territories for the full period (2005-06 to 2012-13), with the exception of Tasmania (which introduced such a system in 2007-08) and SA (which has not yet introduced such a system).</p> <p>Readmissions across state and territory boundaries or movements between public and private hospitals are not captured.</p> <p>No distinction is made between planned and unplanned readmissions because data collection systems in most Australian public mental health services do not include a reliable or consistent method to distinguish a planned from an unplanned admission to hospital.</p> <p>Remoteness and socioeconomic status have been allocated using the client's usual residence, not the location of the service provider. State/territory is reported for the</p>

	state/territory of the service provider.
Timeliness	<p>State and territory health authorities provide these data to Department of Health for national collation, on an annual basis approximately twelve months after the reference period.</p> <p>The latest year of data available is 2012-13.</p>
Accuracy	<p>Coverage of the 'in-scope' separations and readmissions is essentially complete across jurisdictions and years.</p> <p>States and territories are primarily responsible for the quality of these data. The AIHW analyses the data, but cannot independently verify them.</p> <p>Undercounting of readmissions may have occurred in SA and Tasmania in the years that the system of unique identifiers is not in place (see the relevance dimension). Additional undercounting of readmissions may have occurred in SA as admitted patient reporting systems only identify mental health activity based on the discharging ward. However, this factor is believed to be immaterial as the majority of admissions to mental health wards end in hospital discharge from there.</p> <p>Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2011-12 data could differ from previous reports.</p>
Coherence	<p>Data are available from 2005-06 to 2012-13. There has been no major change to the method used to collect the data or to derive the results across years for the majority of jurisdictions, therefore the data are largely comparable across most jurisdictions and years.</p> <p>States and territories differ in their capacity to accurately track clients across organisations or service types, this can affect the comparability of the results across jurisdictions (see the relevance and accuracy dimensions).</p> <p>For data before 2012-13, states and territories differed in the overnight separations that they count as 'in scope'. NSW and Queensland excluded separations where length of stay is one night only and the procedure code for ECT is recorded and the ACT excluded all overnight separations with the procedure code for ECT, whereas the others (Victoria, WA, SA, Tasmania and the NT) included all overnight separations for the procedure code for ECT.</p> <p>For 2012-13, the exclusion of overnight stays of one night with an ECT procedure code became a business rule for the calculation of data for this indicator. The change was considered likely to be minimal, therefore, historical data updates were not considered mandatory. The change is also unlikely to alter the interpretability of long term data trends.</p> <p>Queensland applies in-scope filtering to the subsequent readmission that matches the counterpart in-scope filter for index separations. For example, as outlined above, separations that end by transfer to another acute or psychiatric hospital separations are excluded from the denominator (index separation). By the same token, for the subsequent readmission, Queensland excludes separations that are commenced with code indicating they commenced with transfer from another acute or psychiatric hospital. However, these separations may be eligible for consideration as separate index separation if they did not end with a transfer to another facility.</p> <p>For 2012-13, the ACT has refined its calculation methodology and as such, comparisons to previous years' results should be viewed with caution.</p>
Accessibility	<p>These data are also published in the:</p> <ul style="list-style-type: none"> • COAG national action plan on mental health progress reports available at www.coag.gov.au • National mental health reports available at www.health.gov.au/internet/main/publishing.nsf/Content/mental-data • Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/).
Interpretability	<p>Further information to understand this indicator are available:</p> <ul style="list-style-type: none"> • in the COAG national action plan on mental health — progress report 2010-11 • in National mental health reports www.health.gov.au/internet/main/

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- publishing.nsf/Content/mental-data
 - in the Key Performance Indicators for Australian Public Mental Health Services, Third Edition
 - from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/).

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- No distinction is made between planned and unplanned readmissions.
- States and territories differ in their capacity to accurately track clients across organisations or service types.
- States and territories differ in the overnight separations that they count as 'in scope'.

Cost of inpatient care — average recurrent cost per inpatient bed day

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Cost for inpatient care — average recurrent cost per inpatient bed day
Measure	<u>Description:</u>
(computation)	Average recurrent cost per inpatient bed day. <u>Numerator:</u> Expenditure on State and Territory funded specialised mental health admitted patient services, by hospital and program type and by target population and program type. <u>Denominator:</u> Number of inpatient bed days in State and Territory funded specialised mental health admitted patient services, by hospital and program type and by target population and program type. Disaggregations for numerator and denominator are: <u>By inpatient target population:</u> <ul style="list-style-type: none">• general, by acute and non-acute• child and adolescent, by acute and non-acute• older persons' psychiatry, by acute and non-acute• forensic psychiatry, by acute and non-acute <u>By hospital type:</u> <ul style="list-style-type: none">• psychiatric hospitals, by acute units and non-acute units• public acute hospital with a psychiatric unit or ward, by acute and non-acute units Computation: Expressed as \$ per bed day. Calculation is Numerator/Denominator. Real expenditure is reported across years. The general formula for applying the deflator (used in the attachment tables) to convert nominal dollars to real dollars is: $R_t = \frac{D_t}{N_t} \times 100$ Where: R_t is real dollars in year t D_t is nominal dollars in year t N_t is the new index based in year t. N_t is sourced from ABS unpublished, government final consumption expenditure on hospitals and nursing homes price deflator for 2012-13 dollars (2012-13=100).
Data source/s	Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional environment	The AIHW has provided the data for this indicator. The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website. The data were supplied to the AIHW by state and territory health authorities. The state
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	<p>and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p> <p>States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.</p>
Relevance	<p>The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS.</p> <p>Bed days include those for same day admissions, which are counted as one day. Leave days are excluded. Same day admissions are a confounding issue that require the identification of intent of admission (that is, day care or overnight stay). Leave days also present complexities in the mental health area and further work is required to ensure that it does not distort this indicator.</p> <p>Expenditure data are for services provided in specialised mental health service units in public psychiatric hospitals, public acute hospitals and publicly funded private hospital units. Expenditure comprises direct and indirect expenditure incurred at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The residual indirect expenditure incurred at the state and territory level and that unapportioned from the organisational or regional level is not included in the estimates.</p> <p>Cost per inpatient bed day data are not adjusted for differences in the client mix. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. More relevant measures would be casemix adjusted, for which cost is adjusted to take into account the type and complexity of cases. Data for these measures are not yet available, as casemix funding has not been applied to specialised mental health services.</p>
Timeliness	<p>State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data are 2012-13.</p>
Accuracy	<p>Coverage of the MHE NMDS in-scope mental health services for expenditure and bed days is essentially complete across jurisdictions and years.</p> <p>States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.</p> <p>Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2011-12 data could differ from previous reports.</p> <p>The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.</p>
Coherence	<p>Data are reported for each year from 2005-06 to 2012-13. Data should be reported</p>

consistently across most jurisdiction and across years within most jurisdictions.

Costs per inpatient bed day may not be comparable across jurisdictions. Classification of expenditure into target populations and program type is based on the classification of services as reported to the MHE NMDS rather than the characteristics of their patient populations. For a service to be classified as providing a child and adolescent, older persons' or forensic mental health service for example, it must be recognised by the relevant state or territory funding authority as having a corresponding specialised function and is specifically funded to provide such specialty services. It is likely that the cost per patient day for general mental health services in a jurisdiction that has separate child and adolescent and older persons services (for example, NSW and Victoria), may not be comparable to the average cost in a jurisdiction that has general services only (for example, NT).

For NSW, CADE residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007-08 onwards, including expenditure. Comparison of NSW data over time therefore should be approached with caution.

Caution is required when interpreting historical Queensland data, particularly as several services reported as forensic up to 2008-09 were reclassified as general services in 2009-10 to more accurately reflect the function of these services. For 2010-11 and 2011-12, a small number of Youth services have been included in the General category at the request of Queensland. Queensland public acute hospital data includes costs associated with extended treatment services (campus and non-campus based) reported as non-acute admitted patient services in public acute hospitals. Queensland does not provide any acute services in public psychiatric hospitals. Additionally, Queensland provides older persons' mental health inpatient services using a number of different service models, however the majority of older persons' acute care is reported through general adult units, which limits comparability with jurisdictions that report these services differently. Queensland does not report any acute forensic services, however forensic patients can and do access acute care through general units.

For 2010-11 to 2012-13 data, a small number of Youth services have been included in the General category at the request of Queensland.

For WA data, a review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010-11 collection, to more accurately reflect the function of these services.

ACT average costs for older person's mental health services during 2006-07 are based on a new 20 bed unit opened in March 2007, in which only 6–10 beds operated due to issues related to staffing resources. This has artificially inflated the average cost of older persons' mental health services relative to other jurisdictions and other years for the ACT.

Accessibility

The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia's Health — a mental health chapter is included in this biennial publication
- National Mental Health Reports
- the Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/).

Interpretability

Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Further information to understand this indicator are available:

- in the Key Performance Indicators for Australian Public Mental Health Services, Third Edition
- from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/).

Data Gaps/Issues Analysis

Key data

The Steering Committee notes the following key data gaps/issues:

gaps/issues

- The average recurrent cost per inpatient bed day measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency.
- Data are not provided for the latest reference period (2013-14). Further work is required to ensure availability of more timely data.

Cost of inpatient care — average length of inpatient stay

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Cost of inpatient care — average length of inpatient stay
Measure	<u>Description:</u>
(computation)	Average length of inpatient stay in acute units, by target population. <u>Numerator:</u> Number of inpatient bed days in State and Territory funded specialised mental health admitted patient acute units, by target population. <u>Denominator:</u> Number of separations from State and Territory funded specialised mental health admitted patient acute units, by target population. <u>Disaggregations for numerator and denominator are:</u> <u>By inpatient target population:</u> <ul style="list-style-type: none">• general acute• child and adolescent acute• older persons' psychiatry acute• total acute (excluding forensic) <u>Computation:</u> Expressed as number of days per stay. Calculation is Numerator/Denominator.
Data source/s	Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional environment	<p>The AIHW has provided the data for this indicator.</p> <p>The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.</p> <p>The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p> <p>States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.</p>
Relevance	<p>The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS.</p> <p>Bed days include those for same day admissions, which are counted as one day. Leave days are excluded. Same day admissions are a confounding issue that require the identification of intent of admission (that is, day care or overnight stay). Leave days also present complexities in the mental health area and further work is required to ensure</p>

that it does not distort this indicator.

Average length of stay data are not adjusted for differences in the client mix. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. More relevant measures would be relative stay index, for which the length of stay index takes into account the type and complexity of cases. Data for these measures are not yet available, as casemix analysis has not been applied to specialised mental health services.

Patients days for clients who separated in the reference period that were during the previous period (for example, 2009-10), are excluded. Patient days for clients who remain in hospital (that is, are not included in the separations data) are included.

Average length of stay is not calculated for forensic services as the length of stay is determined by factors outside the control of the specialised mental health service. However, the child and adolescent and older persons' psychiatry target population services may include a forensic component.

Average length of stay is not calculated for non-acute inpatient units due to variability across jurisdictions in the models and mix of care (in particular, variability across jurisdiction in mix of non-acute inpatient and community-based residential care units) that would significantly affect the comparability of the average length of stay data.

Timeliness

State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data are 2012-13.

Accuracy

Coverage of the MHE NMDS in-scope mental health services bed days and separations is essentially complete across jurisdictions.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

The quality of the separations data used to derive this indicator is variable across jurisdictions. Until recently, these separations data were not subject to the level of in depth scrutiny that has applied to other data elements in the MHE NMDS. Therefore, data are only available from 2010-11. It is expected that the quality of these data will improve over time.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

Coherence

Data are reported for 2010-11 to 2012-13.

Average length of stay data may not be comparable across jurisdictions. Classification of inpatient days and separations into target populations and program type is based on the classification of services as reported to the MHE NMDS rather than the characteristics of their patient populations. For a service to be classified as providing a child and adolescent, older persons' or forensic mental health service for example, it must be recognised by the relevant state or territory funding authority as having a corresponding specialised function and is specifically funded to provide such specialty services. It is likely that the average length of stay for a general mental health services in a jurisdiction that has separate child and adolescent and older persons services (for example, NSW and Victoria) may not be comparable to the average length of stay that has general services only (for example, NT).

Queensland provides older persons' mental health inpatient services using a number of different service models, however the majority of older persons' acute care is reported

through general adult units, which limits comparability with jurisdictions that report these services differently.’

A small number of Youth services have been included in the General category at the request of Queensland.

Accessibility

The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia’s Health — a mental health chapter is included in this biennial publication
- National Mental Health Reports
- the Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/).

Interpretability

Metadata information for the MHE NMDS are published in the AIHW’s online metadata repository — METeOR and in the National health data dictionary.

Further information to understand this indicator are available:

- in the Key Performance Indicators for Australian Public Mental Health Services, Third Edition
- from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/).

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- The average length of stay measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency.
- The quality of the separations data used to derive this indicator is variable across jurisdictions.
- Data are not provided for the latest reference period (2013-14). Further work is required to ensure availability of more timely data.

Cost of community-based residential care

DQI for this indicator has been sourced from the AIHW and state and territory health authorities with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Cost of community-based residential care
Measure	<u>Description:</u>
(computation)	Average recurrent cost per patient day for community-based residential care
	<u>Numerator:</u>
	Expenditure on community-based residential care, by target population and staffing provided
	<u>Denominator:</u>
	Number of patient days in community-based residential care, by target population and staffing provided.
	<u>Disaggregations</u> for the numerator and denominator are:
	General adult units
	<ul style="list-style-type: none">• 24 hour staffed• Non-24 hour staffed
	Older people's care units
	<ul style="list-style-type: none">• 24 hour staffed• Non-24 hour staffed
	<u>Computation:</u>
	Expressed as \$ per bed day. Calculation is Numerator/Denominator.
	Real expenditure is reported across years. The general formula for applying the deflator (used in the attachment tables) to convert nominal dollars to real dollars is:
	$R_t = \frac{D_t}{N_t} \times 100$
	Where:
	R_t is real dollars in year t
	D_t is nominal dollars in year t
	N_t is the new index based in year t. N_t is sourced from ABS unpublished, government final consumption expenditure on hospitals and nursing homes price deflator for 2012-13 dollars (2012-13=100).
Data source/s	Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional environment	The AIHW has provided the data for this indicator.
	The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.
	The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory

and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.

Relevance

The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes).

Patient days and expenditure relating to community residential services includes that for publicly funded residential services operated by non-government organisations.

Expenditure data are for services provided in community residential units. Expenditure comprises direct and indirect expenditure incurred at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The residual indirect expenditure incurred at the state and territory level and that unapportioned from the organisational or regional level is not included in the estimates.

Cost per patient day data are not adjusted for differences in the client mix. The client mix in community residential settings can differ — for example, some jurisdictions treat a higher proportion of more complex patients in community residential services. More relevant measures would be casemix adjusted to take into account the type and complexity of cases. Data for these measures are not yet available, as casemix funding has not been applied to specialised mental health services.

Data for child and adolescent community-based residential units are included in the data for general acute units for NSW and the ACT. Other jurisdictions do not have these types of units.

For 2011-12, a small number of Youth services have been included in the General category at the request of WA. For 2012-13, a small number of Youth services have been included in the General category at the request of Victoria, WA and the ACT.

Queensland does not report any in-scope government-operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non-campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non-acute admitted patient services.

Timeliness

State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data are 2012-13.

Accuracy

Coverage of the MHE NMDS in-scope mental health services community residential expenditure and bed days is complete across jurisdictions and years.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2011-12 data could differ from previous reports.

	<p>The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year. Delays caused by this change in completing the NSW 2010-11 MHE NMDS has also meant that the figures provided for the RoGS have not completed full validation and may be different to the finalised data that will be provided for the <i>National Mental Health Report</i>.</p>
Coherence	<p>Data are reported for each year from 2005-06 to 2012-13. Data should be reported consistently across years within most jurisdictions.</p> <p>Average cost of community-based residential care may not be comparable across jurisdictions. Classification of expenditure and inpatient days into target populations is based on the classification of services as reported to the MHE NMDS rather than the characteristics of their patient populations. For a service to be classified as providing a general or older persons' mental health service, it must be recognised by the relevant state or territory funding authority as having a corresponding specialised function and is specifically funded to provide such specialty services. For NSW and the ACT, some child and adolescent services are reclassified to general adult to protect agency confidentiality.</p> <p>For NSW, CADE residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007-08 onwards, including patient days. Comparison of NSW data over time therefore should be approached with caution.</p> <p>Several WA residential services reported as 24-hour staffed services in 2009-10 transitioned to a non-24-hour staffed model of care as of 1 July 2010.</p>
Accessibility	<p>The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:</p> <ul style="list-style-type: none"> • Mental Health Services in Australia — annual publication • Australia's Health — a mental health chapter is included in this biennial publication • National Mental Health Reports.
Interpretability	<p>Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.</p>

Data Gaps/Issues Analysis

Key data gaps/issues	<p>The Steering Committee notes the following key data gaps/issues:</p> <ul style="list-style-type: none"> • The cost of community-based residential care measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency. • Data are not provided for the latest reference period (2013-14). Further work is required to ensure availability of more timely data.
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Cost of ambulatory care

DQI for this indicator has been sourced from the AIHW, state and territory health authorities and Department of Health with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Cost of ambulatory care
Measure	<u>Description:</u>
(computation)	Average treatment days per episode of ambulatory care. Average cost per treatment day of ambulatory care <u>Numerator:</u> (1) Number of treatment days in ambulatory care. (2) Adjusted recurrent expenditure on ambulatory care. <u>Denominator:</u> (1) Number of statistical episodes of ambulatory care. (2) Number of treatment days in ambulatory care. <u>Computation:</u> Expressed as treatment days per episode OR cost per episode. Calculation is Numerator (1 OR 2)/Denominator (1 OR 2).
Data source/s	Numerator (1): AIHW from the CMHC NMDS. Numerator (2): AIHW from the MHE NMDS Denominator/s: AIHW from the CMHC NMDS.

Data Quality Framework Dimensions

Institutional environment	<p>The AIHW has provided the data for this indicator.</p> <p>The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.</p> <p>The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p> <p>States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.</p>
Relevance	<p>The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Ambulatory services managed by non-government organisations are not defined as statistical units for the MHE NMDS and therefore excluded.</p> <p>The scope of the CMHC NMDS is government-operated community (also termed ambulatory) mental health services. Data collected includes information relating to each individual service contact provided by an in-scope mental health service. Examples of data elements are demographic characteristics of patients, such as age and sex, clinical information, such as principal diagnosis and mental health legal status, and service</p>

provision information, such as contact duration and session type. Ambulatory services managed by non-government organisations are not considered in-scope for the CMHC NMDS and are therefore excluded.

All activity (treatment days and statistical episodes) and expenditure associated with non-uniquely identified consumers is excluded.

Expenditure data are for services provided in public specialised mental health ambulatory services. Expenditure comprises direct and indirect expenditure incurred at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The residual indirect expenditure incurred at the state and territory level and that unapportioned from the organisational or regional level is not included in the estimates.

Treatment days per episode or expenditure per treatment day are not adjusted for differences in the client mix. The client mix in ambulatory settings can differ — for example, some jurisdictions treat a higher proportion of more complex patients in ambulatory settings as distinct from treating them in hospitals. More relevant measures would be casemix adjusted to take into account the type and complexity of cases. Data for these measures are not yet available, as casemix funding/analysis has not been applied to specialised mental health services.

Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode. 'One treatment day' episodes are included. These episodes are a confounding issue and a method for accounting for 'one treatment day' ambulatory episodes might provide more relevant measures.

An episode of ambulatory care is a three month period of ambulatory care for an individual registered patient where the patient was under 'active care' (one or more treatment days in the period). Community-based periods relate to the following four fixed three monthly periods: January to March, April to June, July to September, and October to December. The three month period used in this indicator to define a treatment episode is arbitrary. Further development of episode-based funding models may enable more meaningful/relevant measures in future.

Data are not available for Victoria for 2012-13. All Australian totals for 2012-13 exclude Victoria.

Industrial action in Tasmania in 2011-12 and 2012-13 affected the quality and quantity of Tasmania's CMHC data.

Timeliness

State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period.

State and territory health authorities provide the CMHC NMDS data to the AIHW for national collation on an annual basis, approximately six months after the reference period.

The reference period for the most recent data are 2012-13.

Accuracy

Coverage of the MHE NMDS in-scope expenditure is essentially complete across years. Coverage of the CMHC NMDS in-scope mental health services contacts is variable among the jurisdictions, with coverage issues for both the services in-scope for collection and the reporting of service contacts between clinicians and clients. Work is ongoing to clarify coverage for jurisdictions.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not

adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

States and territories are primarily responsible for the quality of the CMHC NMDS data they provide. However, the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is concerned with ensuring that the data file supplied is structurally compliant and correctly formatted. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is series of edit checks to ensure that the data supplied are consistent, logical and with valid values. Potential validation errors are queried with jurisdictions, and where the priority for correction is considered high, resubmissions are requested in response to these edit queries. A series of additional edit checks are conducted by the AIHW including coverage checks, historical validation and state/territory comparisons. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2011-12 data could differ from previous reports.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

Coherence

Data are reported for each year from 2005-06 to 2012-13.

'Non-uniquely identifiable consumers' are defined as those with service contacts for which a unique person identifier was not recorded. The proportion of contacts attributed to these consumers varies across jurisdictions (for example, from zero to 15 per cent) and can vary in one jurisdiction across time (for example, from 76 to 99 per cent). As all activity (treatment days and statistical episodes) and expenditure associated with non-uniquely identified consumers are excluded using these proportions, the coherence and comparability of the results across jurisdictions and across time may be affected.

The Australian totals for 2011-12 and 2012-13 are not comparable to earlier years as they exclude data for Victoria.

Accessibility

The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia's Health — a mental health chapter is included in this biennial publication
- National Mental Health Reports
- the Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/).

Unpublished MHE NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incur in their provision. Cells may be suppressed for confidentiality reasons or where estimates are based on small numbers, resulting in low reliability.

Interpretability

Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Further information to understand this indicator are available:

- in the Key Performance Indicators for Australian Public Mental Health Services, Third Edition
- from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/).

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- The cost of ambulatory care measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency.

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- Data are not provided for the latest reference period (2013-14). Further work is required to ensure availability of more timely data.
 - The exclusion of activity (treatment days and statistical episodes) and expenditure associated with non-uniquely identified consumers means that the coherence and comparability of the results across jurisdictions and across time may be affected.

Rates of illicit and licit drug use

DQI for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Rates of illicit and licit drug use
Measure (computation)	<p><u>Description:</u></p> <p>Proportion of people aged 14 years or over who use specific licit and illicit drugs in the preceding 12 months — by drug type: alcohol, cannabis, ecstasy, cocaine, meth/amphetamine, hallucinogens, Gamma-hydroxybutyrate (GHB), inhalants, and heroin.</p> <p><u>Numerator:</u></p> <p>Number of people aged 14 years or over who use specific licit and illicit drugs in the preceding 12 months — by drug type.</p> <p><u>Denominator:</u></p> <p>Total population aged 14 years or over.</p> <p><u>Computation:</u></p> <p>$(\text{Numerator} \div \text{Denominator}) * 100$</p> <p>Calculated separately, by drug type.</p>
Data source/s	<p>AIHW 2014, <i>National Drug Strategy Household Survey (NDSHS) detailed report 2013</i>, Drug statistics series no. 28, Cat. no. PHE 183, Canberra.</p> <p>AIHW 2011, <i>2010 NDSHS Report</i>, Drug statistics series no. 25, Cat. no. PHE 145.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The NDSHS data were managed, analysed and published by the AIHW. The AIHW is a major national agency set up by the Australian Government under the <i>Australian Institute of Health and Welfare Act 1987</i> to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management Board, and accountable to the Australian Parliament through the Health and Ageing portfolio.</p> <p>The NDSHS is one of the key data collections that support the <i>National Drug Strategy</i>. The last survey in this program was conducted in 2013, with previous surveys in 1985, 1988, 1991, 1993, 1995, 2001, 2004, 2007 and 2010. The data collected from these surveys have contributed to the development of policies for Australia's response to drug-related issues.</p>
Relevance	<p><u>Scope and coverage</u></p> <p>The NDSHS collects self-reported information on tobacco, alcohol and illicit drug use and attitudes from persons aged 12 years and over.</p> <p>Excluded from sampling were non-private dwellings (hotels, motels, boarding houses, etc.) and institutional settings (hospitals, nursing homes, other clinical settings such as drug and alcohol rehabilitation centres, prisons, military establishments and university halls of residence). Homeless persons were also excluded as well as the territories of Jervis Bay, Christmas Island and Cocos Island.</p> <p>The exclusion of people from non-private dwellings and institutional settings, and the difficulty in reaching marginalised people are likely to have affected estimates.</p> <p>The 2013 NDSHS was designed to provide reliable estimates at the national level. The survey was not specifically designed to obtain reliable national estimates for Aboriginal and Torres Strait Islander people, as there was no target sample size for Aboriginal and Torres Strait Islander Australians. In 2013, the sample size for Aboriginal and Torres Strait Islander Australians was smaller than anticipated based on population estimates,</p>

and so estimates based on this population group should be interpreted with caution.

Reference period

The fieldwork was conducted from 31 July to 1 December 2013. Respondents to the survey were asked questions relating to their beliefs and experiences covering differing time periods, predominantly over the previous 12 months.

Geographic detail

In 2013, data were coded to the census collector's district level. Data are generally published at the national level with a selection of data published at the State/Territory and Remoteness Area levels.

Statistical standards

Data on alcohol consumption was collected in accordance with World Health Organization standards and alcohol risk data were reported in accordance with the current 2009 National Health and Medical Research Council's 'Australian Guidelines to Reduce Health Risks from Drinking Alcohol'.

Timeliness

The NDSHS is conducted approximately every three years over a three-four month period. 2013 data were collected between late-July and early December 2013.

A preliminary data set was received by the AIHW in late-January 2014 and initial data checks were completed in early February 2014.

Key findings from the 2013 NDSHS were released on 17 July 2014.

Accuracy

Perceptions of behaviour

It is known from past studies of alcohol consumption that respondents tend to underestimate actual consumption levels (Stockwell et al. 2004). There are no equivalent data on the tendencies for under- or over-reporting of actual illicit drug use.

However, illicit drug users, by definition, have committed illegal acts. They are, in part, marginalised and difficult to reach. Accordingly, estimates of illicit drug use and related behaviours are likely to be underestimates of actual practice

Sample design

The 2013 sample was stratified by region (15 strata in total – capital city and rest of state for each state and territory, with the exception of the ACT, which operated as one stratum). To produce reliable estimates for the smaller states and territories, sample sizes were boosted in Tasmania, the ACT and the NT.

The over-sampling of lesser populated states and territories produced a sample that was not proportional to the state/territory distribution of the Australian population aged 12 years or older. Weighting was applied to adjust for imbalances arising from execution of the sampling and differential response rates, and to ensure that the results relate to the Australian population.

Sampling error

The measure used to indicate reliability of individual estimates reported in 2013 was the relative standard error (RSE). Only estimates with RSEs of less than 25 per cent are considered sufficiently reliable for most purposes. Results subject to RSEs of between 25 per cent and 50 per cent should be considered with caution and those with RSEs greater than 50 per cent should be considered as unreliable for most practical purposes.

Non-sampling error

In addition to sampling errors, the estimates are subject to non-sampling errors. These can arise from errors in reporting of responses (for example, failure of respondents' memories, incorrect completion of the survey form), the unwillingness of respondents to reveal their true responses and the higher levels of non-response from certain subgroups of the population.

Reported findings are based on self-reported data and not empirically verified by blood tests or other screening measures.

Response rates and contact rates

Overall for the 2013 Survey, contact was made with 48 579 in-scope households, of which 23 855 questionnaires were categorised as being complete and useable, representing a response rate for the 2010 survey of 49.1 per cent, slightly lower than the drop and collect component of the 2010 survey (50.6 per cent).

Some survey respondents did not answer all questions, either because they were unable or unwilling to provide a response. The survey responses for these people were retained in the sample, and the missing values were recorded as not answered. No attempt was made to deduce or impute these missing values.

A low response rate does not necessarily mean that the results are biased. As long as the non-respondents are not systematically different in terms of how they would have answered the questions, there is no bias. Given the nature of the topics in this survey, some non-response bias is expected. If non-response bias in the NDSHS is to be eliminated as far as possible, there would need to be additional work conducted to investigate the demographic profile of the non-respondents and the answers they may have given had they chosen to respond.

Aboriginal and Torres Strait Islander Data

The survey was not specifically designed to obtain reliable national estimates for Aboriginal and Torres Strait Islander people, as there was no target sample size for Indigenous Australians. In the 2013 NDSHS, 1.9 per cent of the sample (or approximately 461 respondents) identified as being of Aboriginal or Torres Strait Islander origin. The sample size for Indigenous Australians was smaller than anticipated based on population estimates, and so estimates based on this population group should be interpreted with caution.

The total population of Aboriginal and Torres Strait Islander people forms a very small part of the total Australian population. At the August 2011 census, the Aboriginal and Torres Strait Islander population was officially calculated at 670,000 people, or 2.1 per cent of the total Australian population. At that time, about one-third (35 per cent) of the Aboriginal and Torres Strait Islander population lived in Major cities, 22 per cent in Inner regional areas, 22 per cent in Outer regional areas, 8% in Remote areas and 14 per cent in Very remote areas.

The Aboriginal and Torres Strait Islander population living in Very remote areas shows other differences to populations living in Major cities including in household structure, size and age distribution. The NDSHS sample design is stratified by region and not by remoteness. Due to this sampling design, the NDSHS sample of Indigenous Australians living in Very remote areas comprised of 9 per cent of the population in those regions compared with 14 per cent of Indigenous Australians living in Very remote areas based on the 2011 Census. Therefore, Aboriginal and Torres Strait Islander people in Very remote areas are underrepresented, and it becomes difficult to generalise results from Major cities and regional areas to the whole Indigenous population.

The sampling method employed for the NDSHS invited one participant aged over 12 years to take part in the survey. The sample strategy did not take into account the size of the household selected. This is an issue for respondent selection for Indigenous Australians, as often they live in larger households compared with non-Indigenous Australians. This selection process means that Aboriginal and Torres Strait Islander people are proportionately less likely to be selected.

The NDSHS uses a self-completion questionnaire, and requires good comprehension of the English language (as it is not translated into other languages) and the ability to follow instructions. Practicality of the survey design meant that some Aboriginal communities and those with low levels of English literacy may have been excluded. Response rates are reported in the relevant NDSHS reports.

Coherence

Surveys in this series commenced in 1985. Over time, modifications have been made to the survey's methodology and questionnaire design. The 2013 survey differs from previous versions of the survey in some of the questions asked and also used three follow up attempts by interviewers instead of the two used in 2010.

Methodology

The 2013 survey was the second to exclusively use the drop and collect method, the first being 2010. In 2007 and 2004, a combination of computer-assisted telephone interviews (CATI) and drop and collect methods were used, and in earlier waves,

personal interviews were also conducted.

The change in methodology in 2010 does have some impact on time series data, and users should exercise some degree of caution when comparing data over time.

Fieldwork was conducted between July and December 2013, slightly later than in previous wave. The collection period also coincided with the 2013 federal election, although no questionnaires were placed on that day.

Sample

To produce reliable estimates for the smaller states and territories, sample sizes were boosted in Tasmania, the ACT and the NT.

In 2013 and 2010, to improve the geographic coverage of the survey, interviewers were flown to Very remote areas selected in the sample. In previous surveys, some Very remote areas that were initially selected in the sample would have been deemed inaccessible and not included in the final sample.

Questionnaire

The 2013 questionnaire was modelled on the 2010 version, to maintain maximum comparability. However, some refinements were made to ensure the questions remained relevant and useful. For more information on questionnaire changes in 2013 see chapter 1 of the 2013 NDSHS report.

Accessibility

Results from the 2013 NDSHS are available on the AIHW website. Key findings can be found in the web compendium: Highlights from the 2013 survey and full published results can be found in the 2013 NDSHS report.

Users can request data not available online or in form the AIHW. Requests that take longer than half an hour to compile are charged for on a cost-recovery basis.

A confidentialised unit record file is available for third party analysis through the Australian Data Archive. Access to the master unit record file may be requested through the AIHW Ethics Committee.

Data for this indicator are also reported in the National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data

Interpretability

Information to aid in interpretation of 2013 NDSHS results may be found in chapter 1 of the 2013 NDSHS report titled 'Introduction'. In addition, the 2013 Technical Report, code book and other supporting documentation are available through the Australian Data Archive website or may be requested from AIHW

Further information to understand this indicator are available in:

- the COAG national action plan on mental health — progress report 2010-11
- National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- Respondents tend to underestimate actual alcohol consumption levels.
- Estimates of illicit drug use are also likely to be underestimates of actual practice.
- Reported findings are based on self-reported data and are not independently verified.
- The response rate for the 2013 survey was 49.1 per cent. Some non-response bias is expected — this bias has not been measured

Prevalence of mental illness

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Prevalence of mental illness
Measure (computation)	<p><i>Numerator:</i></p> <p>Number of people aged 16–85 years who had a mental health disorder diagnosed by the World Mental Health Composite Interviewing Diagnostic Instrument (CIDI), with symptoms in last 12 months.</p> <p><i>Denominator:</i></p> <p>Total population aged 16–85 years.</p> <p><i>Computation:</i></p> <p>$(\text{Numerator} \div \text{Denominator}) * 100$</p> <p>Disaggregated by disorder type and age or sex (national only), State and Territory, by disorder type.</p>
Data source/s	ABS unpublished, <i>2007 National Survey of Mental Health and Wellbeing</i> (Cat. no. 4326.0).

Data Quality Framework Dimensions

Institutional environment	For information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, see ABS Institutional Environment (available www.abs.gov.au).
Relevance	<p>The 2007 National Survey of Mental Health and Wellbeing (SMHWP) provides information about the prevalence of selected <i>high prevalence</i> mental disorders in the Australian population aged 16–85 years, the level of impairment associated with these disorders, physical conditions, and the use of health services, such as consultations with health practitioners or visits to hospital. The survey also provides information on the strength of social networks, caring responsibilities and a range of socio-economic and demographic characteristics.</p> <p>The SMHWP was designed to provide prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders (such as social phobia), affective disorders (such as depression) and substance use disorders (such as harmful alcohol use). The SMHWP was not designed to measure the prevalence of all mental health conditions, therefore some severe mental disorders, such as schizophrenia, were not collected.</p> <p>The SMHWP is based on an international survey instrument, the CIDI, developed by the World Health Organization (WHO) for use by participants in the World Mental Health Survey Initiative.</p> <p>The 2007 survey was designed to provide data that were internationally comparable, rather than to provide comparisons with the 1997 survey. The survey was also designed to provide estimates of the prevalence of mental disorders at a national rather than a state/territory level.</p>
Timeliness	<p>The SMHWP was conducted in 1997 and 2007.</p> <p>Results from the 2007 survey were released ten months after the completion of enumeration, in the publication <i>National Survey of Mental Health and Wellbeing: Summary of Results</i> (cat. no. 4326.0).</p>
Accuracy	Estimates from the 2007 SMHWP are subject to sampling and non-sampling errors. The RSE is a measure of the size of the sampling error affecting an estimate; that

is, the error introduced by basing estimates on a sample of the population rather than the full population. Estimates should be considered with reference to their RSEs. Estimates with an RSE between 25 per cent and 50 per cent should be used with caution, and those with an RSE greater than 50 per cent are considered too unreliable for general use. Non-sampling errors are inaccuracies that occur because of imperfections in reporting by respondents and interviewers, as well as errors made in coding and processing the data.

The SMHWP was designed primarily to provide estimates at the national level. Due to the higher than expected non-response rate, RSEs were somewhat larger than originally designed. While broad estimates are available for the larger states, users should exercise caution when using estimates at this level due to relatively high sampling errors.

Coherence The 2007 SMHWP was the second survey of this type conducted by the ABS, with the previous survey conducted in 1997. Care should be exercised when comparing data between surveys as there have been a number of changes to the scope, design, collection, methodology and content.

Supporting documentation released with the survey data can assist in understanding the relationships between data variables within the dataset and in comparisons with data from other sources.

Accessibility The main products available from this survey are:

- National Survey of Mental Health and Wellbeing: Summary of Results, 2007 (Cat. no. 4326.0)
- National Survey of Mental Health and Wellbeing: Users' Guide, 2007 (Cat. no. 4327.0)
- Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded Confidentialised Unit Record Files, 2007 (Cat. no. 4326.0.30.001)
- Technical Manual: National Survey of Mental Health and Wellbeing, Confidentialised Unit Record Files (Cat. no. 4329.0).

Further information may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level.

Interpretability The *National Survey of Mental Health and Wellbeing: Summary of Results* (Cat. no. 4326.0) includes explanatory material to aid the interpretation of the survey results. More detailed information is available in the *National Survey of Mental Health and Wellbeing: Users' Guide* (Cat. no. 4327.0).

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following issues:

- The SMHWP was designed to provide estimates at the national level. Broad estimates are available for the larger states, but users should exercise caution when using estimates at this level due to relatively high sampling errors.
- The SMHWP was designed to provide prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders (such as social phobia), affective disorders (such as depression) and substance use disorders (such as harmful alcohol use). It does not measure the prevalence of some severe mental disorders, such as schizophrenia (which are the mental illnesses most frequently treated by specialised public mental health services).

Mortality due to suicide

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Mortality due to suicide
Measure (computation)	<p><i>Numerator:</i></p> <p>Number of people who have died by suicide over the relevant reference period:</p> <ul style="list-style-type: none">• five year period (2008–2012)• single reference year (2012) <p><i>Denominator:</i></p> <p>ERP.</p> <p><i>Computation:</i></p> <p>$(\text{Numerator} \div \text{Denominator}) * 100\ 000$</p> <p>Expressed as crude, age-specific or age standardised rates.</p> <p>Disaggregated by age and sex (national only), State and territory for all persons, young people (15–24 years), by geographical region and Indigenous status.</p>
Data source/s	<p><i>Numerator:</i> ABS <i>Causes of Death</i> collection (Cat. no. 3303.0)</p> <p><i>Denominator:</i> ABS ERP (Cat. no. 3101.0); Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021 (Cat. no. 3238.0); ASGC (Cat. no. 1216.0).</p>

Data Quality Framework Dimensions

Institutional environment	<p>Statistics presented in <i>Causes of Death, Australia, 2012</i> (Cat. no. 3303.0) are sourced from deaths registrations administered by the various state and territory Registrars of Births, Deaths and Marriages. It is a legal requirement of each state and territory that all deaths are registered. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred on a <i>Death Registration Form</i>. As part of the registration process, information on the cause of death is either supplied by the medical practitioner certifying the death on a <i>Medical Certificate of Cause of Death</i>, or supplied as a result of a coronial investigation.</p> <p>Death records are provided electronically to the ABS by individual Registrars on a monthly basis. Each death record contains both demographic data and medical information from the <i>Medical Certificate of Cause of Death</i> where available. Information from coronial investigations are provided to the ABS through the National Coroners Information System (NCIS).</p> <p>For information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, see ABS Institutional Environment (available www.abs.gov.au).</p>
Relevance	<p>The ABS Causes of Death collection includes all deaths that occurred and were registered in Australia, including deaths of persons whose usual residence is overseas. Deaths of Australian residents that occurred outside Australia may be registered by individual Registrars, but are not included in ABS deaths or causes of death statistics.</p> <p>From the 2007 reference year, the scope of the collection is:</p> <ul style="list-style-type: none">• all deaths registered in Australia for the reference year and are received by the ABS by the end of the March quarter of the subsequent year; and• deaths registered prior to the reference year but not previously received from

the Registrar nor included in any statistics reported for an earlier period.

For example, records received by the ABS during the March quarter of 2011 which were initially registered in 2010 or prior (but not forwarded to the ABS until 2011) are assigned to the 2010 reference year. Any registrations relating to 2010 which are received by the ABS after the end of the March 2011 quarter are assigned to the 2011 reference year.

Data in the Causes of Death collection include demographic items, as well as causes of death information, which is coded according to the International Classification of Diseases (ICD). ICD is the international standard classification for epidemiological purposes and is designed to promote international comparability in the collection, processing, classification, and presentation of causes of death statistics. The classification is used to classify diseases and causes of disease or injury as recorded on many types of medical records as well as death records. The ICD has been revised periodically to incorporate changes in the medical field. The 10th revision of ICD (ICD-10) has been used since 1997.

Non-Indigenous data from the Causes of Death collection do not include death registrations with a 'not stated' Indigenous status.

Timeliness

Causes of death data are published on an annual basis.

There is a focus on fitness for purpose when causes of death statistics are released. To meet user requirements for accurate causes of death data it is necessary to obtain information from other administrative sources before all information for the reference period is available (for example, information from finalisation of coronial proceedings to code an accurate cause of death). A balance therefore needs to be maintained between accuracy (completeness) of data and timeliness. ABS provides the data in a timely manner, ensuring that all coding possible can be undertaken with accuracy prior to publication.

In addition, to address the issues which arise through the publication of causes of death data for open coroners cases, these data are subject to a revisions process. This process enables the use of additional information relating to coroner certified deaths either 12 or 24 months after initial processing.

Accuracy

Information on causes of death is obtained from a complete enumeration of deaths registered during a specified period and are not subject to sampling error. However, deaths data sources are subject to non-sampling error which can arise from inaccuracies in collecting, recording and processing the data. Every effort is made to minimise non-sample error by working closely with data providers, running quality checks throughout the data processing cycle, training of processing staff, and efficient data processing procedures.

Causes of death data for 2006, 2007, 2008, 2009, 2010 and 2011 have been subject to revision. All coroner certified deaths registered after 1 January 2006 are subject to a revision process. This is a change from previous years where all ABS processing of causes of death data for a particular reference period was finalised approximately 13 months after the end of the reference period. Where insufficient information was available to code a cause of death (for example, a coroner certified death was yet to be finalised by the Coroner), less specific ICD codes were assigned as required by the ICD coding rules. The revision process enables the use of additional information relating to coroner certified deaths as it becomes available over time. This results in increased specificity of the assigned ICD-10 codes.

For this year's report, causes of death data for 2010, 2011 were updated as more information became available. Final data for 2006, 2007, 2008, 2009 and revised data for 2010 and 2011 and preliminary data for 2012 have been published in the *2012 Causes of Death* publication, released in March 2014. 2011 and 2012 causes of death will be revised in the 2013 Causes of Death publication due for release in 2015. Revisions will only affect coroner certified deaths, as further information becomes available to the ABS about the causes of these deaths. See *Causes of Death, Australia* (Cat. no. 3303.0).

Some rates are unreliable due to small numbers of deaths over the reference period. Resultant rates could be misleading for example where the non-Indigenous mortality rate is higher than the Aboriginal and Torres Strait Islander mortality rate. All rates for this indicator must be used with caution.

Non-Indigenous population estimates are available for census years only. In the intervening years, Aboriginal and Torres Strait Islander population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the Aboriginal and Torres Strait Islander population from the total population. Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.

Coherence The methods used to construct the indicator are consistent and comparable with other collections and with international practice.

The completeness or quality of older (unrevised) versus newer data (subject to a revisions process) can affect comparisons across time. The accuracy dimension contains information pertinent to coroner certified deaths affected by the revision process.

The ERPs used to derived rates differ across years and tables. Some are derived using ERPs based on the 2001 Census, 2006 Census or 2011 Census. See particular tables for details. Rates derived using ERPs based on different Censuses are not comparable.

Accessibility Causes of death data are available in a variety of formats on the ABS website under the 3303.0 product family. ERP data are available in a variety of formats on the ABS website under the 3101.0 and 3201.0 product families. Further information on deaths and mortality may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level.

Interpretability Information on how to interpret and use cause of death data are available from Explanatory Notes in *Causes of Death, Australia* (Cat. no. 3303.0).

Data Gaps/Issues Analysis

Key data The Steering Committee notes the following issue:

gaps/issues

- Causes of death data are subject to a revisions process. Final data for 2006, 2007, 2008 and 2009 and revised data for 2010 and 2011 have been published in the 2012 Causes of Death publication. Data for 2011 and 2012 causes of death will be revised in 2015.

Social and economic inclusion of people with a mental illness — participation in employment of working age population

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Social and economic inclusion of people with a mental illness — participation in employment of working age population.
Measure (computation)	<p><i>Numerator:</i></p> <p>Number of people aged 16-64 years who are employed (by mental health status)</p> <p><i>Denominator:</i></p> <p>Number of people aged 16-64 years in the population (by mental health status)</p> <p><i>Computation:</i></p> <p>$(\text{Numerator} \div \text{Denominator}) * 100$</p> <p>Note: People with a mental health condition are defined as having a self-reported mental or behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.</p>
Data source/s	ABS unpublished, Australian Health Survey (AHS) 2011-13 (2011-12 National Health Survey component).

Data Quality Framework Dimensions

Institutional environment	<p>The AHS was collected, processed, and published by the ABS. The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment at www.abs.gov.au.</p>
Relevance	<p>Long-term health conditions described in this publication are classified to a classification developed for use in the NHS (or variants of that classification), based on the ICD. The 2011-12 AHS collected data on self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Estimates for people with 'mental illness' will differ to those that are derived under the SMHWB using the CIDI.</p> <p>The definitions of employment, unemployment and the labour force are consistent with those used in ABS labour force surveys.</p>
Timeliness	The AHS is conducted every three years over a 12 month period. Results from the 2011-12 NHS component of the AHS were released in October 2012.
Accuracy	<p>The AHS is conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the NT, where such persons make up a relatively large proportion of the population. The response rate for the 2011-12 NHS component was 85 per cent. Results are weighted to account for non-response.</p> <p>As it is drawn from a sample survey, the indicator is subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to</p>

design surveys. Rates should be considered with reference to their RSE. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use. The attachment tables identify those estimates with RSEs between 25 per cent and 50 per cent.

For information on AHS survey design, see the Australian Health Survey: Users' Guide on the ABS website.

Coherence

The methods used to construct the indicator are consistent and comparable with other collections and with international practise.

Accessibility

See *Australian Health Survey: First Results (cat. no. 4364.0.55.001)* for an overview of results from the NHS component of the AHS. Other information from this survey is also available on request.

Further information may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level.

Interpretability

Information to aid interpretation of the data are available from the Australian Health Survey: Users' Guide on the ABS website.

Many health-related issues are closely associated with age; therefore data for this indicator have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following issues:

- The AHS collects data on self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. The data may not be as reliable as or comparable with the data collected under the SMHWB that uses a diagnostic tool to identify mental illnesses.

Social and economic inclusion of people with a mental illness — participation in education and employment by young people

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Social and economic inclusion of people with a mental illness — participation in education and employment by young people.
Measure (computation)	<p><i>Numerator:</i></p> <p>Number of people aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (studying full or part-time) (by mental health status).</p> <p><i>Denominator:</i></p> <p>Number of people in aged 16–30 years in the population (by mental health status).</p> <p><i>Computation:</i></p> <p>$(\text{Numerator} \div \text{Denominator}) * 100$</p> <p>Note: People with a mental health condition are defined as having a self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more.</p>
Data source/s	ABS unpublished, <i>AHS 2011-13</i> (2011-12 National Health Survey component).

Data Quality Framework Dimensions

Institutional environment	<p>The AHS was collected, processed, and published by the ABS. The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment at www.abs.gov.au.</p>
Relevance	<p>Long-term health conditions described in this publication are classified to a classification developed for use in the NHS (or variants of that classification), based on the ICD. The 2011-12 AHS collected data on self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Estimates for people with 'mental illness' will differ to those that are derived under the SMHWB using the CIDI.</p> <p>The definitions of employment are consistent with those used in ABS labour force surveys.</p>
Timeliness	The AHS is conducted every three years over a 12 month period. Results from the 2011-12 NHS component of the AHS were released in October 2012.
Accuracy	<p>The AHS is conducted in all states and territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the NT, where such persons make up a relatively large proportion of the population. The response rate for the 2011-12 NHS component was 85 per cent. Results are weighted to account for non-response.</p> <p>As it is drawn from a sample survey, the indicator is subject to sampling error. Sampling error occurs because only a small proportion of the population is used</p>

to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their RSE. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use. The attachment tables identify those estimates with RSEs between 25 per cent and 50 per cent.

For information on AHS survey design, see the Australian Health Survey: Users' Guide on the ABS website.

Coherence The methods used to construct the indicator are consistent and comparable with other collections and with international practise.

Accessibility See *Australian Health Survey: First Results (cat. no. 4364.0.55.001)* for an overview of results from the NHS component of the AHS. Other information from this survey is also available on request.

Further information may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level.

Interpretability Information to aid interpretation of the data are available from the Australian Health Survey: Users' Guide on the ABS website.

Many health-related issues are closely associated with age; therefore data for this indicator have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following issues:

- The AHS collects data on self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. The data may not be as reliable as or comparable with the data collected under the National Survey of Mental Health and Wellbeing that uses a diagnostic tool to identify mental illnesses.

Mental health outcomes of consumers of specialised public mental health services

DQI for this indicator has been sourced from the AMHOCN and Australian, State and Territory governments with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Mental health outcomes of consumers of specialised public mental health services. This DQI should be considered in conjunction with DQI for Collection of information on consumers' outcomes.
Measure (computation)	<p><u>Description:</u></p> <p>Proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes. Data are also reported on the proportion who experienced no significant change or a significant deterioration in their mental health outcomes. Data are reported by consumer type: people in ongoing community-based care, people discharged from community-based care and people discharged from a hospital psychiatric inpatient unit.</p> <p><u>Numerator/s:</u></p> <p>Number of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes, by consumer type.</p> <p>Number of people receiving care in specialised public mental health services who had no significant change in their clinical mental health outcomes, by consumer type.</p> <p>Number of people receiving care in specialised public mental health services who had a significant deterioration in their clinical mental health outcomes, by consumer type.</p> <p><u>Denominator:</u></p> <p>Number of specialised public mental health service episodes with completed clinical mental health outcome measures data, by consumer type.</p> <p><u>Computation:</u></p> <p>Expressed as a proportion: $(\text{Numerator} \div \text{Denominator}) * 100$. Calculated separately by consumer type.</p>
Data source/s	State and Territory data reported to NOCC and analysed by AMHOCN.

Data Quality Framework Dimensions

Institutional environment	<p>Health Ministers adopted the routine measurement of consumer outcomes as a priority under the <i>National Mental Health Strategy (1992)</i> and in all subsequent National Mental Health Plans. It is also compatible with State and Territory governments' documented policy emphasis on high quality health services and increased consumer and carer participation.</p> <p>The AMHOCN prepared this indicator using the NOCC data on HoNOS family of measures. The Australian Government (Department of Health) contracts AMHOCN to support the implementation of the NOCC as part of routine clinical practice by undertaking three functions 1) data bureau — receives and processes information 2) analysis and reporting — analyses and reports on the submitted data and 3) training and service development — supports training in the measures and their use for clinical practice, service management and development purposes.</p> <p>The NOCC 1.50 was endorsed by all State and Territory governments in 2003, and all jurisdictions have reported data since 2004-05. The NOCC Technical Specification was revised to 1.60 in 2009. All jurisdictions have supplied, or resupplied NOCC data according to 1.60 from 2007-08. The NOCC protocol prescribes a set of standard measures to be collected at particular times (collection occasions) in the clinical process. Under the NOCC protocol, collection of outcomes data is mandatory at admission, review and discharge. Data collected outside of NOCC protocols are excluded from the analysis.</p>
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Relevance

The scope of the NOCC is all specialised public mental health services managed by, or in receipt of funds from, state or territory health authorities Australian Government funded aged residential services are excluded.

The purpose of the NOCC is to measure consumer outcomes. This indicator relates only to consumer outcomes data collected through the HoNOS family of measures (HoNOS; HoNOS for Older People (HoNOS 65+) and HoNOS for Children and Adolescents (HoNOSCA). Other consumer outcome measures are also collected. For adults and older persons these include: Kessler 10 (K10+), Behavior and Symptom Identification Scales (BASIS-32), or Mental Health Inventory (MHI-38); for children and adolescents, the parent and youth versions of the SDQ. The uptake of these measures is not captured by this indicator.

Only episodes that have valid measures for two specified data collection occasions are included. 'Valid' measures are those with a correctly completed specified number of items, for the:

- HoNOS/HoNOS 65+ — a minimum of 10 of the 12 items
- HoNOSCA — a minimum of 11 of the first 13 items.

Brief ambulatory care episodes are excluded from this indicator.

The denominator for the 'completed inpatient' group excludes those episodes that were partially completed within the year and had a length of less than 3 days. The denominator for the 'completed ambulatory' group is made up of those episodes that started and finished within the year. The denominator for the 'ongoing ambulatory' group is made up of those ambulatory episodes that started within the reference year and were still open at 30 June or were open at the start and end of the reference year.

Outcome scores are classified based on effect size — a statistic used to assess the magnitude of a treatment effect. The effect size is the ratio of the difference between the pre- and post- scores to the standard deviation of the pre-score. Individual episodes are classified as 'significant improvement' if the effect size index is greater than or equal to positive 0.5; 'no change' if the index is between -0.5 and 0.5; and 'significant deterioration' if the effect size index is less than or equal to -0.5.

Outcomes are calculated for each of the following three consumer groups and the calculation varies depending on the setting and the duration of the episode of care:

- people discharged from hospital, episodes for people who were admitted and discharged from inpatient care during the reference period (an individual can have two episodes of care so the data represent episode-counts, rather than person-counts) — the admission and discharge occasions rated during the reference period are used
- people in ongoing community-based care, episodes for people who received community care for the whole of the reference period or who commenced community care sometime after 1 July (beginning of the period) and continued to receive care for the rest of the reference period — the first and last occasions rated during the reference period are used
- people discharged from community-based care, episodes for people who were discharged from community care (not including those discharged to hospital) and who received an episode of community care that started and ended in the reference period — the admission and discharge occasions rated during the reference period are used.

Outcomes are measured for consumers discharged from residential mental health care, but there were too few episodes with completed clinical mental health to derive outcome results.

A single 'average score' by consumer type does not reflect the complex service system in which services are delivered across multiple settings (inpatient, community and residential) and provided as both discrete, short term episodes of care and prolonged care over indefinite periods. The approach separates a consumer's care into segments (hospital versus the community) rather than tracking the person's overall outcomes across treatment settings. In addition, consumers' outcomes are measured from the clinician's perspective and not as the 'lived experience' from the consumer's viewpoint.

Data are not available for Victoria for 2011-12 and 2012-13. All Australian totals for 2011-12 and 2012-13 exclude Victoria.

	Tasmanian data for 2009-10 are considered unreliable and not reported. As a result, 2008-09 data are used in the calculation of the 2009-10 Australian coverage estimates.
Timeliness	<p>State and territory health authorities provide the NOCC data to AMHOCN for national collation on a quarterly/annual basis and all data are to be submitted approximately six months after the reference period.</p> <p>The latest reference period for this data set is 2012-13.</p>
Accuracy	<p>States and territories are primarily responsible for the quality of the NOCC data they provide. However, AMHOCN undertakes extensive validation. Validation is conducted in two stages: (1) The compliance stage, concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage, primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues in relation to the NOCC protocol as well as flagging , including invalid domain values and/or, missing data.</p> <p>The proportion of episodes for which 'valid' outcomes data are collected is less than 50 per cent of expected coverage. It is not known if the results for those for whom data are collected are representative of the consumer population.</p>
Coherence	<p>Data are available for 2007-08 to 2012-13. The comparability of the outcomes data across jurisdictions and years may be affected by the relatively low proportion of episodes for which 'valid' outcomes data are collected and the degree to which this proportion varies across jurisdictions and years.</p> <p>The Australian totals for 2011-12 and 2012-13 are not comparable to earlier years as they exclude data for Victoria.</p>
Accessibility	<p>Data for this indicator are published in the National mental health reports: www.health.gov.au/internet/main/publishing.nsf/Content/mental-data and in the Key Performance Indicators for Australian Public Mental Health Services set (available at mhsa.aihw.gov.au/indicators/nkpi/).</p> <p>NOCC data are available on the AMHOCN website amhocn.org/. The following on-line products are available:</p> <ul style="list-style-type: none"> • web decision support tool • NOCC Standard Reports • NOCC Volume and Percentage Clinical Ratings: Australia
Interpretability	<p>Metadata information for the NOCC are published on the AMHOCN website amhocn.org/.</p> <p>Further information to understand this indicator are available:</p> <ul style="list-style-type: none"> • in the Key Performance Indicators for Australian Public Mental Health Services, Third Edition • from the Key Performance Indicators for Australian Public Mental Health Services (available at mhsa.aihw.gov.au/indicators/nkpi/).

Data Gaps/Issues Analysis

Key data gaps/issues	<p>The Steering Committee notes the following key data gaps/issues:</p> <ul style="list-style-type: none"> • There are differences in the relative proportions of 'matched pair' HoNOS/CA/65+ ratings. <ul style="list-style-type: none"> – NOCC completion rates are for people discharged from hospital and people on ongoing community based care are approximately 85 per cent. – NOCC completion rates for people discharged from community based care, are lower, at approximately 65 per cent. This pattern has been stable over time and generally consistent for all consumer age groups and jurisdictions, with the exception of ACT where technical issues have not enabled linkage of admission and discharge ratings for this consumer group. It is likely that the overall lower completion rate for this consumer group arises when consumers are administratively discharged from care following a period of no active care in the preceding period.
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