Australian Government
Australian Institute of Health and Welfare

Medicare-subsidised GP, allied health and specialist health care across local areas: 2022-23

Web report | Last updated: **07 Mar 2024** | Topic: Primary health care

About

Use of non-hospital Medicare-subsidised health care, such as services provided by General Practitioners (GPs), allied health, specialist, diagnostic imaging, and nursing and Aboriginal health workers, varies across Australia. In 2022–23, 86% of Australians had at least one Medicare-subsidised GP attendance, a decrease from 88% in 2018–19. People living in metropolitan Primary Health Network (PHN) areas were more likely to have a Medicare-subsidised after-hours GP attendance than people from regional areas; while those living in regional areas were more likely to have a GP attendance targeting chronic disease and complex care coordination and management.

Cat. no: PHC 15

Findings from this report:

- After-hours GP attendance use was higher in metropolitan PHN areas (20% of people) than regional areas (9.3%) in 2022–23
- In 2022–23 there were over 4.8 million GP attendances to residential aged care settings (17 per patient)
- The proportion of people who received a Medicare-subsidised specialist attendance ranged from 14% to 41% across PHNs
- In 2022–23 7.9% of people aged 15–24 used a Medicare-subsidised allied mental health service compared to 2.3% aged 65–79

Introduction

Medicare-subsidised services provided in non-hospital settings enable eligible Australians to access a wide range of general practice, diagnostic, allied health, specialist, nursing and Aboriginal health worker services at no or partial cost. This report provides the latest 2022–23 non-hospital Medicare-subsidised service use data, exploring trends in the use of these services.

The Technical information and Technical notes provides details about the data source, scope, limitations and measures included.

The data tables to accompany this report can be found in the Data section of this report.

GP attendances

A decrease in the proportion of Australians who had a GP attendance

Over 22 million people (86% of Australians) had at least one Medicare-subsidised general practitioner attendance (a total of around 166 million attendances). This represents a relative decrease in the percentage of the population who had a GP attendance by 2.0% (down from 88% of Australians) in 2018–19 (Table 1).

Table 1: Use of Medicare-subsidised GP attendances, 2018–19 and 2022–23

Measure	2018-19	2022-23
Percentage of people[(a)(b)] who had a GP attendance	88%	86%
Number of GP attendances per 100 people[(a)(b)]	632 per 100 people	639 per 100 people
Total Medicare benefits paid for GP attendances per 100 people[(a)(b)(c)(d)]	$32,158 per 100 people	$33,384 per 100 people

Notes:

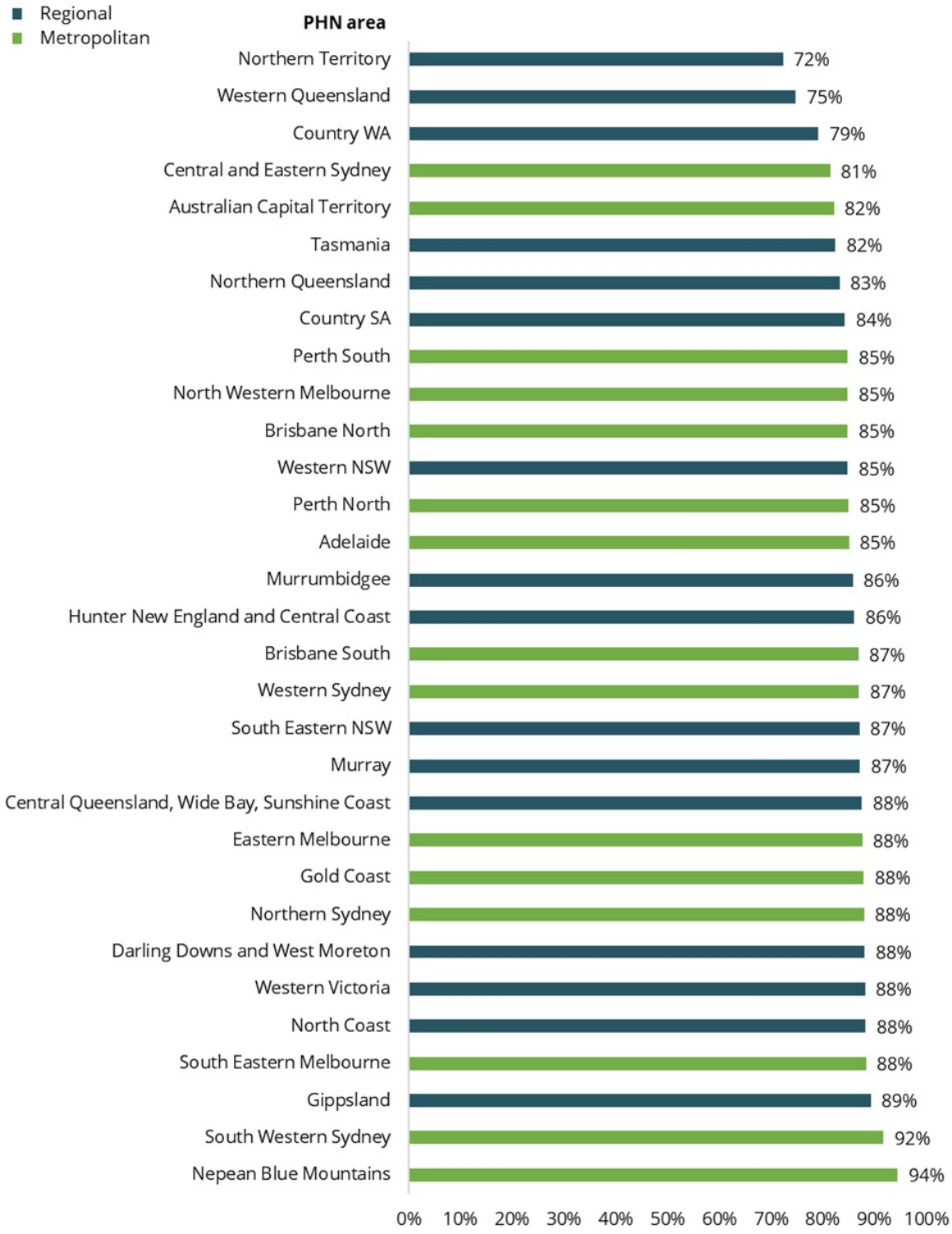
a. The numerator is the number of people who had a GP attendance and the denominator is the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP).
b. GP attendance includes PIP GP attendance items, From 31 October 2022 these items have been removed.
c. Does not include government expenditure on bulk-billing incentives for non-referred attendances. See Technical notes for further details.
d. Expenditure results are not adjusted for inflation.

Sources: AIHW analysis of Department of Health and Aged Care, Medicare Benefits Schedule (MBS) claims Data; ABS ERP.

GP attendances vary depending on where people live

The proportion of people who had a Medicare-subsidised GP attendance ranged from 72% to 94% across Primary Health Networks (PHN). There was greater variation in the proportion of people who received a Medicare-subsidised GP attendance in regional PHNs (72% to 89%) compared to metropolitan PHNs (81% to 94%) (Figure 1). On average, people in metropolitan PHN areas had higher Medicare-subsidised GP attendance (657 per 100 people) compared to those in regional PHN areas (606 per 100 people). This variation may be due to a range of factors, see Interpreting the data for more details.

Figure 1: Percentage of people who had a Medicare-subsidised GP attendance, by Primary Health Network (PHN) area, 2022–23(a)



Note:

(a) GP attendance includes PIP GP attendance items. From 31 October 2022 these items have been removed.

Chart: AIHW. Sources: AIHW analysis of Department of Health and Aged Care, MBS claims data; ABS ERP.

GP attendances

In 2022–23 there were over 4.8 million GP attendances to residential aged care settings (17 GP attendances per residential aged care patient). The number of GP attendances per residential aged care patient was 19 for metropolitan areas and 15 for regional areas (Figure 2).

Figure 2: Number of GP residential aged care attendances per residential aged care patient, by Primary Health Network (PHN) area, 2022–23

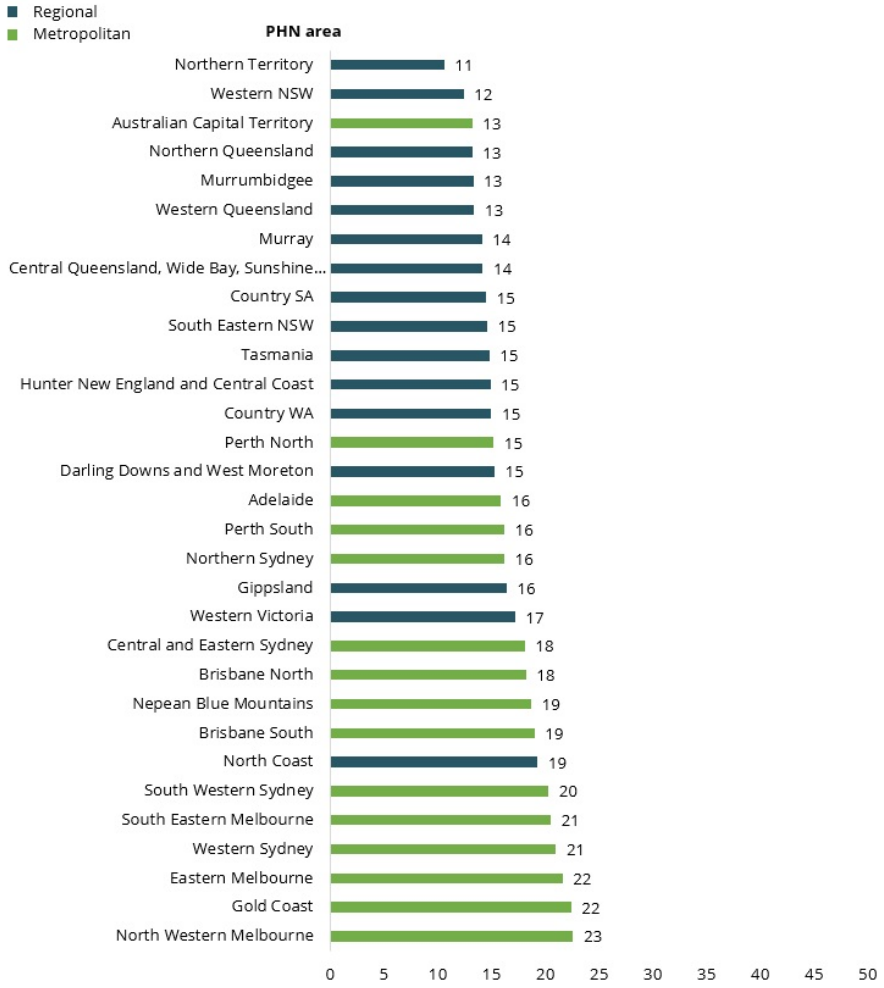


Chart: AIHW. Sources: AIHW analysis of Department of Health and Aged Care, MBS claims data; ABS ERP.

GP attendances

Almost 1 in 4 people had an Enhanced Primary Care GP attendance

People living with complex health conditions, including chronic or terminal medical conditions may receive Medicare-subsidised chronic disease management services from their GP for the diagnosis, treatment, planning, review and coordination of their care.

Over 6 million people (24% of Australians) received a Medicare-subsidised GP Enhanced Primary Care attendance in 2022–23 (Table 2).

Box 1: GP Enhanced Primary Care

In this report, GP Enhanced Primary Care refers to a range of services such as health assessments, medication management reviews, the creation and review of treatment plans, and coordination of care for people living with complex health conditions who require multidisciplinary, team-based care from a GP and at least 2 other providers. For more information, see Technical information.

Table 2: Proportion of people who had a GP Enhanced Primary Care service[(a)], 2018–19 and 2022–23

Enhanced Primary Care services[(b)(c)]	2018–19 (%)	2022–23 (%)
Chronic Disease Management Plan	15.0	15.8
Mental Health	8.8	8.3
Health Assessments	4.2	4.9
Multidisciplinary Case Conference	0.2	0.2
Medication Management Review (domiciliary)	0.3	0.3
Medication Management Review (residential)	0.3	0.3
Total Enhanced Primary Care(c)	23.6	24.2

Note:

a. In this report, GP Enhanced Primary Care refers to a range of non-hospital Medicare-subsidised services such as health assessments, medication management reviews, the creation and review of treatment plans, and coordination for people living with complex health conditions who require multidisciplinary, team-based care from a GP and at least 2 other providers.
b. Refer to Technical information for details on MBS items and description of service groups.
c. People may receive services from more than one subgroup within GP Enhanced Primary Care, but are only counted once in the total.

Sources: AIHW analysis of Department of Health and Aged Care, MBS claims data; ABS ERP.

Higher use of GP Enhanced Primary Care service in regional PHN areas

The proportion of people who had a GP Enhanced Primary Care service was higher for those who live in regional Primary Health Network (PHN) areas (26%) than those in metropolitan areas (23%) (Figure 3).

Box 2: PHN and Statistical Area Level 3 (SA3) geographical groupings

To support comparisons between similar geographical areas, PHNs are grouped into metropolitan and regional PHN areas. Results for SA3s are grouped by similar socioeconomic status (higher, medium and lower) for SA3s *in Major cities*, and by remoteness areas for SA3s in *Inner Regional*, *Outer regional* and *Remote* areas. For more information, see Technical Note – Geography.

Figure 3: Proportion of people who had a Medicare-subsidised GP Enhanced Primary Care service, by Primary Health Network (PHN) area, 2022-23

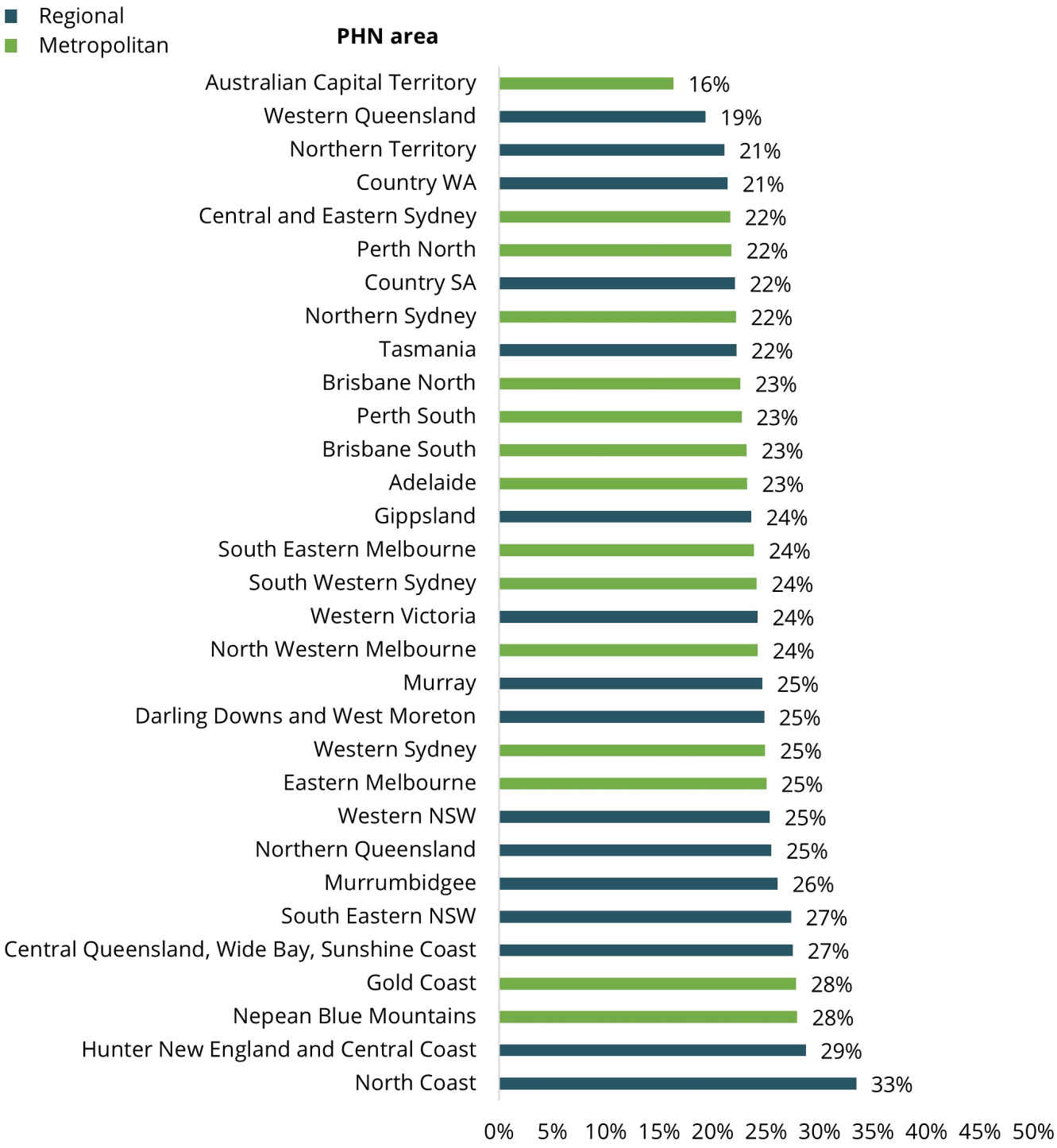


Chart: AIHW. Sources: AIHW analysis of Department of Health and Aged Care, MBS claims data; ABS ERP.

GP attendances

After-hours GP Medicare-subsidised attendances were higher in metropolitan areas and varied across PHNs

After-hours GP attendances are GP and non-specialist medical practitioner attendances provided on a public holiday, a Sunday, and during specified periods between Monday and Saturday depending on the service, see Technical information for specific times. The availability of Medicare-subsidised after-hours GP services can vary based on where a person lives, and this may impact the proportion of people who have this attendance type within a Primary Health Network (PHN).

In 2022–23, after-hours GP attendance use was higher in metropolitan PHN areas (20%) than regional areas (9.3%). Across PHNs, after-hours GP visits ranged from 5.1% to 29% (Figure 4).

Figure 4: Proportion of people who had a Medicare-subsidised after-hours GP attendance, by PHN area, 2022-23

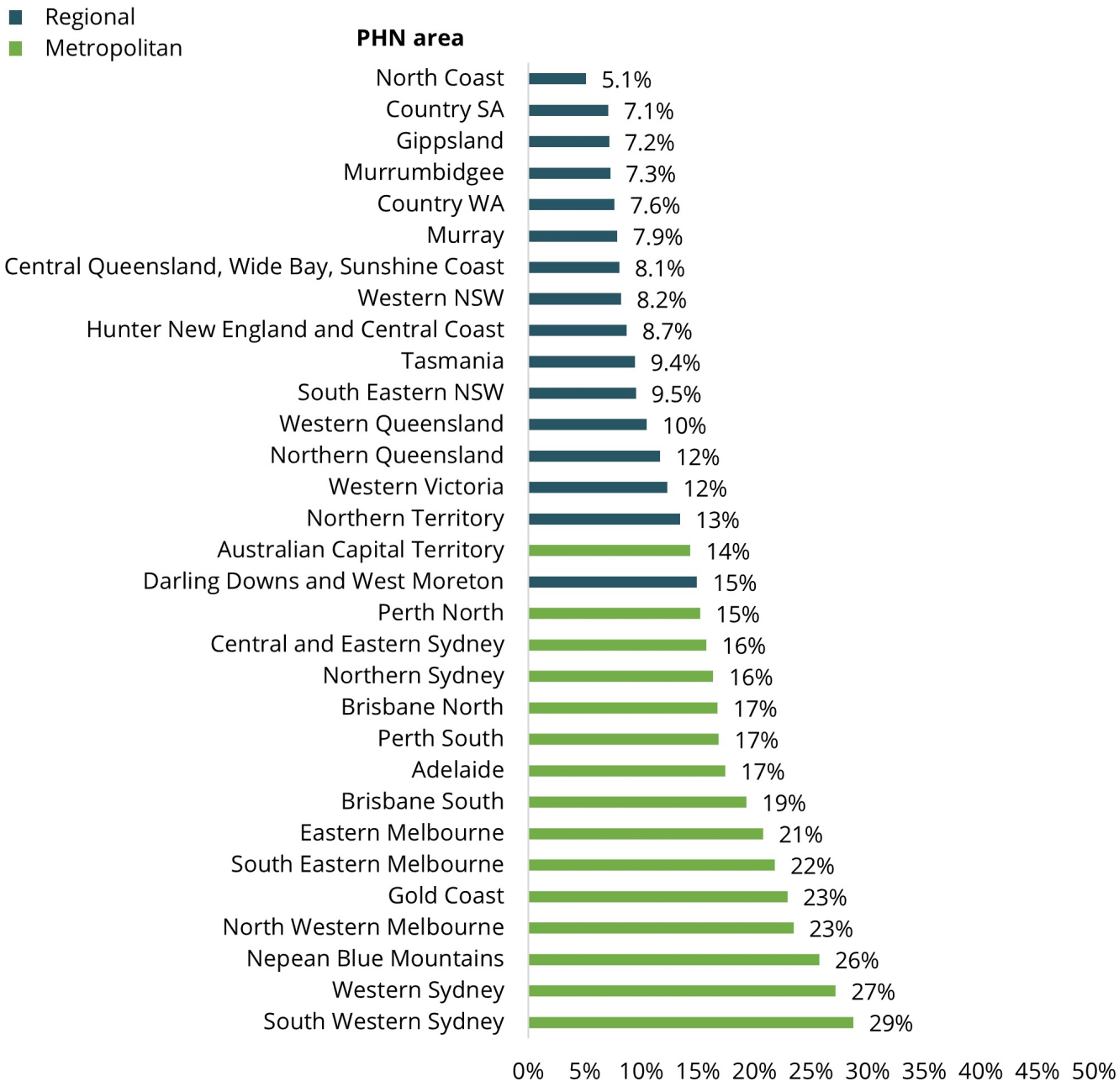


Chart: AIHW. Sources: AIHW analysis of Department of Health and Aged Care, MBS claims data; ABS ERP.

Box 3: After-hours GP attendances

The Australian Government provides a range of Medicare-subsidised after-hours services to support Australians with access to health care in various settings including consulting rooms, consumers' homes or residential aged care facilities. After-hours care is categorised as urgent and non-urgent, depending on when and where care is provided.

In this report, urgent and non-urgent after-hours care are defined as per the Medicare Benefits Schedule. For more details, see Technical information.

After-hours GP attendances in Major cities were highest in lower socioeconomic areas

Of those within *major cities*, a higher proportion of people who live in lower socioeconomic SA3 areas had an after-hours GP attendance, than in medium and higher socioeconomic areas. In 2022–23, 23% of people in lower socioeconomic SA3 areas had an after-hours GP attendance compared with 19% in medium and 14% in higher socioeconomic SA3 areas.

Just over 1 in 20 after-hours GP attendances were urgent

GP after-hours attendances billed as 'urgent' accounted for 6% of all GP after-hours attendances in 2022–23, a decrease from 10% in 2018-19. Urgent after-hours GP attendances accounted for 5% of GP after-hours visits by people in regional areas and 9% in metropolitan areas.

Diagnostic imaging services

Almost 2 in 5 Australians (39% or over 10 million people) received more than 27 million Medicare-subsidised diagnostic imaging services in 2022–23. Between 2018–19 and 2022–23, there was a relative increase in the proportion of the population who had a diagnostic imaging service (1.2%), in the number of services per 100 people (3.5%), and in the Medicare benefits paid (16.6%) (Table 3).

Table 3: Use of Medicare-subsidised diagnostic imaging service, 2018–19 and 2022–23

Measure	2018–19	2022–23
Percentage of people[(a)] who had a diagnostic imaging service	39%	39%
Number of diagnostic imaging services per 100 people[(a)]	103 per 100 people	106 per 100 people
Total Medicare benefits paid for diagnostic imaging services per 100 people[(a)(b)]	$14,285 per 100 people	$16,649 per 100 people

Notes:

a. The numerator is the number of people who had a diagnostic imaging service and the denominator is the ABS ERP.
b. Expenditure results are not adjusted for inflation.

Sources: AIHW analysis of Department of Health and Aged Care, MBS claims data; ABS ERP.

Use of diagnostic imaging services varies across PHN areas

The proportion of people who received a Medicare-subsidised diagnostic imaging service was lower in regional Primary Health Networks (PHN) ranging from 26% to 43%, compared to metropolitan PHNs where it ranged from 31% to 46% (Figure 5).

Figure 5: Proportion of people who had a Medicare-subsidised diagnostic imaging service, by PHN area, 2022–23

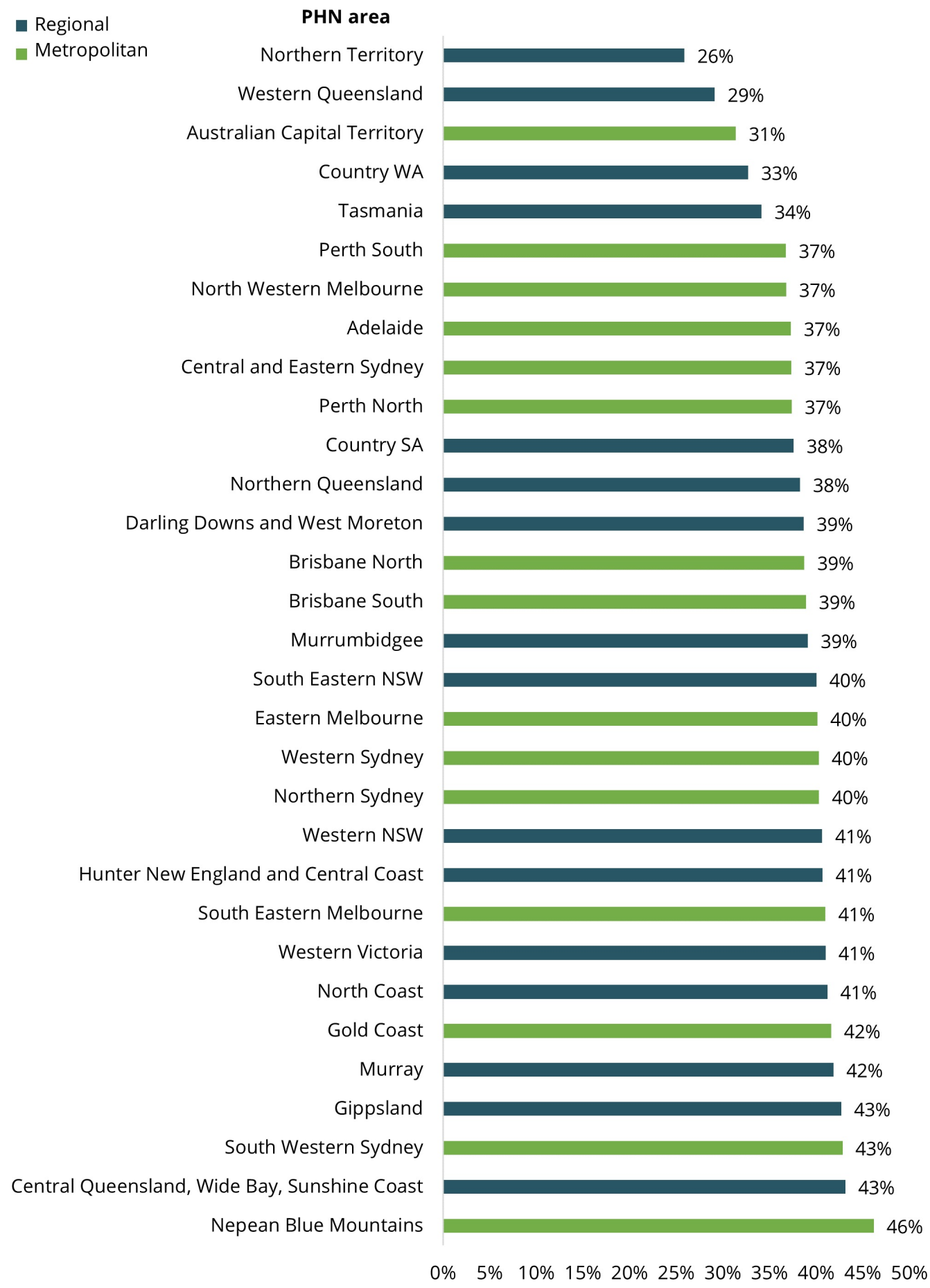


Chart: AIHW. Sources: AIHW analysis of Department of Health and Aged Care, Medicare Benefits claims data; ABS ERP.

Allied health services

Allied health services include a broad range of services delivered by health practitioners who are not doctors, nurses or dentists. Medicare-subsidised allied health services do not cover all allied health treatments. Allied health services are also accessed and funded through many arrangements, such as those subsidised by private health insurance or the Department of Veterans' Affairs.

Over 10 million people (39% of Australians) received a Medicare-subsidised allied health service in 2022–23 (more than 26 million allied health services); a slight increase from 37% in 2018–19 (Table 4). In the same period, the number of services rose from 96 to 102 per 100 people.

The majority of the allied health services subsidised by Medicare are for optometry services, and the increase in the number of services was driven predominantly by an increasing proportion of people who had Medicare-subsidised optometry services (Table 4). Medicare-subsidised optometry service usage is driven by a number of factors including the broad eligibility for Medicare-subsidised eye examinations in Australia without the need for a referral, see the Optometry section of this report for more information.

Table 4: Proportion of people who had a Medicare-subsidised allied health service[(a)], 2018–19 and 2022–23

Service groups[(b)]	**2018–19 (%)**	**2022–23 (%)**
Allied health services[(c)(d)]	37	39
Optometry[(c)]	30	32
Mental health care[(c)(e)]	5.3	5.0
Clinical Psychologist	2.2	2.0
Other Psychologist	2.9	2.7
Other Allied Mental Health	0.4	0.4
Physical health care[(c)(f)]	4.7	5.1
Physiotherapy	3.4	3.7
Exercise Physiology	0.7	0.6
Chiropractic Services	0.6	0.7
Osteopathy	0.3	0.4
Allied health - Other[(c)(g)]	5.8	5.8
Podiatry	4.5	4.6
Dietetics	1.1	0.9
Occupational Therapy	0.1	0.1
Speech Pathology	0.2	0.1
Diabetes Education	0.3	0.3
Audiology	0.1	0.1
Other Allied Health	0.1	0.2

Notes:

a. Non-hospital Medicare-subsidised services only.
b. Refer to Technical Information for details on MBS items and description of service groups.
c. People may receive more than one subgroup service within Mental Health Care, Physical Health Care or Allied health – Other service groups, but will only be counted once in the total.
d. Includes Optometry, Mental health care, Physical health care and Allied health – Other.
e. Includes Clinical Psychologists, Other Psychologists and Other Allied Mental Health service groups.
f. Includes Physiotherapy, Exercise Physiology, Chiropractic Services and Osteopathy service groups.
g. Includes Podiatry, Dietetics, Occupational Therapy, Speech Pathology, Diabetes Education, Audiology and Other Allied Health.

Sources: AIHW analysis of Department of Health and Aged Care, MBS claims data; ABS ERP.

Box 4: What are Medicare-subsidised allied health services?

Allied health includes a broad range of services delivered by health practitioners who are not doctors, nurses or dentists. This includes audiologists, chiropractors, occupational therapists, optometrists, osteopaths, physiotherapists, podiatrists, psychologists and speech pathologists (AHPA 2023). Australians eligible for Medicare-subsidised allied health services can use allied health services through many channels, including Medicare, general private health insurance ('ancillary' or 'extras' cover), or by paying for the service entirely out-of-pocket. At present, there is no national data on allied health service use outside of Medicare or private health insurance (AIHW 2018).

Who is eligible for Medicare-subsidised allied health services?

Medicare-subsidised allied health services account for only a portion of all allied health service use in Australia, and, with the exception of optometry services, are generally only available to people who are referred by a GP, or in some cases a specialist medical practitioner. Common referral pathways include GP Mental Health Treatment Plans for people with a mental health condition and GP Chronic Disease Management Plans for people with a chronic health condition (in this report these are referred to as Enhanced Primary Care GP attendances). For more detail, refer to the Technical Information for this release.

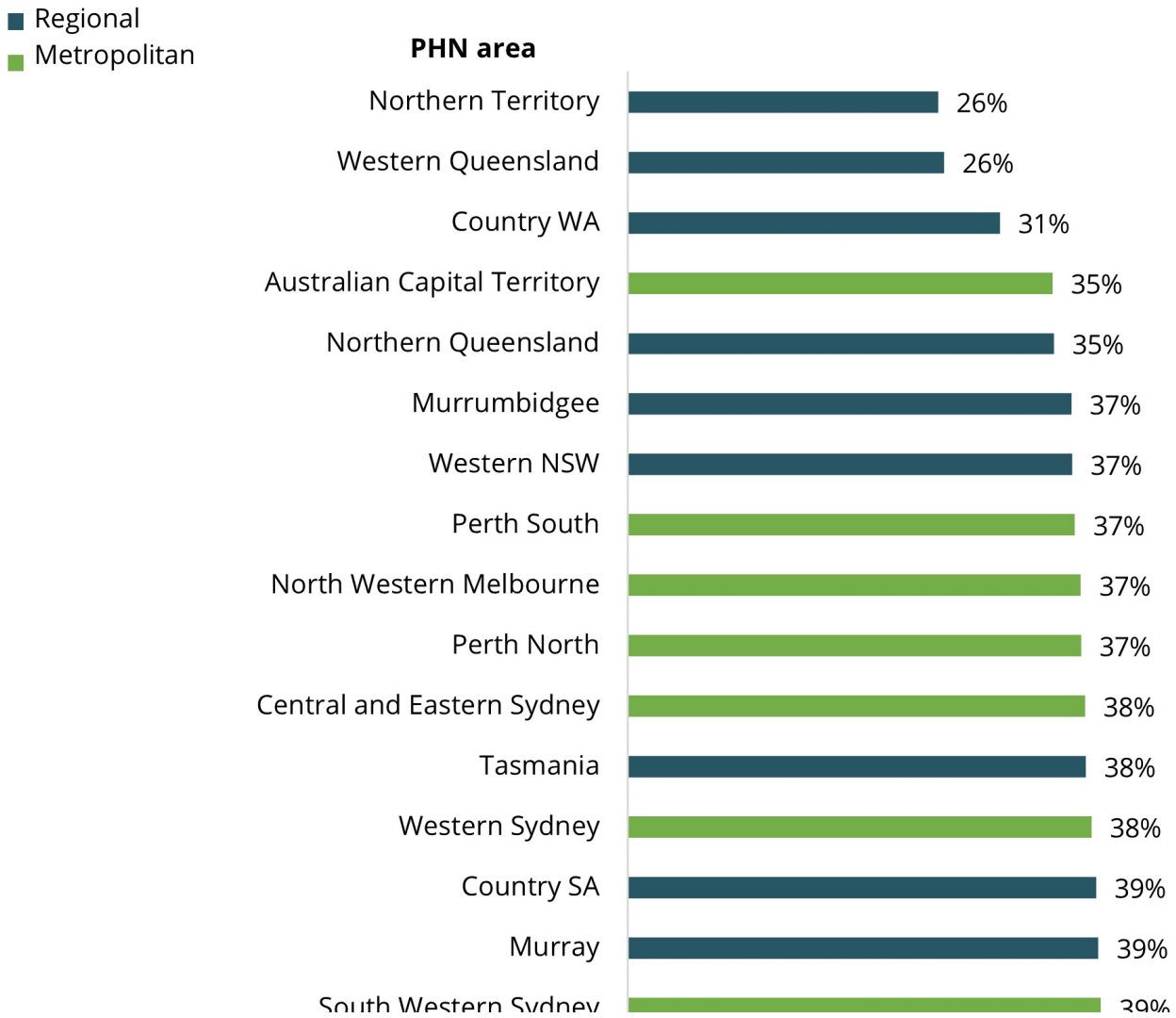
Younger Australians were more likely to see a psychologist or allied mental health care worker

In 2022–23, younger Australians were more likely to see a Medicare-subsidised psychologist or allied mental health care worker than those aged 65 and above. The most common age groups to see these health professionals were those aged 15–24 (7.9%) and 25–44 years (7.2%), compared to only 2.3% for those aged 65–79 and 0.9% of people aged 80 and over).

Medicare-subsidised allied health service use varied across PHN areas

The proportion of Medicare-subsidised allied health services used appear similar for regional and metropolitan Primary Health Networks (PHN), both being 39%. However, there is a considerable range of variation in regional PHNs from 26% in Northern Territory and Western Queensland PHNs to 43% in North Coast PHN as well as variation in metropolitan PHNs from 35% in Australian Capital Territory PHN to 42% Eastern Melbourne and Gold Coast PHNs (Figure 6).

Figure 6: Percentage of people who had a Medicare-subsidised allied health service, by PHN area, 2022-23



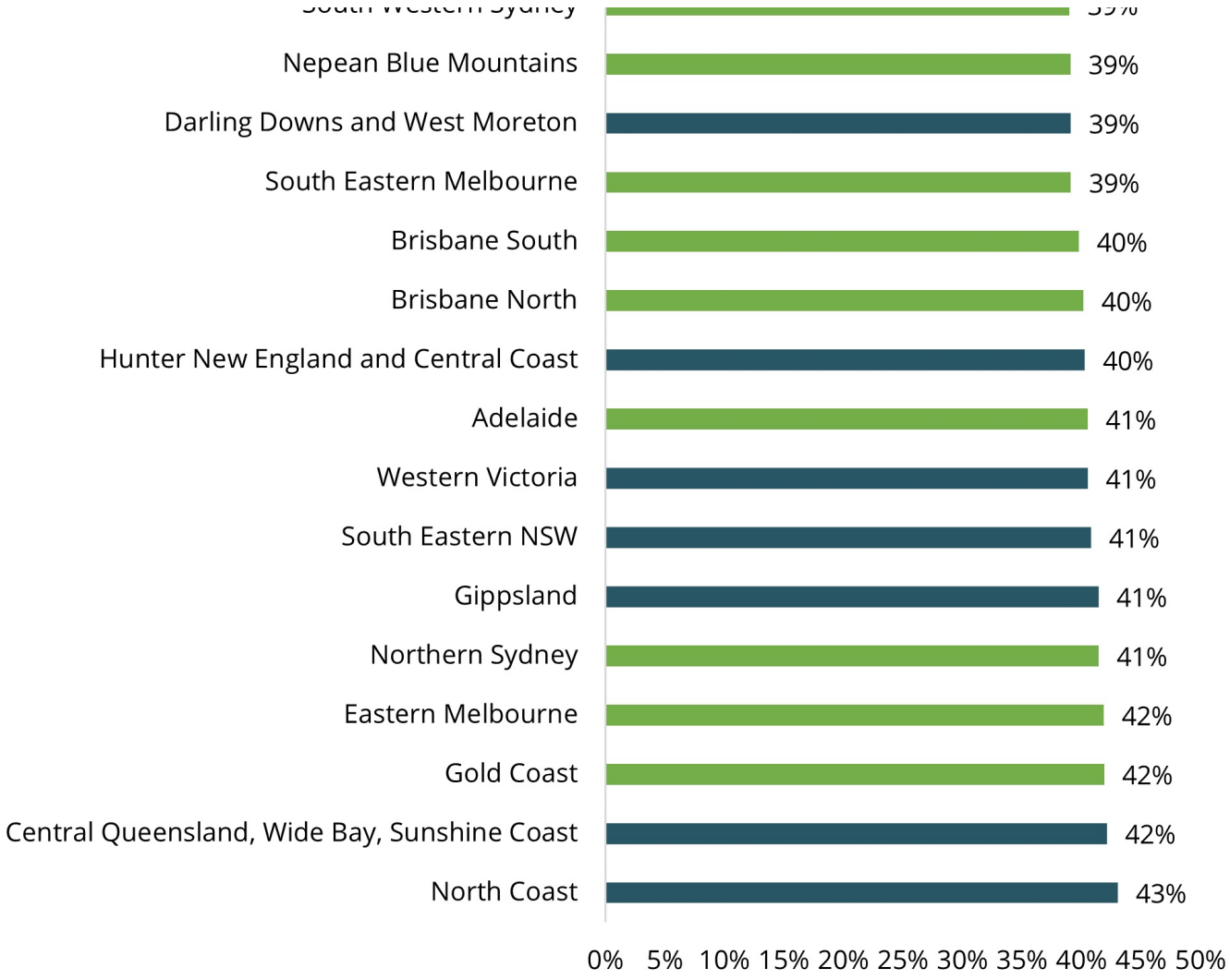


Chart: AIHW.

Sources: AIHW analysis of Department of Health and Aged Care, MBS claims data; ABS ERP.

References

AHPA (Allied Health Professions Australia) 2023. What is allied health. Melbourne: AHPA. Viewed 8 January 2024.

AIHW (Australian Institute of Health and Welfare) 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW. Viewed 8 January 2024.

Allied health services

Almost 1 in 3 Australians used a Medicare-subsidised optometry service

In 2022–23, there were almost 11 million Medicare-subsidised optometry services delivered to around 8 million (32%) Australians.

Medicare-subsidised optometry use was lowest in remote areas

Use of Medicare-subsidised optometry services was highest for people living in *inner regional* areas with 33% of people receiving at least one service and was lowest in *remote* areas with only 21% of people receiving at least one service.

Box 5: Optometry services

Optometrists provide a wide range of services including vision-testing, prescription of glasses and contact lenses, assessment and reporting on fitness to drive, and diagnosis and treatment of other eye conditions (AHPA 2024). Since January 2015, Australians aged under 65 are eligible to receive a Medicare-subsidised comprehensive eye examination every 3 years and annually for those aged 65 and over.

Though Medicare-subsidised optometry services are included in the allied health service group, access to these services are much broader than the other services listed in this service group. The ability to access Medicare-subsidised eye tests without a referral may account for the higher proportion of people who have Medicare-subsided optometry services compared with other allied health services (Services Australia 2023b). See Interpreting the data section and Technical Information for more details.

References

AHPA (Allied Health Professions Australia) 2024. Optometry. Melbourne: AHPA. Viewed 8 January 2024.

Services Australia 2023b *Screening, tests and scans*, Services Australia, Australian Government, accessed 1 February 2024.

Specialist attendances

One in 3 people had a non-hospital Medicare-subsidised specialist attendance

Around 1 in 3 Australians (32%, or 8.2 million people) had a non-hospital Medicare-subsidised specialist attendance in 2022–23, with over 25 million specialist attendances provided (Table 5). This represents a relative increase in the proportion of people who had a specialist attendance of 1.5% from 2018–19.

Table 5: Use of Medicare-subsidised specialist attendances, 2018–19 to 2022–23

Measure	2018–19	2022–23
Percentage of people(a) who had a specialist attendance	31%	32%
Number of specialist attendances per 100 people[(a)]	95 per 100 people	98 per 100 people
Total Medicare benefits paid for specialist attendances per 100 people[(a)(b)]	$8,284 per 100 people	$8,968 per 100 people

Notes:

a. The numerator is the number of people who had a specialist attendance and the denominator is the ABS ERP.
b. Expenditure results are not adjusted for inflation.

Sources: AIHW analysis of Department of Health and Aged Care, MBS claims data; ABS ERP.

Medicare-subsidised specialist attendances outside of hospital continue to vary depending on where people live

Although the proportion of Medicare-subsidised specialist attendances appears similar for regional and metropolitan Primary Health Networks (PHN) overall (31% and 32%, respectively) there was a considerable range of variation from 14% in Northern Territory PHN to 41% in Northern Sydney PHN (Figure 7).

Figure 7: Percentage of people who had a Medicare-subsidised specialist attendance, by PHN area, 2022–23

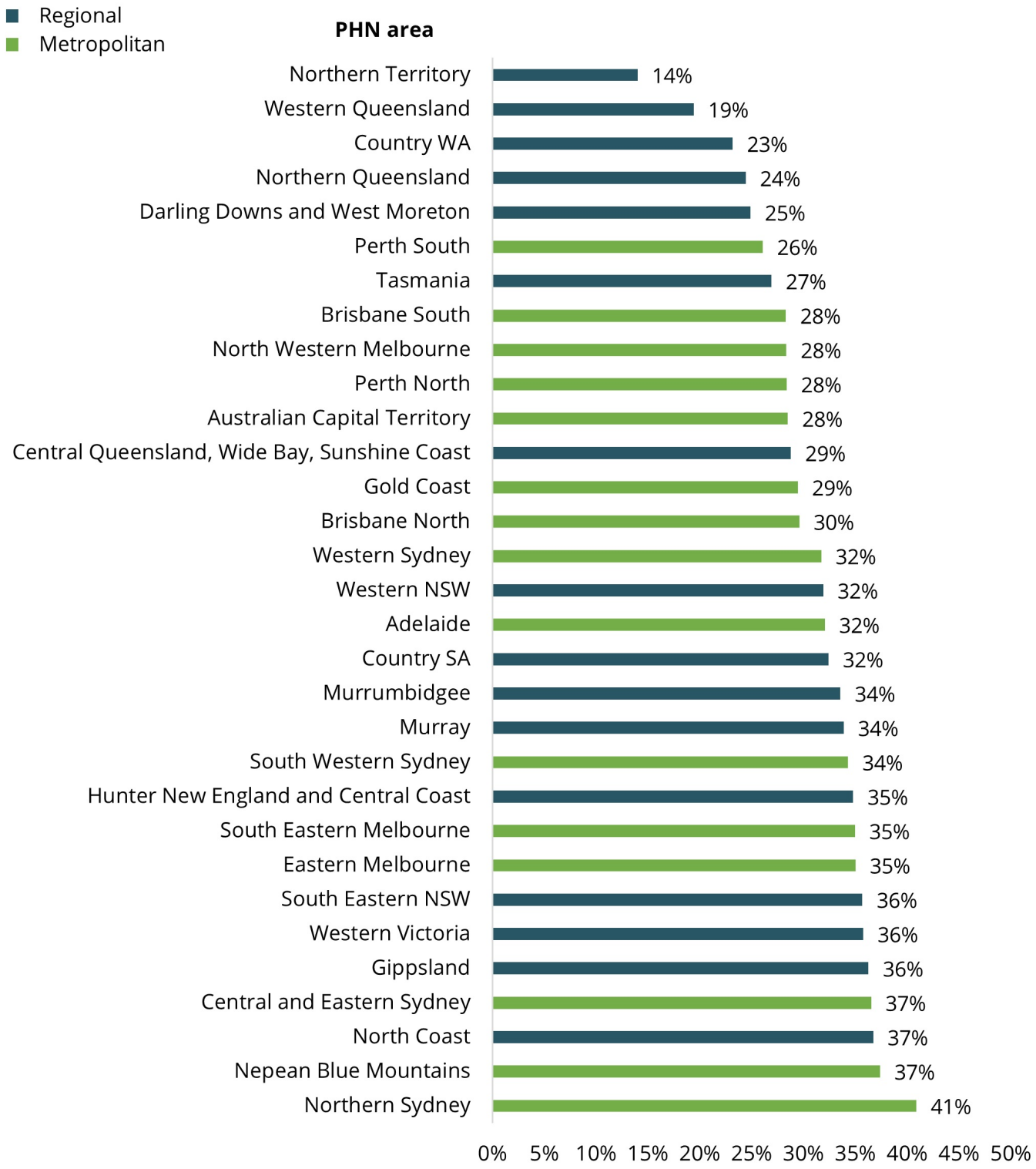


Chart: AIHW. Sources: AIHW analysis of Department of Health and Aged Care, MBS claims data; ABS ERP

Nursing and Aboriginal health workers

The nursing and Aboriginal health worker service group comprises Medicare-subsidised services provided by a nurse practitioner, practice nurse, midwife or Aboriginal health worker.

In Australia, there were over 4 million Medicare-subsidised services provided to 2 million people (7.9% of Australians) by nurses and Aboriginal health care workers in 2022–23. This included:

- 3 million services from a practice nurse or Aboriginal health worker.
- One million services from a nurse practitioner service.
- 200,000 midwifery services.

The proportion of people who received a Medicare-subsidised nursing and Aboriginal health workers service increased with age. Those living in regional Primary Health Networks (PHN) (between 8% to 14%) were more likely to receive a Medicare-subsidised subsidised nursing and/or Aboriginal health worker service compared to metropolitan PHNs (3% to 10%) (Figure 8).

Figure 8: Proportion of people who had a Medicare-subsidised service provided by a nurse practitioner, practice nurse, midwife or Aboriginal health worker, by PHN area, 2022–23

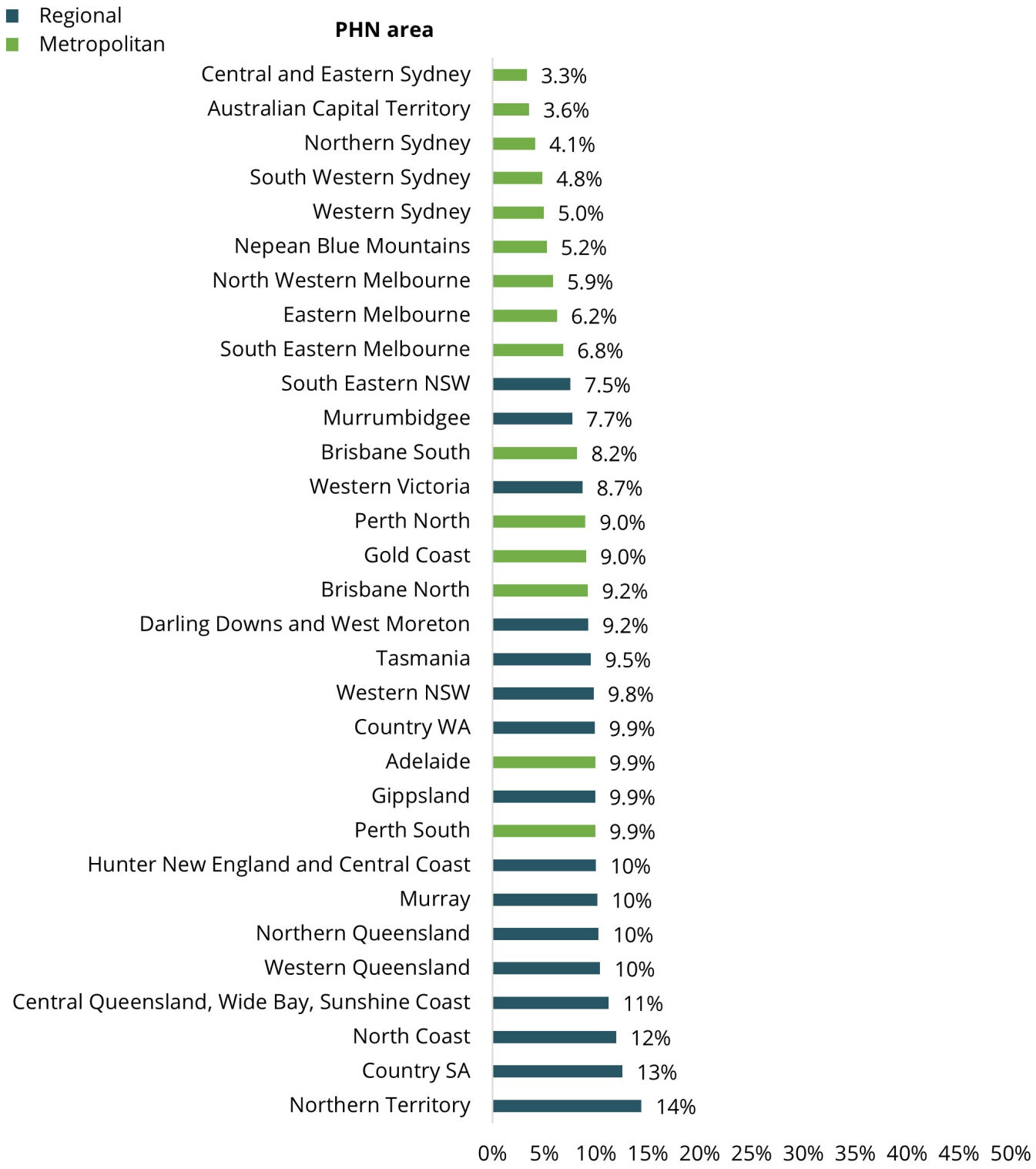


Chart: AIHW. Sources: AIHW analysis of Department of Health and Aged Care, MBS claims data; ABS ERP.

Using non-hospital Medicare service data

How can information in this report be used?

Understanding how people use non-hospital Medicare services helps to:

- inform health policy
- support evidence based decisions about service planning, commissioning and delivery
- improve understanding of how well programs are working
- identify gaps in service provision.

With local knowledge and experience, community-level health service providers may be able to identify the factors relevant to their region and better understand local populations. The information in this report can help Primary Health Network (PHN) organisations and other primary health care providers to coordinate care, understand trends, plan and deliver services to suit the needs and demands of their particular area. It also adds to the evidence base about health care use in Australia, strengthening knowledge about the needs of local populations and their use of health care.

Interpreting the data

There is no ideal rate of health care use and this report draws no conclusions about whether a higher or lower rate of service use is desirable for a particular area, nor does it try to assess the degree to which peoples' needs are being met.

In particular, the reported number of people who receive mental health and chronic condition related services from their GP (for example, asthma or diabetes mellitus cycle of care services) is likely to be an underestimate of total mental health and chronic condition related activity undertaken by GPs, because these services can also be claimed against other general GP items.

Variation in the use of non-hospital Medicare-subsidised services across different groups or regions could be because of a range of factors, including differences in the:

- Age and sex distribution of the population in regions across Australia, for example, an area has a higher proportion of older people which may result in higher rates of health service use.
- Prevalence of health conditions – areas with higher rates of health service use may have more people with complex health conditions.
- Availability and quality of other community-based programs, services and support outside of MBS arrangements (for example, Visiting Optometrists Scheme, Rural Health Outreach Fund or Medical Outreach – Indigenous Chronic Disease Program) (Department of Health and Aged Care 2022; 2023a; 2023d), or equivalent services provided by jurisdictions or other providers, including private health insurance providers for allied health services.
- Changes to MBS arrangements where certain services may be ceased or amended, and new services are introduced (see Technical notes for details).
- Incentives arrangement (for example, bulk-billing).
- Access to and availability of health care providers.

References

Department of Health and Aged Care 2022. Eye and vision health for Aboriginal and Torres Strait Islander people. Canberra: Department of Health and Aged Care. Viewed 12 December 2023.

Department of Health and Aged Care 2023a. Medical Outreach Indigenous Chronic Diseases Program. Canberra: Department of Health and Aged Care. Viewed 12 December 2023.

Department of Health and Aged Care 2023d. Rural Health Outreach Fund. Canberra: Department of Health and Aged Care. Viewed 12 December 2023.

Technical information

Description of non-hospital Medicare-subsidised services

In this report, non-hospital Medicare-subsidised services refers to services provided in non-inpatient settings. This excludes services delivered to people admitted to hospital at the time of receiving the service or where the care was provided as part of an episode of hospital-substitute treatment where the patient received a benefit from a private health insurer. While services provided in-hospital are excluded, the data do include services provided in places like private outpatient clinics (which may or may not be located within the grounds of a hospital).

For detailed information on the reported services and MBS items, see the Australian Government Department of Health and Aged Care: MBS online.

GP attendances

Table 6: GP attendances (total)

Reported service groups	Description	Broad Type Of Service (BTOS)/Group/subgroup/item included[(a)]
GP attendances (total)	GP attendances include Enhanced Primary Care, After-hours GP attendances, Practice Incentive Program (PIP) services, and Other GP attendances. These services are Medicare-subsidised patient/doctor encounters, such as visits and consultations, for which the patient has not been referred by another doctor. These services can be provided by a GP or other medical practitioner. Excludes services provided by practice nurses and Aboriginal and Torres Strait Islander health practitioners on a GP's behalf. From 1 July 2018, new items were introduced to prescribed medical practitioners to provide general attendance services. The terms non-specialist practitioner and other medical practitioner are used interchangeably in this report. For more information see 1 May 2019 Medicare Benefits Schedule book (Department of Health and Aged Care 2019a). GP subgroups affected by this change are footnoted . From 31 October 2022 PIP GP attendance items were removed.	BTOS 101, 102[(b)], 103 (GP subtotals: Enhanced Primary Care, After-hours GP attendances, PIP services, and Other)

For more information see Notes (below).

GP – Enhanced Primary Care

Table 7: GP – Enhanced Primary Care

Reported service groups	Description	BTOS/Group/subgroup/ item included[(a)]

GP subtotal – Enhanced Primary Care	In this report, GP Enhanced Primary Care refers to a range of services such as health assessments, medication management reviews, the creation and review of treatment plans, and coordination of care for people living with complex health conditions who require multidisciplinary, team-based care from a GP and at least 2 other providers. GP subtotal – Enhanced Primary Care includes Health Assessments, Chronic Disease Management Plans, Multidisciplinary Case Conferences, Domiciliary and Residential Medication Management Reviews, and Mental Health services (including preparation or review of mental health treatment plans, extended consultations related to a mental health issue but excluding focussed psychological strategies and family group therapy). These services are designed to provide a structured approach for GPs and non-specialist medical practitioners to care for people with chronic conditions and complex care needs, and to improve coordination of care for people who require multidisciplinary, team-based care.	BTOS 102[(b)]
GP Health Assessment	Health assessment of a patient's physical and psychological health and function and recommendation of preventive health care or education to improve that patient's health and physical, psychological and social function. Eligible patients include: people of Aboriginal and Torres Strait Islander descent, people who have an intellectual disability, refugees and humanitarian entrants, residents of residential aged care facilities, people aged 75 years or older, and people aged 40-49 years with a high risk of developing type 2 diabetes or at risk of developing another chronic disease. From 1 April 2019, Heart Health Assessments were added for people who have or are at risk of developing cardiovascular disease.	Group A14; Subgroups A7.5, A40.11, A40.12; Items 93470, 93479
GP Chronic Disease Management Plan	Services relating to the preparation, coordination and review of a GP Management Plan or Team Care Arrangements, or the contribution to a Multidisciplinary Care Plan for patients with a chronic or terminal medical condition. A chronic medical condition is one that has been, or is likely to be, present for 6 months or longer.	Subgroups A15.1, A40.13, A40.14; Items 229, 230, 231, 232, 233, 93469, 93475
GP Multidisciplinary Case Conference	Service where a medical practitioner (not including a specialist or consultant physician) organises and coordinates, or participates in, multidisciplinary case conferences for patients who have a chronic condition that has been (or is likely to be) present for 6 months or longer, or is terminal, and who has complex multidisciplinary care needs. Case conferences generally involve the patient’s usual GP, or non-specialist medical practitioner, and at least 2 other providers, such as allied health professionals, other medical practitioners, home and community service providers, and care organisers (for example, “meals on wheels” providers).	Items 235, 236, 237, 238, 239, 240, 243, 244, 735, 739, 743, 747, 750, 758
Medication Management Review (domiciliary)	Also known as Home Medicines Review. Available for people living in the community who are at risk of medication misadventure. Intended to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP, or non-specialist medical practitioner, and preferred community pharmacy or accredited pharmacist. These items are claimed by GPs or non-specialist medical practitioners.	Items 245, 900
Medication Management Review (residential)	A collaborative medication management service available to permanent residents of a residential aged care facility for whom quality use of medicines may be an issue or who are at risk of medication misadventure because of a significant change in their condition or medication regimen. These items are claimed by GPs or non-specialist medical practitioners.	Items 249, 903

GP Mental Health	Early intervention, assessment and management of patients with mental disorders by GPs or other medical practitioners (who are not specialists or consultant physicians). These services include assessments, planning patient care and treatments, referring to other mental health professionals, ongoing management and review of the patient's progress. This group comprises MBS items for the preparation and review of GP Mental Health Treatment Plans as well as extended consultations related to mental health issues, excluding GP Focussed Psychological Strategies and Family Group Therapy.	Groups A39, A42; Subgroups A20.1, A36.01, A36.4, A40.3, A40.10; Items 272, 276, 277, 279, 281, 282, 894, 896, 898, 941, 942, 2121, 2150, 2196, 90264, 90265, 92112, 92113, 92114, 92115, 92116, 92117, 92118, 92119, 92120, 92121, 92122, 92123, 92124, 92125, 92126, 92127, 92128, 92129, 92130, 92131, 92132, 92133, 92134, 92135, 92146, 92147, 92148, 92149, 92150, 92151, 92152, 92153, 92154, 92155, 92156, 92157, 92158, 92159, 92160, 92161, 92170, 92171, 92176, 92177, 92182, 92184, 92186, 92188, 92194, 92196, 92198, 92200

For more information see Notes (below).

GP – After-hours GP attendances

Table 8: After-hours GP attendances

Reported service groups	**Description**	**BTOS/Group/subgroup/ item included[(a)]**
GP subtotal – After-hours GP attendances	GP subtotal – After-hours GP attendances include urgent and non-urgent after-hours GP care. GP and non-specialist medical practitioner attendances provided on a public holiday, a Sunday, and during specified periods between Monday and Saturday. Note times vary depending on type of after-hours care, whether urgent or non-urgent, and for services provided at a place other than a consulting room. See After-hours GP (urgent) and After-hours GP (non-urgent) for more information.	Groups A11, A22, A23; Subgroups A7.10, A40.29, A40.30 (all items/groups below)

After-hours GP (urgent)	After-hours GP attendance where the patient's medical condition requires urgent assessment to prevent deterioration or potential deterioration in health and the assessment cannot be delayed until the next in-hours period. Eligibility requirements changed on 1 March 2018, which may affect comparability over time. Prior to this date, patients required urgent medical treatment (rather than assessment) to be eligible, and could book an urgent after-hours service 2 hours in advance (booking option no longer available).
	
	Urgent after-hours are described as follows:
	
	• Social after-hours (prior to 1 March 2018, items 597 and 598; from 1 March 2018, items 585, 588, 591 and 594):
	  ◦ Monday to Friday: 7 am – 8 am and 6 pm – 11 pm
	  ◦ Saturday: Between 7 am – 8 am and 12 noon – 11 pm
	  ◦ Sunday/and or public holiday: Between 7 am – 11 pm
	• Unsociable hours (items 599 and 600):
	  ◦ Monday to Friday: Between 11 pm – 7 am
	  ◦ Saturday: Between 11 pm – 7 am
	  ◦ Sunday/and or public holiday: Between 11 pm – 7 am
		Group A11; Subgroups A40.29, A40.30

After-hours GP (non-urgent)	After-hours GP attendance for non-urgent assessment and treatment. These vary in time and complexity. Includes home visits and visits to residential aged care facilities.
	
	Non-urgent after-hours are described as follows:
	
	• At consulting rooms (items 5000, 5020, 5040, 5060, 5200, 5203, 5207 and 5208):
	  ◦ Monday to Friday: Before 8 am or after 8 pm
	  ◦ Saturday: Before 8 am or after 1 pm
	  ◦ Sunday/and or public holiday: All day
	  ◦ At a place other than consulting rooms (items 5003, 5010, 5023, 5028, 5043, 5049, 5063, 5067, 5220, 5223, 5227, 5228, 5260, 5263, 5265 and 5267):
	  ▪ Monday to Friday: Before 8 am or after 6 pm
	  ▪ Saturday: Before 8 am or after 12 pm
	  ▪ Sunday/and or public holiday: All day
	
	From 1 July 2018, new after-hours attendances provided by a medical practitioner have been introduced, and are described as follows:
	
	• At consulting rooms (items 733, 737, 741 and 745):
	  ◦ Monday to Friday: Before 8 am or after 8 pm
	  ◦ Saturday: Before 8 am or after 1 pm
	  ◦ Sunday/and or public holiday: All day
	• At a place other than consulting rooms (items 761, 763, 766, 769, 772, 776, 788 and 789)
	  ◦ Monday to Friday: Before 8 am or after 6 pm
	  ◦ Saturday: Before 8 am or after 12 pm
	  ◦ Sunday/and or public holiday: All day
		Groups A22, A23; Subgroup A7.10

For more information see Notes (below).

GP – Practice Incentive Program (PIP) services

Table 9: GP – Practice Incentive Program (PIP) services

Reported service groups	**Description**	**BTOS/Group/subgroup/ item included[(a)]**
GP subtotal – PIP	GP subtotal PIP includes services provided as part of the Practice Incentive Program. This program aims to support general practice activities including continuous improvements, quality care, enhance capacity and improve access and health outcomes for patients. A practice must be accredited, or registered for accreditation to participate in PIP services. Includes cervical smear, diabetes mellitus annual cycle of care and asthma cycle of care PIP services. From 31 October 2022 PIP GP attendance items were removed.	Groups A18, A19; Subgroup A7.8 (all items/groups below)
Cervical smear PIP	A service claimed by a GP, or by non-specialist medical practitioners in eligible areas, where a cervical smear is taken from a person between the age of 24 years and 9 months and 74 years inclusive who has not had a cervical smear in the last 4 years. Eligibility requirements changed on 1 December 2017, which may affect comparability over time. Prior to this date, people aged between 20 and 69 years inclusive who have not had a cervical smear in the last 4 years could receive the service. From 31 October 2022 PIP GP attendance items were removed.	Subgroups A18.1, A19.1; Items 251, 252, 253, 254, 255, 256, 257

Diabetes Mellitus Annual Cycle of Care PIP	This service aims to encourage GPs and non-specialist medical practitioners to provide earlier diagnosis and effective management of people with established diabetes mellitus. The Annual Diabetes Cycle of Care must be completed over a period of 11 to 13 months, and includes (but is not limited to) measuring patients' blood pressure, cholesterol and HbA1c, examining eyes and feet and reviewing diet, physical activity and medications. Services counted represent a completed cycle of care claimed by a GP, or non-specialist medical practitioners in eligible areas. The completion of the Diabetes Mellitus Annual Cycle of Care can be used as an indication of GP and non-specialist medical practitioner care for patients with diabetes, but do not reflect the quality of care, prevalence of diabetes, or all diabetes-related care provided in the GP setting. Patients may also use other forms of health care to manage their diabetes, such as standard and long GP consultations, Chronic Disease Management plans, and paediatric and specialist services. From 31 October 2022 PIP GP attendance items were removed.	Subgroups A18.2, A19.2; Items 259, 260, 261, 262, 263, 264
Asthma Cycle of Care PIP	At a minimum the Asthma Cycle of Care includes at least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma. This includes diagnosis and assessment of level of asthma control and severity of asthma, review of the patient's use of and access to asthma related medication and devices, provision of an asthma action plan and asthma self-management education. Services counted represent a completed cycle of care claimed by a GP, or by non-specialist medical practitioners in eligible areas. The completion of the Asthma Cycle of Care can be used as an indication of GP and non-specialist medical practitioner care for patients with asthma, but do not reflect the quality of care, prevalence of asthma, or all asthma-related care provided in the GP setting. Patients may also use other forms of health care to manage their asthma, such as standard and long GP consultations, Chronic Disease Management plans, and paediatric and specialist services. From 31 October 2022 PIP GP attendance items were removed.	Subgroups A18.3, A19.3; Items 265, 266, 268, 269, 270, 271

For more information see Notes (below).

GP – Other

Table 10: GP – Other

Reported service groups	Description	BTOS/Group/subgroup/ item included[(a)]

GP subtotal – Other	GP subtotal – Other includes: GP Short (Level A), GP Standard (Level B), GP Long (Level C), GP Prolonged (Level D), Other non-referred medical practitioner, GP Focussed Psychological Strategies and Family Group Therapy, GP Prolonged - Imminent danger of death, GP Acupuncture, GP Pregnancy support counselling and GP Telehealth (patient-end support) services. These are non-referred attendances by a GP or other medical practitioner. Does not include after-hours, Enhanced Primary Care and PIP GP attendances.	Groups A1, A2, A5, A6, A16, A27, A30, A35, A39 (excluding items 91283, 91285, 91286, 91287, 91371, 91372), A45, A46; Subgroups A7.1, A7.2, A7.3, A7.4, A7.11, A7.12, A20.2, A36.1, A36.3 (excluding items 90266, 90267, 90268, 90269), A36.4, A40.1, A40.2, A40.15, A40.16, A40.21, A40.22, A40.27, A40.28, A40.39, A40.40, A40.41; Items 91818, 91819, 91842, 91843, 91859, 91861, 91864, 91865, 92170, 92171, 92176, 92177, 93660, 93661, 93666
GP Short (Level A)	Professional attendance by a GP for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management. From 1 March 2019, includes telehealth consultations by GPs for patients in selected flood affected areas (item 2095). This item is different to items in GP Telehealth (patient-end support) where the medical practitioner provides clinical support to a patient who is participating in a video conferencing consultation with a specialist or consultant physician. Medicare benefits paid, and the resulting provider fees may be underestimated in 2018–19, as some expenditure relating to residential aged care item 90020 cannot be allocated. This expenditure is claimed under the new item 90001, introduced 1 March 2019 (included in 'GP attendances (total)' and 'GP subtotal – Other' only).	Items 3, 4, 2095, 2461, 90020, 91790, 91795, 91890
GP Standard (Level B)	Professional attendance by a GP lasting less than 20 minutes, involving (where clinically relevant) taking patient history, performing a clinical examination, arranging any necessary investigation, implementing a management plan, and/or providing appropriate preventive health care. From 1 March 2019, includes telehealth consultations by GPs for patients in selected flood affected areas (item 2144). This item is different to items in GP Telehealth (patient-end support) where the medical practitioner provides clinical support to a patient who is participating in a video conferencing consultation with a specialist or consultant physician. Medicare benefits paid, and the resulting provider fees may be underestimated in 2018–19, as some expenditure relating to residential aged care item 90035 cannot be allocated. This expenditure is claimed under the new item 90001, introduced 1 March 2019 (included in 'GP attendances (total)' and 'GP subtotal – Other' only).	Items 23, 24, 2144, 2463, 90035, 91800, 91809, 91891

GP Long (Level C)	Professional attendance by a GP lasting at least 20 minutes, involving (where clinically relevant) taking detailed patient history, performing a clinical examination, arranging any necessary investigation, implementing a management plan, and/or providing appropriate preventive health care. From 1 March 2019, includes telehealth consultations by GPs for patients in selected flood affected areas (item 2180). This item is different to items in GP Telehealth (patient-end support) where the medical practitioner provides clinical support to a patient who is participating in a video conferencing consultation with a specialist or consultant physician. Medicare benefits paid, and the resulting provider fees may be underestimated in 2018–19, as some expenditure relating to residential aged care item 90043 cannot be allocated. This expenditure is claimed under the new item 90001, introduced 1 March 2019 (included in 'GP attendances (total)' and 'GP subtotal – Other' only).	Items 36, 37, 2180, 2464, 90043, 91801, 91810, 91894
GP Prolonged (Level D)	Professional attendance by a GP lasting at least 40 minutes, involving (where clinically relevant) taking extensive patient history, performing a clinical examination, arranging any necessary investigations, implementing a management plan, and/or providing appropriate preventive health care. From 1 March 2019, includes telehealth consultations by GPs for patients in selected flood affected areas (item 2193). This item is different to items in GP Telehealth (patient-end support) where the medical practitioner provides clinical support to a patient who is participating in a video conferencing consultation with a specialist or consultant physician. Medicare benefits paid, and the resulting provider fees may be underestimated in 2018–19, as some expenditure relating to residential aged care item 90051 cannot be allocated. This expenditure is claimed under the new item 90001, introduced 1 March 2019 (included in 'GP attendances (total)' and 'GP subtotal – Other' only).	Items 44, 47, 2193, 2465, 90051, 91802, 91811
Other Non-referred Medical Practitioner attendances	Non-referred professional attendance by a medical practitioner who is not a vocationally registered GP. These services are broadly similar to the other GP attendances included in this report. Includes services provided to patients in the community and residential aged care facilities. From 1 March 2019, includes telehealth consultations by medical practitioners for patients in selected flood affected areas (items 899, 901, 905 and 906). These items are different to items in GP Telehealth (patient-end support) where the medical practitioner provides clinical support to a patient who is participating in a video conferencing consultation with a specialist of consultant physician. From 1 July 2018, for Group A2 and Subgroups A7.2, A35.3 and A35.4, changes in provider eligibility in selected geographic areas may impact comparability over time.	Groups A2, A16; Subgroups A7.2, A30.6, A30.7, A35.3, A35.4; Items 899, 901, 905, 906, 90002, 91792, 91794, 91797, 91799, 91803, 91804, 91805, 91806, 91807, 91808, 91812, 91813, 91814, 91815, 91816, 91817, 91892, 91895, 92716, 92717, 92719, 92720, 92722, 92723, 92725, 92726, 92732, 92733, 92735, 92736, 92738, 92739, 92741, 92742, 92747, 93660, 93661, 93681, 93682, 93684, 93685, 93691, 93692, 93694, 93695, 93701, 93702, 93704, 93705
GP Focussed Psychological Strategies and Family Group Therapy	Includes Focussed Psychological Strategies for patients with assessed mental disorders, and family group therapy. The provision of Focussed Psychological Strategies to a patient must be made either in the context of a GP Mental Health Treatment Plan, shared care plan or a psychiatrist assessment and management plan. Family group therapy services can be provided by medical practitioners, including specialists and consultant physicians other than consultant psychiatrists. Prior to 1 July 2018, Focussed Psychological Strategy services could be provided by eligible medical practitioners who practiced in a general practice (other than a specialist or a consultant physician). From 1 July 2018, these items were not restricted to being provided in a general practice.	Group A6; Subgroups A7.4, A20.02, A41.01, A41.02; Items 283, 285, 286, 287, 00309, 00311, 00313, 00315, 371, 372

GP Prolonged - Imminent danger of death	Prolonged attendance for a patient in imminent danger of death. Services range from at least 1 hour to 5 hours or more. From 1 July 2018, new items were introduced to enable non-specialist medical practitioners to provide general attendance services.	Group A5; Subgroup A7.3
GP Acupuncture	Professional attendance at which acupuncture is performed by a medical practitioner who is a qualified medical acupuncturist by application of stimuli on or through the surface of the skin by any means. For the purpose of payment of Medicare benefits "acupuncture" is interpreted as including treatment by means other than the use of acupuncture needles where the same effect is achieved without puncture, for example, by application of ultrasound, laser beams, pressure or moxibustion, etc.	Items 173, 193, 195, 197, 199
GP Pregnancy Support Counselling	Non-directive pregnancy support counselling services provided to a person who is pregnant or who has been pregnant in the 12 months preceding the first service, by a medical practitioner (including a GP, but not including a specialist or consultant physician). From 1 July 2018, new items were introduced to enable non-specialist medical practitioners to provide general attendance services.	Group A27; Subgroups A7.11, A40.15, A40.16
GP Telehealth (patient-end support)	Provision of clinical support by a medical practitioner to a patient (in a telehealth eligible area) who is participating in a video conferencing consultation with a specialist or consultant physician. Does not include telephone or email consultations. From 1 July 2018, new items were introduced to enable non-specialist medical practitioners to provide general attendance services.	Subgroups A30.1, A30.2; Items 812, 827, 829, 867, 868, 869, 873, 876, 881, 885, 891, 892

For more information see Notes (below).

GP attendances relating to residential aged care facilities

Table 11: GP attendances relating to residential aged care facilities

Reported service	**Description**	**BTOS/Group/subgroup/ item included[a][b]**
GP attendances relating to residential aged care facilities	Professional attendance by a GP, non-specialist practitioner or other medical practitioner at a residential aged care facility or consulting room situated within such a complex where the patient is accommodated in the residential aged care facility (Group A35). Refer to the following service groups for more information GP Chronic Disease Management Plan (item 232 and 731), Medication Management Review (residential) (item 249 and 903) GP after-hours (non-urgent) (items 772, 776, 788, 789, 5010, 5028, 5049, 5067, 5260, 5263, 5265 and 5267) and GP Telehealth (patient-end support) (items 829, 869, 881, 892, 2125, 2138, 2179 and 2220).	Group A35; Items 232, 249, 731, 772, 776, 788, 789, 829, 869, 881, 892, 903, 2125, 2138, 2179, 2220, 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267, 92102, 92071, 92058, 92027

For more information see Notes (below).

Diagnostic Imaging

Table 12: Diagnostic Imaging

Reported service groups	**Description**	**BTOS/Group/subgroup/item included[a]**

Diagnostic Imaging services (total)	Medicare-subsidised diagnostic imaging procedures such as X-rays, computerised tomography scans, ultrasound scans, magnetic resonance imaging scans and nuclear medicine scans. From 1 July 2022, 2 new MBS items have been introduced for prostate-specific membrane antigen (PSMA) positron emission tomography (PET) study for the initial staging of intermediate to high-risk patients with prostate cancer and for the restaging of patients with recurrent prostate cancer.	BTOS 600

For more information see Notes (below).

Allied Health attendances

Table 13: Allied Health attendances

Reported service groups	Description	BTOS/Group/subgroup/item included[(a)]
Allied Health attendances (total)	Allied Health attendances (total) includes Medicare-subsidised primary health services provided by a broad range of health professionals who are not doctors, nurses or dentists, comprising all services provided in the Optometry, Mental Health Care, Physical Heath Care, and 'Other' allied health subtotals. With the exception of optometry, these services are generally only available to patients with chronic, mental, developmental, and/or complex health conditions with a referral from a GP or specialist medical practitioner.	BTOS 150(c) 900 (Allied health subtotals: Optometry, Mental Health Care, Physical Health Care and Other)

For more information see Notes (below).

Allied Health – Optometry

Table 14: Allied Health – Optometry

Reported service groups	Description	BTOS/Group/subgroup/item included[(a)]
Allied Health subtotal – Optometry	Optometry services provided by eligible optometrists for the assessment of vision and diagnosis and treatment of other eye conditions. In general, asymptomatic patients aged less than 65 years are eligible for a Medicare-subsidised comprehensive optometry service every 3 years, while asymptomatic patients aged 65 or over are eligible ever year. Some patients may be eligible for more frequent Medicare-subsidised services (for example, patients with progressive disorders or significant changes in visual function). Prior to 1 January 2015, all asymptomatic patients, regardless of age, were eligible for a comprehensive service every 2 years. From 1 September 2015, includes patient-end telehealth support services, where optometrists can provide clinical support to their patient during video consultations with ophthalmologists. Does not include the purchase of glasses or contact lenses; cosmetic surgery; tests for fitness to undertake sporting, leisure or vocational activities; or attendances on behalf of teaching institutions on patients of supervised students of optometry.	BTOS 900

Allied Health – Mental Health Care

Table 15: Allied Health – Mental Health Care

Reported service groups	Description	BTOS/Group/subgroup/ item included[(a)]

Allied Health subtotal – Mental Health Care	Allied Health subtotal – Mental Health Care includes assessment, treatment and management of patients with mental disorders by clinical psychologists, other psychologists and other allied mental health workers. Does not include psychiatry services. Note: From 1 November 2017, patients living in telehealth eligible areas (*regional*, *rural* and *remote* Australia) were able to claim telehealth psychological services.	Groups M6, M7, M17, M25, M26, M27, M28; Subgroups M16.2, M16.3, M16.5, M18.1, M18.2, M18.3, M18.4, M18.6, M18.7, M18.8, M18.9, M18.13, M18.14, M18.15, M18.16; Items 10956, 10968, 81325, 81355, 82000, 82015, 93076, 93079, 93084, 93087, 93100, 93103, 93110, 93113, 93118, 93121, 93134, 93137, 93512, 93535, 93557, 93590
Clinical Psychologist[(c)]	Psychological therapy services provided by eligible clinical psychologists. Includes individual attendances, group therapy, and telehealth video consultations. Note: Clinical psychologists may also claim services included in the 'Other Psychologists' and 'Other Allied Mental Health' categories.	Groups M6, M25, M27; Subgroups M16.2, M18.1, M18.6; Items 91000, 91001, 91005, 91010, 91011, 91015, 93076, 93079, 93110, 93113
Other Psychologist[(c)]	Focussed Psychological Strategies and enhanced primary care services provided by any eligible psychologist, including clinical and other psychologists (that is, fully registered psychologists in the relevant jurisdiction regardless of any specialist clinical training). Includes individual attendances, group therapy, and telehealth video consultations. Items 80126, 80136, 80146, 80151, 80161 and 80171 refer to telehealth services provided to people located in eligible areas.	Groups M26, (excluding items 93322, 93323, 93326, 93327, 93356, 93357, 93358, 93359, 93360, 93361, 93362, 93363, 93364, 93365, 93366, 93367), M28 (excluding items 93383, 93384, 93385, 93386); Subgroups M16.3, M18.2, M18.7, M18.13, M18.14; Items 10968, 80100, 80101, 80102, 80105, 80106, 80110, 80111, 80112, 80115, 80116, 80120, 80121, 80122, 80123, 80127, 80128, 81355, 82000, 82015, 91100, 91101, 91105, 91110, 91111, 91115, 93032, 93035, 93040, 93043, 93084, 93087, 93118, 93121, 93512, 93535, 93557, 93590
Other Allied Mental Health	Mental health services provided by other allied health professionals such as occupational therapists, mental health nurses, Aboriginal health workers and some social workers. Psychologists (clinical or other) may also provide some of these services, however, they cannot be readily separated from the other mental health workers included in the group. These services cover Focussed Psychological Strategies – allied mental health (occupational therapist and social worker items) and enhanced primary care – allied health (mental health worker item). Includes individual attendances, group therapy, and telehealth video consultations.	Groups M26.3, M26.4; Subgroups M18.3, M18.4, M18.8, M18.9; Items 10956, 80125, 80126, 80129, 80130, 80131, 80135, 80136, 80137, 80140, 80141, 80145, 80146, 80147, 80148, 80150, 80151, 80152, 80153, 80154, 80155, 80156, 80160, 80161, 80162, 80165, 80166, 80170, 80171, 80172, 80173, 80174, 80175, 81325, 82376, 82377, 82378, 82379, 82380, 82381, 82382, 82383, 91125, 91126, 91130, 91135, 91136, 91140, 91150, 91151, 91155, 91160, 91161, 91165, 93033, 93036, 93041, 93044, 93100, 93103, 93134, 93137, 93383, 93384, 93385, 93386

For more information see Notes (below).

Allied Health – Physical Health Care

Table 16: Allied Health – Physical Health Care

Reported service groups	Description	BTOS/Group/subgroup/ item included[(a)]
Allied Health subtotal – Physical Health Care	Allied Health subtotal – Physical Health Care includes physiotherapy, exercise physiology, chiropractic and osteopathy services provided to a person who has a chronic condition and complex care needs, and/or is of Aboriginal or Torres Strait Islander descent who has had a health check and identified as needing a follow-up allied health service.	Items 10953, 10960, 10964, 10966, 81110, 81115, 81315, 81335, 81345, 81350, 93504, 93508, 93510, 93511, 93518, 93520, 93527, 93531, 93533, 93534, 93549, 93553, 93555, 93556, 93571, 93573, 93582, 93586, 93588, 93589, 93607, 93614
Physiotherapy	Physiotherapy service involving the non-surgical treatment of musculoskeletal and related pain and movement issues. Provided by an eligible physiotherapist to a person who has a chronic condition and complex care needs, and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service.	Items 10960, 81335, 93508, 93520, 93531, 93553, 93573, 93586
Exercise Physiology	Exercise physiology service involving exercise-based interventions for a broad range of health conditions. Provided by an eligible exercise physiologist to a person who has a chronic condition and complex care needs, and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service. Includes individual and group services.	Items 10953, 81110, 81115, 81315, 93504, 93518, 93527, 93549, 93571, 93582, 93607, 93614
Chiropractic Services	Chiropractic service involving the non-surgical treatment of musculoskeletal and related pain and movement issues. Provided by an eligible chiropractor to a person who has a chronic condition and complex care needs, and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service.	Items 10964, 81345, 93510, 93533, 93555, 93588
Osteopathy	Osteopathy service involving the non-surgical treatment of musculoskeletal and related pain and movement issues. Provided by an eligible osteopath to a person who has a chronic condition and complex care needs, and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service.	Items 10966, 81350, 93511, 93534, 93556, 93589

For more information see Notes (below).

Allied Health – Other

Table 17: Allied Health – Other

Reported service groups	Description	BTOS/Group/subgroup/ item included[(a)]

Allied Health subtotal – Other	Allied Health subtotal – Other includes podiatry, dietetics, occupational therapy, speech pathology, diabetes education, audiology and other allied health services provided to a person who has a chronic, developmental, and/or complex health condition and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service.	Group M15; Subgroups M16.1, M16.4, M18.19, M18.21, M18.25, M18.26; Items 10950, 10951, 10952, 10954, 10958, 10962, 10970, 81000, 81005, 81010, 81100, 81105, 81120, 81125, 81300, 81305, 81310, 81320, 81330, 81340, 81360, 82005, 82010, 82020, 82025, 82030, 82035, 82300, 82306, 82309, 82312, 82315, 82318, 82324, 82327, 82332, 93000, 93013, 93048, 93061, 93092, 93095, 93126, 93129, 93502, 93503, 93505, 93507, 93509, 93513, 93519, 93525, 93526, 93528, 93530, 93532, 93536, 93547, 93548, 93550, 93552, 93554, 93558, 93572, 93580, 93581, 93583, 93585, 93587, 93591, 93606, 93608, 93613, 93615
Podiatry	Podiatry service involving diagnosis and treatment of disorders of the foot, ankle and lower extremity. Provided by an eligible podiatrist to a person who has a chronic condition and complex care needs, and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service.	Items 10962, 81340, 93509, 93532, 93554, 93587
Dietetics	Dietetics service provided by an eligible dietitian to help patients appropriately manage their diet and nutrition. Eligible patients include people who have a chronic condition and complex care needs, and/or are of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service. Includes individual and group services.	Subgroups M16.1, M1819, M1821, M1825, M1826; Items 10954, 81120, 81125, 81320, 93505, 93528, 93550, 93583, 93608, 93615
Occupational Therapy	Occupational therapy service involving the assessment and intervention to develop, recover, or maintain meaningful activities, or occupations. Provided by an eligible occupational therapist to a person who has a chronic condition and complex care needs; and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service; or is a child aged under 15 years for the diagnosis or treatment of a pervasive developmental disorder (PDD) or an eligible disability.	Subgroup M16.4; Items 10958, 81330, 82010, 82025, 93092, 93095, 93126, 93129, 93507, 93519, 93530, 93552, 93572, 93585
Speech Pathology	Speech pathology service involving the diagnosis and treatment of communication disorders of eligible patients with a referral, including people with chronic and complex conditions; people of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service; children aged under 13 years; or for the treatment of a PDD for children aged under 15 years.	Items 10970, 81360, 82005, 82020, 93513, 93536, 93558, 93591
Diabetes Education	Diabetes education service to assist in managing diabetes by enhancing patient's knowledge about diabetes and self-management. Provided by an eligible diabetes educator to a person who has a chronic condition and complex care needs, and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service. Includes individual and group services.	Items 10951, 81100, 81105, 81305, 93502, 93525, 93547, 93580, 93606, 93613
Audiology	Audiology service involving the diagnosis, treatment, and monitoring of disorders of the auditory and vestibular systems. Provided by an eligible audiologist to a person who has a chronic condition and complex care needs; and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service; or for the diagnosis and/or treatment and/or management of ear disease or a related disorder; or for the detection of permanent congenital hearing impairment of an infant or child.	Group M15; Items 10952, 81310, 82300, 82306, 82309, 82312, 82315, 82318, 82324, 82327, 82332, 93503, 93526, 93548, 93581

Other Allied Health	Medicare-subsidised allied health services not included in the above 6 sub-groups. Includes Aboriginal or Torres Strait Islander health services by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner; non-directive pregnancy support counselling services provided by an eligible psychologist, social worker or mental health nurse; and audiology, optometry, orthoptic or physiotherapy health services provided to a child aged under 13 years with a PDD or eligible disability. To protect confidentiality, these items were combined.	Items 10950, 10955, 10957, 10959, 81000, 81005, 81010, 81300, 82001, 82002, 82003, 82030, 82035, 93000, 93013, 93048, 93061

For more information see Notes (below).

Specialist attendances

Table 18: Specialist attendances

Reported services	**Description**	**BTOS/Group/subgroup/ item included[(a)]**
Specialist attendances (total)	Specialist attendances include psychiatry services and early intervention services for children, as well as other specialist attendances not reported separately in this report. Specialist attendances are Medicare-subsidised referred patient/doctor encounters, such as visits, consultations, and attendances by video conference, involving medical practitioners who have been recognised as specialists or consultant physicians for Medicare benefits purposes.	BTOS 200 (Psychiatry, Early Intervention and other services (not reported separately))
Psychiatry	Medicare-subsidised services provided by a psychiatrist, including patient attendances (or consultations), group psychotherapy, tele-psychiatry, case conferences and electroconvulsive therapy. Electroconvulsive therapy may be provided by either a psychiatrist or another medical practitioner together with an anaesthetist.	Group A8[(d)]; Subgroups A40.6, A40.9; Items 855, 857, 858, 861, 864, 866, 14224, 90260, 90262, 90266, 90268, 92162, 92166, 92172, 92178
Early Intervention Services for Children	Professional attendance of at least 45 minutes, by a consultant paediatrician, consultant physician or specialist of another discipline, or GP, for assessment, diagnosis and preparation of a treatment and management plan for a child aged under 13 years with autism, another PDD or another eligible disability. This may include referral to Medicare-subsidised allied health treatment services available through the *Helping Children with Autism* program.	Group A29

For more information see Notes (below).

Nursing and Aboriginal Health Workers

Table 19: Nursing and Aboriginal Health Workers

Reported service groups	**Description**	**BTOS/Group/subgroup/ item included[(a)]**
Nursing and Aboriginal Health Workers (total)	Includes services provided by Practice Nurses, Aboriginal Health Workers, Midwives and Nurse Practitioners.	Groups M2, M12, M13, M14 (Practice Nurse/Aboriginal Health Worker, Midwifery and Nurse Practitioner items); Subgroups M18.5, M18.10, M18.23, M18.24, M19.1, M19.2
Practice Nurse/Aboriginal Health Worker	Service by a practice nurse, Aboriginal health worker or Aboriginal and Torres Strait Islander health practitioner provided on behalf of, and under the supervision of, a medical practitioner. This group includes telehealth patient-end support services. These services do not require a referral.	Groups M2, M12; Subgroups M18.23, M18.24

Midwifery	Antenatal, intrapartum and postnatal care provided by participating midwives who have a collaborative arrangement with an authorised medical practitioner in place that must provide for consultation, referral or transfer of care as clinical needs dictate, to ensure safe, high quality maternity care. This group includes telehealth patient-end support services.	Group M13; Subgroup M19.1, M19.2
Nurse practitioners	Services provided by nurse practitioners who have a collaborative arrangement with an authorised medical practitioner so they can assist if clinically relevant. Includes, but is not limited to, clinical examinations, implementing management plans, and telehealth patient-end support services.	Group M14; Subgroups M18.5, M18.0

For more information see Notes (below).

Notes

Sources: AHPA 2023; Department of Health 2023b

a. Medicare codes are based on the 1 July 2023 Medicare Benefits Schedule (Department of Health and Aged Care 2023b). Broad Type of Service (BTOS) groups similar Medicare services. For information on BTOS groups, see the Department of Health and Aged Care's Annual Medicare . MBS items can also be grouped into a hierarchy of Group – Subgroup – Item. MBS Groups start with a letter followed by 2 numbers, for example, Group A15. All items within a nominated group are included, unless stated. An MBS Subgroup is represented by a Group code followed by a full stop and a number, for example, Subgroup A15.1. This indicates all items within the subgroup have been included, unless stated. Where a Group or Subgroup is followed by numbers in brackets (for example, A15.2 (735–779)), only the MBS items in the brackets are included.
b. These items refer to GP attendances within residential aged care facilities. People who live in residential aged care facilities may access other GP attendances, including visiting a GP at their practice outside of the facility. In particular this group does not include MBS items 244, 225, 226, 227, 701, 703, 705 or 707 (health assessments) or items 235, 236, 237, 238, 239, 240, 243, 244, 735, 739, 743, 747, 750 or 758 (case conferences), which can also be provided to permanent residents of residential aged care facilities. In MBS claims data, it is not possible to distinguish between patients who are permanent residents and those who are receiving respite care in residential aged care facilities.
c. Clinical psychologist refers to Clinical psychologist psychological therapy services. Other psychologist includes other psychology services that can be provided by clinical psychologists or other psychologists. Psychologists (clinical or other) also provide some Other Allied Mental Health services.
d. Does not include items 297, 320, 322, 324, 326 and 328 as these items refer to attendances in hospitals. However, a small number of services for these items were processed as non-hospital in 2014–15 and 2015–16, which may be due to administrative error (see Technical notes for more information). These small number of services have been included in the report for 2014–15 and 2015–16.
e. Items discontinued, but Medicare group listed here for completeness.

References

AHPA (Allied Health Professions Australia) 2023. What is allied health?. Melbourne: AHPA. Viewed 8 January 2024.

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Technical notes

About the data measures

Scope and measures of the report

About the method

Technical notes

The release uses 2 data sources:

- Medicare Benefits Schedule
- Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) at 30 June 2001 (see Age standardised rates) and 2022.

The release presents data on the following non-hospital Medicare-subsidised services:

- General Practitioner (GP) attendances
- Diagnostic imaging services
- Allied health attendances
- Specialist attendances
- Attendances provided by Practice Nurses, Aboriginal Health Workers, Midwives and Nurse Practitioners.

About the data measures

About the data source

Data for the report were sourced from the Medicare Benefits Schedule (MBS) claims data, which are managed by the Australian Government Department of Health and Aged Care. The claims data are derived from administrative information on services that qualify for a Medicare benefit under the *Health Insurance Act 1973* and for which a claim has been processed by Services Australia.

When a health practitioner provides a clinically relevant service to a Medicare-eligible person, the practitioner or patient can make a claim with Medicare. Medicare will then provide a rebate, or benefit, to cover all or part of the cost of the service. For more detailed information on the MBS services and item types, see the Department of Health and Aged Care: MBS online.

Scope of the MBS claims data

Under MBS arrangements, Medicare claims can be made by eligible persons. An 'eligible person' is a person who resides permanently in Australia. This includes New Zealand citizens and holders of permanent residence visas. Applicants for permanent residence may also be eligible persons, depending on circumstances. Eligible persons must enrol with Medicare before they can receive Medicare benefits. Medicare covers services provided only in Australia. It does not refund treatment or evacuation expenses overseas (Department of Health and Aged Care 2023b). It is important to note that some Australian residents may obtain similar medical services through other arrangements. MBS claims data do not include:

- services provided to patients where no MBS benefit has been processed (even if the service is eligible for a rebate)
- services provided to public patients in hospitals
- services subsidised by the Department of Veterans' Affairs
- services delivered in public outpatient departments, or public accident and emergency departments
- services for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability
- non-hospital services subsidised by private health insurance
- services provided through other publicly funded programs including jurisdictional salaried GP attendances provided in *remote* outreach clinics
- health screening services.

Some areas and service types have a higher proportion of services that are not Medicare-subsidised than others and this may affect comparability when estimating total health care use in Australia. In particular, caution should be taken when interpreting use of Medicare-subsidised allied health services, which with the exception of optometry are generally only available to patients with chronic, developmental or mental health conditions with a referral from a GP or specialist medical practitioner. Some Australians also access subsidised allied health services through their general ('ancillary' or 'extras') private health insurance, or pay for services entirely out-of-pocket. At present, there is no national data on allied health service use outside of Medicare or private health insurance (AIHW 2018).

Scope and measures of the report

This report provides non-hospital Medicare-subsidised services data based on year of Service. In this report non-hospital Medicare-subsidised services refers to services provided in non-inpatient settings. This excludes services delivered to patients admitted to hospital at the time of receiving the service or where the care was provided as part of an episode of hospital-substitute treatment where the patient received a benefit from a private health insurer. While services provided in-hospital are excluded, the data do include services provided in places like private outpatient clinics (which may or may not be located within the grounds of a hospital).

The geography is based on a person's Medicare enrolment postcode and not the location or availability of health care services in these areas.

The report includes information about use of the following non-hospital Medicare-subsidised services from 2022–23:

- GP attendances, broken down into 26 sub-groups
- Allied health attendances, broken down into 18 sub-groups
- Specialist attendances, including Psychiatry and Early Intervention Services for children
- Attendances provided by Practice Nurses, Aboriginal Health Workers, Midwives and Nurse Practitioners
- Diagnostic Imaging services.

See Technical Information, containing details on the service groups, including descriptions of how MBS items are allocated to each group, reported in this publication.

Medicare service groups are defined by the MBS item billed for the service, not the health care providers' specialty.

Data are reported by the financial year in which the Medicare service was rendered (see 'Reporting year').

These analyses exclude services delivered to patients admitted to hospital at the time of receiving the service or where the care was provided as part of an episode of hospital-substitute treatment where the patient received a benefit from a private health insurer. Further information about out-of-hospital Medicare-subsidised services, by broad type of service, are available in the Department of Health and Aged Care's Annual Medicare Statistics.

The following information is reported for each Medicare service group:

- percentage of the population who claimed the service
- services per 100 people
- Medicare benefits per 100 people
- number of patients
- number of services
- total Medicare benefits paid
- total provider fees
- estimated population of the area.

See Table A for how each measure is defined.

All Medicare service groups listed in the Technical information are reported by Primary Health Network (PHN) areas and by smaller geographic areas known as Statistical Areas Level 3 (SA3s, or 'local areas') (ABS 2016).

Note: GP aged care attendances are only reported by PHN area.

To support comparisons between similar areas, PHN areas are grouped into metropolitan and regional PHN areas. Results for SA3s are grouped by similar socioeconomic status (higher, medium and lower) for SA3s in *Major cities*, and by remoteness areas for SA3s in *Inner regional, Outer regional,* and *Remote* areas. See Geography – metropolitan and regional PHN areas and Local areas (SA3) groups for more information.

Where possible, measures are disaggregated by sex and age (PHN age groups: 0–14, 15–24, 25–44, 45–64, 65–79, 80+ years, and SA3 age groups 0-24, 25-44, 45-64 and 65+).

What are the limitations of the data?

The MBS is managed by the Department of Health and Aged Care, and over time MBS items are introduced, amended, deleted or replaced (see Department of Health and Aged Care: MBS online for the latest MBS). This may affect comparability over time, for instance changes to patient eligibility or provider incentives to claim the item. In some cases, providers may bill a 'general' item (for example, items in 'GP Standard (Level B)') for a service that could have qualified as a health-specific item (for example, GP Health Assessment). This may underestimate the true use of more specific service types.

MBS claims data are an administrative by-product of Services Australia's administration of the Medicare fee-for-service payment system. There may be some administrative errors in the recording of the MBS item billed, and patients' location, age, and sex. Discrepancies may also occur as a result of negative adjustments made after the service was first processed (for example, due to cancelled cheques).

For some results that are disaggregated by age, the number of patients is higher than the ERP. Affected results have been annotated with a footnote to interpret these with caution. This may be due to several factors (including the above MBS data limitations):

- This release uses the ERP at the beginning of the financial year. As the population changes, some people may be included in the numerator (MBS data), but not the denominator (ERP), for instance a person who migrated to Australia after 30 June 2020 but who claimed a service in 2022–23.
- The ERP includes people who usually live in Australia, that is, people who have been residing in Australia for a period of 12 months or more over the last 16 months. Some temporary visitors who are not included in the ERP are able to claim Medicare services, for instance through reciprocal health care agreements. However, some residents who usually live in Australia (for example, international students or those on working visas) are not eligible for Medicare.
- The ERP, the official estimate of the Australian population, is produced by the ABS using a range of data sources, including the Census of Population and Housing, and births, deaths, and migration administrative data. ERP data sources are subject to non-sampling error, which may arise from inaccuracies in collecting, recording and processing data (ABS 2022).

Table A: List of measures included in the report and their calculation[(a)]

Measure	Calculation
Percentage of population who claimed the service (%)	**Numerator:** Number of patients who had at least one eligible service rendered in the reporting year for the specified service type. The unique number of patients were identified through the Patient Identification Numbers (PINs) in the Medicare claim records. **Denominator:** ABS ERP as at 30 June at the end of the previous financial year **Calculation:** (Numerator ÷ denominator) x 100
Services per 100 people	**Numerator:** Sum of services from eligible claims for the specified service type. This does not include any bulk billed incentive items or other top-up items. **Denominator:** ABS ERP as at 30 June at the end of the previous financial year **Calculation:** (Numerator ÷ denominator) x 100
Services per 100 people (age standardised)	**Numerator:** Sum of services from eligible claims for the specified service type. This does not include any bulk billed incentive items or other top-up items. **Denominator:** ABS ERP as at 30 June at the end of the previous financial year **Standard population:** ABS ERP at 30 June 2001 **Method:** Direct age standardisation method (see 'Age standardised rates'). **Note:** this measure is reported for the following service groups (as defined in the Technical notes) by PHN area: • GP attendances (total) • GP subtotal – After-hours • Allied Health attendances (total) • Diagnostic imaging (total). • Specialist attendances (total).
Medicare benefits per 100 people ($)	**Numerator:** Sum of benefits paid for eligible claims for the specified service type. Results are rounded to the whole dollar. This does not include any payments associated with bulk billed incentive items or other top-up items. **Denominator:** ABS ERP as at 30 June at the end of the previous financial year **Calculation:** (Numerator ÷ denominator) x 100 **Note:** Expenditure results are not adjusted for inflation.
No. patients	Number of patients who had at least one eligible service in total rendered in the reporting year for the specified service type. The unique number of patients were identified through the PINs in the Medicare claim records. Totals and subtotals of patients may be less than the sum of each service group as a patient may receive more than one type of service but will be counted only once in the relevant total
No. services	Sum of services from eligible claims for the specified service type. This does not include any bulk billed incentive items or other top-up items
Total Medicare benefits paid ($)	Sum of benefits paid by Medicare for eligible claims for the specified service type. Results are rounded to the whole dollar. This does not include any payments associated with bulk billed incentive items or other top-up items. **Note:** Expenditure results are not adjusted for inflation.
Total provider fees ($)	Sum of fees charged by the health care provider for eligible claims for the specified service type, comprising the benefits paid by Medicare and patients' out-of-pocket costs. Results are rounded to the whole dollar. **Note:** Expenditure results are not adjusted for inflation.
Estimated Population	ABS Estimated Resident Population (ERP) as at 30 June at the end of the previous financial year (for example, 30 June 2022 for 2022–23 results).

GP attendances per residential aged care patient	**Numerator:** Sum of services from eligible claims for the specified service type. This does not include any bulk billed incentive items or other top-up items. **Denominator:** Number of patients who had at least one GP attendance in a residential aged care facility rendered in the reporting year. **Calculation:** (Numerator ÷ denominator) x 100

Note:

(a) Data reported prior to 2019-2020 were reported by the financial year in which the service was rendered, not the date the service occurred.

About the method

Reporting year

Data are reported in the financial year in which an attendance/service occurred and not the financial year in which a benefit for the service was processed.

Number of patients

'Number of patients' refers to patients who received at least one eligible service in total (for the respective service type) in the reporting year, as identified through the Patient Identification Numbers (PINs) in the Medicare claim records. Totals and subtotals of patients may be less than the sum of each service group as a patient may receive more than one type of service but will be counted only once in the relevant total.

Percentage of people or proportion of population

The terms 'people' or 'population' refer to the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) at 30 June at the end of the previous financial year (for example, 30 June 2013 for 2013–14 results). This release used the preliminary ERP at 30 June 2022.

Disaggregation by age and sex

In addition to results for the total population in an area, results by PHN area and SA3 are reported by sex and by the following age groups:

- PHN area level analysis by 6 age groups (0–14, 15–24, 25–44, 45–64, 65–79, 80+)
- SA3 analysis by 4 age groups (0–24, 25–44, 45–64, 65+). Due to smaller populations, SA3 results by age and sex are reported for the 'total' Medicare service groups only.

Where the group was too small to report, age groups were combined where possible (for example, 0–24 and 25–44 becomes 0–44 years) for 2013–14 to 2017–18. This method was revised for 2018–19 and later years, with data presented for 6 age groups by PHN and 4 age groups by SA3, where possible. Data were not published if it met any of the suppression rules (see *Suppression*).

Measures that are disaggregated by age group and sex use the patient's date of birth and sex as recorded at the last service rendered (for any MBS service) in the reporting year. Where multiple services were rendered on the last date of service, age and sex was taken from the last date of processing on that date of service.

If a patient's age was recorded as unknown or over 116, their records were excluded from the age group results. Similarly, if a patient's sex was missing, their records were excluded from the sex group results.

Age standardised rates

Age standardised rates are hypothetical rates that would have been observed if the populations studied had the same age distribution as the standard population. This facilitates comparisons between populations with different age structures and changes over time within an area. This adjustment is important because the prevalence of health conditions and rates of health service use vary with age.

The direct method of age standardisation was applied to the data (AIHW 2005). Age standardised rates were derived by calculating crude rates by 5-year age groupings of 0–4 years to 85+ years. These crude rates were then given a weight that reflected the age composition of the standard population (ABS ERP for Australia as at 30 June 2001). If a patient's age was recorded as unknown or over 116, their records were excluded from the age standardised rates.

Suppression

Information about an area was suppressed (marked 'n.p. – not published') if any of the following conditions were met:

- There were fewer than 6 patients or fewer than 6 health service providers in the area (SA3/PHN) – note a patient/provider was only included if they provided or received at least one service in the area.
- One provider provided more than 85% of services or 2 providers provided more than 90% of services.
- One patient received more than 85% of services or 2 patients received more than 90% of services.
- The number of attendances/services was fewer than 20 for an area.
- The total population of an area was fewer than 1,000.

- The population of the reported age group or sex group in an area was fewer than 300.

Consequential suppression was applied to manage confidentiality. This is the process of suppressing information which, whilst not necessarily confidential, may be used to derive confidential data.

For age standardised rates, if the population of an area (denominator) was fewer than 30 in any of the standard age groupings, then the rate was marked ‘interpret with caution’, as these rates are considered potentially volatile. For each of these interpret with caution rates, the effect of increasing the numerator by one on the rank of the area was examined. If the rank changed considerably so that the area was on the cusp of changing 2 deciles, the rate was suppressed.

Technical notes

All results are based on the patient's Medicare enrolment postcode, not where they received the health care service. Patients may use services outside of their Medicare enrolment postcode. The accuracy of the patient's Medicare enrolment postcode cannot be determined, and may not reflect the primary residence (for example, the Medicare enrolment postcode may be a PO box postcode).

The report presents information nationally and at the geography of:

Primary Health Network (PHN) areas – 31 geographic areas covering Australia, with boundaries defined by the Australian Government Department of Health and Aged Care (2023).

Metropolitan and regional PHN groups – PHN areas have been assigned into 2 groups: metropolitan and regional

Statistical Areas Level 3 (SA3s) – 340 geographic areas covering Australia, with boundaries defined by the ABS (2016).

SA3 groups – SA3s have been assigned into 6 groups: *Major cities* (Higher socioeconomic), *Major cities* (Medium socioeconomic), *Major cities* (Lower socioeconomic), *Inner regional*, *Outer regional* and *Remote* (ABS 2018a, 2018b).

Measures calculated at PHN area and SA3 were compiled by applying a geographic concordance to the unit record data. The concordance used the patient's Medicare enrolment postcode as recorded on the last claim processed (for any MBS service) in the reporting year. If a patient had more than one postcode listed on their last date of processing in the year, then the postcode was taken from the last date of service on that date of processing. Records with invalid or missing postcodes were included in the national total but not allocated to a PHN area or SA3.

Where a postcode boundary overlapped more than one PHN area or SA3, the percentage of records attributed to each area was the same as the percentage of the postcode population that fell within each area. Postcodes are updated (introduced, retired or changed) over time, which can affect the comparability of how patients are allocated to regions over time.

Figures were rounded at the end of the calculations to avoid truncation error. Individual area results may not add to national totals due to rounding and missing location data.

Metropolitan and regional PHN groups

PHN areas with at least 85% of the population residing in *Major cities* are classified as metropolitan, as defined by the ABS (2018a), using the population distribution as of 30 June 2016. All other PHN areas are classified as regional PHN areas.

Local area (SA3) groups

Identification of SA3s with similar socioeconomic or remoteness characteristics can help when making comparisons between areas. Results for local areas (SA3s) are presented by ABS categories of remoteness and, in *Major cities*, also by socioeconomic status. Results are grouped into the following categories:

- *Major cities*
    1. Higher socioeconomic areas
    2. Medium socioeconomic areas
    3. Lower socioeconomic areas
- *Inner regional*
- *Outer regional*
- *Remote* (includes *Very remote*).

SA3s in major cities

The majority of SA3s (190 of 340) across Australia are in the *Major cities* category (based on the Australian Statistical Geography Standard (ASGS) 2016, ABS 2018a). SA3 populations can be diverse in terms of socioeconomic status. To better enable fair comparisons within city areas, SA3s were divided into 3 socioeconomic groups: higher, medium and lower using the 2016 ABS Index of Relative Socioeconomic Disadvantage (IRSD) and the population as of 30 June 2016. IRSD is one of the Socio-Economic Indexes for Area (SEIFA) produced by the ABS (2018b). It ranks Statistical Area Level 1s (SA1s) from the most disadvantaged area (lowest quantile) to the least disadvantaged area (highest quantile), based on the relative socioeconomic conditions at an overall area level, not at an individual level.

The socioeconomic groups were defined as follows to produce 3 groups:

- Lower: IRSD quintiles 1 and 2
- Medium: IRSD quintiles 3 and 4
- Higher: IRSD quintile 5.

SA3s in *Major cities* were allocated to a socioeconomic group based on the largest number of SA1s in each group.

SA3s by remoteness

SA3 boundaries align well with the ABS remoteness classification for *Major cities*, *Inner regional* and *Outer regional* areas (ABS 2018a). SA3s are not as well defined between *Remote* and *Very remote* areas, so these categories were combined into a single category (*Remote*) for this analysis.

SA3s were allocated to one remoteness category based on the largest percentage of the population in each of the categories, using the population distribution as of 30 June 2016.

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Data

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