Australian Government
Australian Institute of
Health and Welfare

Aboriginal and Torres Strait Islander specific primary health care: results from the nKPI and OSR collections

Web report

Cat. no: IHW 227

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Note: this is not the most recent version of this report. Please visit the AIHW website for updates.

Information on organisations funded by the Australian Government under its Indigenous Australians' Health Programme (IAHP) to deliver culturally appropriate primary health care services to Aboriginal and Torres Strait Islander people is available through two data collections—the Online Services Report (OSR); and the national Key Performance Indicators (nKPI).

This release contains nKPI data up to the June 2020 collection and OSR data up to the 2019–20 collection. Data tables accompanying this release can be found on the AIHW website.

Contents

Key findings

1. 196 Indigenous-specific primary health care organisations employed about 7,400 full-time equivalent staff in 2019–20
2. Indigenous-specific primary health care organisations cared for 469,000 clients in 2019–20
3. Clients had 5.4 million contacts with Indigenous-specific primary health care organisations in 2019–20
4. There was an average of 11.6 contacts per client at Indigenous-specific primary health care organisations in 2019–20
5. At June 2020, 33% of Indigenous regular clients aged 15 and over had never smoked
6. At June 2020, 42% of Indigenous regular clients aged 50 and over were immunised against influenza

Overview

Summary

Aboriginal and Torres Strait Islander specific primary health care organisations play a critical role in improving the health of Indigenous Australians. In 2019–20:

196

organisations provided Indigenous-specific primary health care

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7,400

full-time equivalent staff were employed

READ MORE ON WORKFORCE >

469,000

clients were cared for

READ MORE ON CLIENTS >

Most of these organisations provide data on a set of 24 process-of-care and health-outcome indicators for Indigenous Australians, focusing on maternal and child health, preventative health, and chronic disease management. At June 2020, these showed that, for Indigenous regular clients (an Indigenous client who has visited a particular primary health care organisation 3 or more times in the previous 2 years):

34%

aged 0–4 had a MBS health assessment in the last year

READ MORE ON MATERNAL AND CHILD HEALTH INDICATORS >

50%

had risk factors recorded to enable cardiovascular disease assessment

READ MORE ON PREVENTATIVE HEALTH INDICATORS >

36%

with Type 2 diabetes had a HbA1c (blood sugar) result within recommended guidelines in the last 6 months

READ MORE ON CHRONIC DISEASE MANAGEMENT INDICATORS >

About this report

Indigenous-specific primary health care organisations play a critical role in improving the health of Aboriginal and Torres Strait Islander people (hereafter referred to as Indigenous Australians). Indigenous Australians may access either mainstream or Indigenous-specific primary health care organisations (hereafter referred to as organisations).

Information on organisations funded by the Australian Government under its Indigenous Australians’ Health Programme (IAHP) is available through two data collections, the Online Services Report (OSR) and the national Key Performance Indicators (nKPI):

- OSR—collects contextual information annually (covering the period 1 July–30 June) on the organisations, such as client numbers, client contacts, episodes of care, and staffing levels
- nKPI—collects information twice a year (with census dates in June and December) from the organisations on a set of 24 process-of-care and health-outcome indicators for Indigenous Australians, focusing on maternal and child health, preventative health, and chronic disease management.

This report presents the latest results from these collections.

Purpose of the OSR and nKPI collections

The main purpose of the OSR and nKPI collections is to support continuous quality improvement (CQI) activity among organisations funded under the IAHP. They can also be used to support policy and service planning at the national and state/territory levels, by monitoring progress and highlighting areas for improvement. In addition to this, information from the collections helps monitor progress against the Council of Australian Governments (COAG) Closing the Gap targets, and supports the national health goals set out in the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023.

Most organisations contribute to both the OSR and nKPI collections (Table 1).

Table 1: Number of organisations reporting to the OSR and nKPI collections[a]

2019–20 (OSR)/June 2020 (nKPI)[b]

IAHP funding type	Reporting to OSR	Reporting to nKPI	Reporting to both collections
Primary health care	196	197	182
Maternal and child health[c]	19	23	18
Total	**215**	**220**	**200**

2018–19 (OSR)/June 2019 (nKPI)

IAHP funding type	Reporting to OSR	Reporting to nKPI	Reporting to both collections
Primary health care	210	213	201
Maternal and child health[c]	22	21	21
Total	**232**	**234**	**222**

2017–18 (OSR)/June 2018 (nKPI)

IAHP funding type	Reporting to OSR	Reporting to nKPI	Reporting to both collections
Primary health care	198	215	184
Maternal and child health[c]	19	18	16
Total	**217**	**233**	**200**

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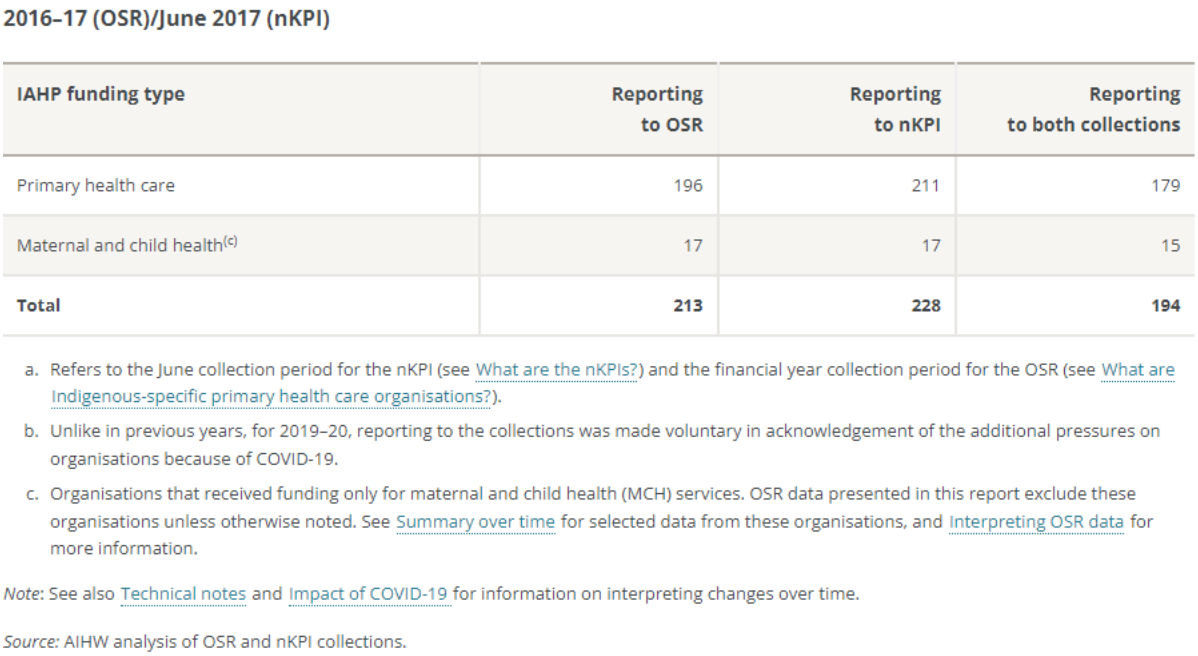


2016–17 (OSR)/June 2017 (nKPI)

IAHP funding type	Reporting to OSR	Reporting to nKPI	Reporting to both collections
Primary health care	196	211	179
Maternal and child health[c]	17	17	15
Total	**213**	**228**	**194**

a. Refers to the June collection period for the nKPI (see What are the nKPIs?) and the financial year collection period for the OSR (see What are Indigenous-specific primary health care organisations?).

b. Unlike in previous years, for 2019–20, reporting to the collections was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19.

c. Organisations that received funding only for maternal and child health (MCH) services. OSR data presented in this report exclude these organisations unless otherwise noted. See Summary over time for selected data from these organisations, and Interpreting OSR data for more information.

Note: See also Technical notes and Impact of COVID-19 for information on interpreting changes over time.

Source: AIHW analysis of OSR and nKPI collections.

All organisations receiving IAHP funding share a commitment to providing holistic, comprehensive and culturally appropriate health care. These organisations can be split into two main types—Aboriginal Community Controlled Health Organisations (ACCHOs) and non-Community Controlled Health Organisations (non-ACCHOs). ACCHOs are initiated and operated by their local Aboriginal communities through locally elected Boards of Management. Non-ACCHOs are a mix of government-run organisations (such as local health districts) and non-government organisations (such as not-for-profit charitable health services). As such, these types of organisations can have very different profiles (Table 2) and caution should be used when interpreting the OSR and nKPI data by organisation type presented in this report. For more information on interpreting data in this report, see Technical notes and Glossary.

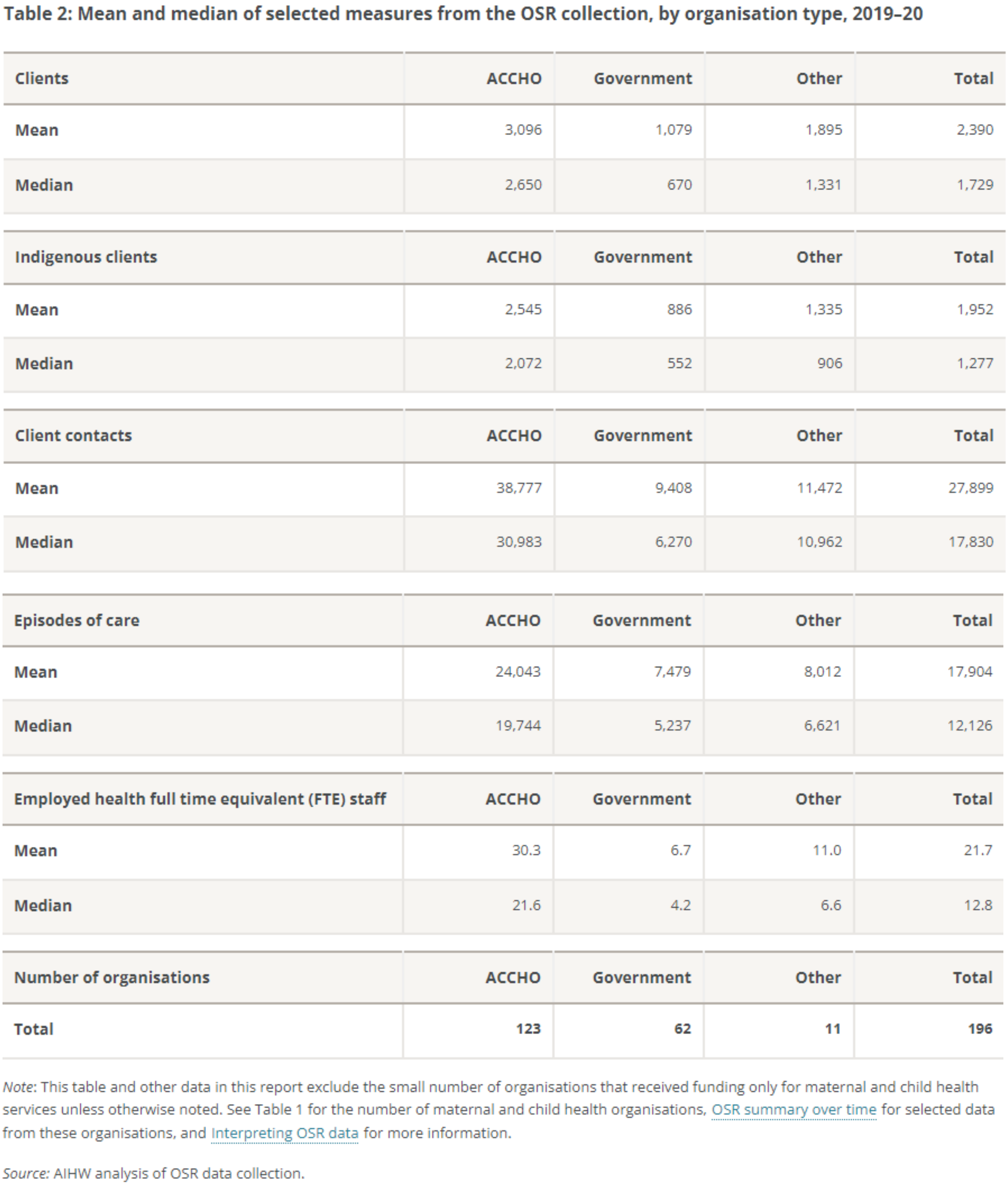


Table 2: Mean and median of selected measures from the OSR collection, by organisation type, 2019–20

Clients	ACCHO	Government	Other	Total
Mean	3,096	1,079	1,895	2,390
Median	2,650	670	1,331	1,729

Indigenous clients	ACCHO	Government	Other	Total
Mean	2,545	886	1,335	1,952
Median	2,072	552	906	1,277

Client contacts	ACCHO	Government	Other	Total
Mean	38,777	9,408	11,472	27,899
Median	30,983	6,270	10,962	17,830

Episodes of care	ACCHO	Government	Other	Total
Mean	24,043	7,479	8,012	17,904
Median	19,744	5,237	6,621	12,126

Employed health full time equivalent (FTE) staff	ACCHO	Government	Other	Total
Mean	30.3	6.7	11.0	21.7
Median	21.6	4.2	6.6	12.8

Number of organisations	ACCHO	Government	Other	Total
Total	**123**	**62**	**11**	**196**

Note: This table and other data in this report exclude the small number of organisations that received funding only for maternal and child health services unless otherwise noted. See Table 1 for the number of maternal and child health organisations, OSR summary over time for selected data from these organisations, and Interpreting OSR data for more information.

Source: AIHW analysis of OSR data collection.

What are Indigenous-specific primary health care organisations?

Introduction

Comprehensive and culturally appropriate primary health care services play a key role in improving the health and wellbeing of Indigenous Australians through prevention, early intervention, health education, and the timely identification and management of physical and psychological issues (Griew et al. 2008).

To this end, the Australian Government provides funding through its Indigenous Australians' Health Programme (IAHP) to organisations delivering Indigenous-specific primary health care services (referred to hereafter as organisations). These organisations, designed to be accessible to Indigenous clients, are administered and run by:

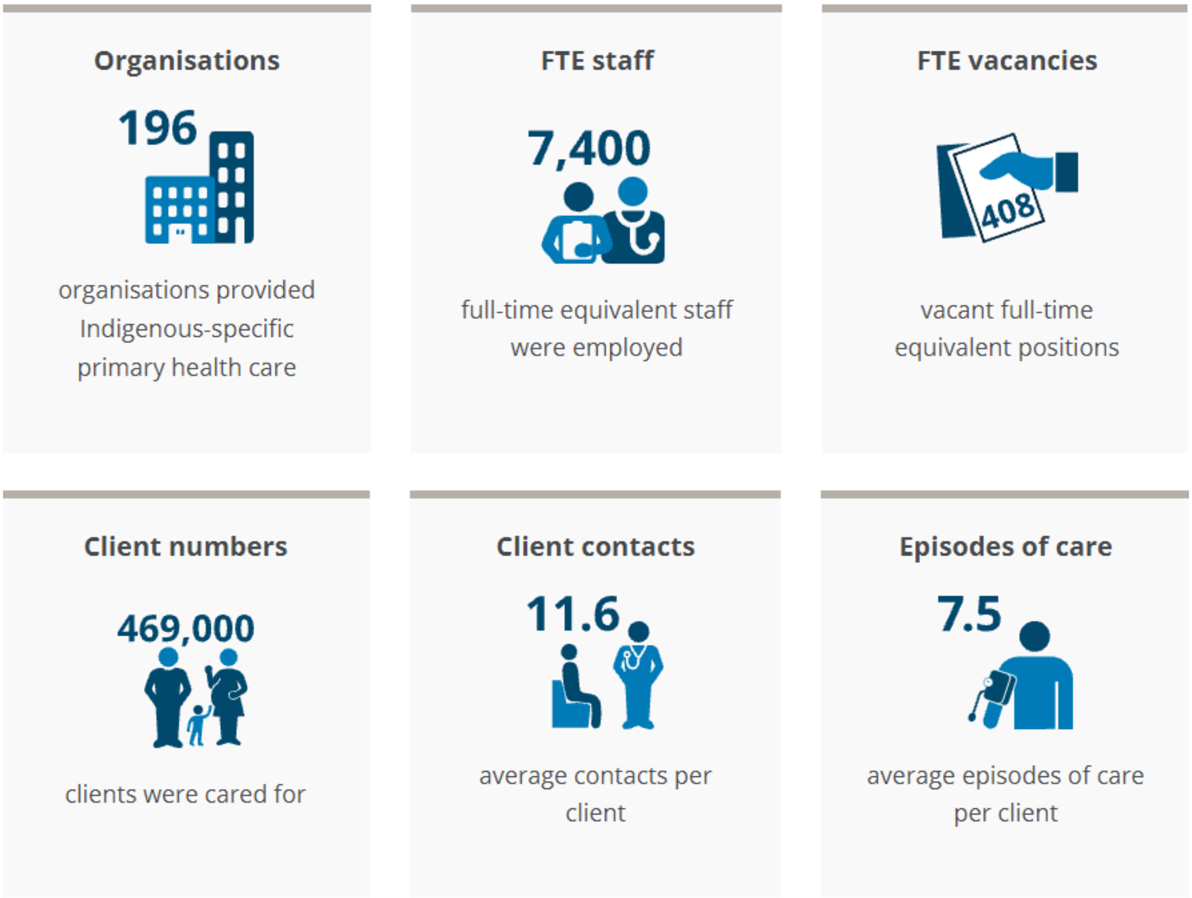
- Aboriginal Community Controlled Health Organisations (ACCHOs)
- state/territory/local health services
- non-government organisations (NGOs) (a small proportion of services).

They vary in size, location, governance structure, length of time in operation, workforce composition, sources of funding, the services they offer, the ways in which they operate (for example, stand-alone or part of a consortium), and the needs of their clients. What they all share in common is a holistic approach to meeting the needs of their Indigenous clients, which often involves addressing a complex mix of health conditions.

Each organisation provides contextual information about their organisation to the Online Services Report (OSR) collection once each financial year (covering the period 1 July–30 June). The OSR includes all activities of the organisations, regardless of the percentage of those activities funded by the IAHP.

The OSR data presented in this report exclude the small number of organisations that received funding only for maternal and child health services unless otherwise noted (see Summary over time for selected data from these organisations and Interpreting OSR data for more information).

The following boxes show key results for 2019–20. Clicking on a box will go to more information on the selected topic.



Organisations

196

organisations provided Indigenous-specific primary health care

FTE staff

7,400

full-time equivalent staff were employed

FTE vacancies

408

vacant full-time equivalent positions

Client numbers

469,000

clients were cared for

Client contacts

11.6

average contacts per client

Episodes of care

7.5

average episodes of care per client

Reference

Griew R, Tilton E, Cox W, Thomas D 2008. The link between primary health care and health outcomes for Aboriginal and Torres Strait Islander Australians. Waverly, NSW: Robert Griew Consulting.

Summary over time

Table 1 presents a selection of results over time for organisations reporting to the Online Services Reporting (OSR) collection.

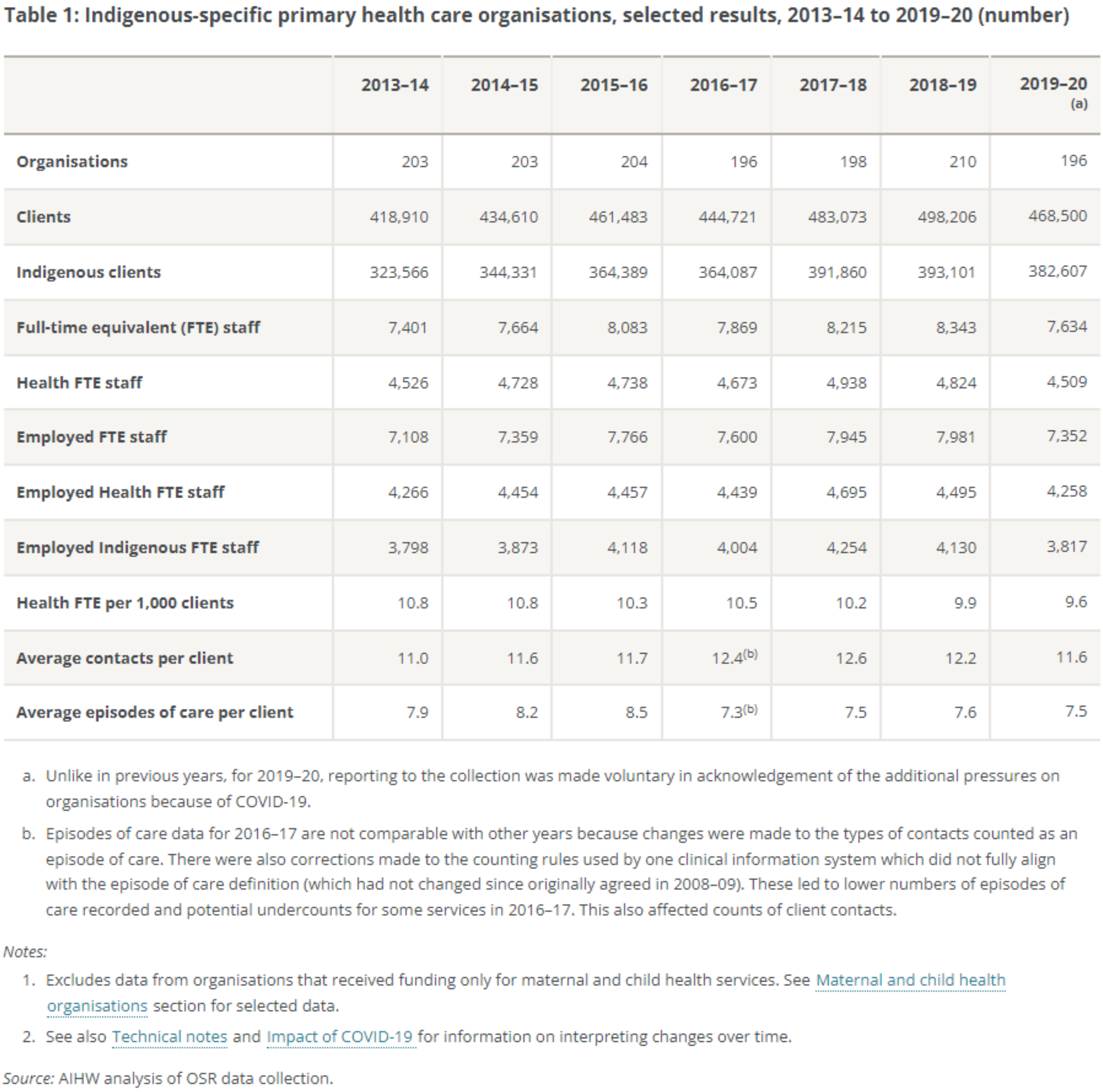


Table 1: Indigenous-specific primary health care organisations, selected results, 2013–14 to 2019–20 (number)

	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20 (a)
Organisations	203	203	204	196	198	210	196
Clients	418,910	434,610	461,483	444,721	483,073	498,206	468,500
Indigenous clients	323,566	344,331	364,389	364,087	391,860	393,101	382,607
Full-time equivalent (FTE) staff	7,401	7,664	8,083	7,869	8,215	8,343	7,634
Health FTE staff	4,526	4,728	4,738	4,673	4,938	4,824	4,509
Employed FTE staff	7,108	7,359	7,766	7,600	7,945	7,981	7,352
Employed Health FTE staff	4,266	4,454	4,457	4,439	4,695	4,495	4,258
Employed Indigenous FTE staff	3,798	3,873	4,118	4,004	4,254	4,130	3,817
Health FTE per 1,000 clients	10.8	10.8	10.3	10.5	10.2	9.9	9.6
Average contacts per client	11.0	11.6	11.7	12.4[b]	12.6	12.2	11.6
Average episodes of care per client	7.9	8.2	8.5	7.3[b]	7.5	7.6	7.5

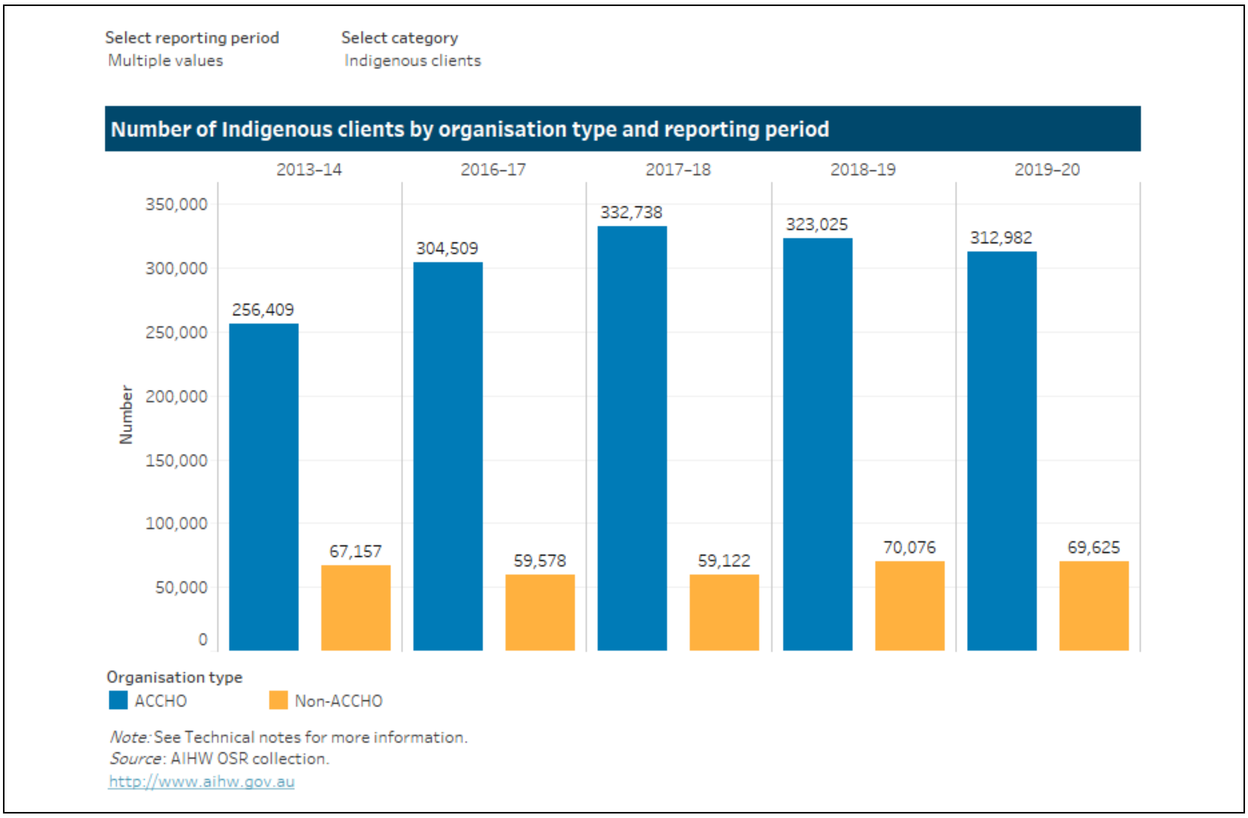
a. Unlike in previous years, for 2019–20, reporting to the collection was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19.

b. Episodes of care data for 2016–17 are not comparable with other years because changes were made to the types of contacts counted as an episode of care. There were also corrections made to the counting rules used by one clinical information system which did not fully align with the episode of care definition (which had not changed since originally agreed in 2008–09). These led to lower numbers of episodes of care recorded and potential undercounts for some services in 2016–17. This also affected counts of client contacts.

Notes:

1. Excludes data from organisations that received funding only for maternal and child health services. See Maternal and child health organisations section for selected data.
2. See also Technical notes and Impact of COVID-19 for information on interpreting changes over time.

Source: AIHW analysis of OSR data collection.



Note: See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

Maternal and child health organisations reporting to the OSR

Results presented in this report exclude data from the OSR organisations that received funding only for maternal and child health services. Selected data from these organisations are presented in Table 2.

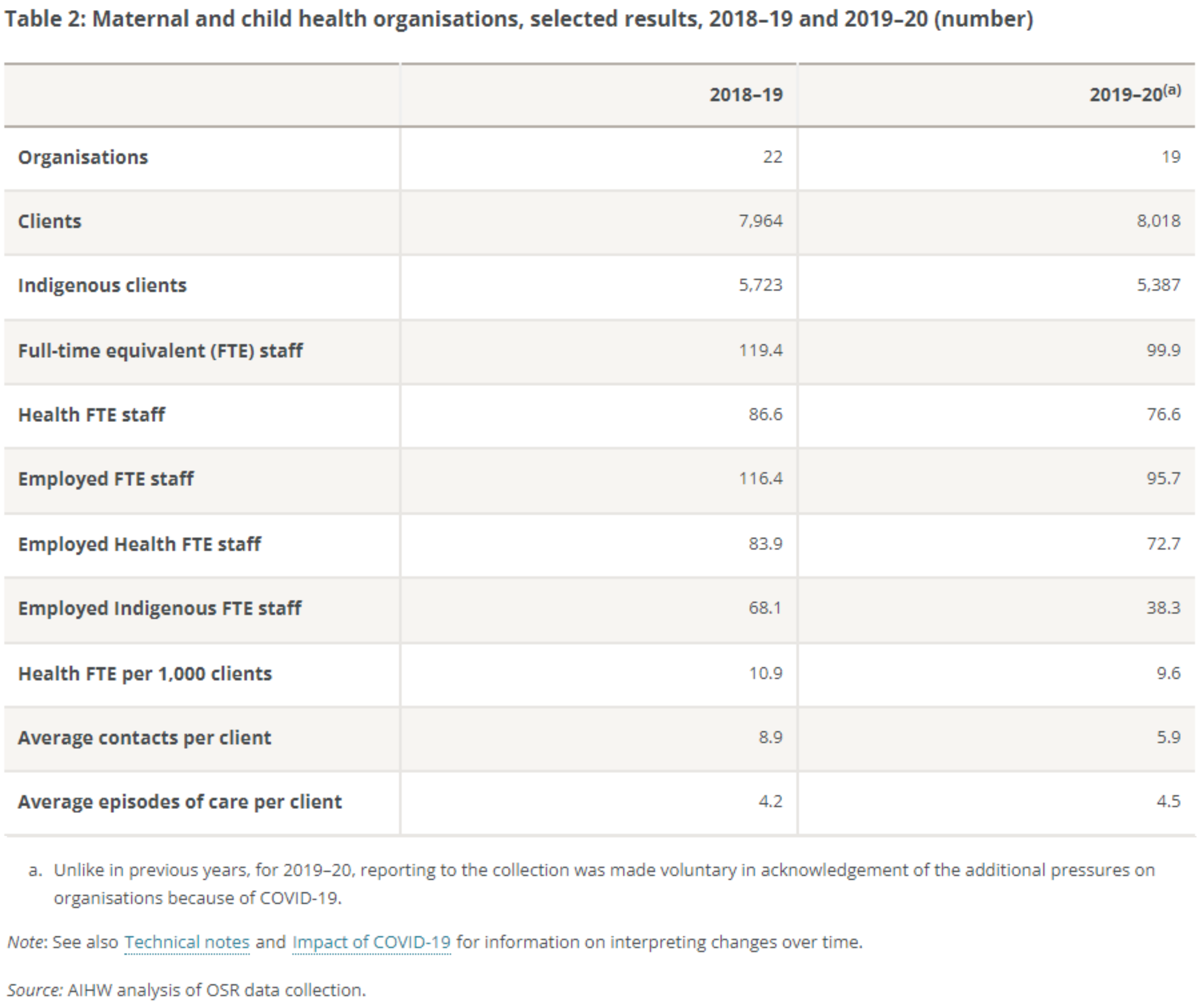


Table 2: Maternal and child health organisations, selected results, 2018–19 and 2019–20 (number)

	2018–19	2019–20[(a)]
Organisations	22	19
Clients	7,964	8,018
Indigenous clients	5,723	5,387
Full-time equivalent (FTE) staff	119.4	99.9
Health FTE staff	86.6	76.6
Employed FTE staff	116.4	95.7
Employed Health FTE staff	83.9	72.7
Employed Indigenous FTE staff	68.1	38.3
Health FTE per 1,000 clients	10.9	9.6
Average contacts per client	8.9	5.9
Average episodes of care per client	4.2	4.5

a. Unlike in previous years, for 2019–20, reporting to the collection was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19.

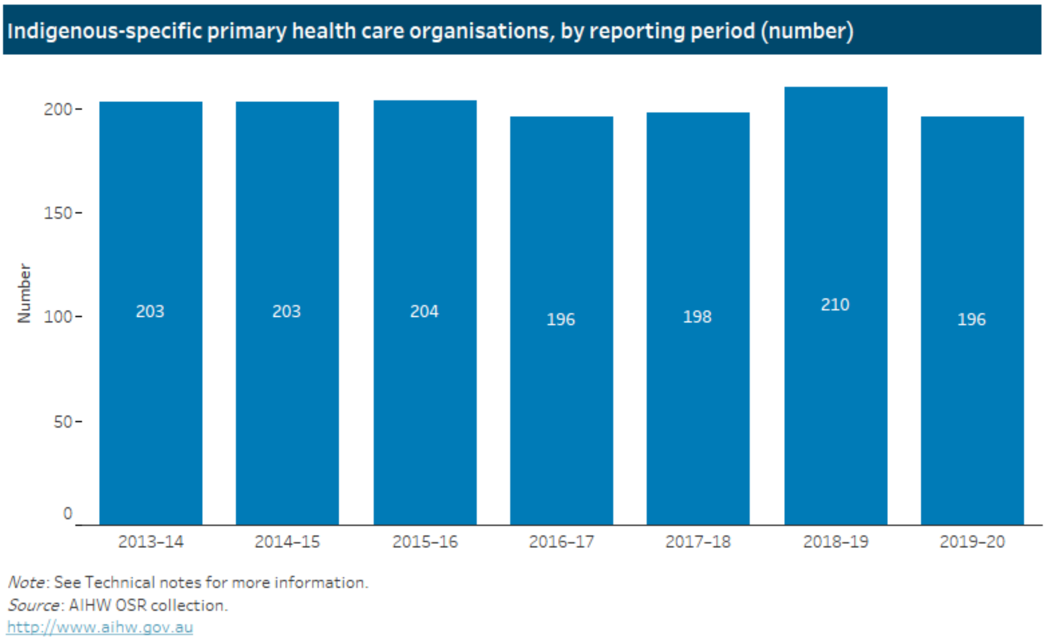
Note: See also Technical notes and Impact of COVID-19 for information on interpreting changes over time.

Source: AIHW analysis of OSR data collection.

Organisations

In 2019–20, 196 organisations reported to the Online Services Reporting (OSR) collection. Of these:

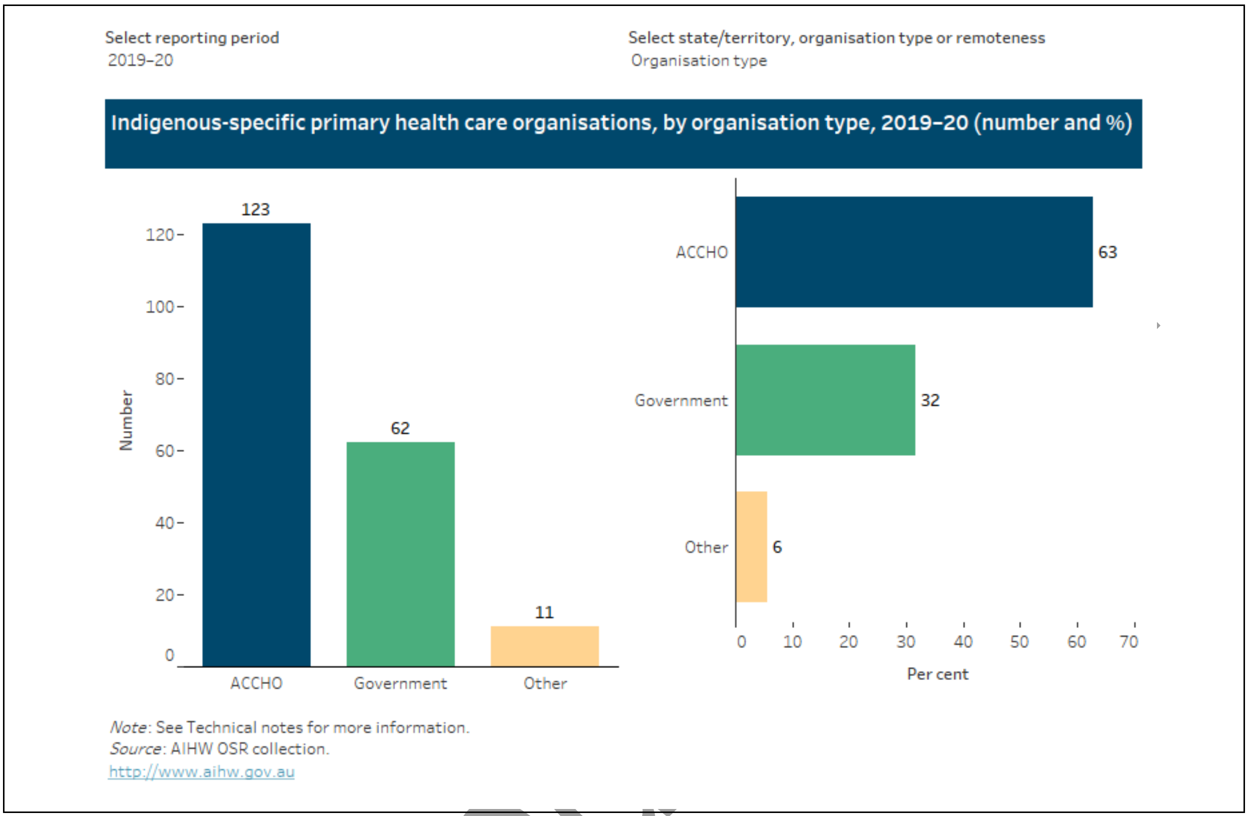
- over one-third (35% or 68) were in the Northern Territory
- over one-third (37% or 72) were in *Very remote* areas, 13% in *Remote* areas, 18% in *Outer regional* areas, 20% in *Inner regional* areas and 12% in *Major cities*
- around two-thirds (63% or 123) were Aboriginal Community Controlled Health Organisations (ACCHOs), 32% were government-run organisations (many of these were Northern Territory Government-run clinics) and 6% were other non-government-run organisations.



Indigenous-specific primary health care organisations, by reporting period (number)

Note: See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

The decrease in the number of organisations reporting in 2019–20 was partly a result of a change in the nature of reporting that period. Unlike in previous years, reporting to the collection was made voluntary for 2019–20 in acknowledgement of the additional pressures on organisations because of COVID-19. See also Technical notes and Impact of COVID-19 for information on interpreting changes over time.



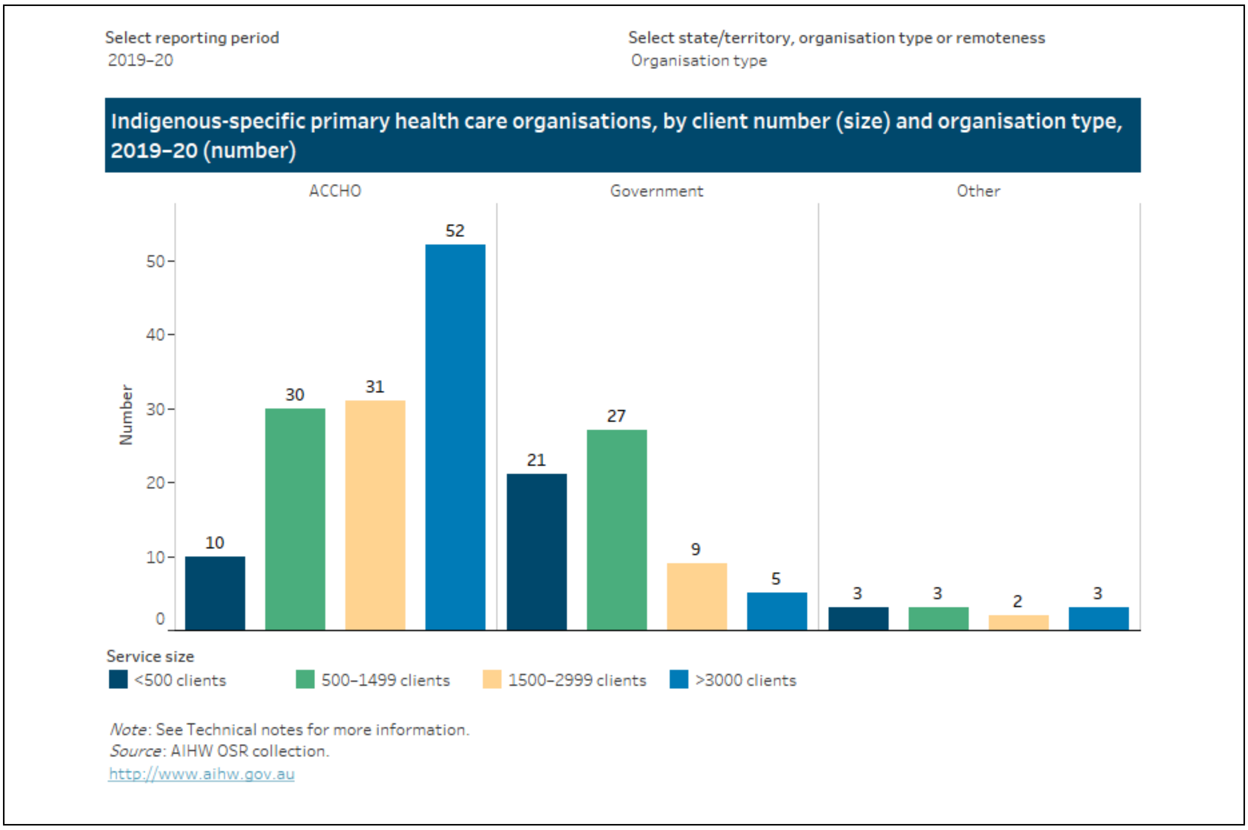
Select reporting period
2019–20

Select state/territory, organisation type or remoteness
Organisation type

Indigenous-specific primary health care organisations, by organisation type, 2019–20 (number and %)

Note: See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

The size of organisations, in terms of their number of clients, varies by jurisdiction, remoteness and organisation type.



Select reporting period
2019–20

Select state/territory, organisation type or remoteness
Organisation type

Indigenous-specific primary health care organisations, by client number (size) and organisation type, 2019–20 (number)

Note: See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

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Workforce

The Online Services Report (OSR) collection contains 2 measures of the workforce of organisations—full-time equivalent (FTE) staff and FTE vacancies.

Full-time equivalent

Full-time equivalent (FTE) is a standard measure of the size of a workforce that takes into account both the number of workers and the hours that each works. For example, if a workforce comprises 2 people working full-time 40 hours a week and 2 working half-time, this is the same as 3 working full-time—an FTE of 3.

In the OSR this is the count of:

- employed staff—how many FTE positions an organisation paid the wages or salary for at 30 June
- visiting staff—how many staff worked for but were not paid for by the organisation during the collection period
- vacant positions—how many vacant positions there were at 30 June.

The following boxes show key results for 2019–20. Clicking on a box will go to more information on the selected topic.

FTE staff

Indigenous staff

52%

of employed full-time equivalent staff were Indigenous

Health staff

58%

of employed full-time equivalent staff were health staff

Remoteness

38%

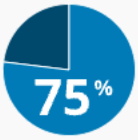
of employed full-time equivalent staff were in *Remote* or *Very remote* areas

Vacant FTE positions

Indigenous vacancies

of vacant full-time equivalent positions were for Aboriginal and Torres Strait Islander health workers and practitioners

Health vacancies



of full-time equivalent vacancies were for health staff

Remoteness

of full-time equivalent vacancies were in *Remote* or *Very remote* areas

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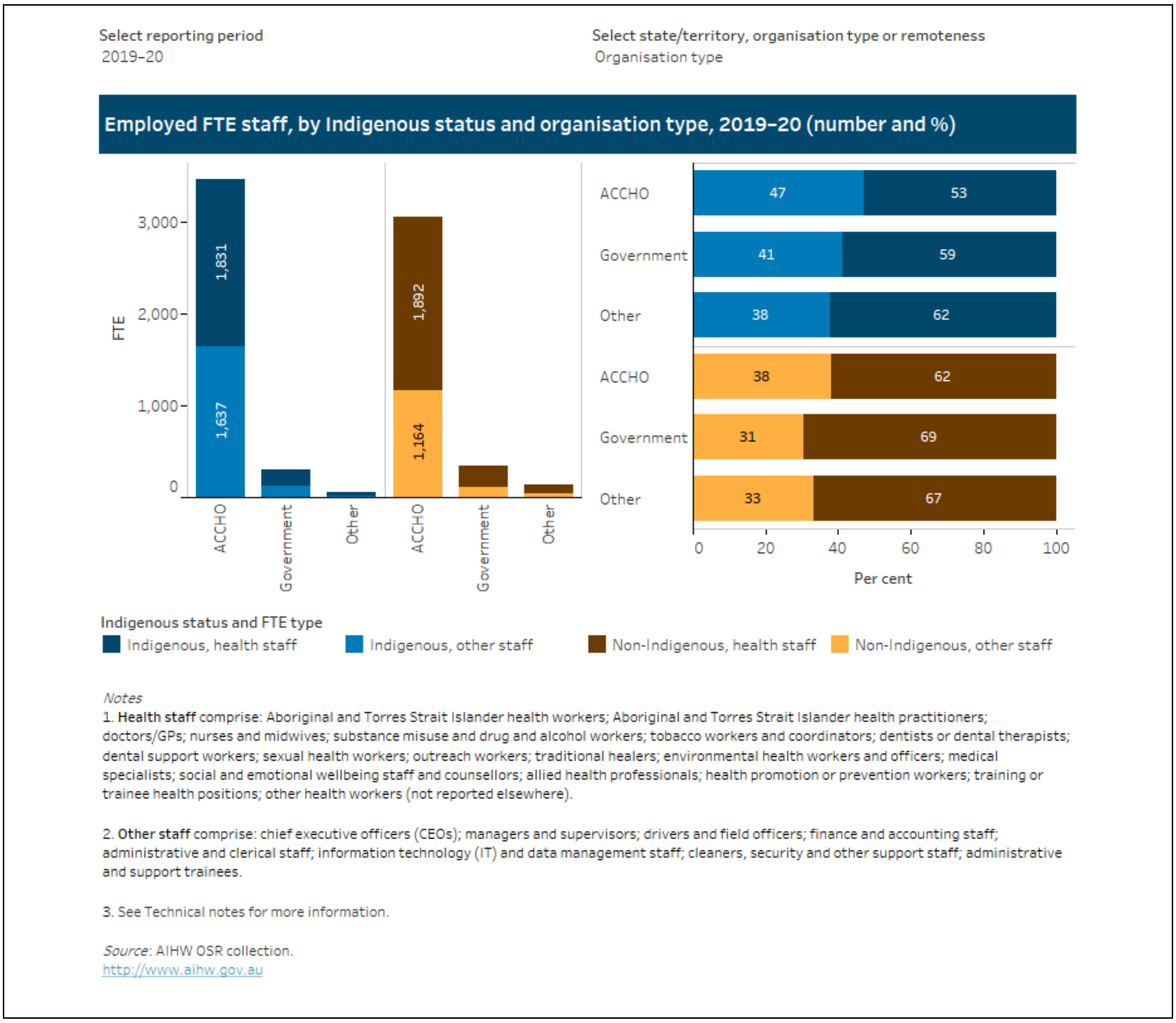
Staffing (FTE)

At 30 June 2020, organisations employed nearly 7,400 full-time equivalent (FTE) staff. They also had around 282 visiting FTE staff not paid for by the organisations themselves. Of the employed FTE staff:

- over half (58% or nearly 4,300 FTE) were health staff, with 15% being nurses and midwives, 11% being Aboriginal and Torres Strait Islander health workers and practitioners, and 8% being general practitioners (GPs)
- just over half (52% or just over 3,800) were Indigenous
- 23% (or just under 1,700 FTE) were in Queensland
- 22% (or around 1,600) were in *Outer regional* areas
- 89% (or over 6,500) were at Aboriginal Community Controlled Health Organisations (ACCHOs).


Select reporting period
2019–20

Select state/territory, organisation type or remoteness
Organisation type

Employed FTE staff, by Indigenous status and organisation type, 2019–20 (number and %)

Indigenous status and FTE type
■ Indigenous, health staff ■ Indigenous, other staff ■ Non-Indigenous, health staff ■ Non-Indigenous, other staff

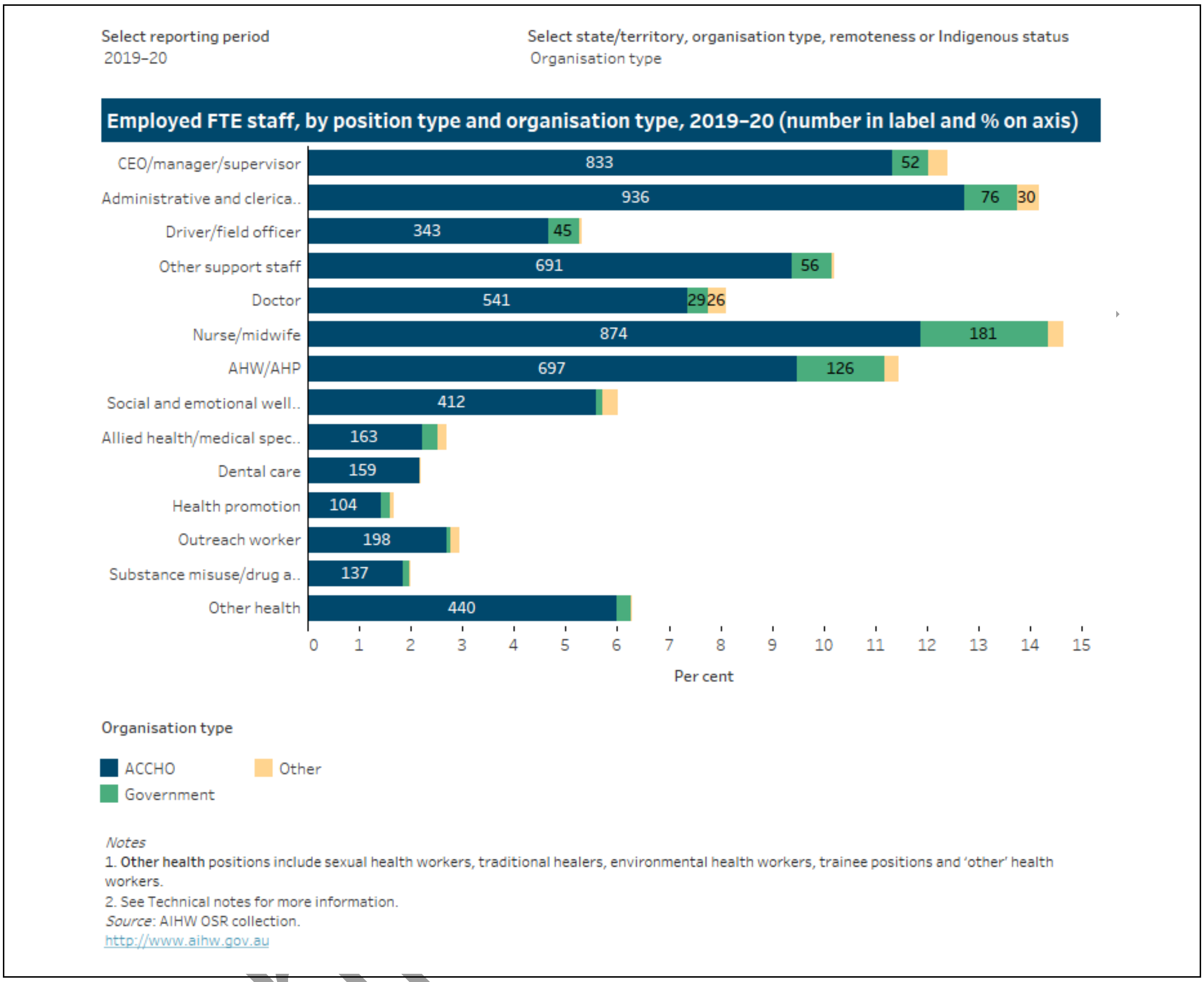
Notes

1. **Health staff** comprise: Aboriginal and Torres Strait Islander health workers; Aboriginal and Torres Strait Islander health practitioners; doctors/GPs; nurses and midwives; substance misuse and drug and alcohol workers; tobacco workers and coordinators; dentists or dental therapists; dental support workers; sexual health workers; outreach workers; traditional healers; environmental health workers and officers; medical specialists; social and emotional wellbeing staff and counsellors; allied health professionals; health promotion or prevention workers; training or trainee health positions; other health workers (not reported elsewhere).

2. **Other staff** comprise: chief executive officers (CEOs); managers and supervisors; drivers and field officers; finance and accounting staff; administrative and clerical staff; information technology (IT) and data management staff; cleaners, security and other support staff; administrative and support trainees.

3. See Technical notes for more information.

Source: AIHW OSR collection.
http://www.aihw.gov.au



Select reporting period
2019–20

Select state/territory, organisation type, remoteness or Indigenous status
Organisation type

Employed FTE staff, by position type and organisation type, 2019–20 (number in label and % on axis)

Notes
1. **Other health** positions include sexual health workers, traditional healers, environmental health workers, trainee positions and 'other' health workers.
2. See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

Vacancies (FTE)

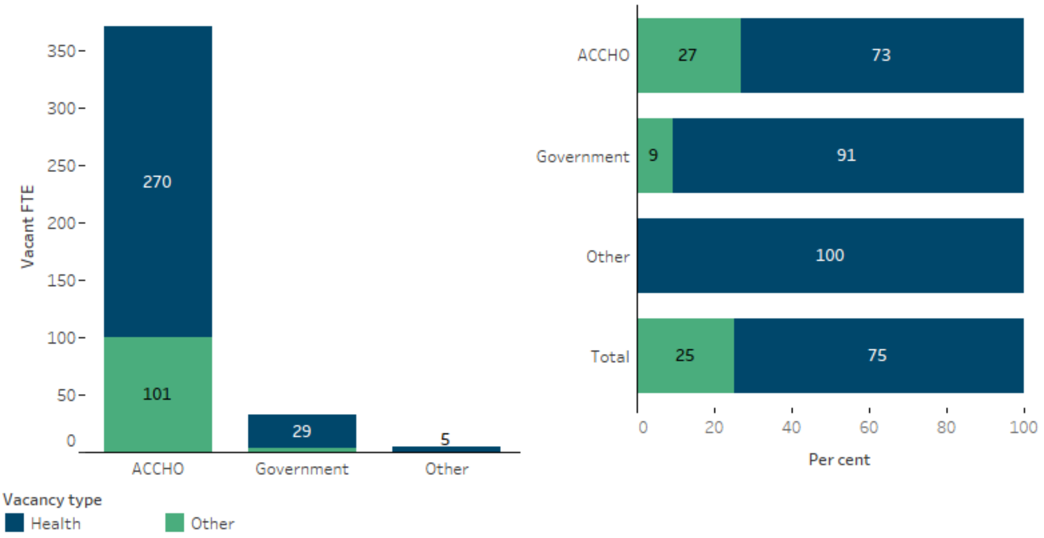
At 30 June 2020, organisations had around 408 vacant full-time equivalent (FTE) positions. Of these:

- 75% (or nearly 305) were for health positions
- 42% (or nearly 172) were in the Northern Territory
- 38% (or around 153) were in *Remote* areas
- 20% (or around 81) were for Aboriginal and Torres Strait Islander health workers and practitioners
- 91% (or just under 371) were at Aboriginal Community Controlled Health Organisations (ACCHOs).

Select reporting period
2019–20

Select state/territory, organisation type or remoteness
Organisation type

Vacant FTE positions, by vacancy type and organisation type, 2019–20 (number and %)



Notes

1. **Health staff** comprise: Aboriginal and Torres Strait Islander health workers; Aboriginal and Torres Strait Islander health practitioners; doctors/GPs; nurses and midwives; substance misuse and drug and alcohol workers; tobacco workers and coordinators; dentists or dental therapists; dental support workers; sexual health workers; outreach workers; traditional healers; environmental health workers and officers; medical specialists; social and emotional wellbeing staff and counsellors; allied health professionals; health promotion or prevention workers; training or trainee health positions; other health workers (not reported elsewhere).

2. **Other staff** comprise: chief executive officers (CEOs); managers and supervisors; drivers and field officers; finance and accounting staff; administrative and clerical staff; information technology (IT) and data management staff; cleaners, security and other support staff; administrative and support trainees.

3.See Technical notes for more information.

Source: AIHW OSR collection.
http://www.aihw.gov.au

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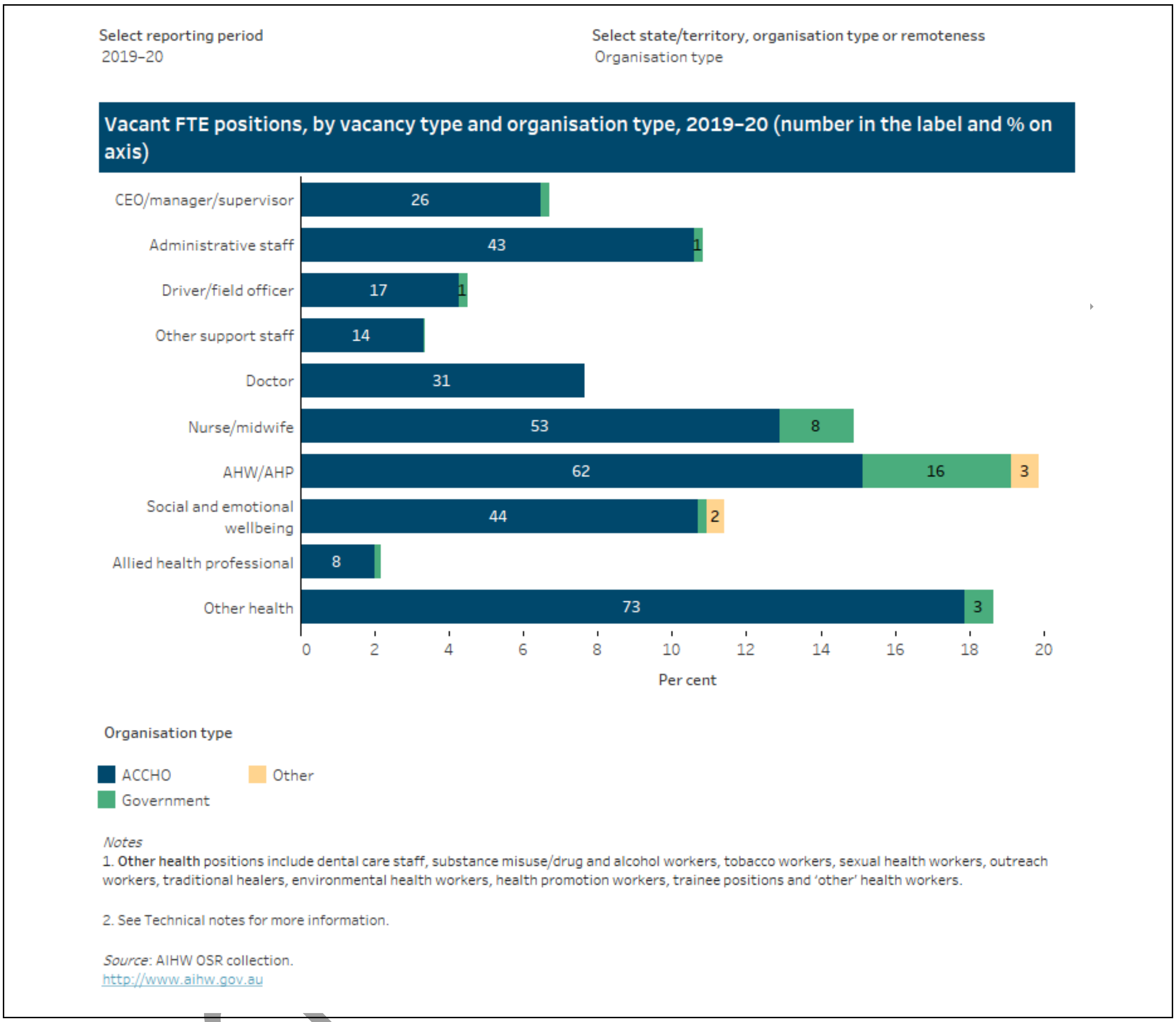


Select reporting period
2019–20

Select state/territory, organisation type or remoteness
Organisation type

Vacant FTE positions, by vacancy type and organisation type, 2019–20 (number in the label and % on axis)

Notes
1. **Other health** positions include dental care staff, substance misuse/drug and alcohol workers, tobacco workers, sexual health workers, outreach workers, traditional healers, environmental health workers, health promotion workers, trainee positions and 'other' health workers.

2. See Technical notes for more information.

Source: AIHW OSR collection.
http://www.aihw.gov.au

There were 0.9 vacant FTE positions per 1,000 clients. This was highest for:

- health positions (0.7)
- the Northern Territory (1.7)
- *Remote* areas (2.0)
- ACCHOs (1.0).

Select reporting period
2019–20

Select state/territory, organisation type or remoteness
Organisation type

Vacant FTE positions per 1,000 clients, by vacancy type and Organisation type, 2019–20

Notes

1. **Health staff** comprise: Aboriginal and Torres Strait Islander health workers; Aboriginal and Torres Strait Islander health practitioners; doctors/GPs; nurses and midwives; substance misuse and drug and alcohol workers; tobacco workers and coordinators; dentists or dental therapists; dental support workers; sexual health workers; outreach workers; traditional healers; environmental health workers and officers; medical specialists; social and emotional wellbeing staff and counsellors; allied health professionals; health promotion or prevention workers; training or trainee health positions; other health workers (not reported elsewhere).

2. **Other staff** comprise: chief executive officers (CEOs); managers and supervisors; drivers and field officers; finance and accounting staff; administrative and clerical staff; information technology (IT) and data management staff; cleaners, security and other support staff; administrative and support trainees.

3. See Technical notes for more information.

Source: AIHW OSR collection.
http://www.aihw.gov.au

Clients

The Online Services Report (OSR) collection contains 3 measures related to the clients that organisations see—client numbers, client contacts and episodes of care.

Client numbers

Client numbers refers to how many individuals receive health care from an organisation during the collection period. Each individual is counted as a client once only within an organisation, regardless of how many times they are seen. Visitors and transient clients are included in client counts, but clients attending group activities only (and who do not receive individual care) are excluded.

A client may attend more than one organisation. The extent this occurs is not known and is not adjusted for.

See also Regular client in Technical notes.

Client contacts

Client contacts are a count of the contacts made by each type of health worker in an organisation (both employed and visiting health staff), and include those made by drivers and field officers (transport contacts). Client contacts do not include administrative contacts or those relating to groups and residential care.

Counts of client contacts in 2016–17 were affected by changes to episodes of care in that year. See also Episodes of care and Technical notes.

Episodes of care

An episode of care is a contact between a client and 1 or more health workers in an organisation in 1 calendar day. All contacts with the same client on the same day are counted as 1 episode of care only, but if more than 1 health worker sees that client in the same day (for example, both a nurse and doctor see the same client) then 1 episode of care will count as multiple client contacts. An episode of care may be provided by employed or visiting health staff, either on site or off site, and includes outreach, hospital contact with clients, telephone contacts of a clinical nature, care delivered over the phone which results in an update to a client's record and other clinical consultations. Episodes of care do not include administrative contacts or those relating to groups and residential care.

Episodes of care data for 2016–17 are not comparable with other years because changes were made to the types of contacts counted as an episode of care. There were also corrections made to the counting rules used by one clinical information system which did not fully align with the episode of care definition (which had not changed since originally agreed in 2008–09). These led to lower numbers of episodes of care recorded and potential undercounts for some services in 2016–17. See also Client contacts and Technical notes.

The following boxes show key results for 2019–20. Clicking on a box will go to more information on the selected topic.

Client numbers

Organisation type

81%

of clients (380,800) were seen by Aboriginal Community Controlled Health Organisations

Indigenous clients

82%

of clients (382,600) were Indigenous

Remoteness

162,000

clients (34%) were seen in *Remote* or *Very remote* areas

Client contacts

Organisation type

4.7Million

client contacts (87%) at Aboriginal Community Controlled Health Organisations

Indigenous clients

31%

of Indigenous client contacts (1.7 million) were with a nurse/midwife

Remoteness

2.0Million

client contacts (37%) in *Remote* or *Very remote* areas

Episodes of care

Organisation type

3.0 Million

episodes of care (84%) by Aboriginal Community Controlled Health Organisations

Indigenous clients

86%

of episodes of care (3.0 million) were with Indigenous clients

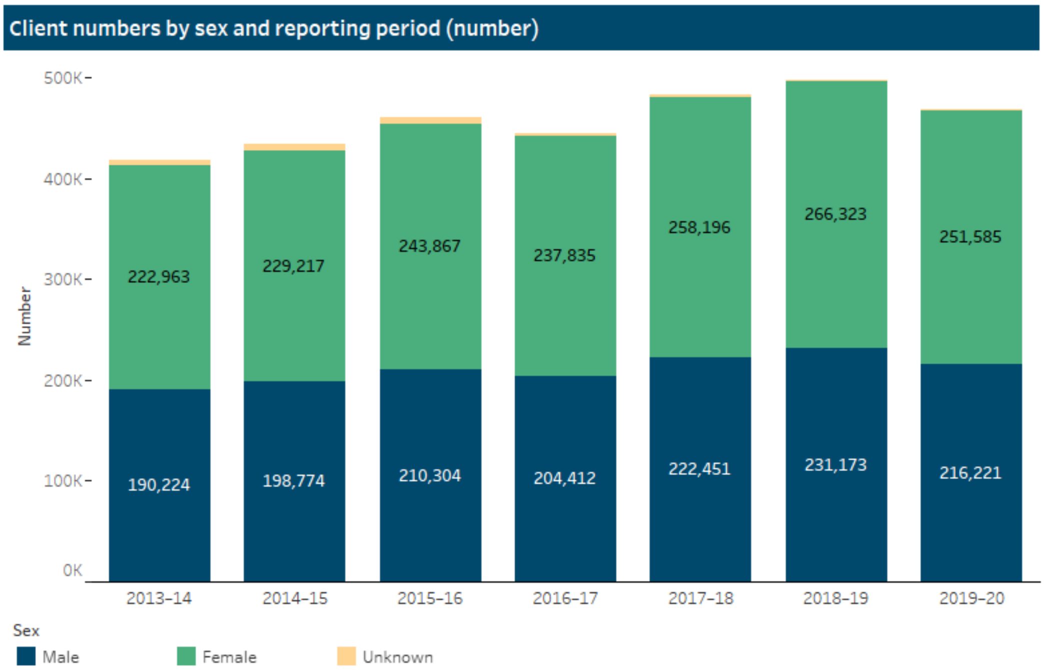
Remoteness

1.3 Million

episodes of care (38%) provided in *Remote* or *Very remote* areas

Client numbers

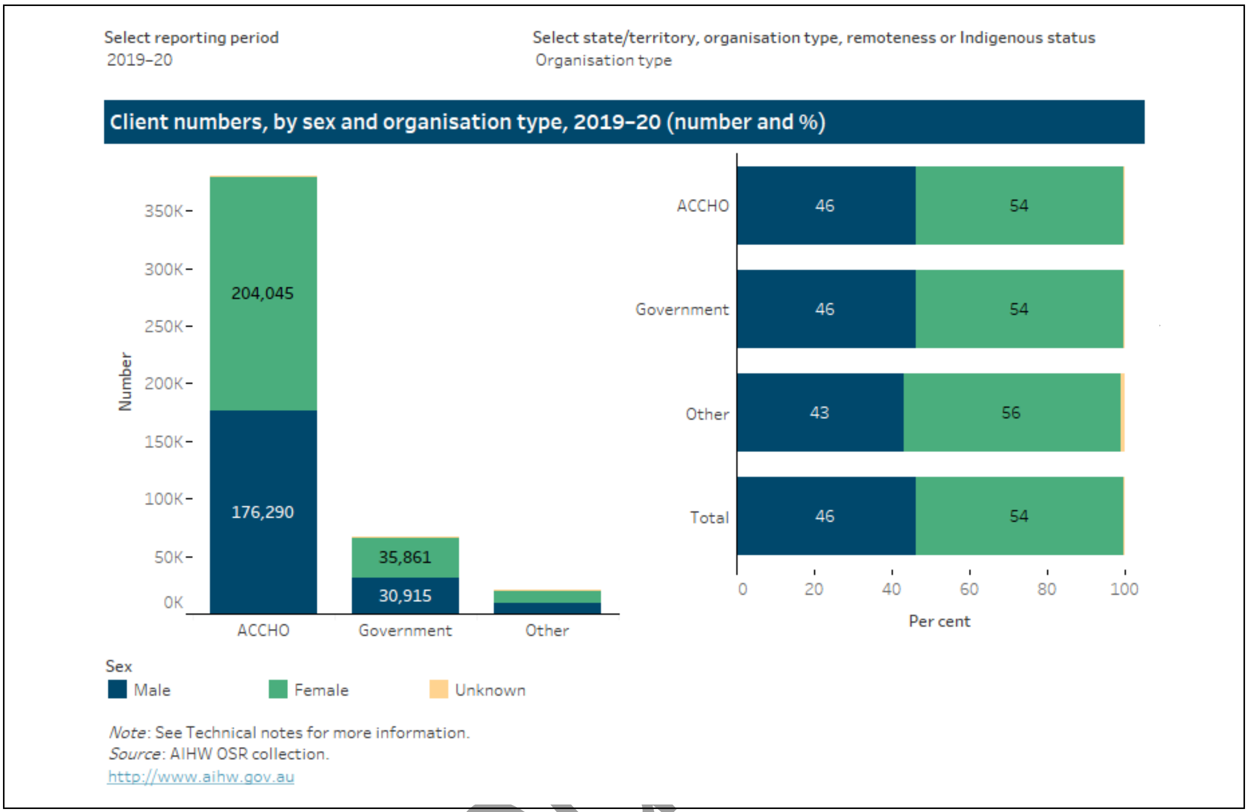
In 2019–20, organisations saw around 469,000 clients.



Note: See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

Of these:

- 54% (251,600) were female
- 82% (382,600) were Indigenous
- 27% (125,400) were seen in Queensland
- 23% (106,300) were seen in *Outer regional* areas
- 81% (380,800) were seen by Aboriginal Community Controlled Health Organisation (ACCHOs).



Select reporting period
2019–20

Select state/territory, organisation type, remoteness or Indigenous status
Organisation type

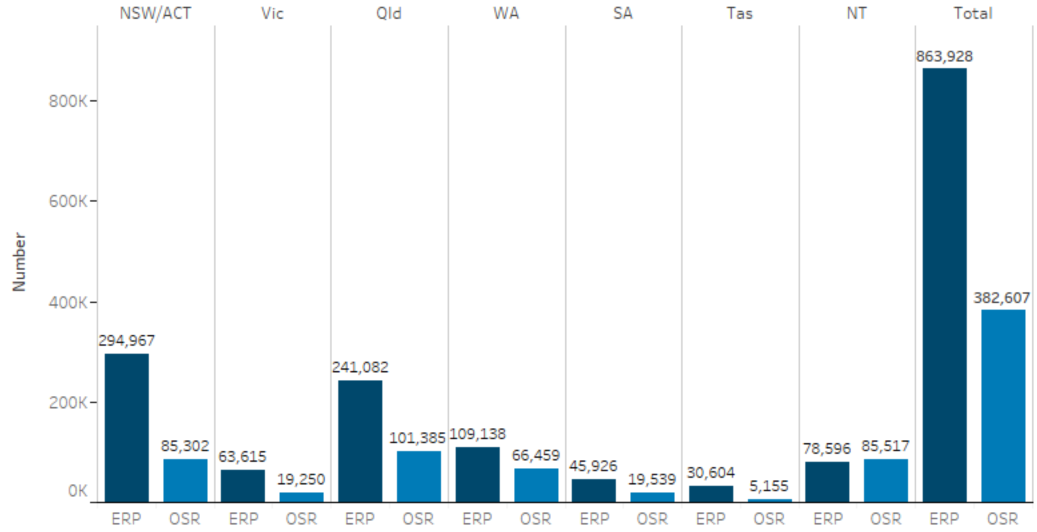
Client numbers, by sex and organisation type, 2019–20 (number and %)

Note: See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

In 2019–20, around 44% (382,600) of the estimated resident Indigenous population (864,000) were Indigenous clients of organisations reporting to the OSR collection.

Select reporting period
2019–20

Indigenous clients compared to estimated resident Indigenous population, by state/territory, 2019–20



Notes

1.In some cases clients may be counted at more than 1 organisation. The number of clients may therefore be greater than the Indigenous ERP.

2. ERP is as at 30 June of the relevant reporting period.

3. Total is the sum of the states and territories and does not include external territories.

4. See Technical notes for more information.

Source: ABS 2019; AIHW OSR collection.

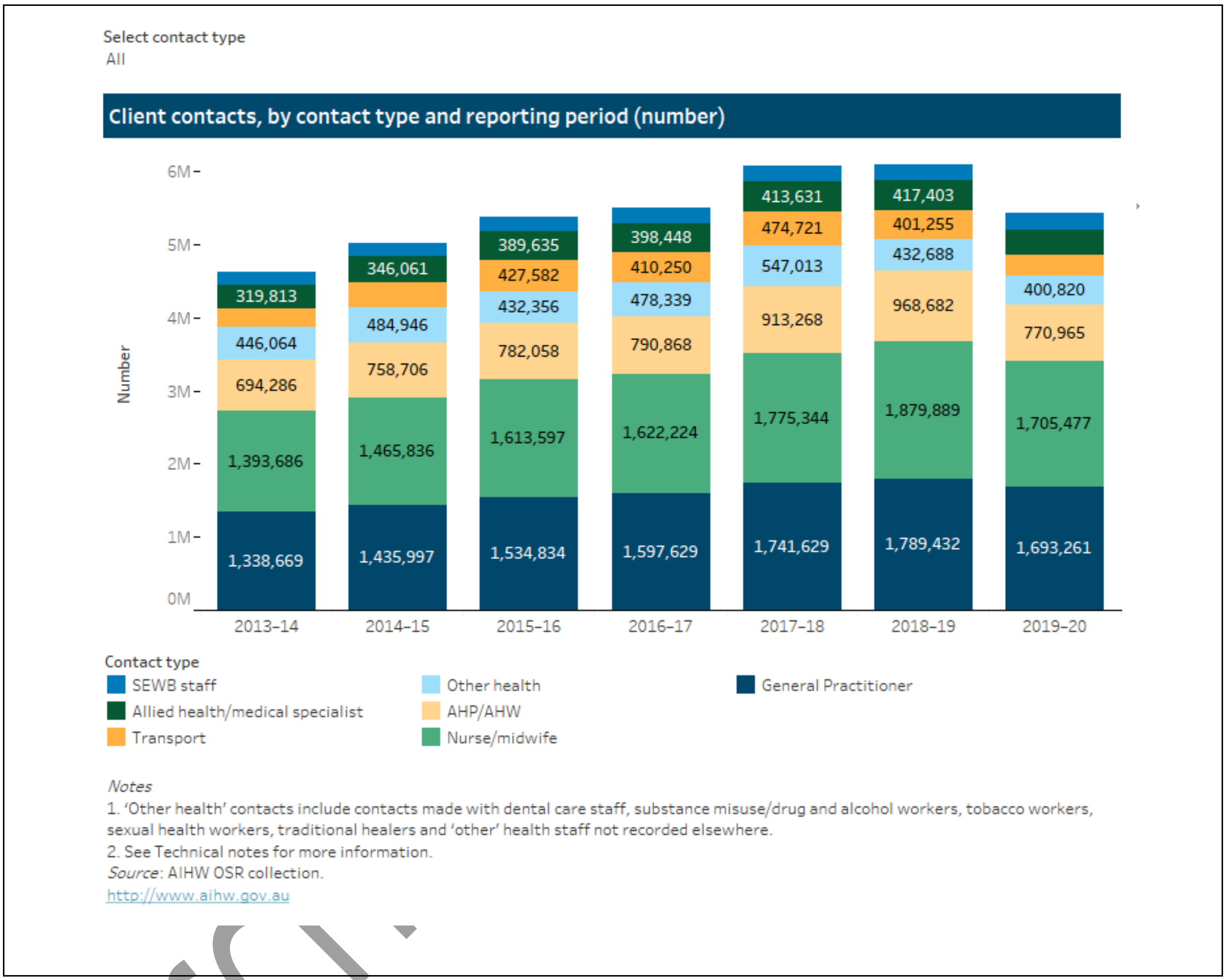
http://www.aihw.gov.au

Reference

ABS (Australian Bureau of Statistics) 2019. Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2006 to 2031. ABS cat. no. 3238.0. Canberra: ABS. [Series B projections]

Client contacts

In 2019–20, organisations had around 5.4 million client contacts.



Notes

1. 'Other health' contacts include contacts made with dental care staff, substance misuse/drug and alcohol workers, tobacco workers, sexual health workers, traditional healers and 'other' health staff not recorded elsewhere.
2. See Technical notes for more information.

Source: AIHW OSR collection.

http://www.aihw.gov.au

Of these:

- 86% (4.7 million) were with Indigenous clients
- 25% (1.4 million) were provided in Queensland
- 22% (1.2 million) were provided in *Outer regional* areas
- 87% (4.7 million) were provided by Aboriginal Community Controlled Health Organisations (ACCHOs)
- 31% (1.7 million) were made by nurses and midwives
- 31% (1.7 million) were made by a general practitioner (GP)

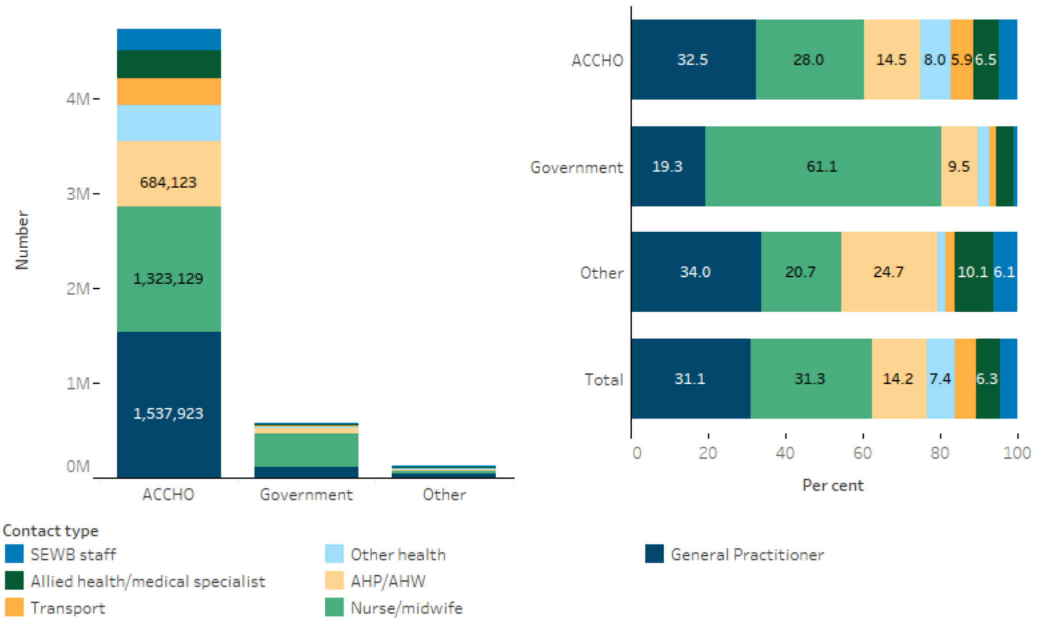
- 14% (771,000) were made by Aboriginal and Torres Strait Islander health workers and practitioners.

Select reporting period
2019–20

Select state/territory, remoteness, organisation type or Indigenous status
Organisation type

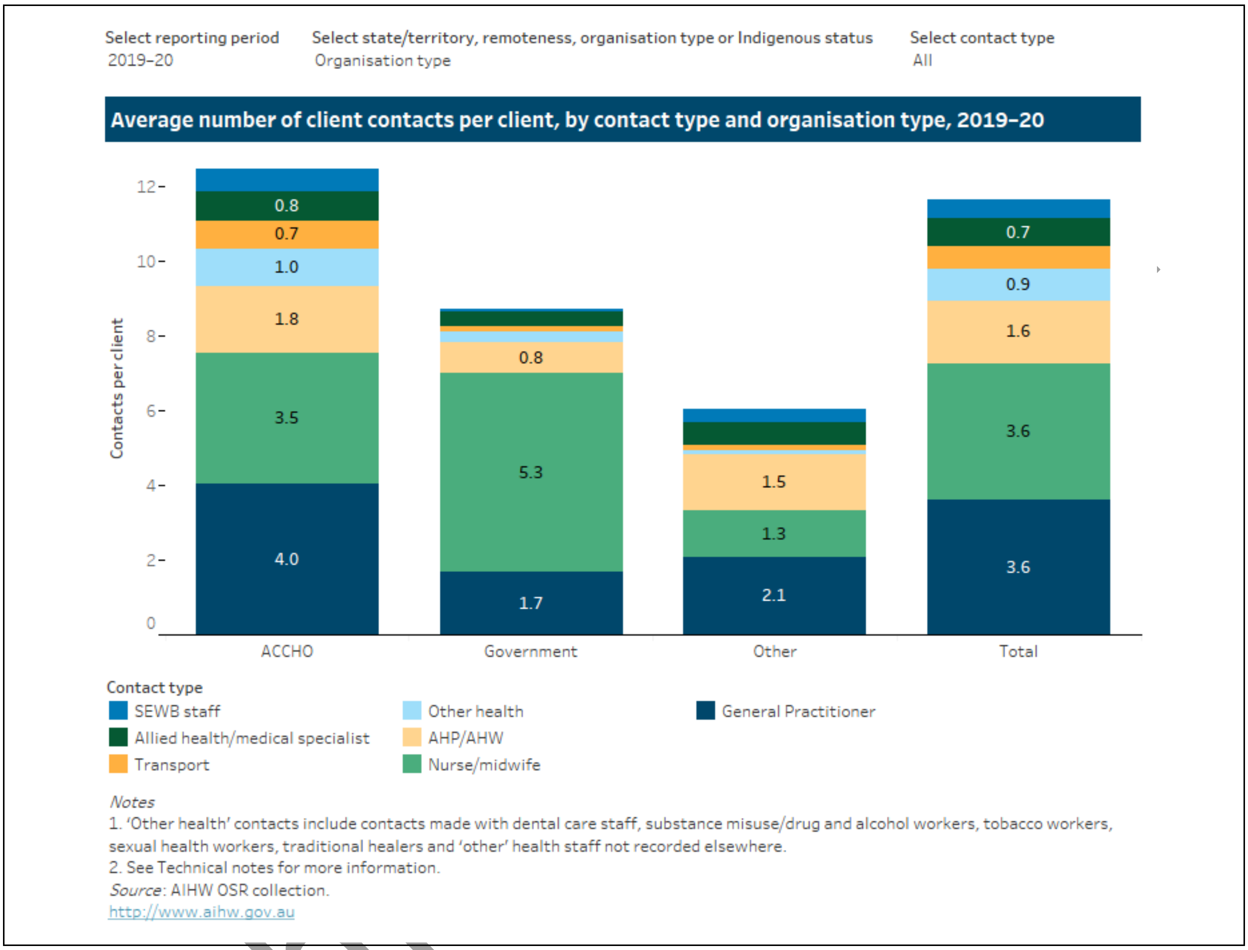
Select contact type
All

Client contacts, by contact type and organisation type, 2019–20 (number and %)



Notes
1. 'Other health' contacts include contacts made with dental care staff, substance misuse/drug and alcohol workers, tobacco workers, sexual health workers, traditional healers and 'other' health staff not recorded elsewhere.
2. See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

There was an average of 11.6 contacts per client.



Select reporting period
2019–20

Select state/territory, remoteness, organisation type or Indigenous status
Organisation type

Select contact type
All

Average number of client contacts per client, by contact type and organisation type, 2019–20

Notes

1. 'Other health' contacts include contacts made with dental care staff, substance misuse/drug and alcohol workers, tobacco workers, sexual health workers, traditional healers and 'other' health staff not recorded elsewhere.

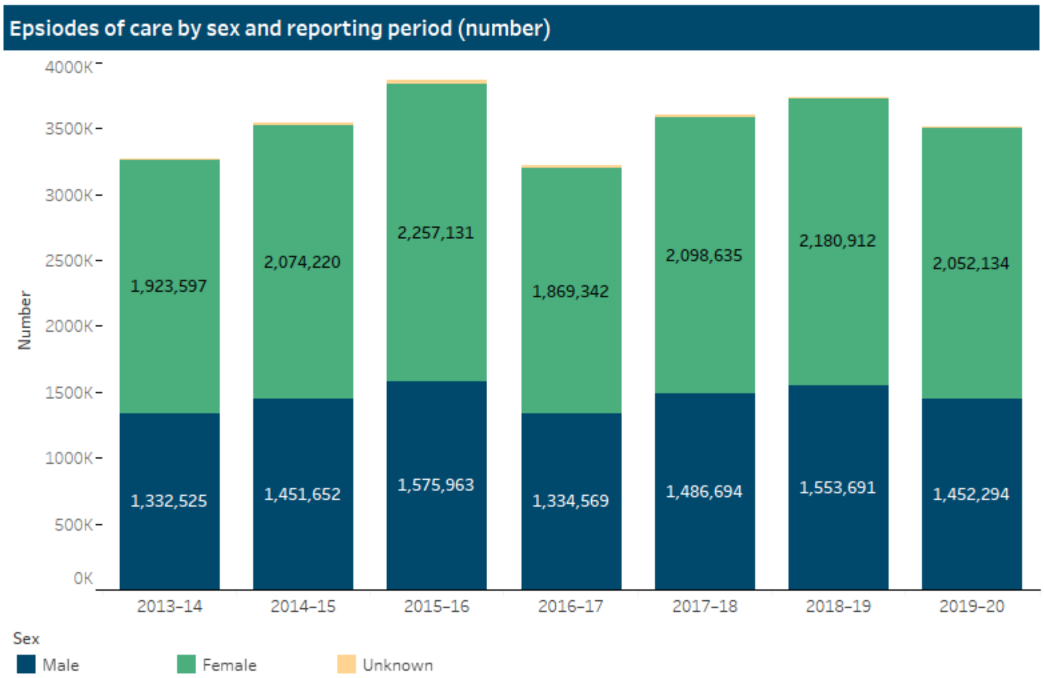
2. See Technical notes for more information.

Source: AIHW OSR collection.

http://www.aihw.gov.au

Episodes of care

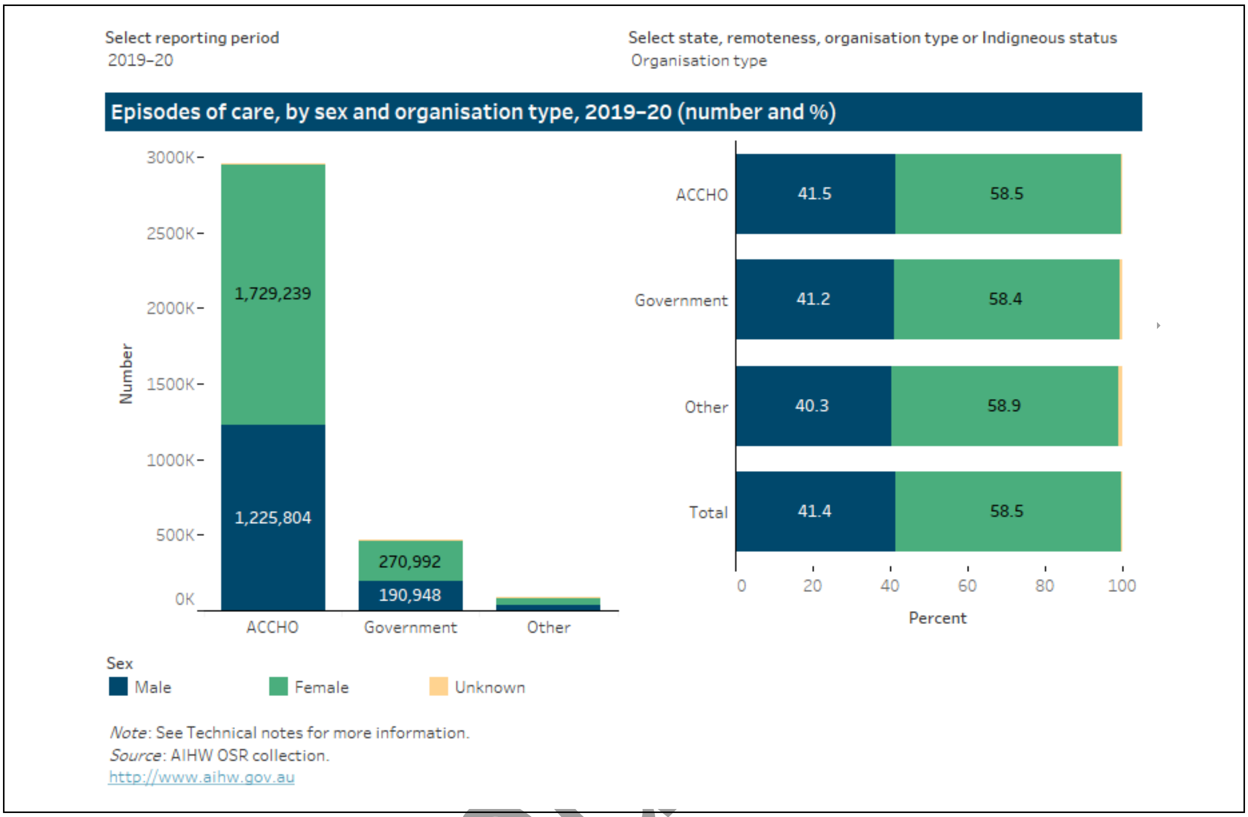
In 2019–20, organisations had around 3.5 million episodes of care.



Note: See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

Of these:

- 86% (3.0 million) were with Indigenous clients
- 58% (2.1 million) were with female clients
- 25% (880,700) were provided in Queensland
- 22% (758,800) were provided in *Major cities*
- 84% (3.0 million) were provided by Aboriginal Community Controlled Health Organisations (ACCHOs).

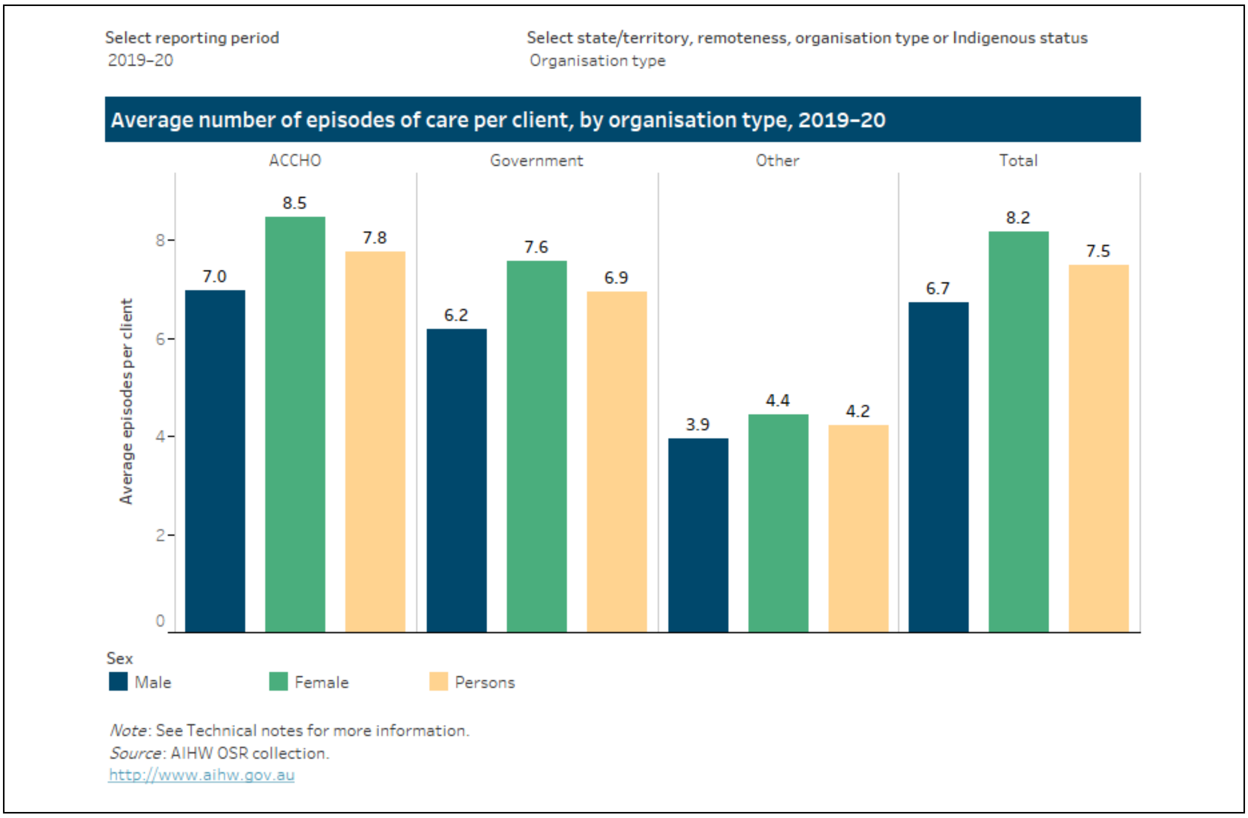


Select reporting period
2019–20

Select state, remoteness, organisation type or Indigneous status
Organisation type

Note: See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

There was an average of 7.5 episodes of care per client.



Average number of episodes of care per client, by organisation type, 2019–20

Note: See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

Services provided

An organisation may deliver services from 1 or more sites. In 2019–20, Indigenous-specific primary health care was delivered by 196 organisations from 287 service delivery sites. Of these, 123 organisations were Aboriginal Community Controlled Health Organisations (ACCHOs) who delivered services from 204 sites.

Data on services provided were not collected in 2018–19 or 2019–20. Work is underway to revise and reintroduce this item for future collections. As such, the following data on services provided are from 2017–18 and are the latest available data.

Most sites provided clinical services such as the diagnosis and treatment of chronic illnesses (88%), mental health and counselling services (88%), maternal and child health care (86%), and antenatal care (78%) (Table 1). Around two-thirds provided tobacco programs (69%) and substance-use and drug and alcohol programs (66%).

Table 1: Service delivery sites, type of service, 2017–18

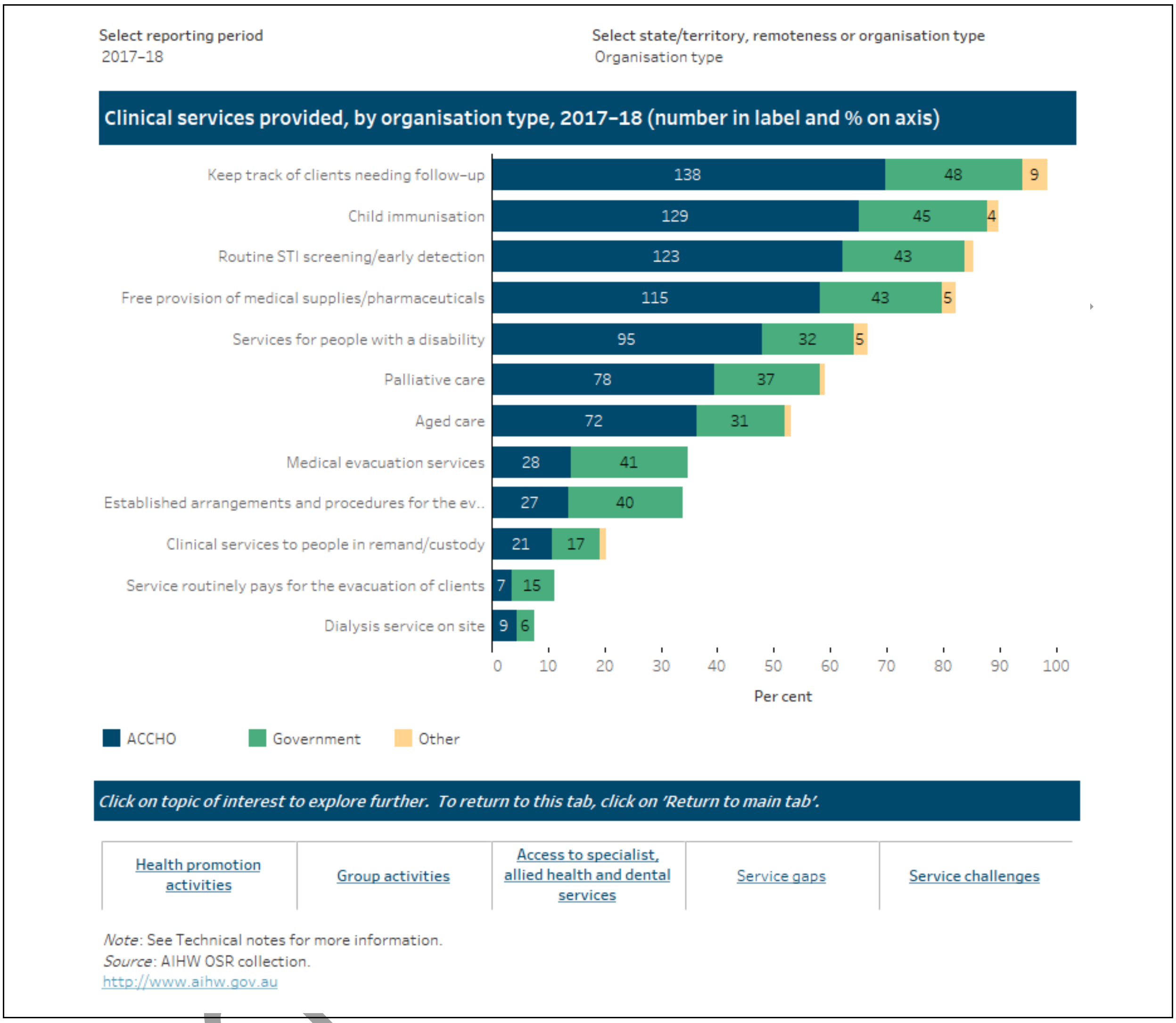
Type of service	Number	%
Social and emotional wellbeing/mental health/counselling	337	88.0
Diagnosis/treatment of chronic illness/disease	336	87.7
Transport	331	86.4
Maternal/child health care	328	85.6
Treatment of injury	317	82.8
Diagnosis/treatment of infectious illness/disease	316	82.5
Antenatal care	298	77.8
Tobacco programs	265	69.2
Substance use/drug and alcohol programs	252	65.8
Total sites	**383**	**100.0**

Most organisations provided access to a doctor (86%) and just over half (54%) delivered a wide range of services, including all of the following during usual opening hours: the diagnosis and treatment of illness and disease; antenatal care; maternal and child health care; social and emotional wellbeing/counselling services; substance use programs; and on-site or off-site access to specialist, allied health and dental care services.

Most organisations (95%) also provided group activities as part of their health promotion and prevention work. For example, in 2017–18, these organisations provided around:

- 8,400 physical activity/healthy weight sessions
- 3,700 living skills sessions
- 4,600 chronic disease client support sessions
- 4,100 tobacco-use treatment and prevention sessions.

In addition to the services they provide, organisations reported on service gaps and challenges they faced and could list up to 5 of each from predefined lists. These were not ranked in terms of priority. In 2017–18, around two-thirds of organisations (68%) reported mental health/social and emotional health and wellbeing services as a gap faced by the community they served. This was followed by youth services (54%). Over two-thirds of organisations (71%) reported the recruitment, training and support of Aboriginal and Torres Strait Islander staff as a challenge in delivering quality health services.



Select reporting period
2017–18

Select state/territory, remoteness or organisation type
Organisation type

Clinical services provided, by organisation type, 2017–18 (number in label and % on axis)

Click on topic of interest to explore further. To return to this tab, click on 'Return to main tab'.

Note: See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

What are the national Key Performance Indicators?

Introduction

The national Key Performance Indicators (nKPI) collection is a set of 24 indicators provided by organisations receiving funding under the Indigenous Australians' Health Programme (IAHP) to deliver comprehensive and culturally appropriate primary health care services to Indigenous Australians. Some indicators have more than one part (for example, an indicator might be collected by different types of chronic diseases).

Data are supplied on the Indigenous regular clients of each organisation twice a year, with census dates in June and December. The period of data covered varies by indicator. For example, for the June 2020 census date, data provided covers, depending on the indicator:

- 6 months up to the census date, that is, from, 1 January 2020 to 30 June 2020, or
- 12 months up to the census date, that is, from 1 July 2019 to 30 June 2020, or
- 24 months up to the census date, that is, from 1 July 2018 to 30 June 2020, or
- 2, 3 and 5 years up to the census date (for cervical screening only).

Indigenous regular clients

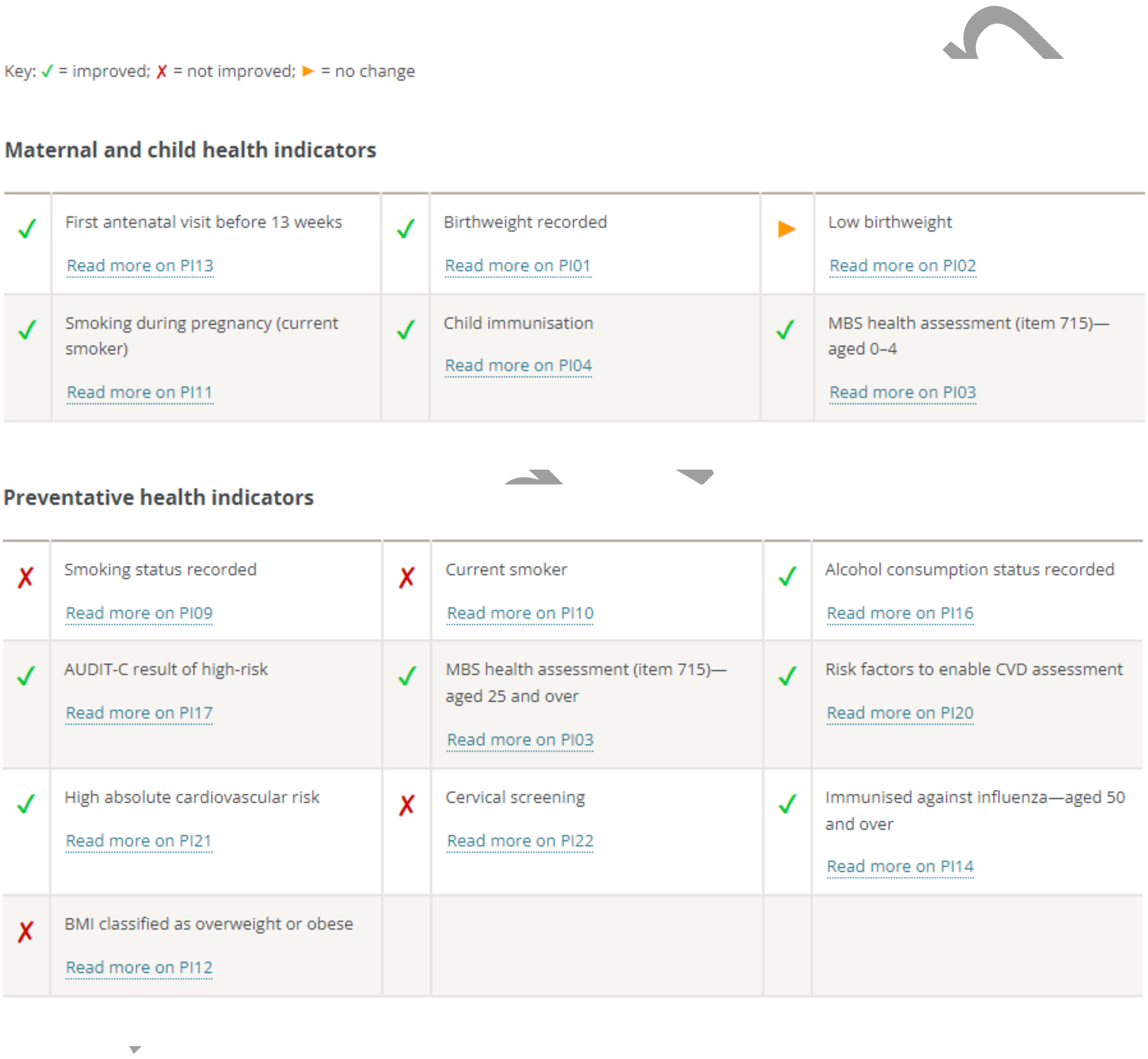
Organisations reporting to the nKPI collection may see a mix of Indigenous and non-Indigenous clients. Some of these are considered regular clients of the organisation. Only data for Indigenous regular clients are included in the nKPI collection.

For the purposes of the nKPI collection, an Indigenous regular client is defined as an Aboriginal or Torres Strait Islander person who has an active medical record—that is, who attended a particular primary health care organisation at least 3 times in the previous 2 years. This definition is consistent with the RAGCP definition of an active patient (RACGP 2020). See Technical notes and Glossary for more information.

The nKPI collection consists of 15 process-of-care and 9 health-outcome indicators organised under three domains (see Technical notes for a list of indicators by domain and type). While the process-of-care indicators are largely (but not completely) under the control of organisations and indicate good practice in primary health care, health outcomes are influenced by a range of factors known as social determinants (such as education, employment, housing, access to resources, racism) some of which are beyond the immediate control of organisations.

As such, the indicators needs to be viewed in context of the broader environment in which organisations operate and in which the data are collected. In particular, it is important to acknowledge that the indicators capture only a subset of the important work that organisations do each day. Data from this collection, however, can make an important contribution when used by health service providers at the local level to identify opportunities and to measure progress towards achieving change, or when used by policy makers to inform policy decisions.

The following boxes show key trends between the June 2017 and June 2020 reporting periods for each indicator. Clicking on a box will go to more information on the associated indicator.



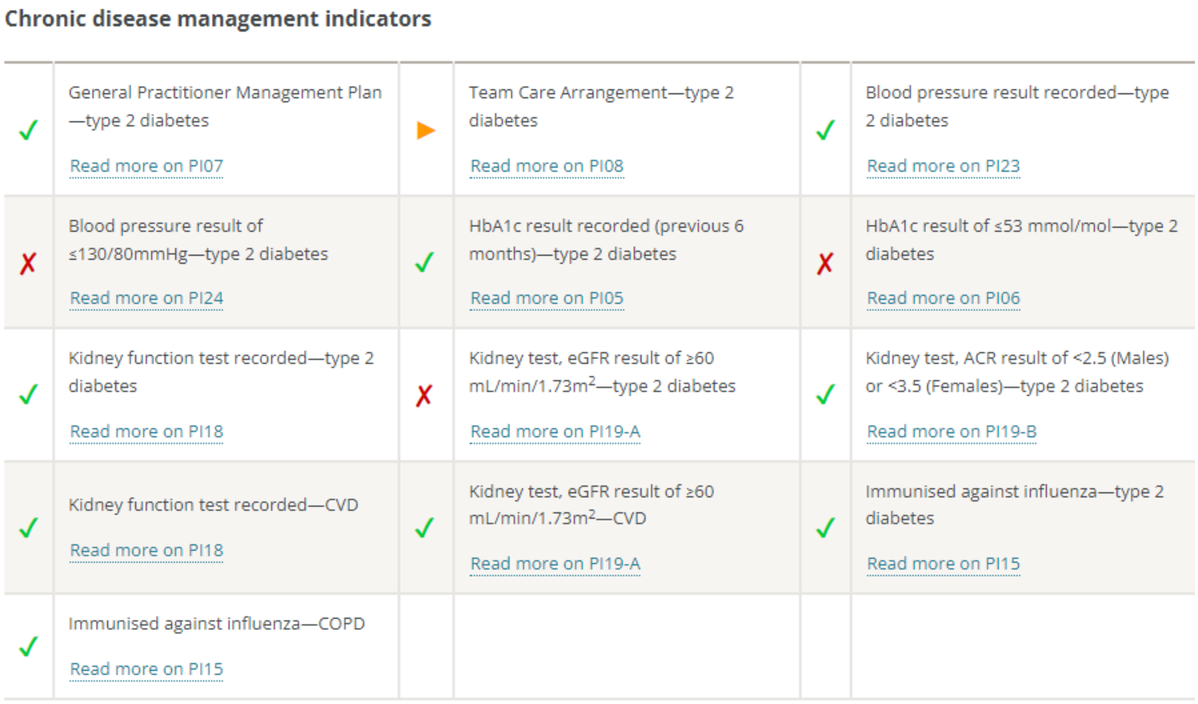
Key: ✓ = improved; ✗ = not improved; ▶ = no change

Maternal and child health indicators

✓	First antenatal visit before 13 weeks Read more on PI13	✓	Birthweight recorded Read more on PI01	▶	Low birthweight Read more on PI02
✓	Smoking during pregnancy (current smoker) Read more on PI11	✓	Child immunisation Read more on PI04	✓	MBS health assessment (item 715)—aged 0–4 Read more on PI03

Preventative health indicators

✗	Smoking status recorded Read more on PI09	✗	Current smoker Read more on PI10	✓	Alcohol consumption status recorded Read more on PI16
✓	AUDIT-C result of high-risk Read more on PI17	✓	MBS health assessment (item 715)—aged 25 and over Read more on PI03	✓	Risk factors to enable CVD assessment Read more on PI20
✓	High absolute cardiovascular risk Read more on PI21	✗	Cervical screening Read more on PI22	✓	Immunised against influenza—aged 50 and over Read more on PI14
✗	BMI classified as overweight or obese Read more on PI12				



Chronic disease management indicators

✓	General Practitioner Management Plan —type 2 diabetes Read more on PI07	▶	Team Care Arrangement—type 2 diabetes Read more on PI08	✓	Blood pressure result recorded—type 2 diabetes Read more on PI23
✗	Blood pressure result of ≤130/80mmHg—type 2 diabetes Read more on PI24	✓	HbA1c result recorded (previous 6 months)—type 2 diabetes Read more on PI05	✗	HbA1c result of ≤53 mmol/mol—type 2 diabetes Read more on PI06
✓	Kidney function test recorded—type 2 diabetes Read more on PI18	✗	Kidney test, eGFR result of ≥60 mL/min/1.73m^2—type 2 diabetes Read more on PI19-A	✓	Kidney test, ACR result of <2.5 (Males) or <3.5 (Females)—type 2 diabetes Read more on PI19-B
✓	Kidney function test recorded—CVD Read more on PI18	✓	Kidney test, eGFR result of ≥60 mL/min/1.73m^2—CVD Read more on PI19-A	✓	Immunised against influenza—type 2 diabetes Read more on PI15
✓	Immunised against influenza—COPD Read more on PI15				

Reference

The Royal Australian College of General Practitioners 2020. Standards for general practices, 5th edition. East Melbourne, Vic: RACGP.

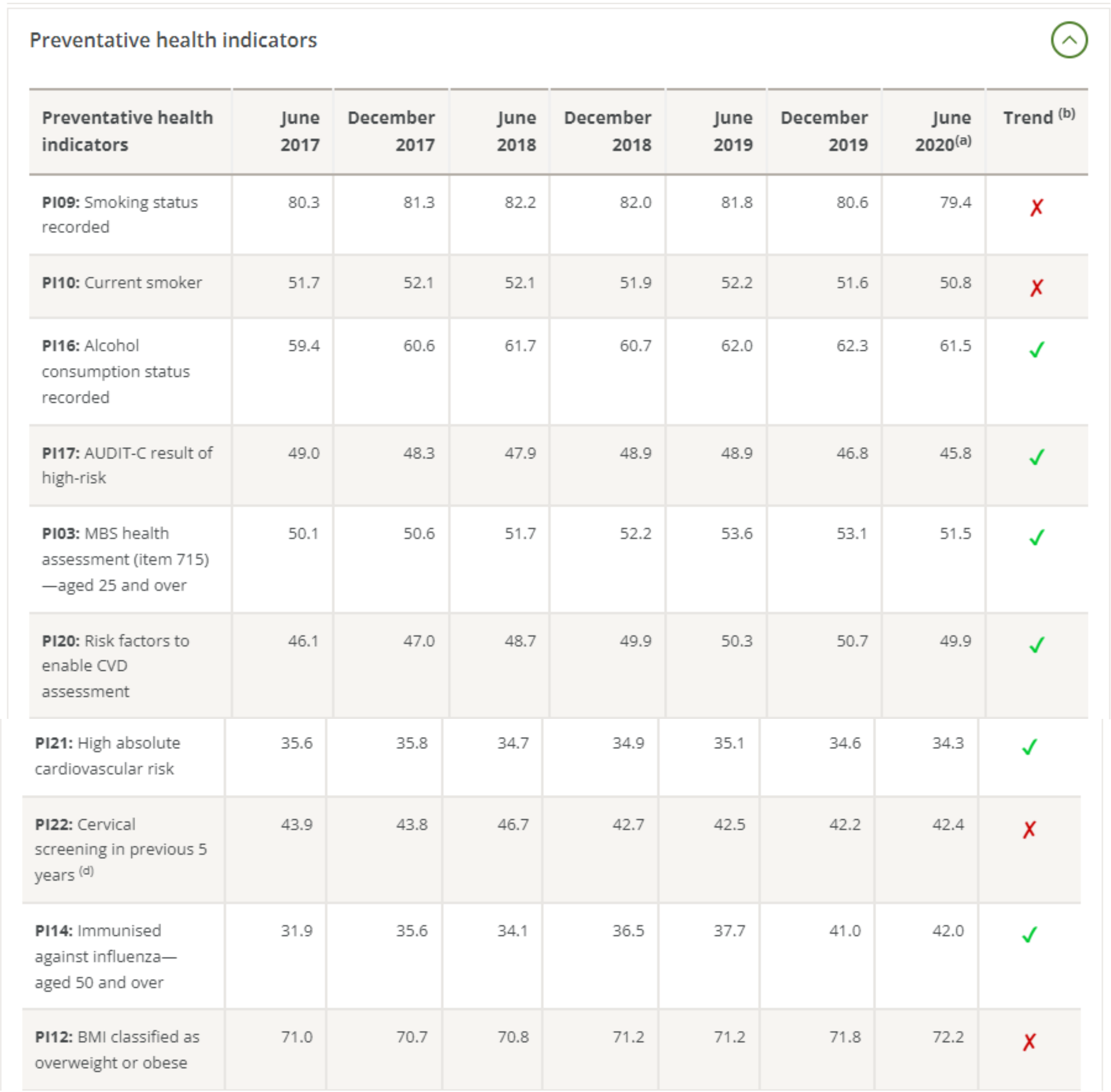
Summary over time

Table 1 presents results and trends from the national Key Performance Indicators (nKPI) collection between the June 2017 and June 2020 reporting periods. Of the 29 measures presented (noting some of the 24 indicators have more than one part), 20 have improved, 2 have had no (or limited) change, and 7 have not improved.

Table 1: Summary of nKPI results and trends over time, by domain, June 2017 to June 2020 (%)

Maternal and child health indicators

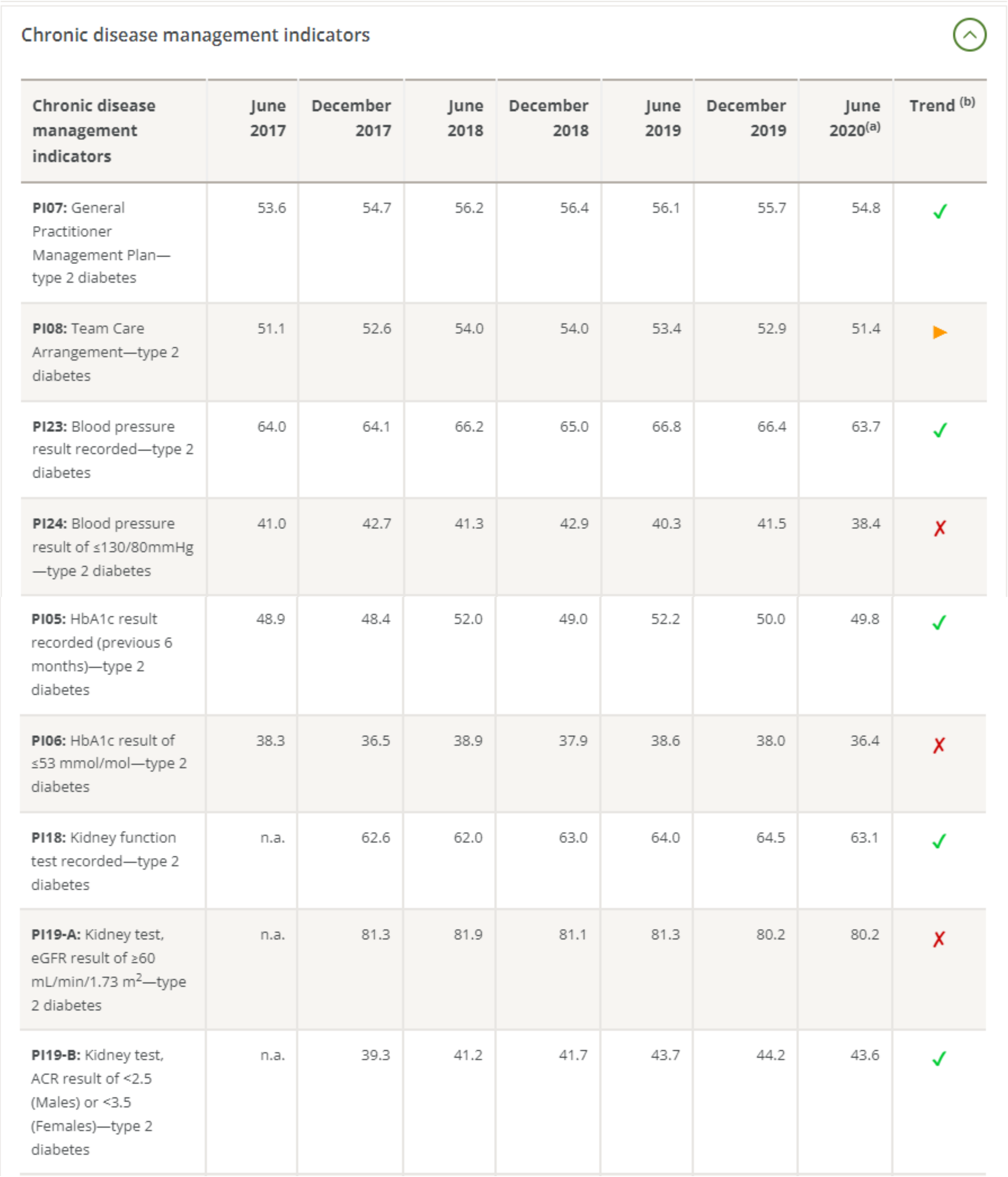
Maternal and child health indicators	June 2017	December 2017	June 2018	December 2018	June 2019	December 2019	June 2020[(a)]	Trend [(b)]
PI13: First antenatal visit before 13 weeks	39.2	41.2	42.4	42.0	40.6	41.6	41.5	✓
PI01: Birthweight recorded	69.5	72.8	73.7	73.2	71.1	76.1	77.9	✓
PI02: Low birthweight	11.4	12.4	13.2	12.1	11.6	10.6	11.1	▶
PI11: Smoking during pregnancy (current smoker)	48.9	50.0	49.2	48.0	48.2	46.5	45.9	✓
PI04: Child immunisation[(c)]	69.1	69.1	73.4	69.5	73.0	71.3	72.5	✓
PI03: MBS health assessment (item 715)—clients aged 0–4	35.0	35.0	37.1	36.7	38.4	37.0	34.2	✓



Preventative health indicators

Preventative health indicators	June 2017	December 2017	June 2018	December 2018	June 2019	December 2019	June 2020[(a)]	Trend [(b)]
PI09: Smoking status recorded	80.3	81.3	82.2	82.0	81.8	80.6	79.4	✗
PI10: Current smoker	51.7	52.1	52.1	51.9	52.2	51.6	50.8	✗
PI16: Alcohol consumption status recorded	59.4	60.6	61.7	60.7	62.0	62.3	61.5	✓
PI17: AUDIT-C result of high-risk	49.0	48.3	47.9	48.9	48.9	46.8	45.8	✓
PI03: MBS health assessment (item 715)—aged 25 and over	50.1	50.6	51.7	52.2	53.6	53.1	51.5	✓
PI20: Risk factors to enable CVD assessment	46.1	47.0	48.7	49.9	50.3	50.7	49.9	✓
PI21: High absolute cardiovascular risk	35.6	35.8	34.7	34.9	35.1	34.6	34.3	✓
PI22: Cervical screening in previous 5 years [(d)]	43.9	43.8	46.7	42.7	42.5	42.2	42.4	✗
PI14: Immunised against influenza—aged 50 and over	31.9	35.6	34.1	36.5	37.7	41.0	42.0	✓
PI12: BMI classified as overweight or obese	71.0	70.7	70.8	71.2	71.2	71.8	72.2	✗

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.



Chronic disease management indicators

Chronic disease management indicators	June 2017	December 2017	June 2018	December 2018	June 2019	December 2019	June 2020[a]	Trend [b]
PI07: General Practitioner Management Plan—type 2 diabetes	53.6	54.7	56.2	56.4	56.1	55.7	54.8	✓
PI08: Team Care Arrangement—type 2 diabetes	51.1	52.6	54.0	54.0	53.4	52.9	51.4	▶
PI23: Blood pressure result recorded—type 2 diabetes	64.0	64.1	66.2	65.0	66.8	66.4	63.7	✓
PI24: Blood pressure result of ≤130/80mmHg—type 2 diabetes	41.0	42.7	41.3	42.9	40.3	41.5	38.4	✗
PI05: HbA1c result recorded (previous 6 months)—type 2 diabetes	48.9	48.4	52.0	49.0	52.2	50.0	49.8	✓
PI06: HbA1c result of ≤53 mmol/mol—type 2 diabetes	38.3	36.5	38.9	37.9	38.6	38.0	36.4	✗
PI18: Kidney function test recorded—type 2 diabetes	n.a.	62.6	62.0	63.0	64.0	64.5	63.1	✓
PI19-A: Kidney test, eGFR result of ≥60 mL/min/1.73 m^2—type 2 diabetes	n.a.	81.3	81.9	81.1	81.3	80.2	80.2	✗
PI19-B: Kidney test, ACR result of <2.5 (Males) or <3.5 (Females)—type 2 diabetes	n.a.	39.3	41.2	41.7	43.7	44.2	43.6	✓

PI18: Kidney function test recorded—CVD	n.a.	57.9	58.9	60.9	62.0	63.0	62.3	✓
PI19-A: Kidney test, eGFR result of ≥60 mL/min/1.73 m^2—CVD	n.a.	76.2	76.2	76.6	77.3	77.1	76.6	✓
PI15: Immunised agains influenza—type 2 diabetes	30.6	36.1	33.8	36.2	36.0	40.3	38.7	✓
PI15: Immunised against influenza—COPD	31.9	37.1	37.2	40.4	38.1	41.1	41.6	✓

a. Unlike in previous years, for 2019–20, reporting to the nKPI collection was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19.

b. Trend is calculated as a linear trend between the June 2017 and June 2020 reporting periods, including the December reporting periods.

c. There are data quality concerns with this indicator. It captures far fewer cases of fully immunised Indigenous children than Australian Immunisation Register (AIR) data and may therefore be an underestimate. See Technical notes for more information.

d. This is affected by changes to the indicator definition in June 2018. See Technical notes for more information.

Notes:

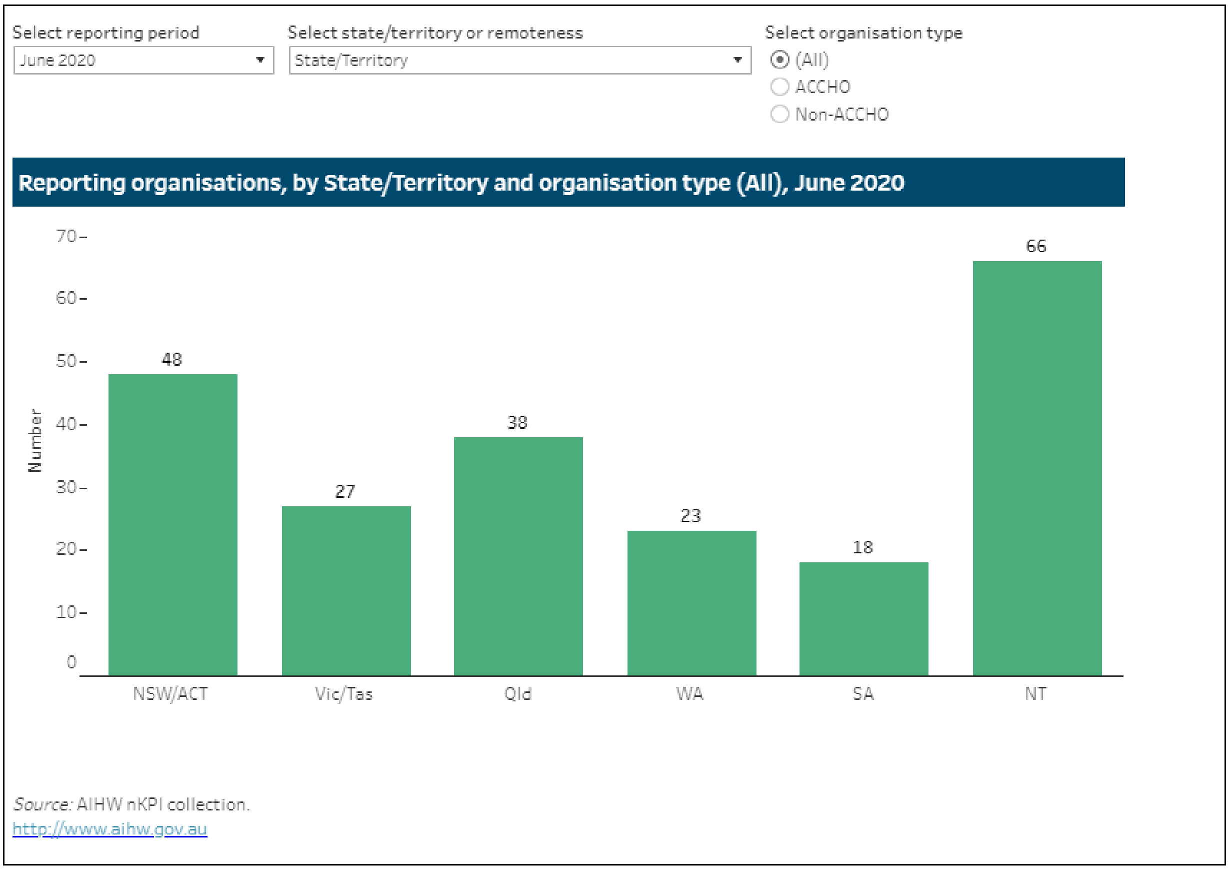
1. Key: ✓ = improved; ✗ = not improved; ▶ = no change.
2. Data in this table are rounded to 1 decimal place.
3. See Technical notes and Impact of COVID-19 for information on interpreting changes over time.

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.

Organisations and clients

At June 2020, 220 organisations reported to the national Key Performance Indicators (nKPI) collection. Of these:

- around one-third (30% or 66) were in the Northern Territory
- over one-third (35% or 78) were in *Very remote* areas
- over half (59% or 130) were Aboriginal Community Controlled Health Organisations (ACCHOs), of which:
  - 25% were in Queensland, 25% were in New South Wales/the Australian Capital Territory (combined), 18% were in Victoria/Tasmania (combined), 12% were in Western Australia, 12% were in the Northern Territory, and 8% were in South Australia
  - over one-quarter (27%) were in *Inner regional* areas, 23% were in *Outer regional* areas, 22% were in *Very remote* areas, 14% were in *Major cities*, and 14% were in *Remote* areas.
- 41% (or 90) were organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs), of which:
  - over half (57%) were in the Northern Territory, 18% were in New South Wales/the Australian Capital Territory (combined), 8% were in Western Australia, 8% were in South Australia, 7% were in Queensland, and 3% were in Victoria/Tasmania (combined)
  - over half (54%) were in *Very remote* areas, 12% were in *Major cities*, 12% were in *Outer regional* areas, 11% were in *Inner regional* areas, and 10% were in *Remote* areas.


Select reporting period: June 2020

Select state/territory or remoteness: State/Territory

Select organisation type:
● (All)
○ ACCHO
○ Non-ACCHO

Reporting organisations, by State/Territory and organisation type (All), June 2020

Source: AIHW nKPI collection.
http://www.aihw.gov.au

The number of organisations reporting each period varies—at June 2017 there were 228 organisations, increasing to 233 at June 2018, and again to 234 at June 2019 before decreasing to 220 at June 2020. The decrease at June 2020 was partly a result of a change in the nature of reporting that year. Unlike in previous years, reporting to the collection was made voluntary for 2019–20 in acknowledgement of the additional pressures on organisations because of COVID-19. See also Technical notes and Impact of COVID-19 for information on interpreting changes over time.

There were over 347,200 Indigenous regular clients at June 2020 (that is, Indigenous clients who had 3 visits in the 2 years up to 30 June 2020). This is based on estimates provided by the organisations, and may differ from the number of Indigenous regular clients reported as indicator denominators (see Data for more information).

Of these:

- 28% (or around 96,900) were seen in Queensland
- 24% (or around 85,000) were seen in *Major cities*
- 82% (or just over 283,000) were seen in Aboriginal Community Controlled Health Organisations (ACCHOs), of which:
    - 29% were seen in Queensland, 27% in New South Wales/the Australian Capital Territory (combined), 16% in Western Australia, 16% in the Northern Territory, 7% in Victoria/Tasmania (combined) and 6% in South Australia
    - 27% were seen in *Major cities*, 23% in *Outer regional* areas, 22% in *Inner regional* areas, 16% in *Remote* areas and 12% in *Very remote* areas.

- 18% (or 64,200) were seen in organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs), of which:
  - 58% were seen in the Northern Territory, 23% were seen in Queensland, 12% in New South Wales/the Australian Capital Territory (combined), 4% in Western Australia, 3% in South Australia and 1% in Victoria/Tasmania (combined)
  - 60% were seen in *Very remote* areas, 13% in *Major cities*, 13% in *Remote* areas, 9% in *Inner regional* areas and 5% in *Outer regional* areas.

Select reporting period
June 2020

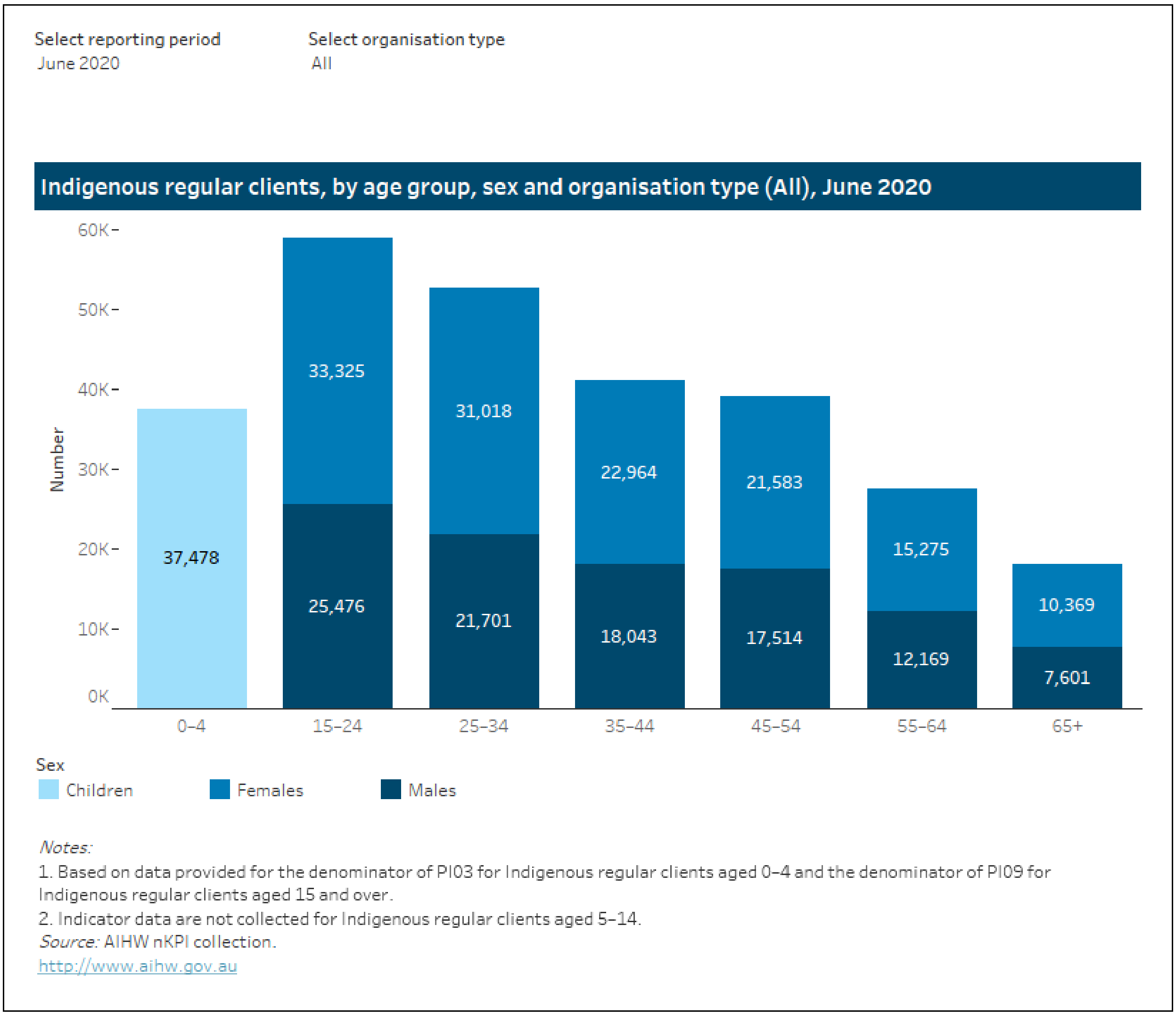
Select state/territory or remoteness
State/Territory

Select organisation type
All

Indigenous regular clients, by State/Territory and organisation type (All), June 2020

Notes:
1. Based on data provided on the number of Indigenous regular clients with age and sex recorded.
2. Includes Indigenous regular clients of all ages.

Source: AIHW nKPI collection.
http://www.aihw.gov.au



Select reporting period
June 2020

Select organisation type
All

Indigenous regular clients, by age group, sex and organisation type (All), June 2020

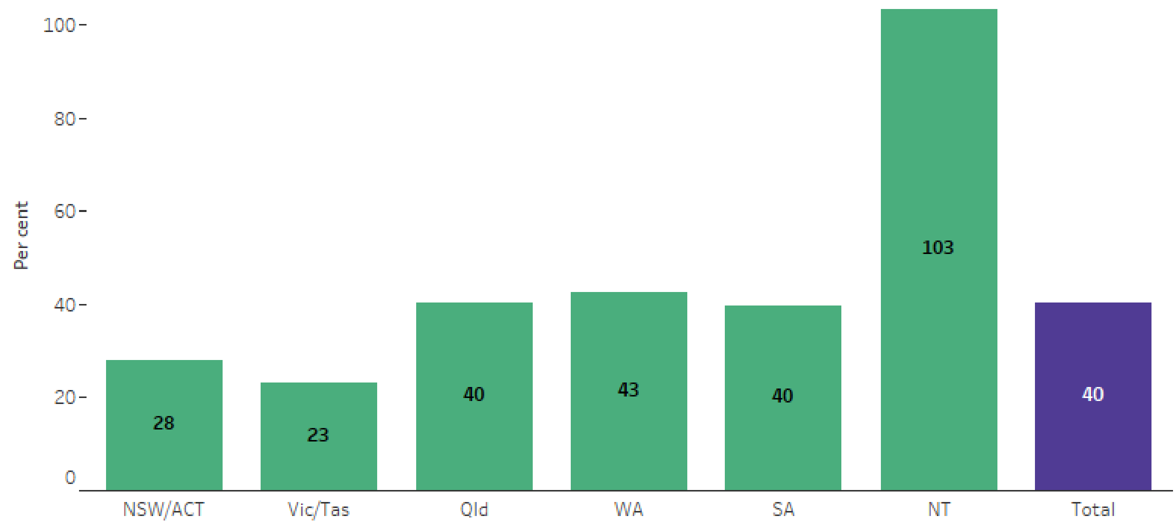
Notes:
1. Based on data provided for the denominator of PI03 for Indigenous regular clients aged 0–4 and the denominator of PI09 for Indigenous regular clients aged 15 and over.
2. Indicator data are not collected for Indigenous regular clients aged 5–14.

Source: AIHW nKPI collection.
http://www.aihw.gov.au

The number of Indigenous regular clients varies each reporting period, and decreased between June 2019 (356,900) and June 2020 (347,200). It is difficult to be definitive about the reason for this change, for example: whether it was mainly a product of the voluntary nature of reporting for June 2020 (and the associated decrease in the number of organisations reporting to the collection); or whether it was also partly due to changes in organisation or client behaviour as a result of COVID-19 (such as fewer clients attending or staff being available because of restrictions on travel). See Technical notes and Impact of COVID-19 for information on interpreting changes over time.

At June 2020, around 40% of the estimated resident Indigenous population were Indigenous regular clients of organisations reporting to the nKPI collection.

Indigenous regular clients as a proportion of the estimated resident Indigenous population, by State/Territory, June 2020

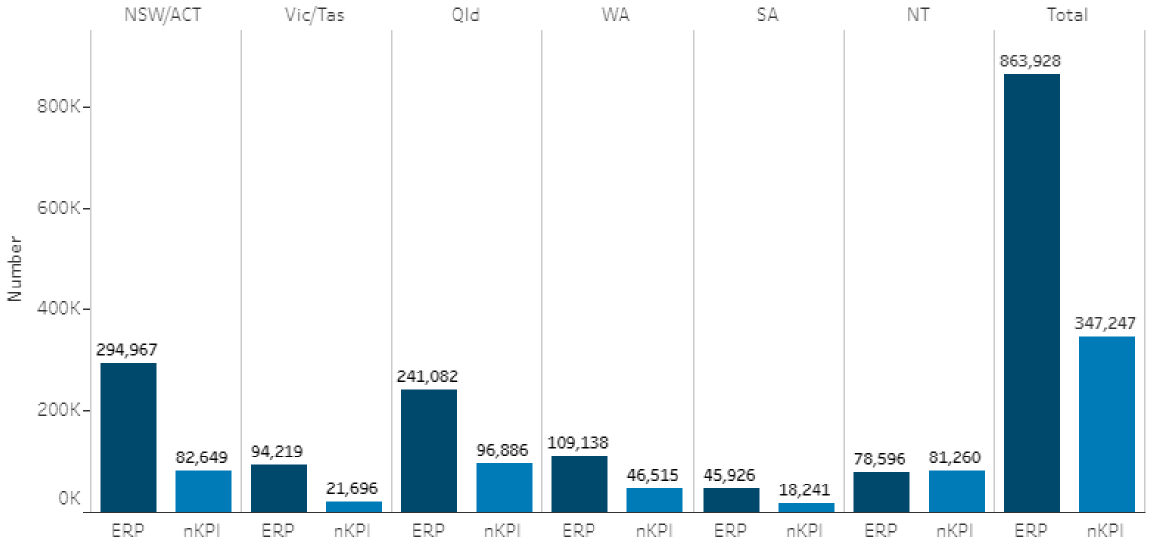


Note:
1. In some cases clients may be counted at more than 1 organisation. The number of clients may therefore be greater than the Indigenous ERP.
2. ERP is as at 30 June of the relevant reporting period.
3. Total is the sum of the states and territories and does not include external territories.

Sources: ABS 2019; AIHW nKPI collection.

http://www.aihw.gov.au

Indigenous regular clients compared to estimated resident Indigenous population, by State/Territory, June 2020



Notes:

1. In some cases clients may be counted at more than 1 organisation. The number of clients may therefore be greater than the Indigenous ERP.
2. ERP is as at 30 June of the relevant reporting period.
3. Total is the sum of the states and territories and does not include external territories.
4. nKPI data are based on data provided on the number of Indigenous regular clients with age and sex recorded.
5. Includes all ages.

Sources: ABS 2019; AIHW nKPI collection.

http://www.aihw.gov.au

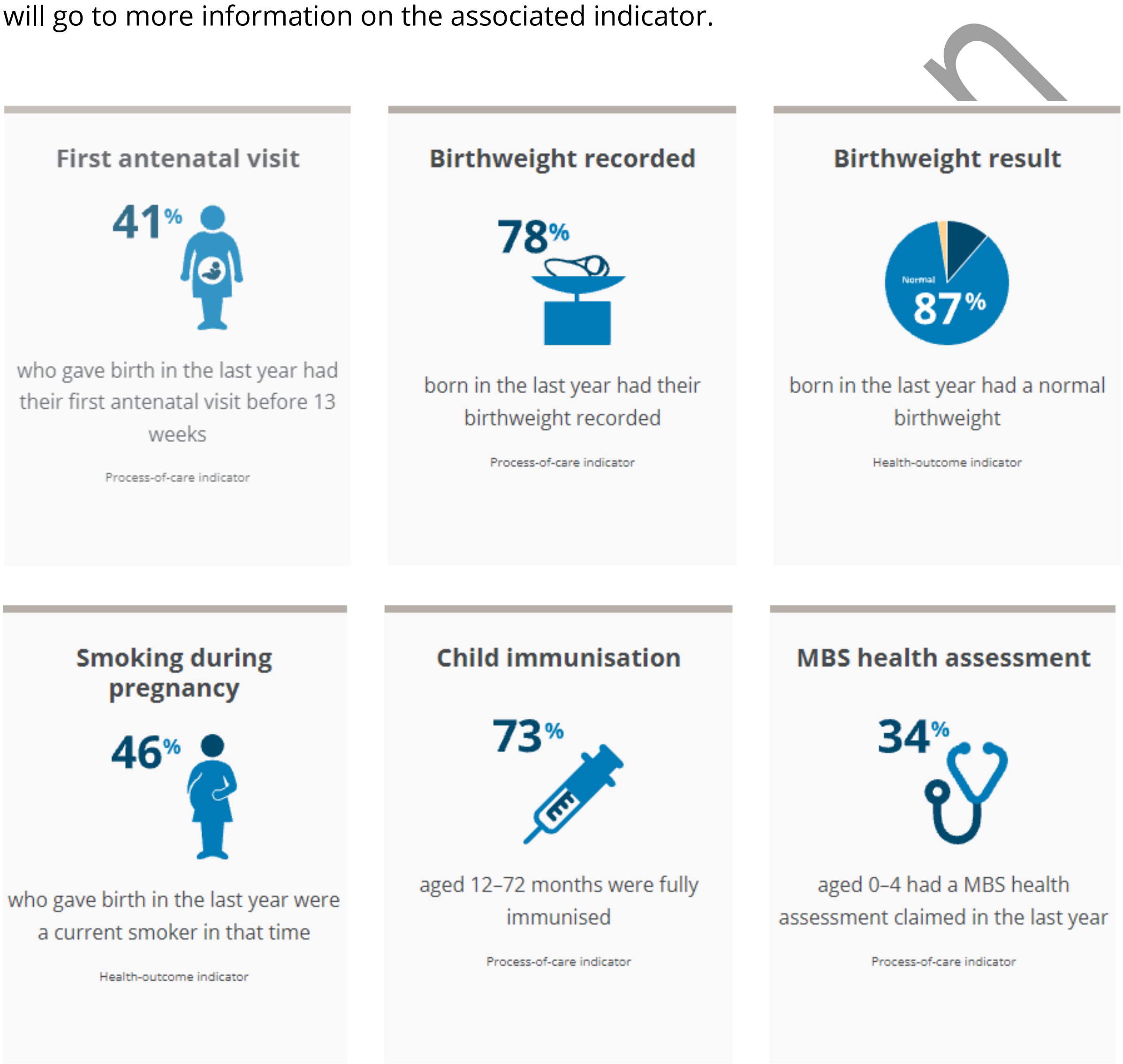
Reference

ABS (Australian Bureau of Statistics) 2019. Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2006 to 2031. ABS cat. no. 3238.0. Canberra: ABS. [Series B projections]

Maternal and child health indicators

Maternal and child health indicators in the national Key Performance Indicators (nKPI) collection consist of 4 process-of-care and 2 health-outcome indicators.

The following boxes show key results for Indigenous regular clients. Clicking on a box will go to more information on the associated indicator.



First antenatal visit

41%

who gave birth in the last year had their first antenatal visit before 13 weeks

Process-of-care indicator

Birthweight recorded

78%

born in the last year had their birthweight recorded

Process-of-care indicator

Birthweight result

87%

born in the last year had a normal birthweight

Health-outcome indicator

Smoking during pregnancy

46%

who gave birth in the last year were a current smoker in that time

Health-outcome indicator

Child immunisation

73%

aged 12–72 months were fully immunised

Process-of-care indicator

MBS health assessment

34%

aged 0–4 had a MBS health assessment claimed in the last year

Process-of-care indicator

First antenatal visit (PI13)

This indicator is the proportion of female Indigenous regular clients who gave birth within the previous 12 months who had their first antenatal care visit within the following periods:

- before 13 weeks
- 13–19 weeks
- 20 or more weeks
- not recorded or no visit.

It is collected for age groups:

- less than 20
- 20–34
- 35 and over.

Why antenatal care is important

Antenatal care is a planned visit between a pregnant woman and a midwife or doctor to assess and improve the wellbeing of the mother and baby throughout pregnancy. It does not include visits where the sole purpose is to confirm the pregnancy.

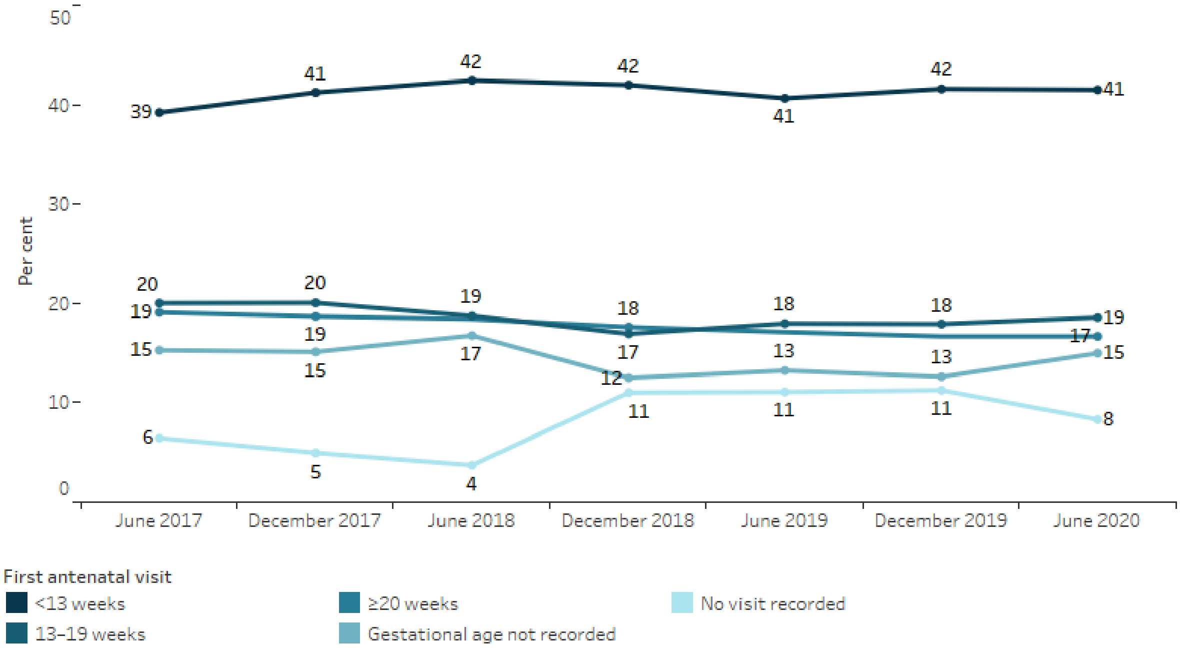
Antenatal care provides an opportunity to find, treat, and provide advice on chronic or pre-existing conditions that might cause pregnancy-related complications, such as hypertension, diabetes, mental health problems, sexually transmitted infections, tobacco and alcohol misuse, inadequate nutrition, and unhealthy weight.

Regular antenatal care, and especially that starting in the first trimester, is associated with less pregnancy-related complications and with positive maternal and child health outcomes.

Indigenous mothers are less likely than non-Indigenous mothers to have their first antenatal care visit in the first trimester (AIHW 2020). However, the proportion of Indigenous mothers attending an antenatal visit in the first trimester has increased.

At June 2020, 41% of female Indigenous regular clients who gave birth in the previous 12 months had their first antenatal visit in the first trimester (before 13 weeks gestational age). The definition of first trimester in the national Key Performance Indicators (nKPI) collection is different to that collected in the National Perinatal Data Collection (NPDC), which considers the first trimester as before 14 weeks gestational age.

Timing of first antenatal visit, by reporting period



Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

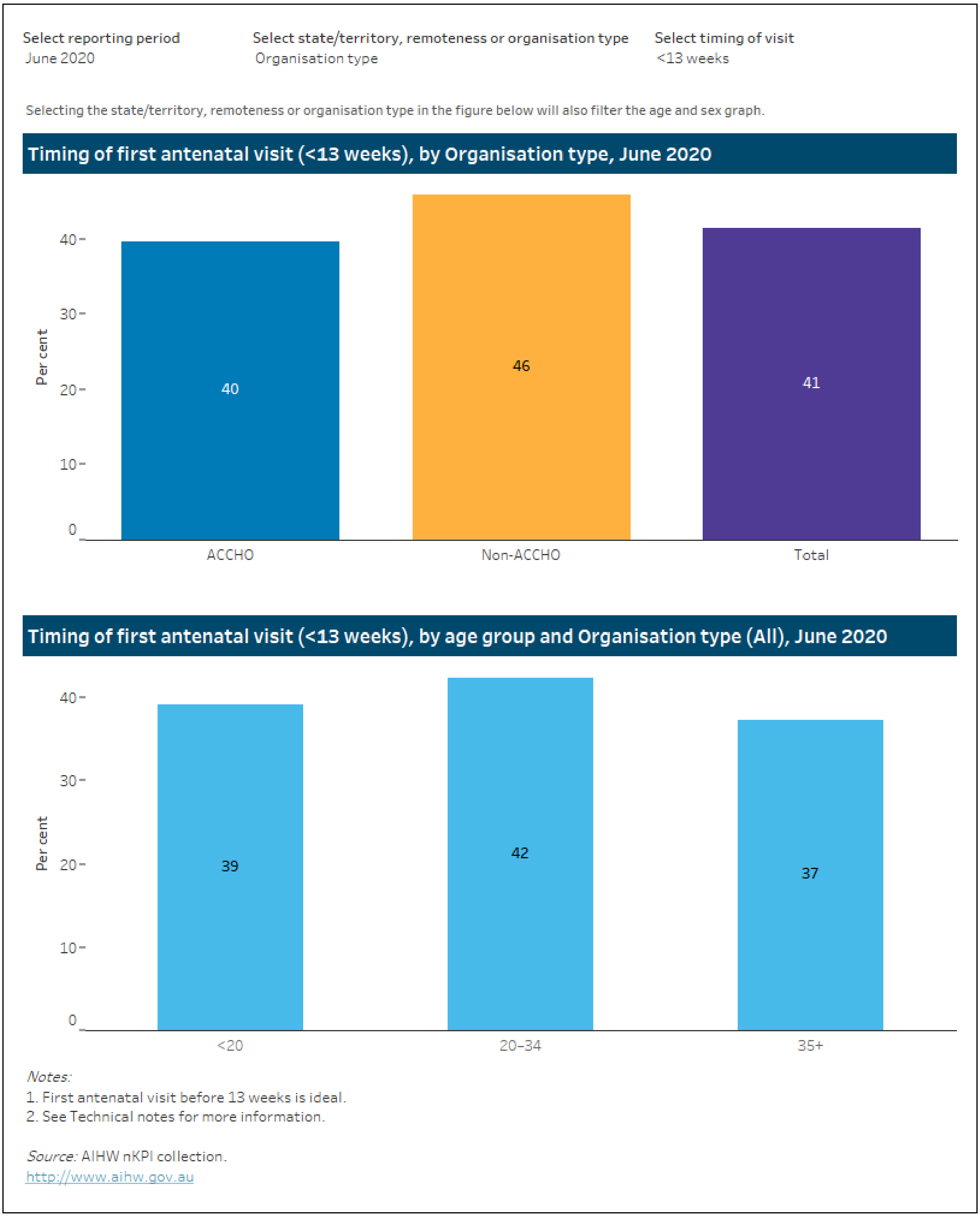
Having the first antenatal visit in the first trimester was highest in

- South Australia (51%)
- *Inner regional* areas (50%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (46%).

It was lowest in:

- Queensland (36%)
- *Major cities* (33%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (40%).

This, however, is affected by the completeness of the recording of antenatal visits in each jurisdiction (see Technical notes for more information).



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Select timing of visit
<13 weeks

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

Timing of first antenatal visit (<13 weeks), by Organisation type, June 2020

Timing of first antenatal visit (<13 weeks), by age group and Organisation type (All), June 2020

Notes:
1. First antenatal visit before 13 weeks is ideal.
2. See Technical notes for more information.

Source: AIHW nKPI collection.
http://www.aihw.gov.au

Reference

AIHW 2020. Australia's mothers and babies—data visualisations. Cat. no. PER 101. Canberra: AIHW.

Birthweight (PI01 and PI02)

Indicators related to birthweight in the national Key Performance Indicators (nKPI) collection are:

- the proportion of Indigenous babies born within the previous 12 months whose birthweight was recorded
- the proportion of Indigenous babies born within the previous 12 months whose birthweight result was low, normal or high.

Why birthweight is important

Birthweight is a key indicator of a baby's immediate health and a determinant of their future health. Low birthweight babies (less than 2,500 grams), for example, are more likely to die in infancy or to be at increased risk of illness in infancy. Measuring birthweight allows infants to be given early and suitable intervention, which can mitigate adverse outcomes.

Indigenous mothers are less likely to have a baby of normal birthweight than non-Indigenous mothers (AIHW 2020). There has been little change in this in recent years.

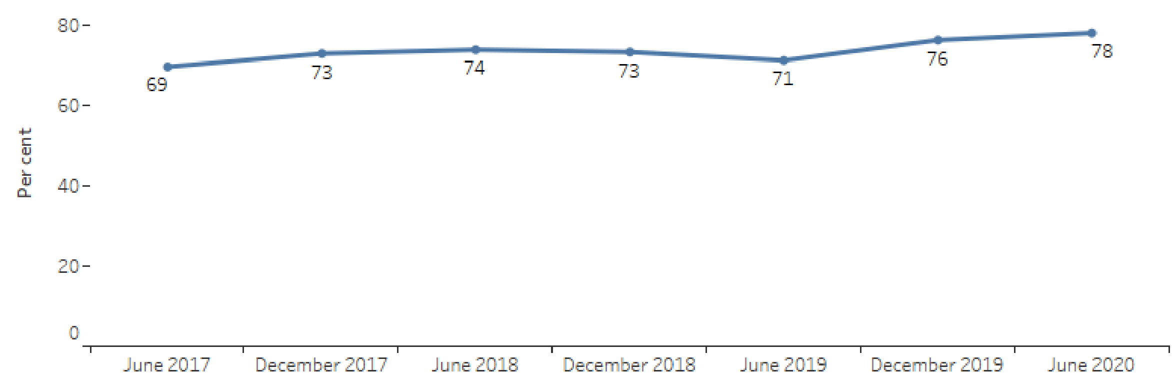
The targets in the refreshed National Agreement on Closing the Gap include several aimed at children, including a target to increase the proportion of Indigenous babies with a healthy birthweight to 91% by 2031.

Birthweight recorded (PI01)

This indicator is the proportion of Indigenous babies born within the previous 12 months whose birthweight was recorded.

At June 2020, 78% of Indigenous babies born in the previous 12 months had their birthweight recorded.

Birthweight recorded, by reporting period



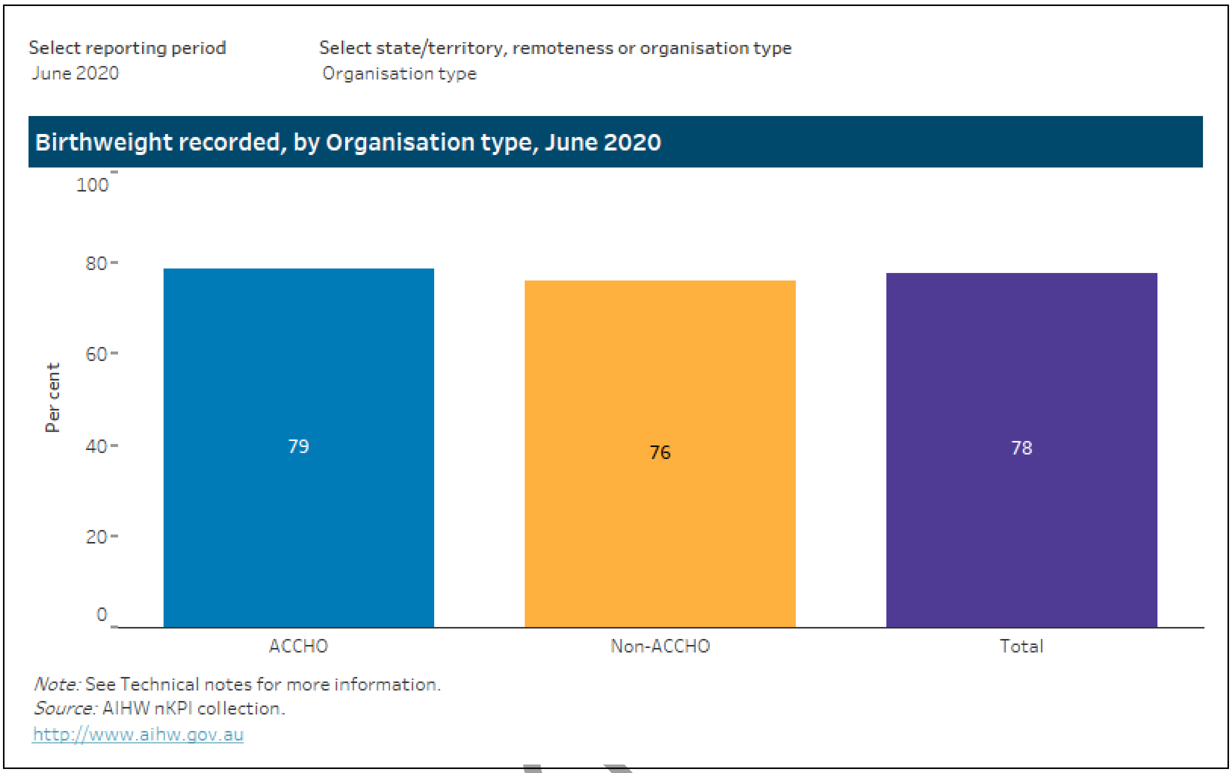
Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Recording of birthweight was highest in:

- South Australia and Victoria/Tasmania (combined) (both 90%)
- *Major cities* (88%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (79%).

It was lowest in:

- the Northern Territory (58%)
- *Very remote* areas (64%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (76%).



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

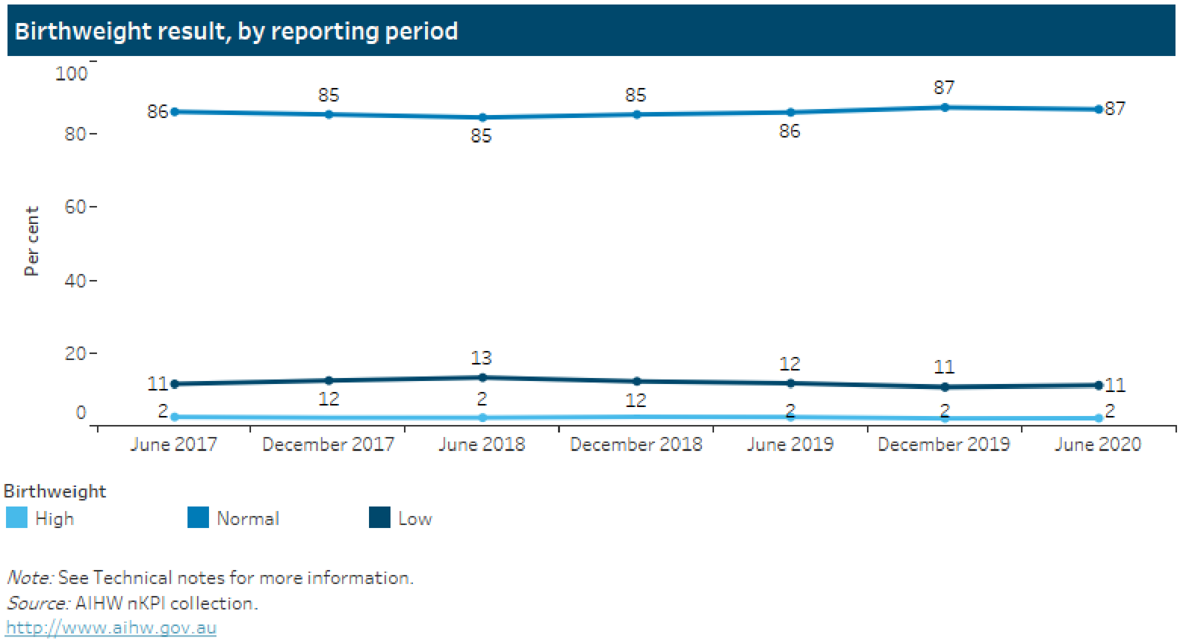
Birthweight recorded, by Organisation type, June 2020

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Birthweight result (PI02)

This indicator is the proportion of Indigenous babies born within the previous 12 months whose birthweight result was low, normal or high.

At June 2020, 87% of Indigenous babies born in the previous year had a normal birthweight.



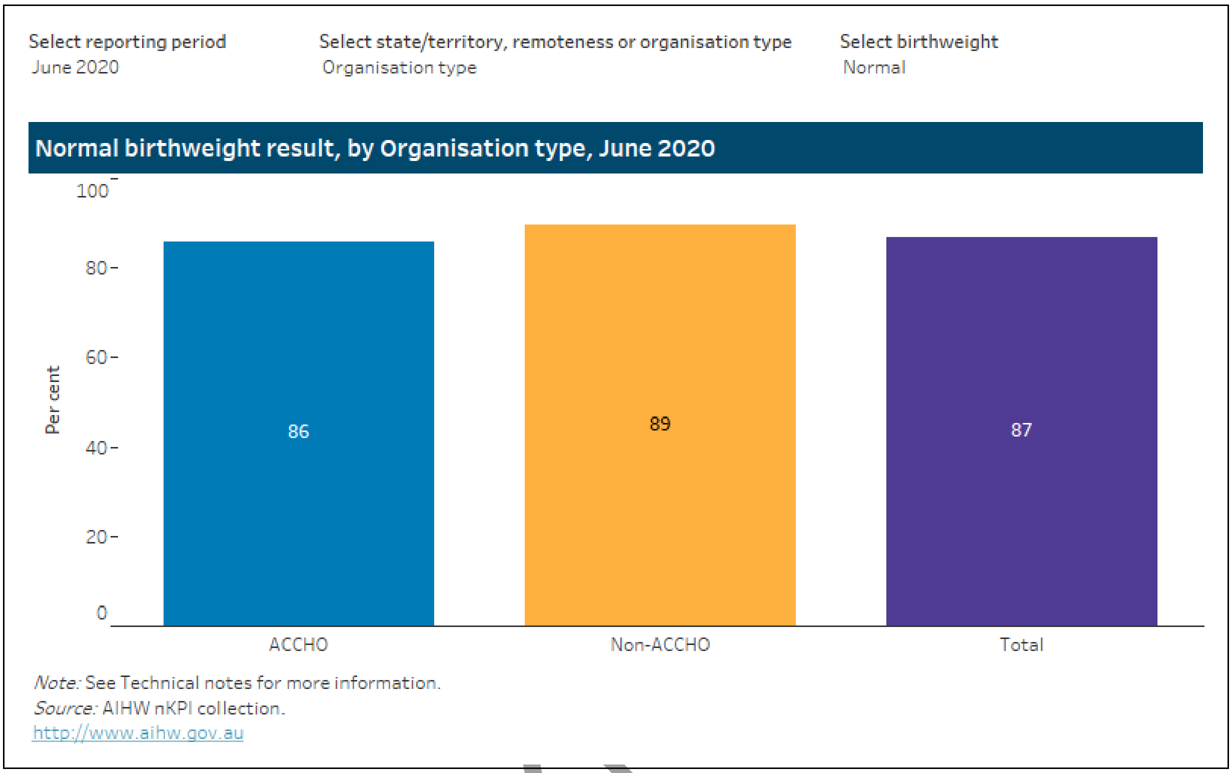
Having a normal birthweight was highest in:

- South Australia and Queensland (both 88%)
- *Major cities* (90%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (89%).

It was lowest in:

- the Northern Territory (84%)
- *Remote* areas (82%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (86%).

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Select birthweight
Normal

Normal birthweight result, by Organisation type, June 2020

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Reference

AIHW 2020. Australia's mothers and babies—data visualisations. Cat. no. PER 101. Canberra: AIHW.

Smoking during pregnancy (PI11)

This indicator is the proportion of female Indigenous regular clients aged 15 and over who gave birth within the previous 12 months and whose smoking status was recorded within the previous 12 months as:

- current smoker
- ex-smoker
- never smoked.

It is collected for age groups:

- 15–19
- 20–24
- 25–34
- 35 and over.

Why not smoking during pregnancy is important

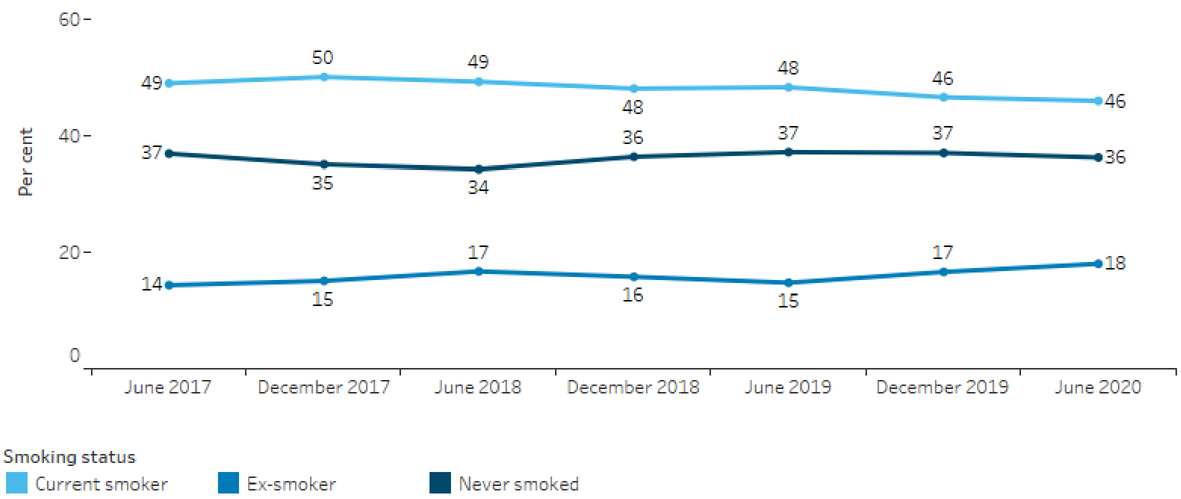
Tobacco smoking is the smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, cigars or pipes.

Tobacco smoking during pregnancy is the most common preventable risk factor for pregnancy complications, and is associated with poorer perinatal outcomes, including low birthweight, being small for gestational age, pre-term birth and perinatal death. Women who stop smoking during pregnancy can reduce the risk of adverse outcomes for themselves and their babies.

Indigenous mothers are more likely to smoke during pregnancy than non-Indigenous mothers. However, the proportion of Indigenous mothers who smoke during pregnancy has decreased (AIHW 2020).

At June 2020, 46% of Indigenous regular clients who gave birth in the previous 12 months were a current smoker in that time.

Smoking during pregnancy, by reporting period



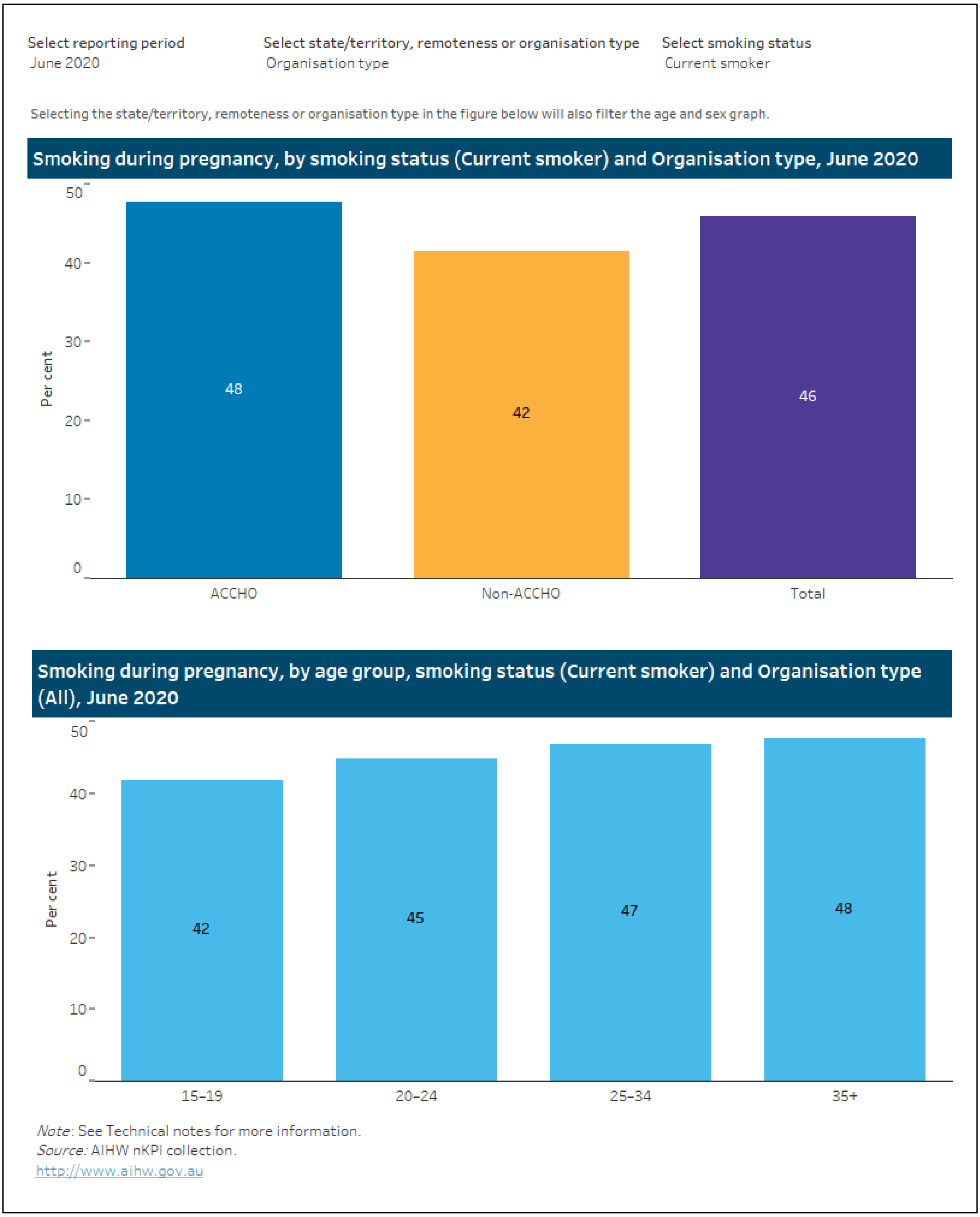
Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was lowest in:

- Victoria/Tasmania (combined) and New South Wales/the Australian Capital Territory (combined) (both 42%)
- *Major cities* (38%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (42%).

It was highest in:

- the Northern Territory (50%)
- *Very remote* areas (52%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (48%).



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Select smoking status
Current smoker

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

Smoking during pregnancy, by smoking status (Current smoker) and Organisation type, June 2020

Smoking during pregnancy, by age group, smoking status (Current smoker) and Organisation type (All), June 2020

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Reference

AIHW 2020. Australia's mothers and babies—data visualisations. Cat. no. PER 101. Canberra: AIHW.

Child immunisation (PI04)

This indicator is the proportion of Indigenous child regular clients who were ‘fully immunised’.

It is collected for age groups:

- 12–<24 months
- 24–<36 months
- 60–<72 months.

Why child immunisation is important

Vaccination initiates the body’s natural defence mechanism—the immune response—to build resistance to specific infections (immunise). It is a safe and effective way to protect against harmful communicable diseases.

Immunisation also helps to protect people who are not immunised through a process called ‘herd immunity’, where enough people are immunised against a disease to stop the infection from spreading. Herd immunity helps to protect those more at risk of getting the disease, as well as those who are unvaccinated, so that those who are too young or too sick to be vaccinated can be protected. Outbreaks can occur where there is low immunisation coverage.

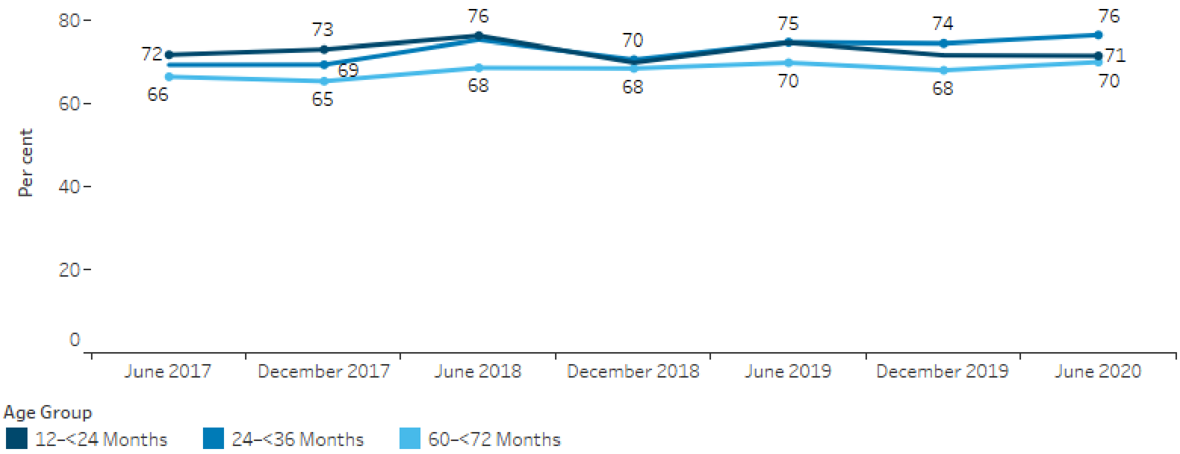
Children who do not receive complete and timely vaccinations are at risk of contracting vaccine-preventable diseases and the short and long-term health consequences associated with these. Data from the Australian Immunisation Register (AIR) show indicate that Indigenous children aged 2 have lower rates of full immunisation than non-Indigenous children (AIHW 2019a).

At June 2020, 73% of Indigenous child regular clients aged 12–<72 months were fully immunised:

- 71% aged 12–<24 months
- 76% aged 24–<36 months
- 70% aged 60–<72 months.

However, this indicator captures far fewer cases of fully immunised Indigenous children than the Australian Immunisation Register (AIR). Anecdotal evidence suggests that not all organisations rely on their internal Clinical Information Systems (CIS) to track immunisation status. Also, in some instances, organisations providing data to the national Key Performance Indicators (nKPI) collection might not be the only or the major vaccination provider, which reduces the priority that some organisations give to maintaining immunisation status information within their CIS. This indicator may therefore be an underestimate (see AIHW 2018 for more information).

Fully immunised children, by age group and reporting period



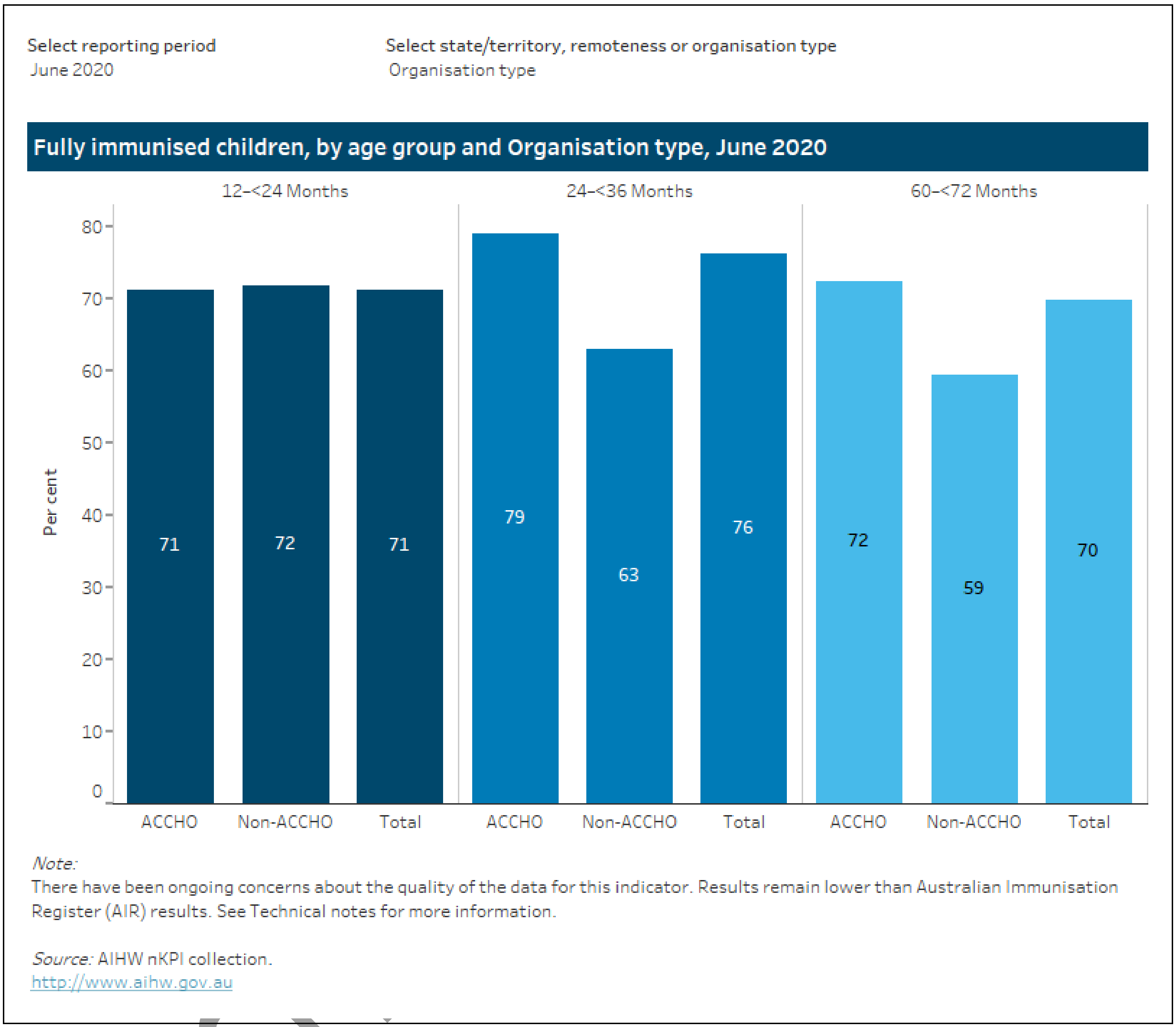
Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Full immunisation of Indigenous children aged 12–<72 months was highest in:

- South Australia (93%)
- *Inner regional* areas (84%)
- Aboriginal Community Controlled Health Organisations (non-ACCHOs) (74%).

It was lowest in:

- Queensland (59%)
- *Major cities* (60%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (65%).


Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Fully immunised children, by age group and Organisation type, June 2020

Note:
There have been ongoing concerns about the quality of the data for this indicator. Results remain lower than Australian Immunisation Register (AIR) results. See Technical notes for more information.

Source: AIHW nKPI collection.
http://www.aihw.gov.au

References

AIHW (Australian Institute of Health and Welfare) 2018. National key performance indicators for Aboriginal and Torres Strait Islander primary health care series no. 5. Cat. no. IHW 200. Canberra: AIHW.

AIHW 2019. Australia's children: immunisation. Cat. No. CWS 69. Canberra: AIHW.

MBS health assessment—aged 0–4 (PI03)

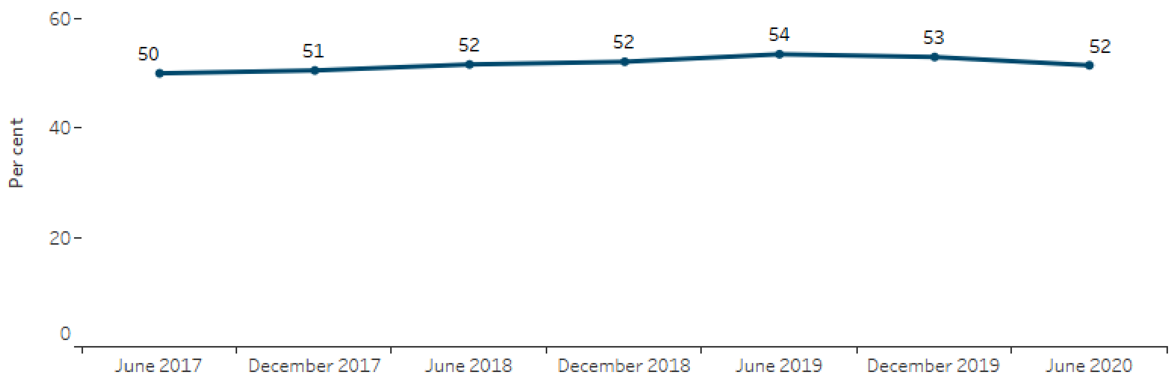
This indicator is the proportion of Indigenous regular clients aged 0–4 for whom a MBS health assessment for Aboriginal and Torres Strait Islander people (MBS item 715) was claimed within the previous 12 months.

Why health checks are important

Through Medicare (MBS item 715), Indigenous Australians can receive Indigenous-specific health checks from their doctor, as well as referrals for Indigenous-specific follow-up services. The Indigenous-specific health checks were introduced in recognition that Indigenous Australians, as a group, experience some particular health risks. The aim of the Indigenous-specific health check is to encourage early detection and treatment of common conditions that cause ill health and early death.

At June 2020, 34% of Indigenous regular clients aged 0–4 had a MBS health assessment (MBS item 715) in the previous 12 months.

MBS health assessment (item 715)—aged 25 and over, by reporting period



Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was highest in:

- Queensland (39%)
- *Major cities* (37%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (37%).

It was lowest in:

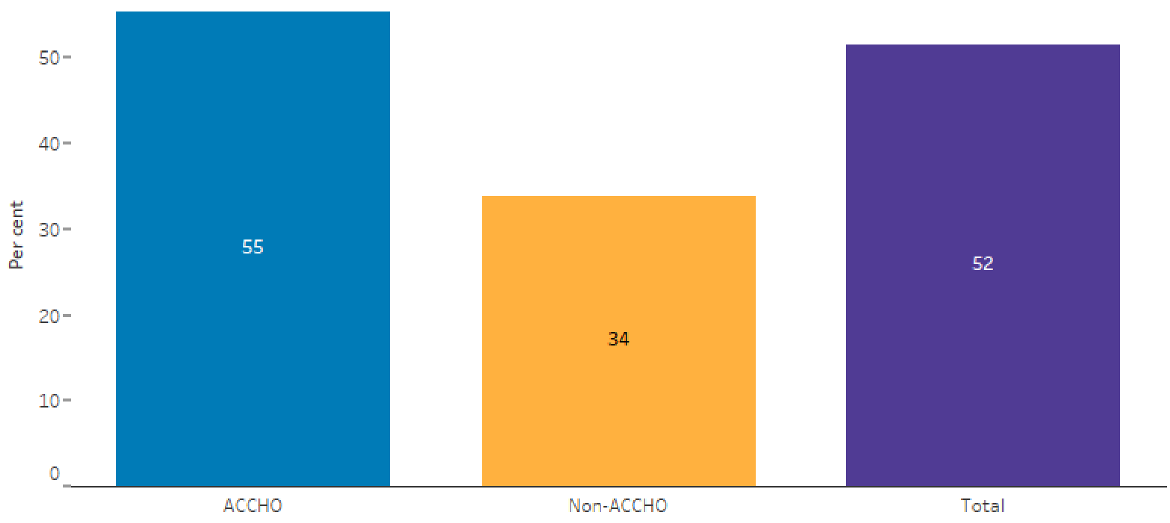
- South Australia (28%)
- *Remote* areas (31%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (21%).

Select reporting period
June 2020

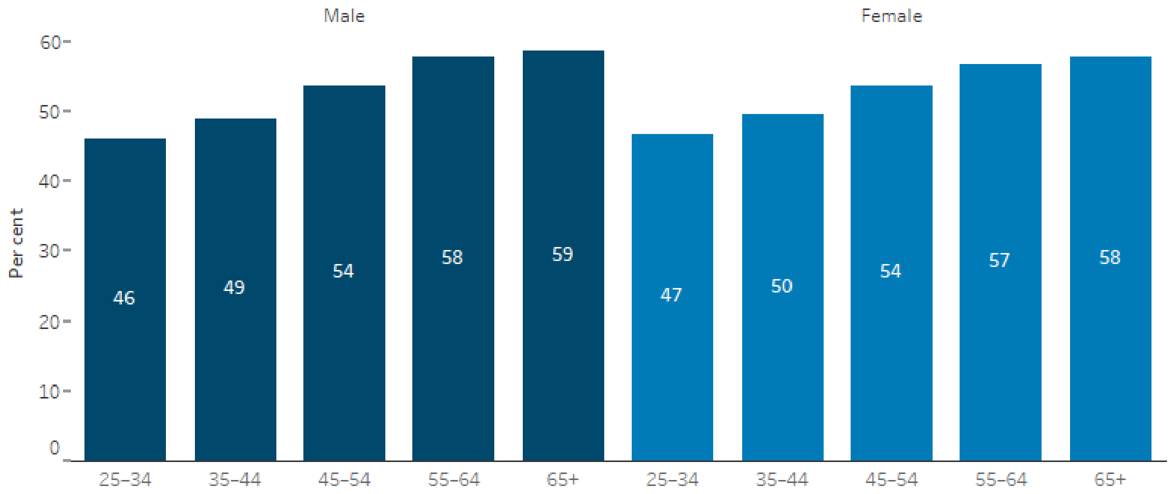
Select state/territory, remoteness or organisation type
Organisation type

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

MBS health assessment (item 715)—aged 25 and over, by Organisation type, June 2020



MBS health assessment (item 715)—aged 25 and over, by sex, age group and Organisation type (All), June 2020

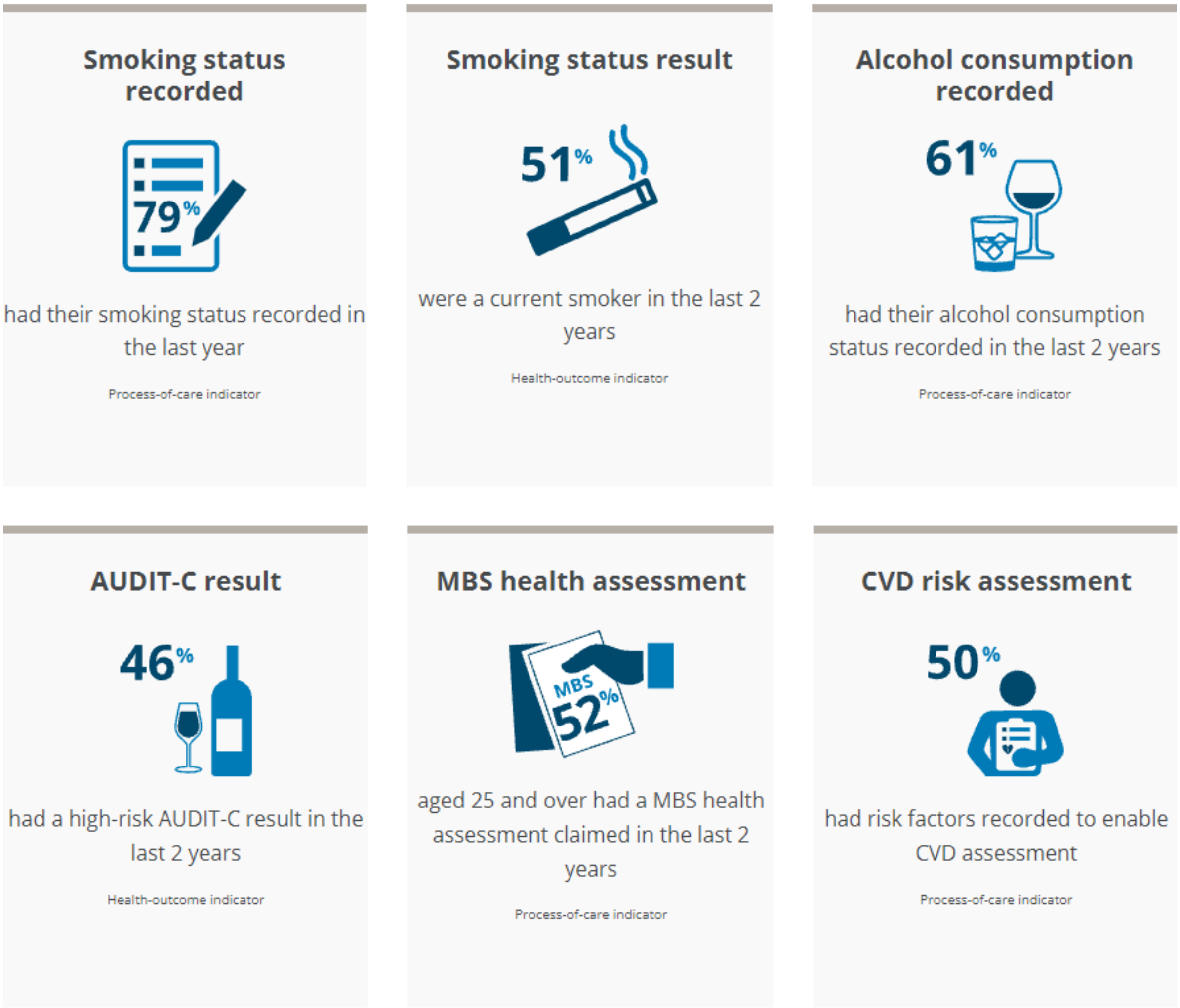


Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Preventative health indicators

Preventative health indicators in the national Key Performance Indicators (nKPI) collection consist of 6 process-of-care and 4 health-outcome indicators.

The following boxes show key results for Indigenous regular clients. Clicking on a box will go to more information on the associated indicator.



Smoking status recorded

79%

had their smoking status recorded in the last year

Process-of-care indicator

Smoking status result

51%

were a current smoker in the last 2 years

Health-outcome indicator

Alcohol consumption recorded

61%

had their alcohol consumption status recorded in the last 2 years

Process-of-care indicator

AUDIT-C result

46%

had a high-risk AUDIT-C result in the last 2 years

Health-outcome indicator

MBS health assessment

MBS 52%

aged 25 and over had a MBS health assessment claimed in the last 2 years

Process-of-care indicator

CVD risk assessment

50%

had risk factors recorded to enable CVD assessment

Process-of-care indicator

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.

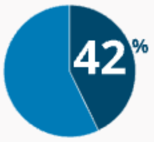
CVD risk assessment result

34%

had a high absolute cardiovascular risk in the last 2 years

Health-outcome indicator

Cervical screening



of females had a cervical screening test in the last 5 years

Process-of-care indicator

Immunised against influenza

42%

aged 50 and over were immunised against influenza

Process-of-care indicator

BMI of overweight or obese

72%

had their BMI classified as overweight or obese in the last 2 years

Health-outcome indicator

Smoking (PI09 and PI10)

Indicators related to smoking in the national Key Performance Indicators (nKPI) collection are:

- the proportion of Indigenous regular clients aged 15 and over whose smoking status was recorded within the previous 24 months
- the proportion of Indigenous regular clients aged 15 and over whose smoking status was recorded within the previous 24 months as current smoker, ex-smoker or never smoked.

An indicator related to smoking during pregnancy is also collected, with data presented under the Maternal and child health domain.

Why not smoking is important

Tobacco smoking is the smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, cigars or pipes.

It is an important cause of preventable ill health and death in Australia and is a leading risk factor for the development of many chronic health conditions and premature death. Health conditions often affected by tobacco smoking include many types of cancer, respiratory disease and heart disease.

Indigenous adults are more likely to smoke than non-Indigenous adults (AIHW 2020). However, the proportion of Indigenous adults who smoke has decreased.

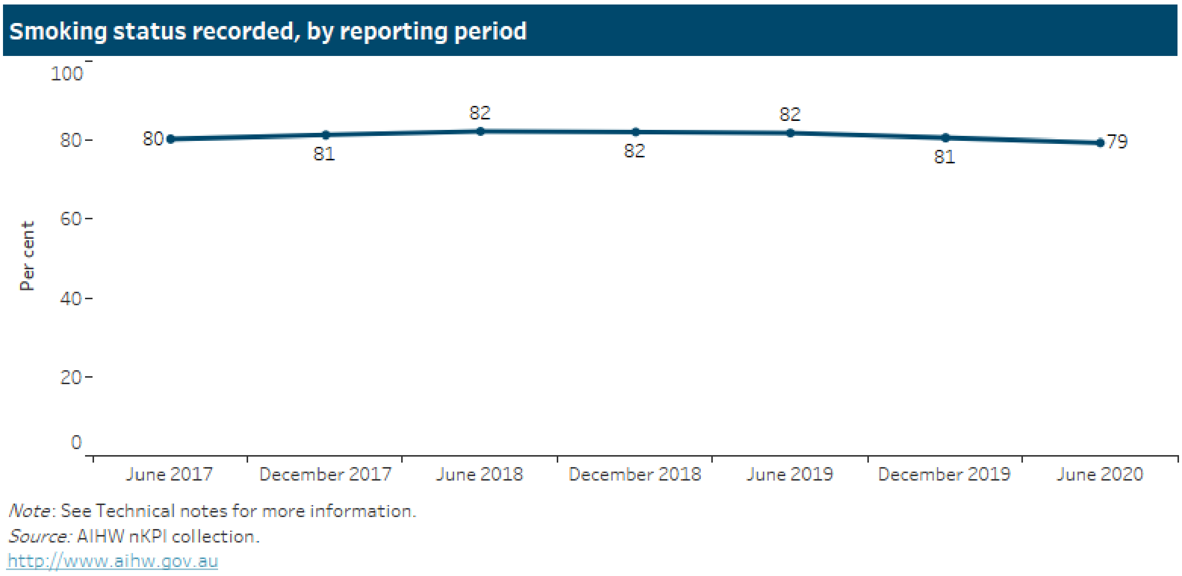
Smoking status recorded (PI09)

This indicator is the proportion of Indigenous regular clients aged 15 and over whose smoking status was recorded within the previous 24 months.

It is collected for males and females in age groups:

- 15–24
- 25–34
- 35–44
- 45–54
- 55–64
- 65 and over.

At June 2020, 79% of Indigenous regular clients aged 15 and over had their smoking status recorded within the previous 24 months.

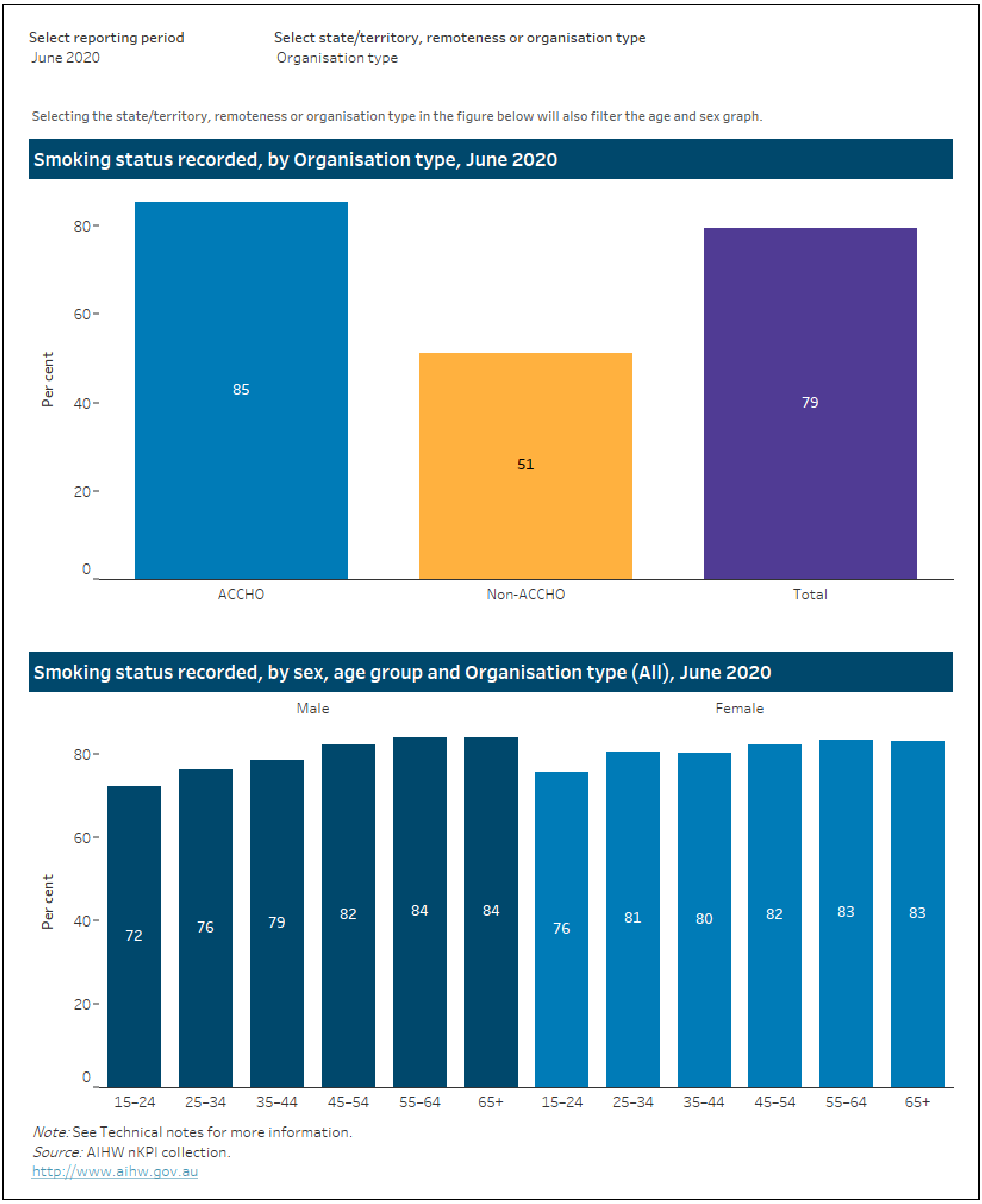


This was highest in:

- New South Wales/the Australian Capital Territory (combined) (88%)
- *Inner regional* areas (89%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (85%).

It was lowest in:

- the Northern Territory (68%)
- *Very remote* areas (63%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (51%).



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

Smoking status recorded, by Organisation type, June 2020

Smoking status recorded, by sex, age group and Organisation type (All), June 2020

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.

Smoking status result (PI10)

This indicator is the proportion of Indigenous regular clients aged 15 and over whose smoking status was recorded within the previous 24 months as:

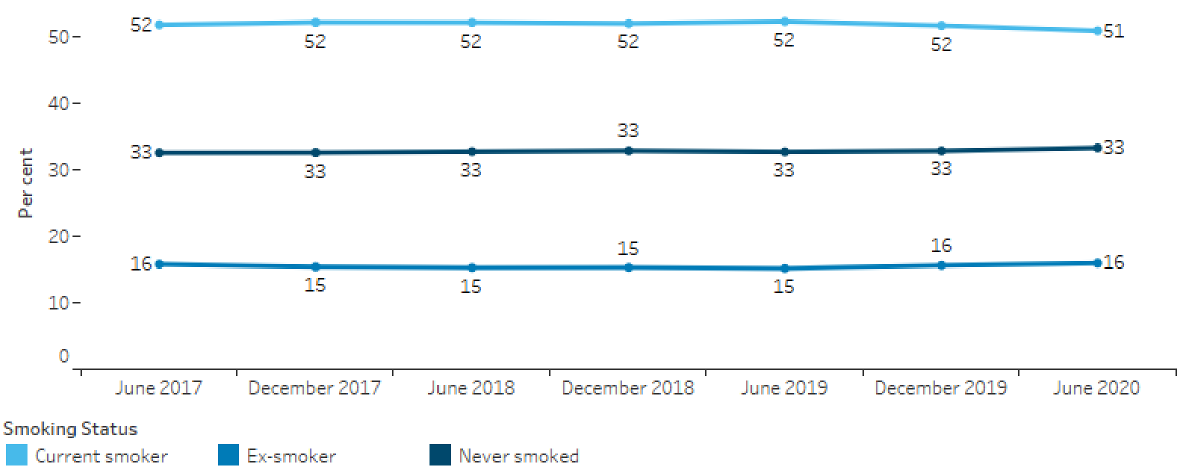
- current smoker
- ex-smoker
- never smoked.

It is collected for males and females in age groups:

- 15–24
- 25–34
- 35–44
- 45–54
- 55–64
- 65 and over.

At June 2020, 51% of Indigenous regular clients aged 15 and over were current smokers, 33% had never smoked and 16% were ex-smokers.

Smoking status result, by smoking status and reporting period



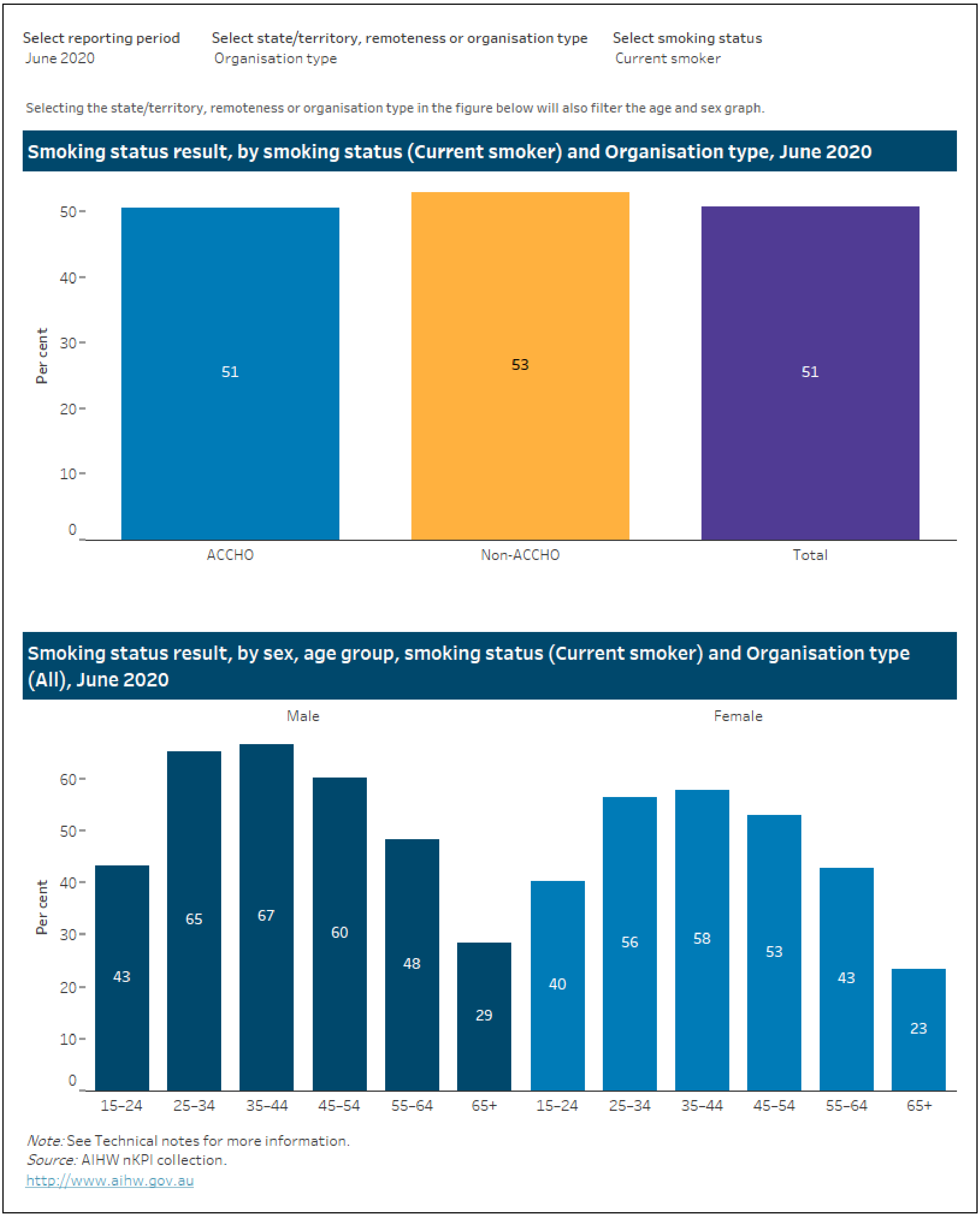
Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Being a current smoker was lowest in:

- Queensland (46%)
- *Major cities* (46%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (51%).

It was highest in:

- South Australia (58%)
- *Very remote* areas (56%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (53%).



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Select smoking status
Current smoker

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

Smoking status result, by smoking status (Current smoker) and Organisation type, June 2020

Smoking status result, by sex, age group, smoking status (Current smoker) and Organisation type (All), June 2020

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Reference

AIHW (Australian Institute of Health and Welfare) 2020. Australia's health 2020: in brief. Cat. no: AUS 232. Canberra: AIHW.

Alcohol consumption (PI16 and PI17)

Indicators related to alcohol consumption in the national Key Performance Indicators (nKPI) collection are:

- the proportion of Indigenous regular clients aged 15 and over who had their alcohol consumption status recorded within the previous 24 months
- the proportion of Indigenous regular clients aged 15 and over who had an AUDIT-C result recorded in the previous 24 months with a score of either:
  - high risk (greater than or equal to 4 in males and 3 in females)
  - low risk (less than 4 in males and 3 in females).

Why recording alcohol consumption and level is important

Alcohol consumption refers to the consumption of drinks containing ethanol, commonly referred to as alcohol. The quantity, frequency or regularity with which alcohol is drunk provides a measure of the level of alcohol consumption.

AUDIT-C is a screening tool used to help identify hazardous drinking or active alcohol use disorders. It is scored on a scale of 0–12. Generally the higher the score, the more likely it is that the person’s drinking is affecting their safety. A total score of 4 or more in males and 3 or more in females is considered to indicate an increased risk of hazardous or harmful drinking (RACGP 2015).

The harmful use of alcohol has both short-term and long-term health effects. Short-term effects are mainly related to potential injury suffered by the drinker and/or others who may be affected by the drinker’s behaviour. Over the longer term, harmful drinking may result in alcohol dependence and other chronic conditions, such as high blood pressure, cardiovascular diseases, cirrhosis of the liver, types of dementia, mental health problems and various cancers. Excessive drinking can impair judgment and coordination, and contributes to crime, violence, anti-social behaviours and accidents. Alcohol use during pregnancy is associated with severe adverse perinatal outcomes, such as foetal alcohol syndrome and alcohol-related birth defects and developmental disorders.

Indigenous adults are more likely to have consumed alcohol at risky levels than non-Indigenous Australians (single occasion and lifetime risk) (AIHW 2020a, 2020b). However, the proportion of Indigenous adults who abstain from alcohol has increased in recent years (AIHW 2020b).

Alcohol consumption recorded (PI16)

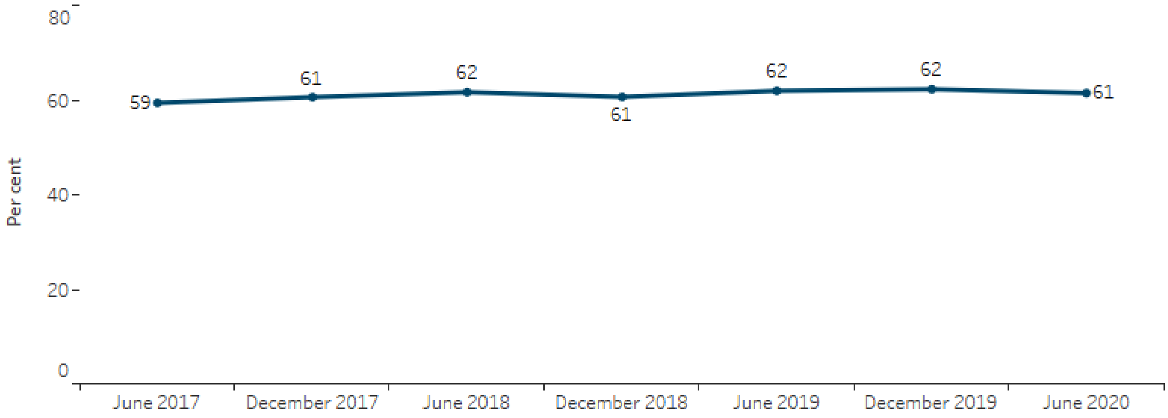
This indicator is the proportion of Indigenous regular clients aged 15 and over who had their alcohol consumption status recorded within the previous 24 months.

It is collected for males and females in age groups:

- 15–24
- 25–34
- 35–44
- 45–54
- 55–64
- 65 and over.

At June 2020, 61% of Indigenous regular clients aged 15 and over had their alcohol consumption status recorded within the previous 24 months.

Alcohol consumption status recorded, by reporting period



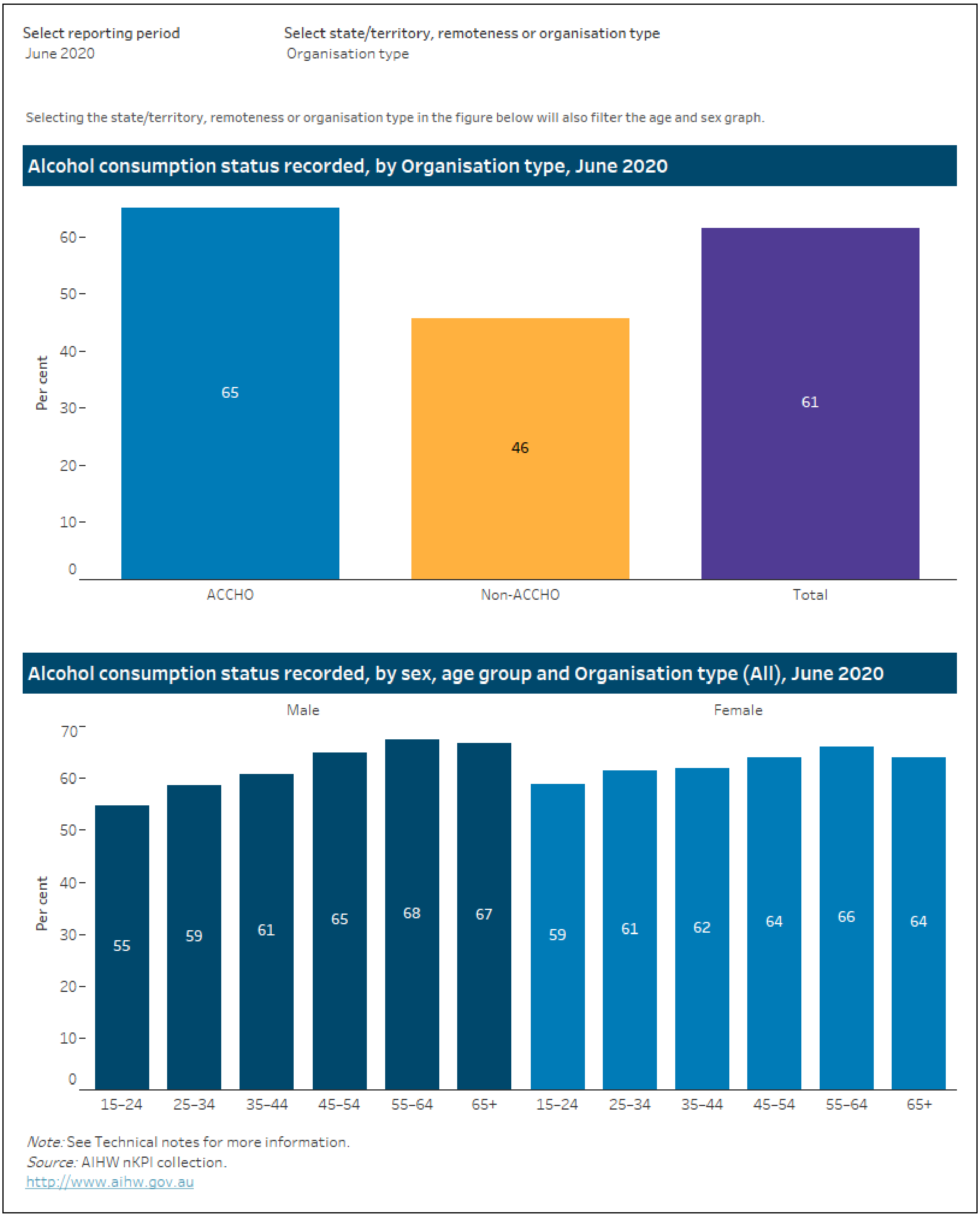
Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was highest in:

- Western Australia (70%)
- *Major cities* (69%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (65%).

It was lowest in:

- the Northern Territory (54%)
- *Very remote* areas (51%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (46%).



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

Alcohol consumption status recorded, by Organisation type, June 2020

Alcohol consumption status recorded, by sex, age group and Organisation type (All), June 2020

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

AUDIT-C result (PI17)

This indicator is the proportion of Indigenous regular clients aged 15 and over who had an AUDIT-C result recorded in the previous 24 months with a score of:

- high risk—4 or more in males and 3 or more in females
- low risk—less than 4 in males and less than 3 in females.

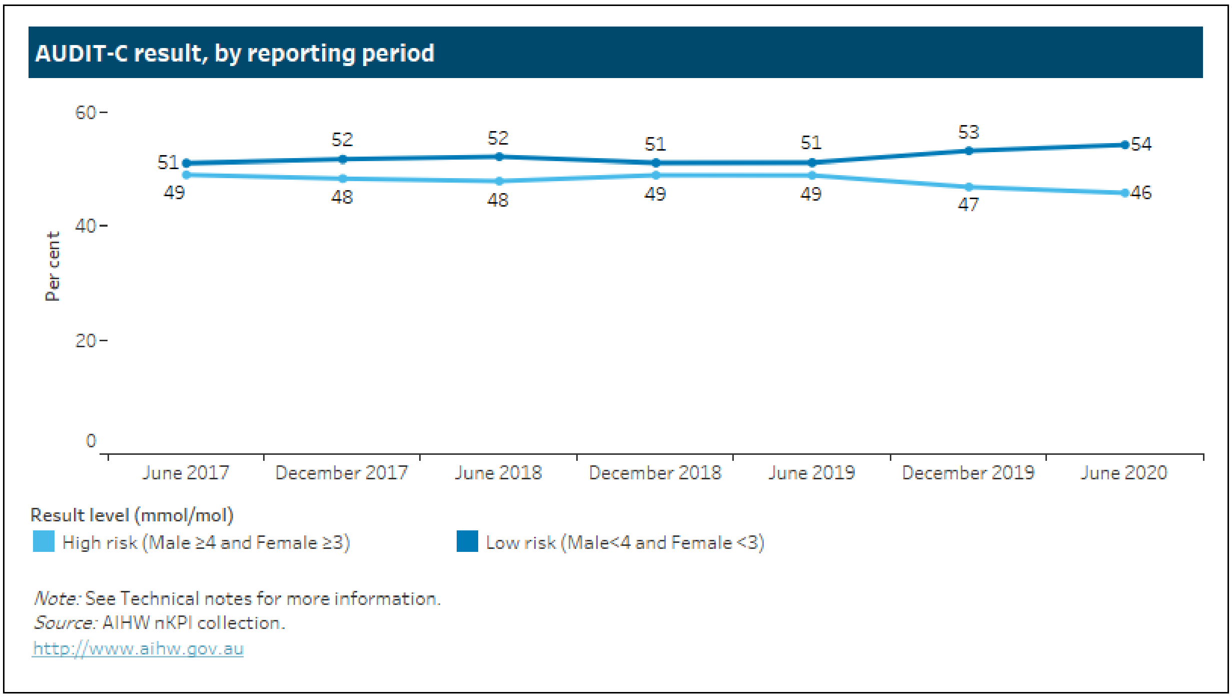
It is collected for males and females in age groups:

- 15–24
- 25–34
- 35–44
- 45–54
- 55–64
- 65 and over.

At June 2020:

- 54% of Indigenous regular clients aged 15 and over had an AUDIT-C result of low risk
- 46% had a result of high risk.

AUDIT-C result, by reporting period



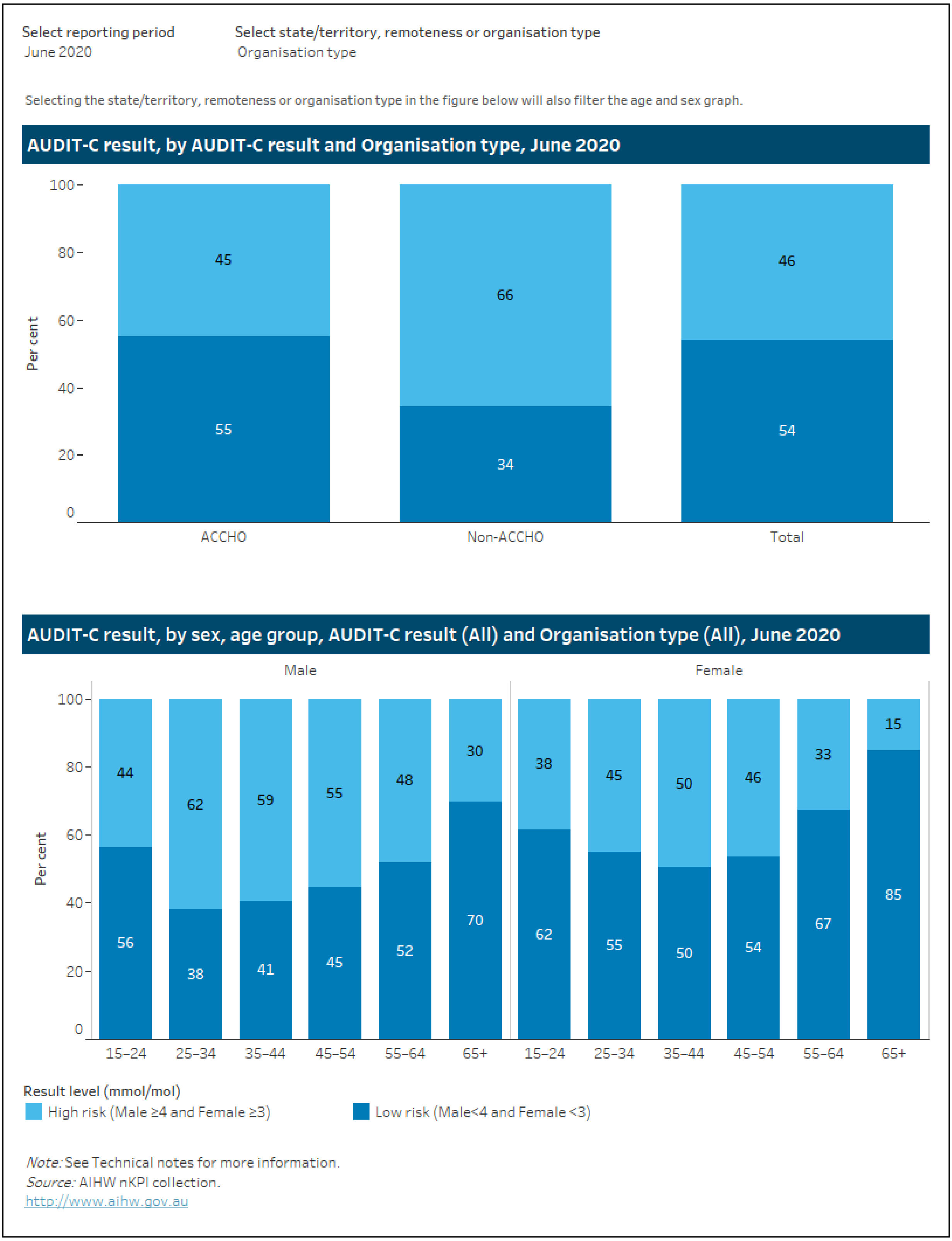
Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Having a low risk AUDIT-C result was highest in:

- Queensland (59%)
- *Major cities* (61%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (55%).

It was lowest in:

- Victoria/Tasmania (combined, 49%)
- *Very remote* areas (50%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (34%).



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

AUDIT-C result, by AUDIT-C result and Organisation type, June 2020

AUDIT-C result, by sex, age group, AUDIT-C result (All) and Organisation type (All), June 2020

Result level (mmol/mol)
▨ High risk (Male ≥4 and Female ≥3)
■ Low risk (Male<4 and Female <3)

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

References

AIHW (Australian Institute of Health and Welfare) 2020a. Australia's health 2020: snapshots—health risk factors among Indigenous Australians. Cat. no: AUS 232. Canberra: AIHW.

AIHW 2020b. Alcohol, tobacco and other drugs in Australia. Cat. no: PHE 221. Canberra: AIHW.

AIHW (Australian Institute of Health and Welfare) 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Australian Burden of Disease Study series no. 6. Cat. no. BOD 7. Canberra: AIHW.

The Royal Australian College of General Practitioners (RACGP) 2015. Smoking, nutrition, alcohol, physical activity (SNAP): a population health guide to behavioural risk factors in general practice, 2nd edition. Melbourne: RACGP.

MBS health assessment (item 715)—aged 25 and over (PI03)

This indicator is the proportion of Indigenous regular clients aged 25 and over for whom a MBS health assessment for Aboriginal and Torres Strait Islander people (MBS item 715) was claimed within the previous 24 months.

It is collected for males and females in age groups:

- 25–34
- 35–44
- 45–54
- 55–64
- 65 and over.

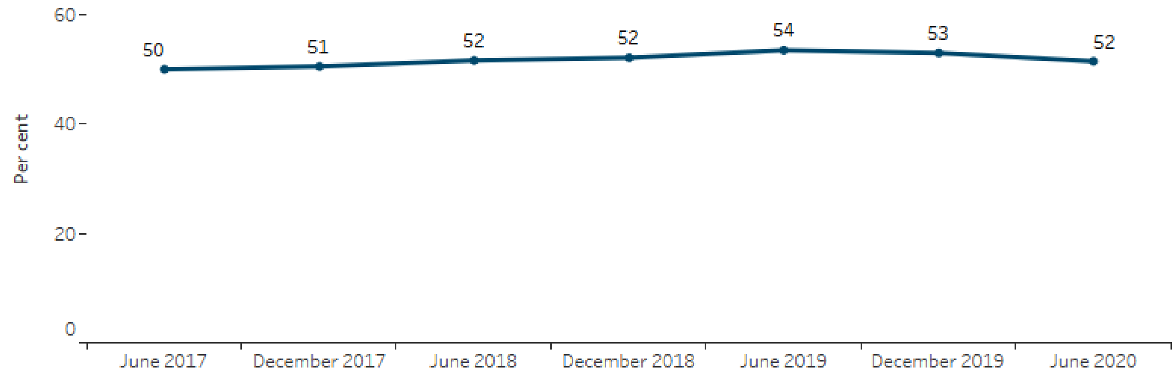
Why health checks are important

Through Medicare (MBS item 715), Indigenous Australians can receive Indigenous-specific health checks from their doctor, as well as referrals for Indigenous-specific follow-up services.

The aim of the Indigenous-specific health check is to encourage early detection and treatment of common conditions that cause ill health and early death—for example, diabetes and heart disease.

At June 2020, 52% of Indigenous regular clients aged 25 and over had a MBS health assessment for Aboriginal and Torres Strait Islander people (MBS item 715) claimed within the previous 24 months.

MBS health assessment (item 715)—aged 25 and over, by reporting period



Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was highest in:

- Queensland (60%)
- *Major cities* and *Outer regional* (58%)

- Aboriginal Community Controlled Health Organisations (ACCHOs) (55%).

It was lowest in:

- South Australia (42%)
- *Very remote* areas (44%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (34%).

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

MBS health assessment (item 715)—aged 25 and over, by Organisation type, June 2020

MBS health assessment (item 715)—aged 25 and over, by sex, age group and Organisation type (All), June 2020

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.

Cardiovascular disease (CVD) risk assessment (PI20 and PI21)

Indicators related to CVD risk assessment in the national Key Performance Indicators (nKPI) collection are:

- the proportion of Indigenous regular clients aged 35–74 with no known history of CVD who had information available to calculate their absolute CVD risk in the previous 24 months
- the proportion of Indigenous regular clients aged 35–74 with no known history of CVD who had an absolute CVD risk recorded as high, moderate or low in the previous 24 months.

Why CVD risk assessment is important

Cardiovascular disease (CVD) is a major cause of disease and death in Australia. CVD includes a range of conditions that affect the heart and blood vessels. The most common and serious types of CVD include coronary heart disease, stroke and heart failure.

CVD is preventable in many cases, as a number of its risk factors are modifiable, such as overweight and obesity, tobacco smoking, high blood pressure, high blood cholesterol, insufficient physical activity, poor nutrition and diabetes.

Absolute CVD risk assessment combines risk factors to calculate the probability that an individual will develop a cardiovascular event or other vascular disease within a specified time frame (usually 5 years) (RACGP 2018).

Indigenous Australians generally have CVD hospitalisation and death rates that are far higher than non-Indigenous Australians (AIHW 2020).

Cardiovascular disease (CVD) risk assessment (PI20)

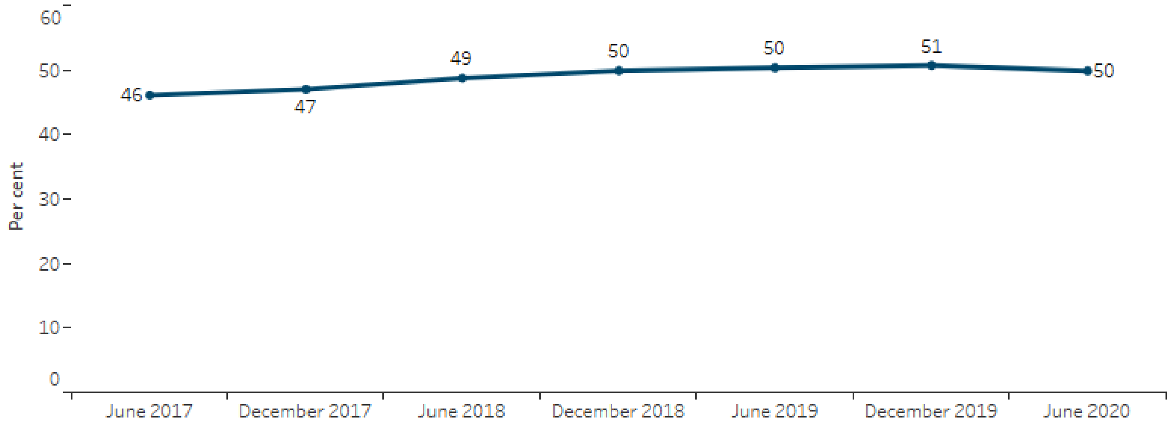
This indicator is the proportion of Indigenous regular clients aged 35–74 with no known history of CVD who had information available to calculate their absolute CVD risk in the previous 24 months.

It is collected for males and females in age groups:

- 35–44
- 45–54
- 55–64
- 65–74.

At June 2020, 50% of Indigenous regular clients aged 35–74 with no known history of CVD had information available to calculate their absolute CVD risk in the previous 24 months.

CVD risk assessment, by reporting period



Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was highest in:

- Western Australia and the Northern Territory (both 56%)
- *Remote* areas (61%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (52%).

It was lowest in:

- Victoria/Tasmania (combined, 40%)
- *Inner regional* areas (44%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (40%).

Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

CVD risk assessment, by Organisation type, June 2020

CVD risk assessment, by sex, age group and Organisation type (All), June 2020

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.

Cardiovascular disease risk assessment result (PI21)

This indicator is the proportion of Indigenous regular clients aged 35–74 with no known history of CVD who had an absolute CVD risk recorded in the previous 24 months as:

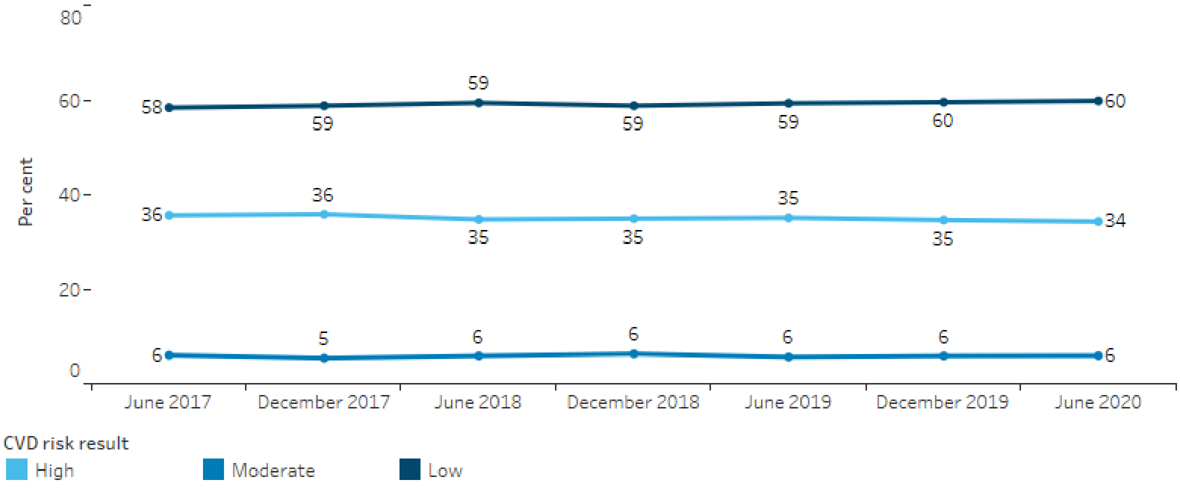
- high—greater than 15% chance of a cardiovascular event in the next 5 years
- medium—10–15% chance of a cardiovascular event in the next 5 years
- low—less than 10% chance of a cardiovascular event in the next 5 years.

It is collected for males and females in age groups:

- 35–44
- 45–54
- 55–64
- 65–74.

At June 2020, 60% of Indigenous regular clients aged 35–74 with no known history of CVD who had an absolute CVD risk recorded in the previous 24 months had a low absolute CVD risk, 6% moderate, and 34% high.

CVD risk assessment result, by reporting period



Note: See Technical notes for more infomation.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

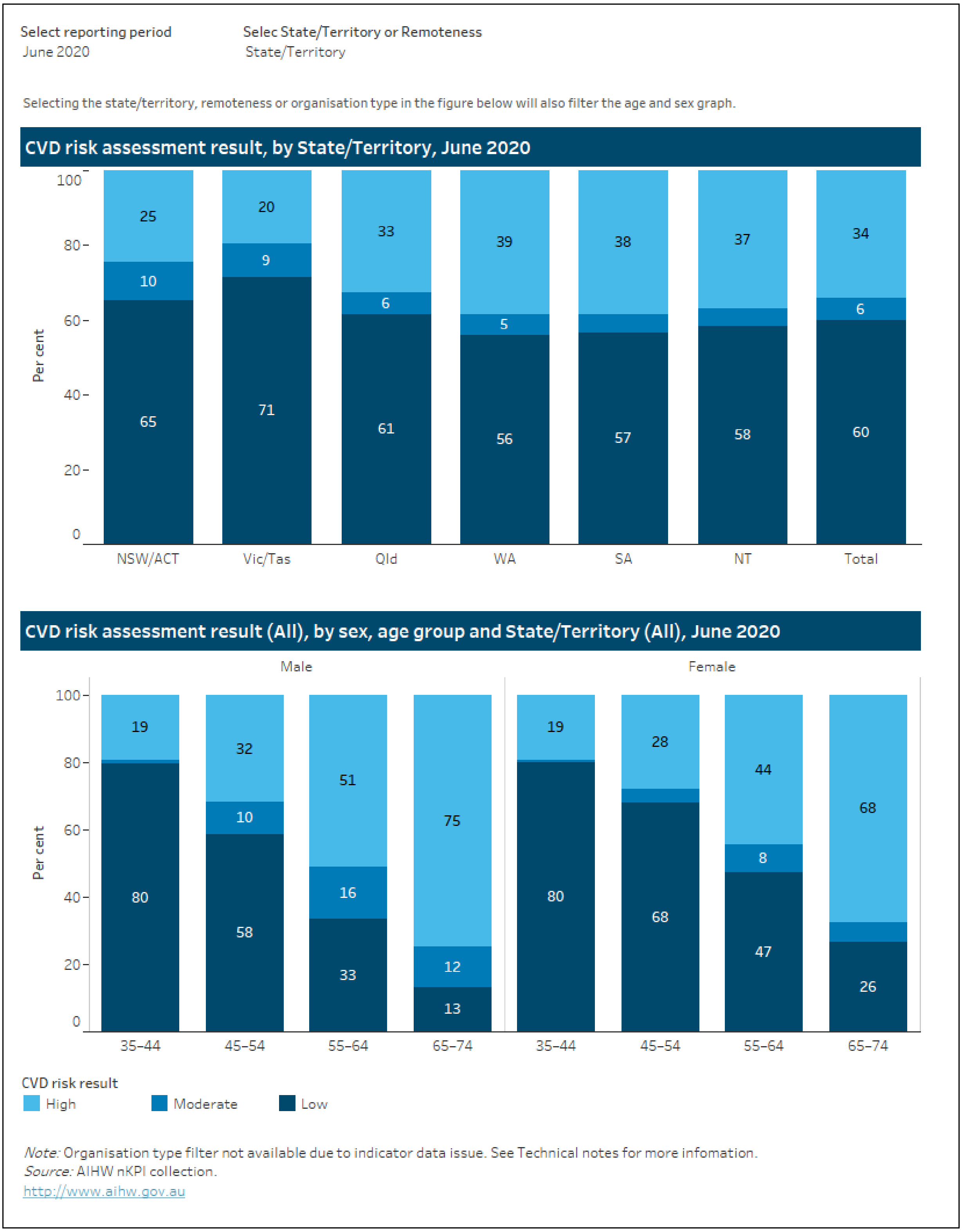
Having a low absolute CVD risk was highest in:

- Victoria/Tasmania (combined, 71%)
- *Inner regional* areas (67%).

It was lowest in:

- Western Australia (56%)
- *Very remote* areas (54%).

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.



Select reporting period
June 2020

Selec State/Territory or Remoteness
State/Territory

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

Note: Organisation type filter not available due to indicator data issue. See Technical notes for more infomation.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

References

AIHW (Australian Institute of Health and Welfare) 2020. Cardiovascular disease. Cat. no. CVD83. Canberra: AIHW.

RACGP (The Royal Australian College of General Practitioners) 2018. Guidelines for preventive activities in general practice. 9th edition, updated. East Melbourne, Vic: RACGP.

Cervical screening (PI22)

From the June 2018 collection, this indicator is the proportion of female Indigenous regular clients aged 20–74 who have not had a hysterectomy and who had cervical screening within the previous 2, 3 and 5 years.

It is collected for females in age groups:

- 20–24
- 25–34
- 35–44
- 45–54
- 55–64
- 65–69
- 70–74.

Prior to June 2018, this indicator was collected for those aged 20–69 and a different definition of 'cervical screening' applied. See *Why cervical screening is important* and Technical notes for more information.

Why cervical screening is important

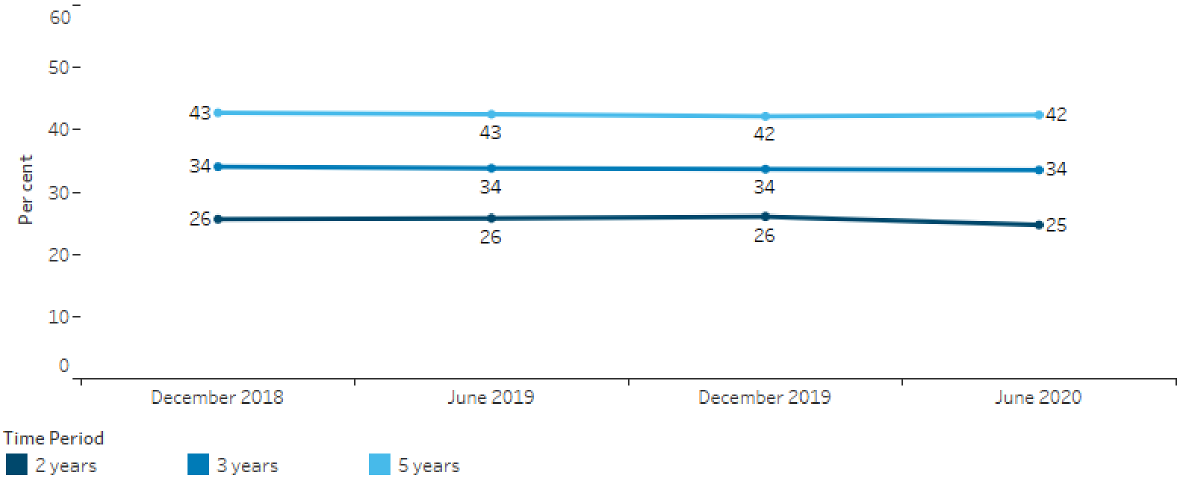
Cervical screening aims to detect and treat precancerous abnormalities that might otherwise progress to cervical cancer. Indigenous women generally experience a high burden from cervical cancer compared with non-Indigenous women (AIHW 2019).

The National Cervical Screening Program (NCSP), which aims to reduce mortality from cervical cancer, was originally targeted at women aged 20–69 for a 2-yearly Papanicolaou (Pap) smear, or 'Pap test', to detect precancerous abnormalities of the cervix. From 1 December 2017, the NCSP changed to 5-yearly cervical screening for women aged 25–74 using a primary human papilloma virus (HPV) test with partial HPV genotyping and reflex liquid-based cytology triage.

While the HPV vaccine is very effective at protecting against the 2 most common cervical cancer-causing types of HPV, it doesn't protect against all types of HPV that can lead to cervical cancer. This means that both HPV-vaccinated and unvaccinated women are recommended to have regular Cervical Screening Tests (the Pap test replacement) to reduce their risk of developing cervical cancer.

At June 2020, 42% of female Indigenous regular clients aged 20–74 who have not had a hysterectomy had cervical screening within the previous 5 years.

Cervical screening, by time period and reporting period



Note:
Due to a change in indicator specifications, only data from December 2018 onwards are shown. See Technical notes for more information.

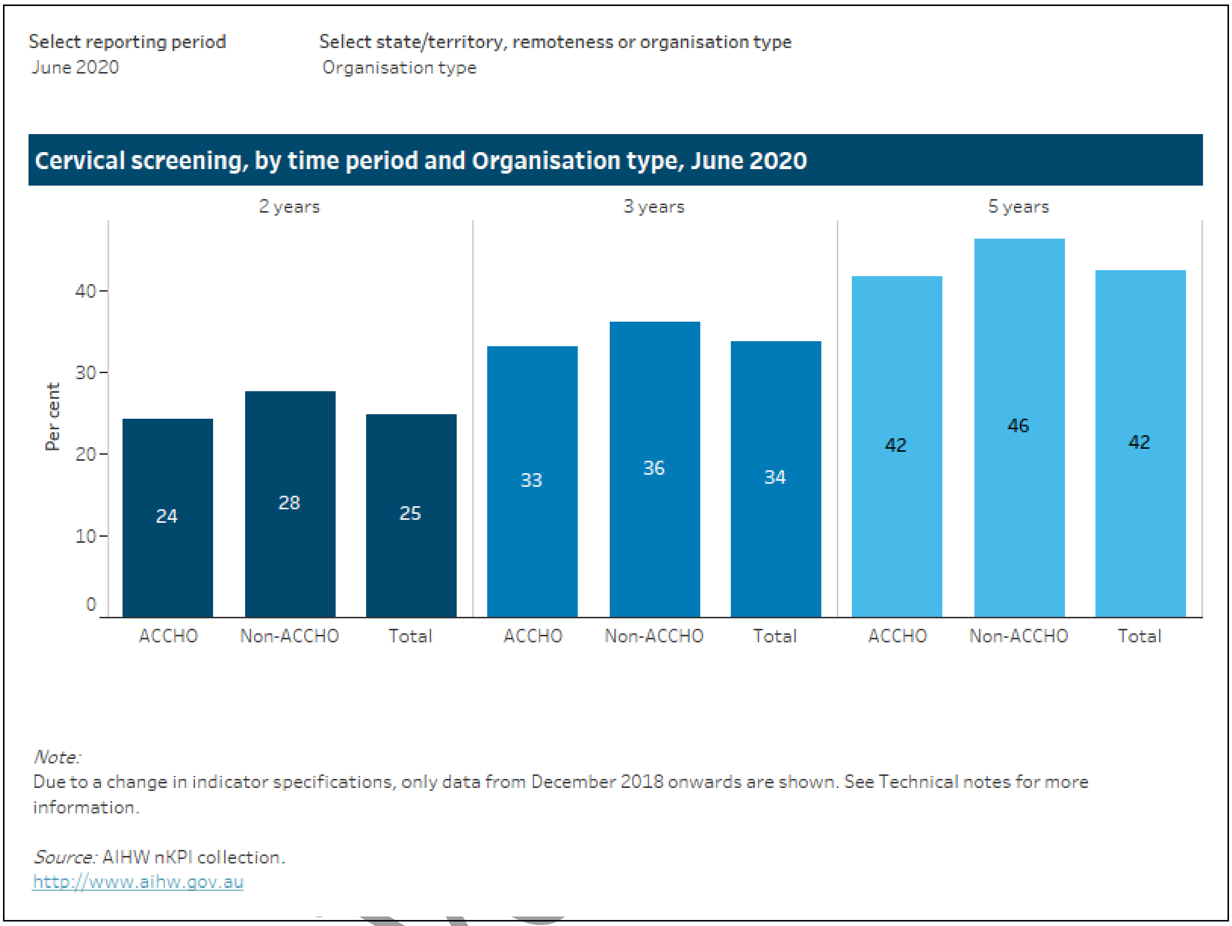
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was highest in:

- the Northern Territory (54%)
- *Very remote* areas (51%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (46%).

It was lowest in:

- New South Wales/the Australian Capital Territory (combined, 35%)
- *Inner regional* areas (37%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (42%).



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Cervical screening, by time period and Organisation type, June 2020

Note:
Due to a change in indicator specifications, only data from December 2018 onwards are shown. See Technical notes for more information.

Source: AIHW nKPI collection.
http://www.aihw.gov.au

Reference

Australian Institute of Health and Welfare 2019. Cervical screening in Australia 2019. Cancer series no. 123. Cat. no. CAN 124. Canberra: AIHW.

Immunised against influenza—aged 50 and over (PI14)

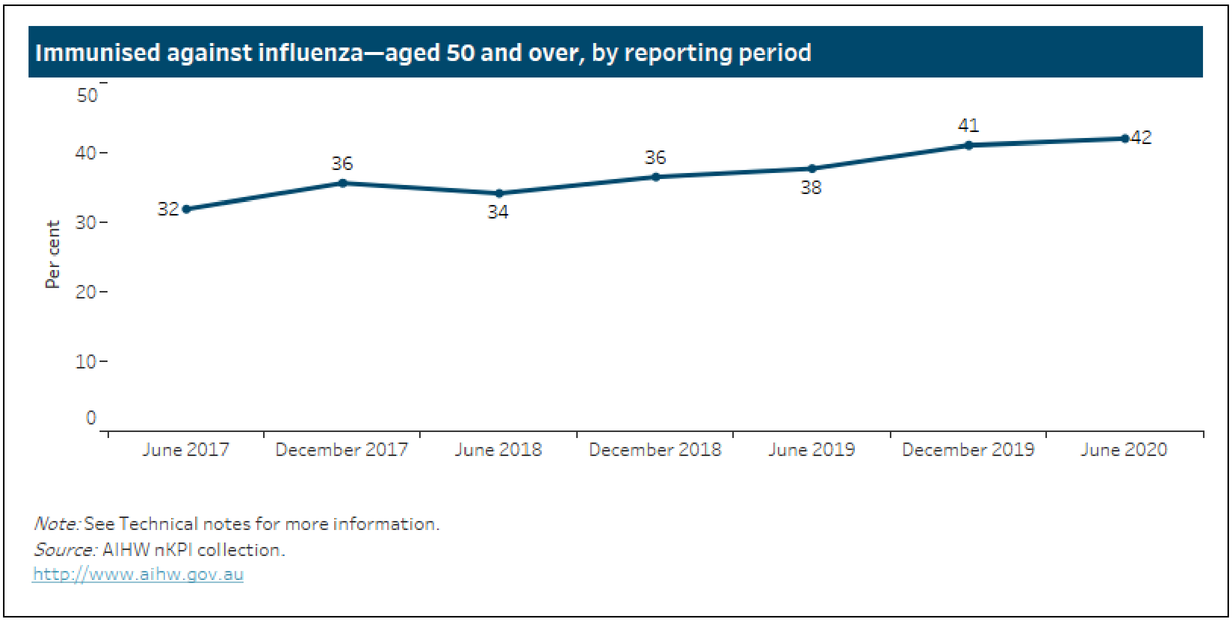
This indicator is the proportion of Indigenous regular clients aged 50 and over who had an influenza immunisation within the previous 12 months. It is collected for males and females.

Why immunisation against influenza is important

Influenza (the flu) is a contagious respiratory disease that causes seasonal epidemics in Australia. Anyone can be infected with influenza but some people, such as Indigenous Australians, have a higher chance of serious illness and complications, such as pneumonia. Some people with influenza die as a result of their infection. Annual vaccination is the best way to prevent severe infections, hospitalisation and death due to influenza.

While immunisation against influenza is recommended for all Indigenous Australians aged 6 months and over, it is particularly important for those who are at a greater risk of complications, such as those aged 50 and over. Influenza vaccination substantially reduces the risk of hospitalisation and death from influenza and pneumonia for older Indigenous Australians (AIHW 2018).

At June 2020, 42% of Indigenous regular clients aged 50 and over had an influenza immunisation within the previous 12 months.



Immunised against influenza—aged 50 and over, by reporting period

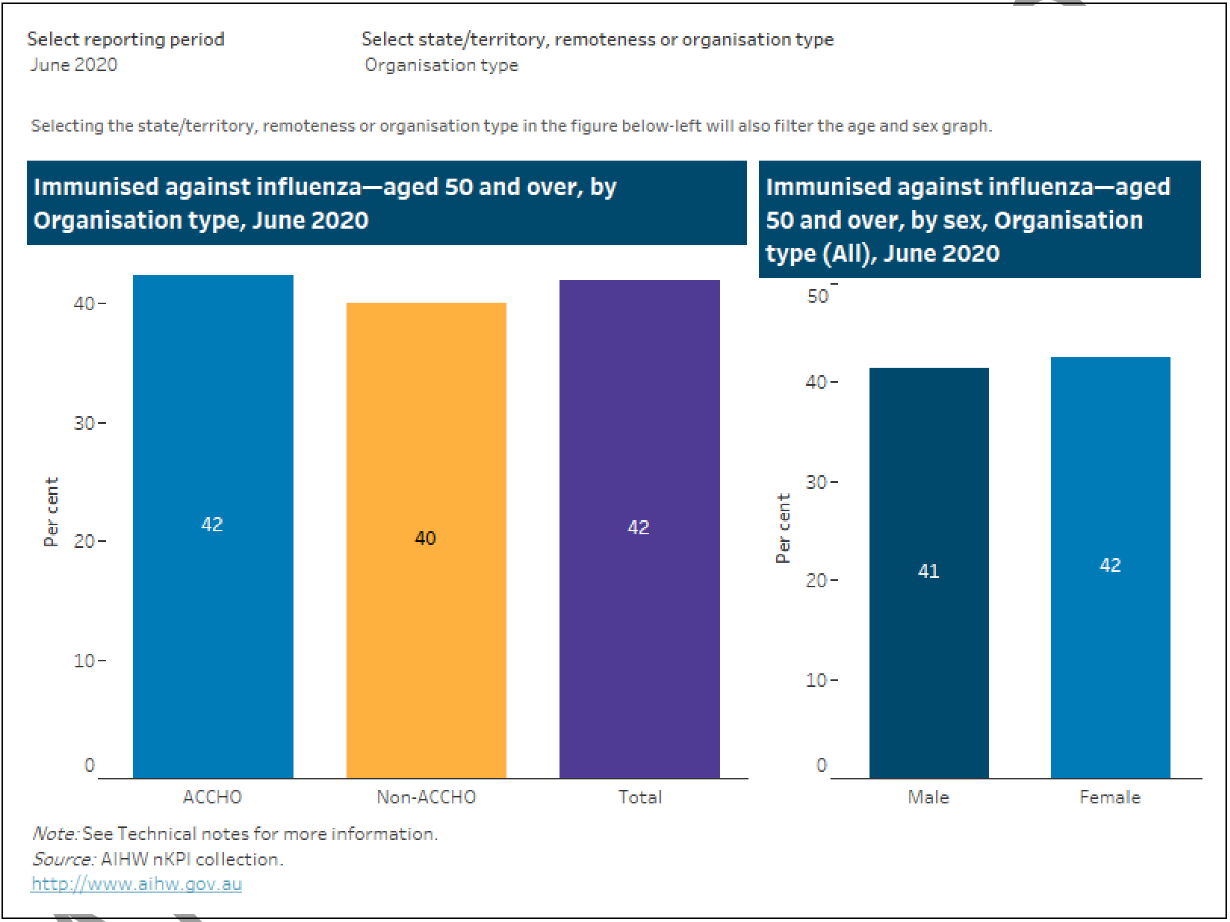
Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was highest in:

- the Northern Territory (49%)
- *Very remote* areas (50%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (42%).

It was lowest in:

- New South Wales/the Australian Capital Territory (combined, 36%)
- *Inner regional* areas (37%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (40%).



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Selecting the state/territory, remoteness or organisation type in the figure below-left will also filter the age and sex graph.

Immunised against influenza—aged 50 and over, by Organisation type, June 2020

Immunised against influenza—aged 50 and over, by sex, Organisation type (All), June 2020

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Reference

AIHW (Australian Institute of Health and Welfare) 2018. Vaccine-preventable diseases fact sheets. Cat no. PHE 236. Canberra: AIHW.

Body Mass Index (BMI) classified as overweight or obese (PI12)

This indicator is the proportion of Indigenous regular clients aged 25 and over who had their Body Mass Index (BMI) classified as overweight or obese within the previous 24 months.

It is collected for males and females in age groups:

- 25–34
- 35–44
- 45–54
- 55–64
- 65 and over.

Why not being overweight or obese is important

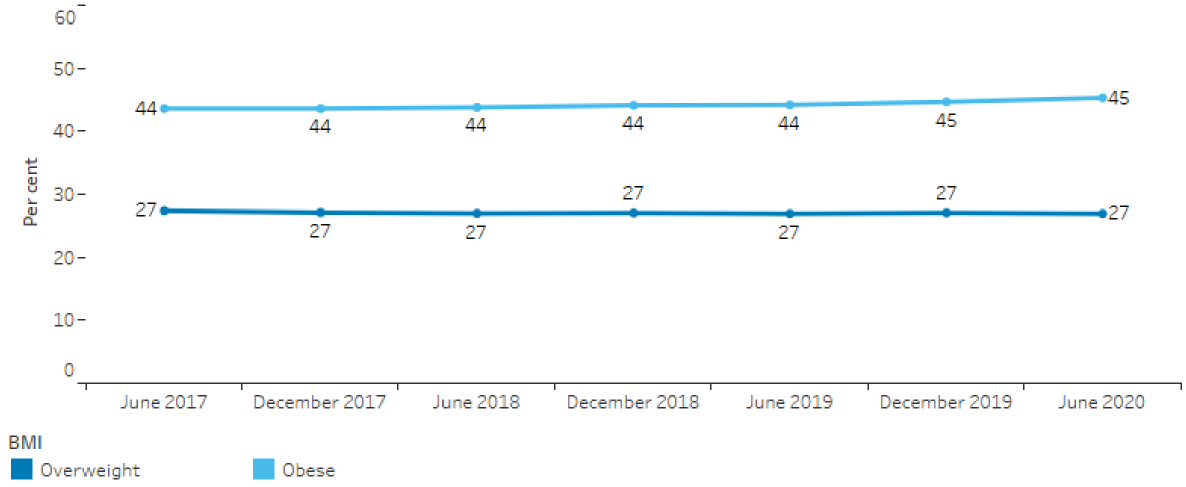
Excess weight is a major risk factor for many diseases, such as cardiovascular disease, type 2 diabetes, some musculoskeletal conditions and some cancers. As the level of excess weight increases, so does the risk of developing these conditions. In addition, being overweight or obese can hamper the ability to control or manage chronic conditions.

Indigenous Australians are more likely to be overweight or obese than non-Indigenous Australians (AIHW 2020). The proportion of Indigenous Australians who are overweight or obese has increased.

At June 2020, 72% of Indigenous regular clients aged 25 and over had their BMI classified as overweight or obese within the previous 24 months:

- 27% as overweight
- 45% as obese.

BMI classified as overweight or obese, by reporting period



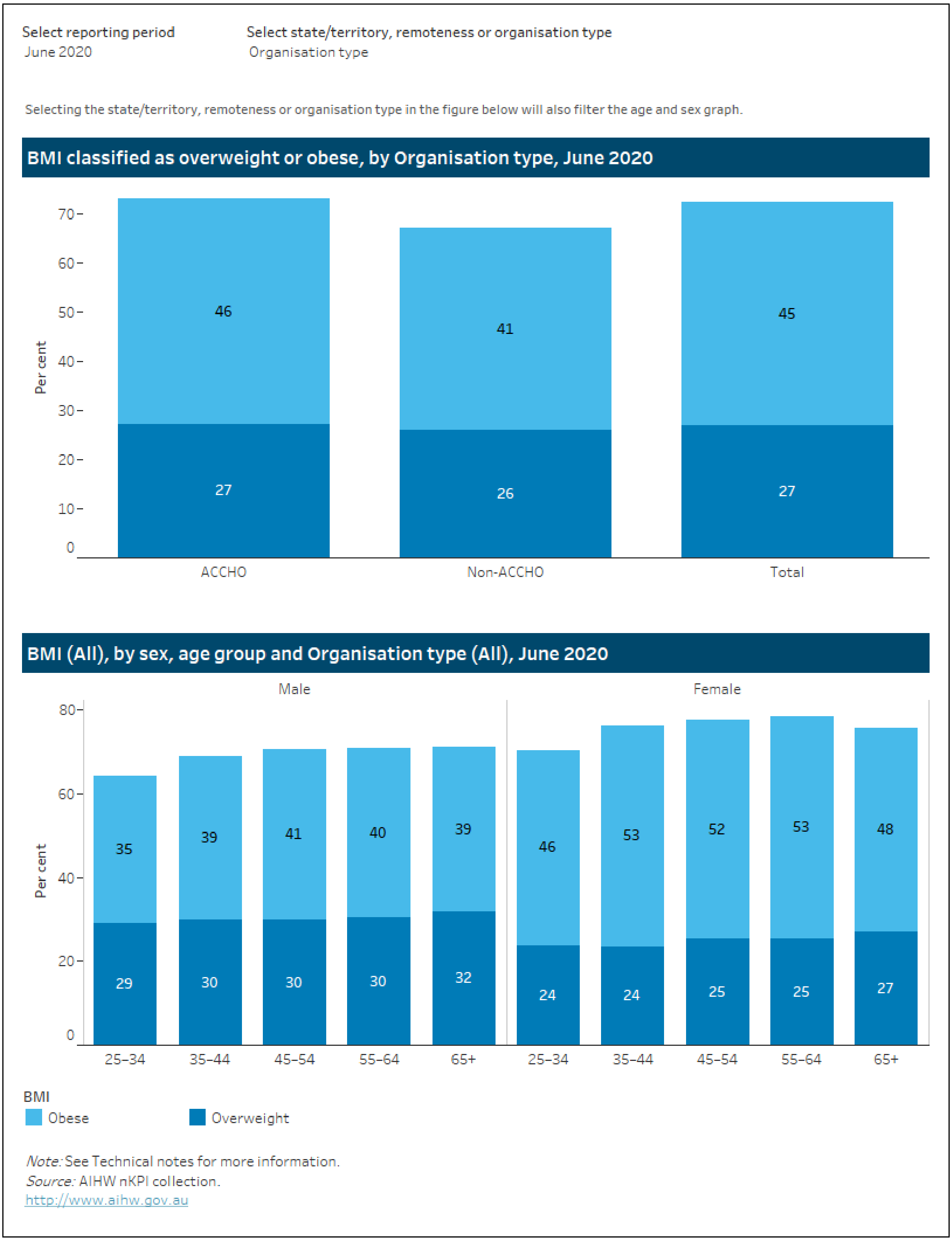
Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was lowest in:

- the Northern Territory (63%)
- *Very remote* areas (66%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (67%).

It was highest in:

- New South Wales/the Australian Capital Territory (combined) and Queensland (76%)
- *Inner regional* areas (77%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (73%).



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

BMI classified as overweight or obese, by Organisation type, June 2020

BMI (All), by sex, age group and Organisation type (All), June 2020

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

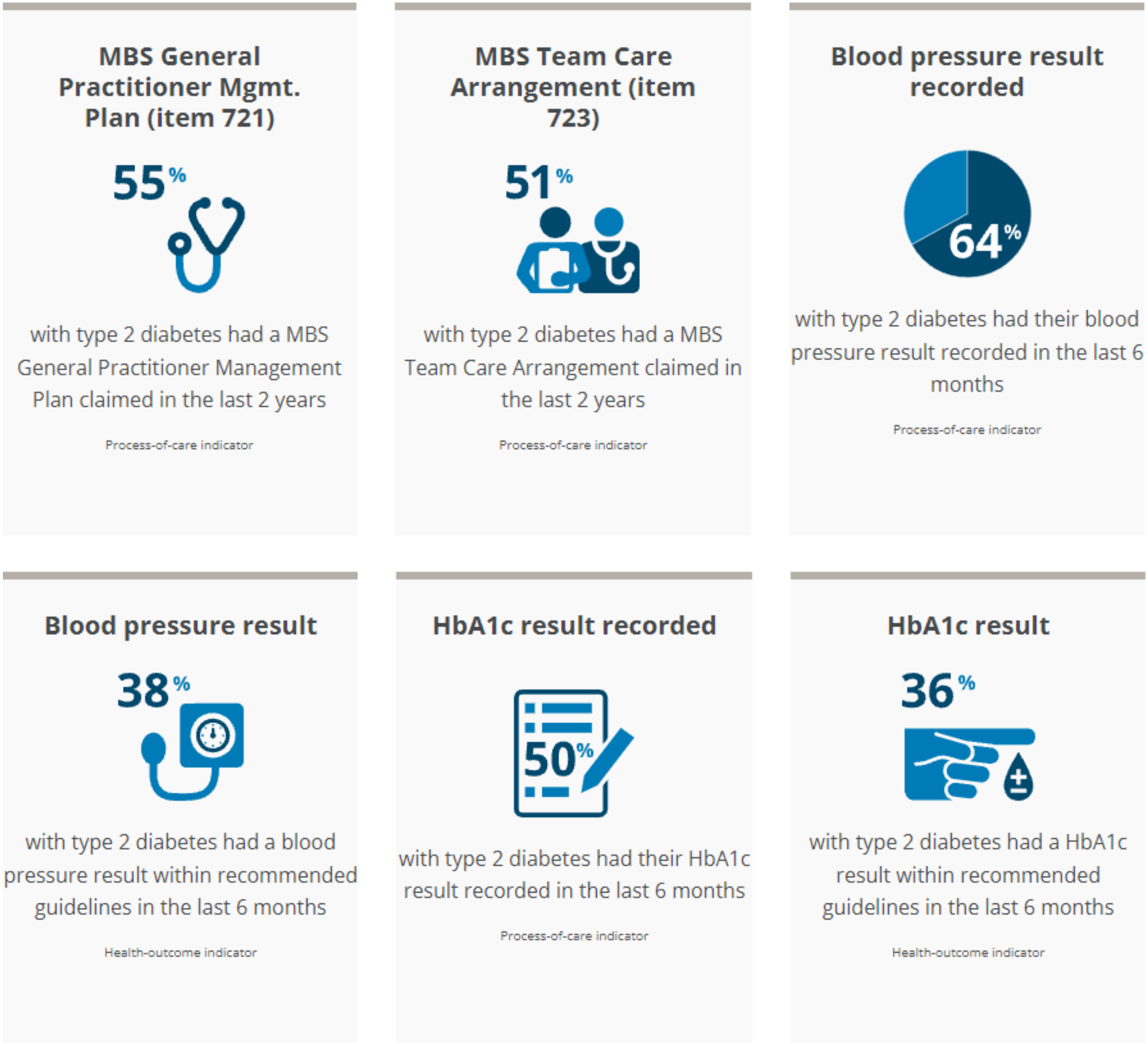
Reference

AIHW (Australian Institute of Health and Welfare) 2020. Aboriginal and Torres Strait Islander Health Performance Framework. Canberra: AIHW.

Chronic disease management indicators

Chronic disease management indicators in the national Key Performance Indicators (nKPI) collection consist of 6 process-of-care and 3 health-outcome indicators. Some indictors have more than one part (for example, an indicator might be collected by different types of chronic diseases).

The following boxes show key results for Indigenous regular clients. Clicking on a box will go to more information on the associated indicator.



MBS General Practitioner Mgmt. Plan (item 721)

55%

with type 2 diabetes had a MBS General Practitioner Management Plan claimed in the last 2 years

Process-of-care indicator

MBS Team Care Arrangement (item 723)

51%

with type 2 diabetes had a MBS Team Care Arrangement claimed in the last 2 years

Process-of-care indicator

Blood pressure result recorded

64%

with type 2 diabetes had their blood pressure result recorded in the last 6 months

Process-of-care indicator

Blood pressure result

38%

with type 2 diabetes had a blood pressure result within recommended guidelines in the last 6 months

Health-outcome indicator

HbA1c result recorded

50%

with type 2 diabetes had their HbA1c result recorded in the last 6 months

Process-of-care indicator

HbA1c result

36%

with type 2 diabetes had a HbA1c result within recommended guidelines in the last 6 months

Health-outcome indicator

Kidney function test recorded

63%

with type 2 diabetes had a kidney function test recorded in the last year

Process-of-care indicator

Kidney function test recorded

62%

with CVD had a kidney function test recorded in the last year

Process-of-care indicator

Kidney function test result (eGFR)

80%

with type 2 diabetes had a normal eGFR test result in the last year

Health-outcome indicator

Kidney function test result (ACR)

44%

with type 2 diabetes had a normal ACR test result in the last year

Health-outcome indicator

Kidney function test result (eGFR)

77%

with CVD had a normal eGFR test result in the last year

Health-outcome indicator

Immunised against influenza

39%

with type 2 diabetes were immunised against influenza

Process-of-care indicator

Immunised against influenza

42%

with COPD were immunised against influenza

Process-of-care indicator

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.

MBS General Practitioner Management Plan (item 721)—type 2 diabetes (PI07)

This indicator is the proportion of Indigenous regular clients with type 2 diabetes for whom a General Practitioner Management Plan (MBS item 721) was claimed within the previous 24 months.

It is collected for males and females in age groups from 0–4 to 65 and over. It is presented here for males and females in age groups:

- under 35
- 35–44
- 45–54
- 55–64
- 65 and over.

Why MBS General Practitioner Management Plan (item 721) is important

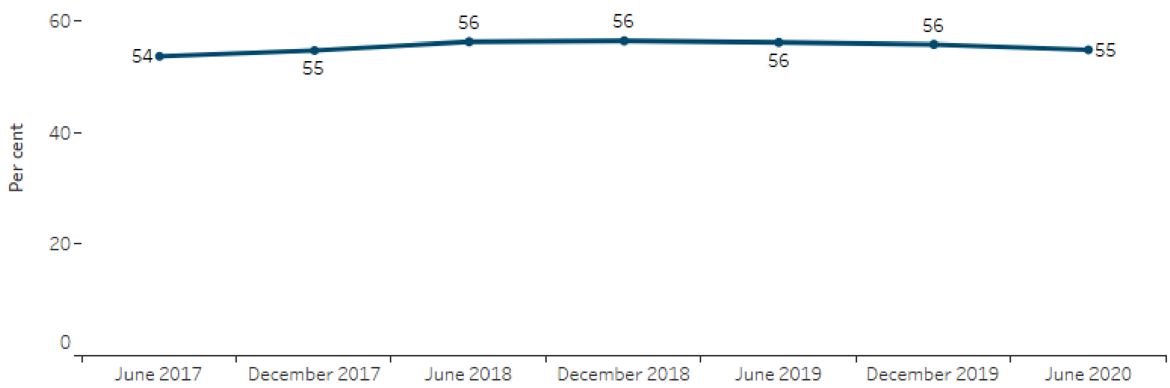
Much of the burden of disease among Indigenous Australians is due to chronic disease.

Effective management of chronic disease can delay the progression of disease, decrease the need for high-cost interventions, improve quality of life, and increase life expectancy. The development of a GP Management Plan is one way in which appropriate care can be planned.

The MBS General Practitioner Management Plan (item 721) provides a rebate for a GP to prepare a management plan for a patient who has a chronic or terminal medical condition with or without multidisciplinary care needs.

At June 2020, 55% of Indigenous regular clients with type 2 diabetes had a MBS item 721 claimed within the previous 24 months.

MBS General Practitioner Management Plan (item 721)—type 2 diabetes, by reporting period



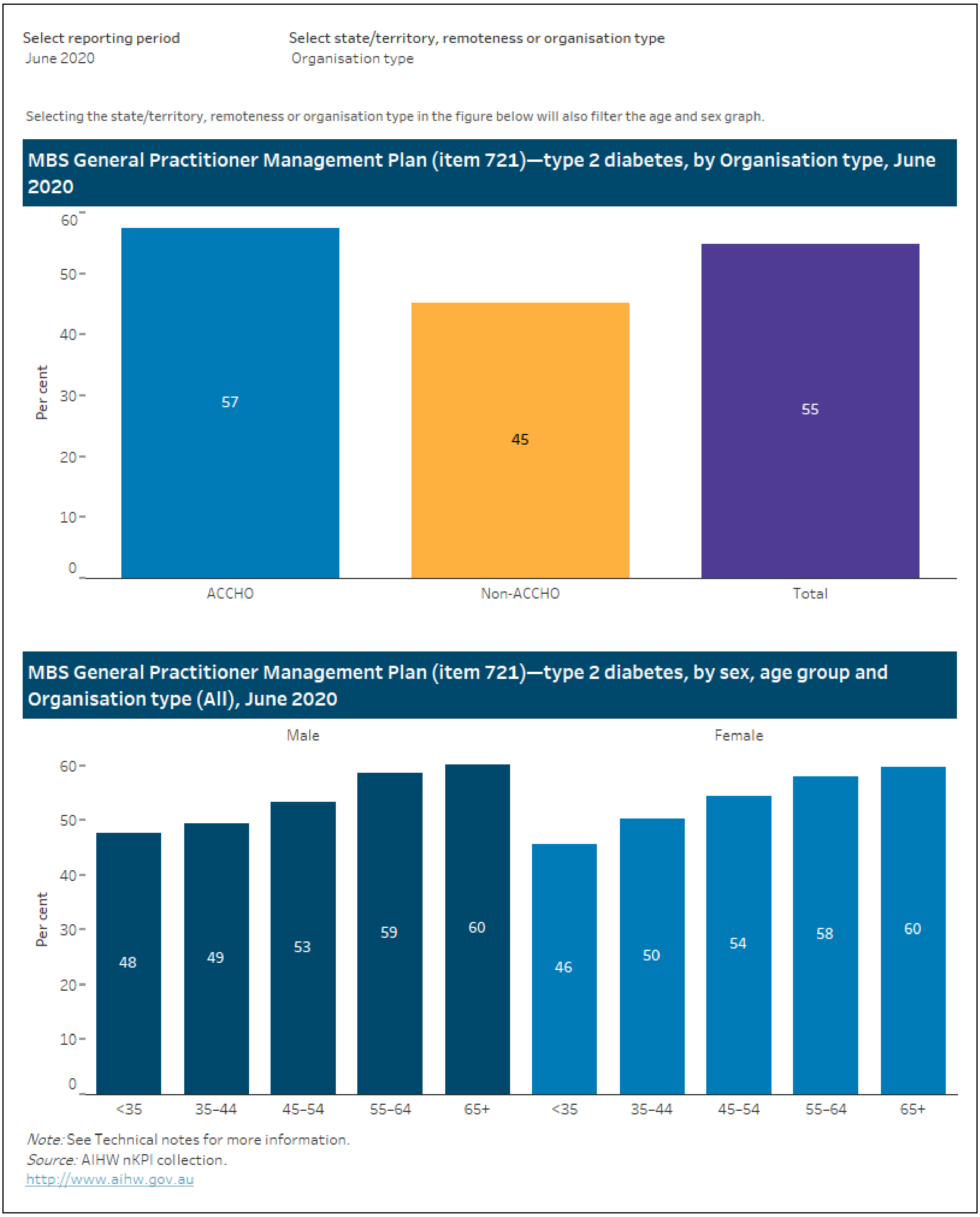
Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was highest in:

- Queensland (60%)
- *Major cities* and *Outer regional* areas (both 57%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (57%).

It was lowest in:

- South Australia (47%)
- *Inner regional* areas (51%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (45%).



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

MBS General Practitioner Management Plan (item 721)—type 2 diabetes, by Organisation type, June 2020

MBS General Practitioner Management Plan (item 721)—type 2 diabetes, by sex, age group and Organisation type (All), June 2020

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

MBS Team Care Arrangement (item 723)—type 2 diabetes (PI08)

This indicator is the proportion of Indigenous regular clients with type 2 diabetes for whom a Team Care Arrangement (MBS item 723) was claimed within the previous 24 months.

It is collected for males and females in age groups from 0–4 to 65 and over. It is presented here for males and females in age groups:

- under 35
- 35–44
- 45–54
- 55–64
- 65 and over.

Why MBS Team Care Arrangement (item 723) is important

Much of the burden of disease among Indigenous Australians is due to chronic disease.

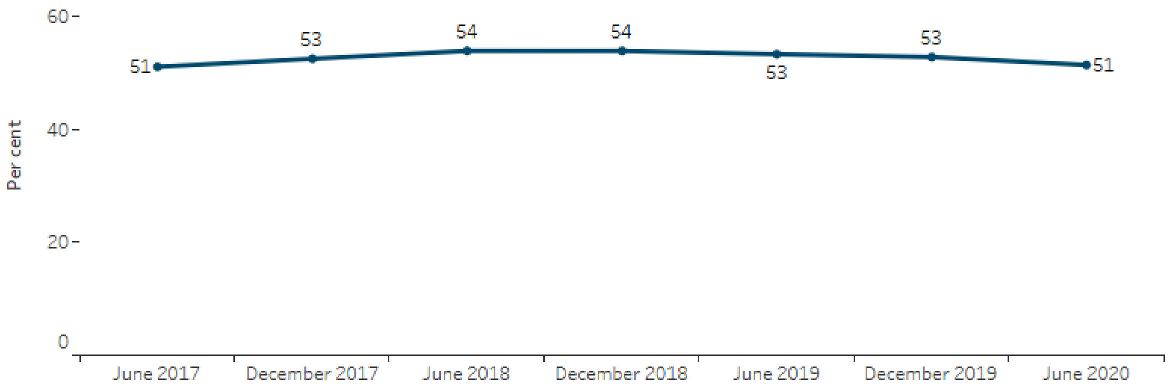
Effective management of chronic disease can delay the progression of disease, decrease the need for high-cost interventions, improve quality of life, and increase life expectancy. As good quality care for people with chronic disease can involve multiple health-care providers across multiple settings, the development of multidisciplinary care plans is one way in which appropriate care can be arranged and coordinated.

A Team Care Arrangement (TCA) provides a rebate for a GP to coordinate the preparation of a TCA for a patient who has a chronic or terminal medical condition who requires ongoing care from a multidisciplinary team of at least three health or care providers.

A person who has a chronic or terminal medical condition (with or without multidisciplinary care needs) can have a GP Management Plan (GPMP) service. A person with a chronic or terminal medical condition and complex care needs, requiring care from a multidisciplinary team, can have a GPMP and Team Care Arrangements (TCAs).

At June 2020, 51% of Indigenous regular clients with type 2 diabetes had a MBS item 723 claimed within the previous 24 months.

MBS Team Care Arrangement (item 723)—type 2 diabetes, by reporting period



Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

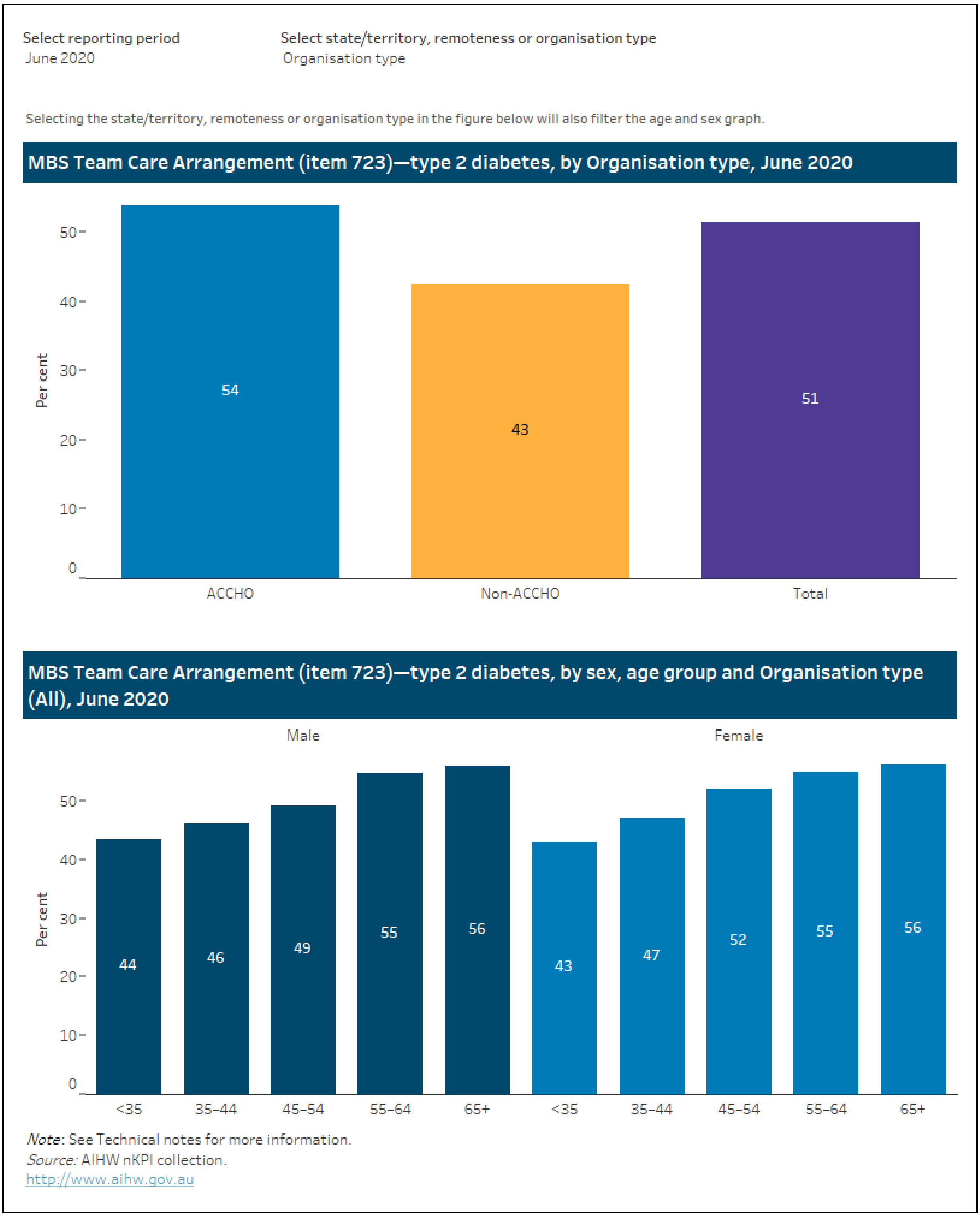
This was highest in:

- Queensland (57%)
- *Major cities and Outer regional* areas (54%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (54%).

It was lowest in:

- Victoria/Tasmania (combined) (44%)
- *Inner regional* areas (48%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (43%).

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

MBS Team Care Arrangement (item 723)—type 2 diabetes, by Organisation type, June 2020

MBS Team Care Arrangement (item 723)—type 2 diabetes, by sex, age group and Organisation type (All), June 2020

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Blood pressure result—type 2 diabetes (PI23 and PI24)

Indicators related to blood pressure in the national Key Performance Indicators (nKPI) collection are:

- the proportion of Indigenous regular clients with type 2 diabetes whose blood pressure result was recorded in the last 6 months
- the proportion of Indigenous regular clients with type 2 diabetes whose blood pressure result recorded in the last 6 months was less than or equal to 130/80mmHg.

Why blood pressure result is important

Blood pressure is the force exerted by the blood on the walls of the arteries and is written as systolic/diastolic (for example, 120/80 mmHg, stated as '120 over 80'). High blood pressure—also known as hypertension—is a risk factor for chronic conditions, including stroke, coronary heart disease, heart failure and chronic kidney disease.

Managing a healthy blood pressure can reduce the risk and slow the progression of chronic conditions, such as cardiovascular disease, nephropathy, and diabetic eye disease. People with type 2 diabetes have a higher risk of developing high blood pressure. The Royal Australian College of General Practitioners (RACGP) 2016–18 diabetes management guidelines that aligned with this indicator recommended a target blood pressure of 130/80 mmHg for people with type 2 diabetes (RACGP 2016). Updated 2020 guidelines note that the general target blood pressure for people with type 2 diabetes is now less than or equal to 140/90 mmHg (RACGP 2020). Revisions to the nKPI collection to reflect this change are underway.

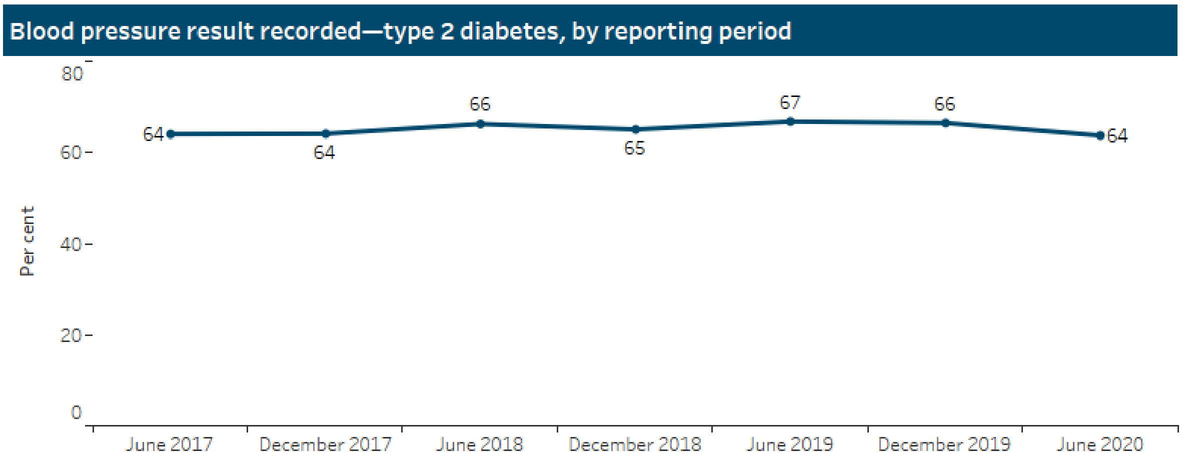
Blood pressure result recorded—type 2 diabetes (PI23)

This indicator is the proportion of Indigenous regular clients with type 2 diabetes whose blood pressure result was recorded in the last 6 months.

It is collected for males and females in age groups from 0–4 to 65 and over. It is presented here for males and females in age groups:

- under 35
- 35–44
- 45–54
- 55–64
- 65 and over.

At June 2020, 64% of Indigenous regular clients with type 2 diabetes had their blood pressure result recorded in the last 6 months.



Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was highest in:

- Western Australia and Queensland (both 67%)
- *Remote* areas (67%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (67%).

It was lowest in:

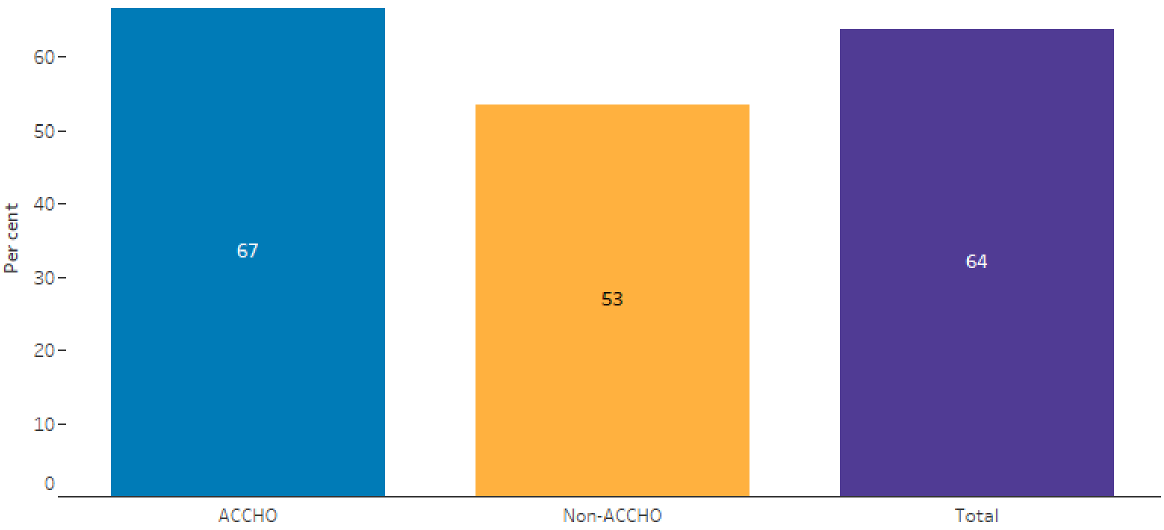
- Victoria/Tasmania combined (57%)
- *Very remote* areas (61%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (53%).

Select reporting period
June 2020

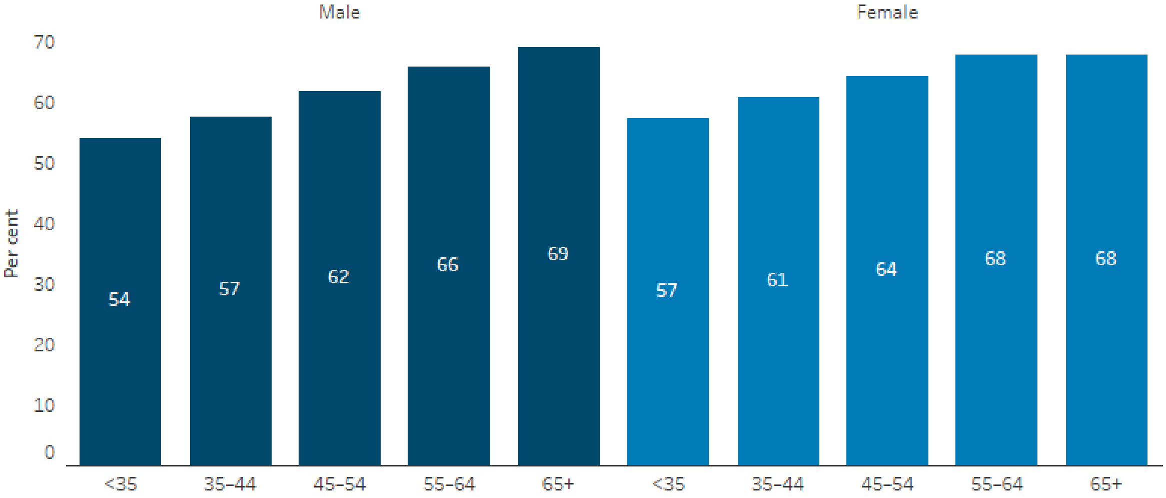
Select state/territory, remoteness or organisation type
Organisation type

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

Blood pressure result recorded—type 2 diabetes, by Organisation type, June 2020



Blood pressure result recorded—type 2 diabetes, by sex, age group and Organisation type (All), June 2020



Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Blood pressure result—type 2 diabetes (PI24)

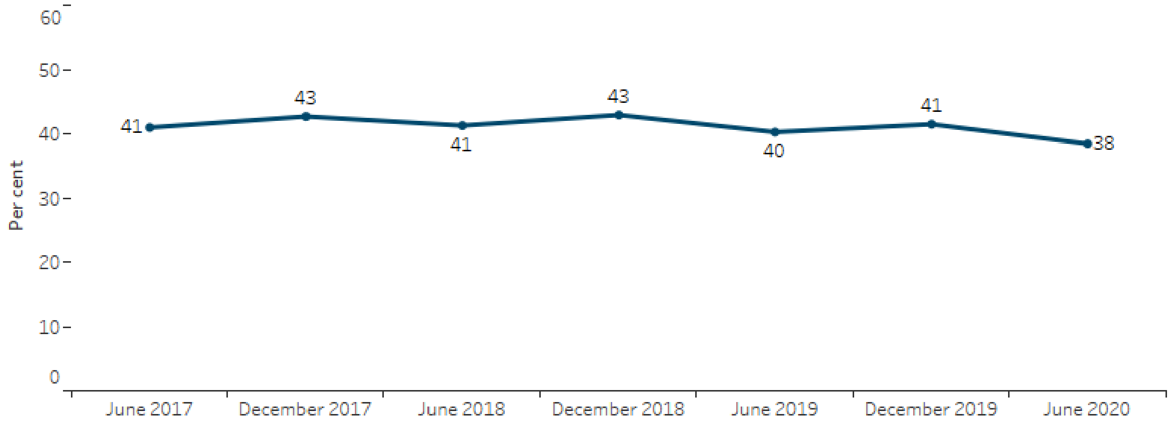
This indicator is the proportion of Indigenous regular clients with type 2 diabetes whose blood pressure result recorded in the last 6 months was less than or equal to 130/80mmHg.

It is collected for males and females in age groups:

- under 35
- 35–44
- 45–54
- 55–64
- 65 and over.

At June 2020, 38% of Indigenous regular clients with type 2 diabetes had a blood pressure result recorded in the last 6 months of less than or equal to 130/80mmHg.

Blood pressure result ≤130/80mmHg—type 2 diabetes, by reporting period



Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was highest in:

- the Northern Territory (42%)
- *Remote* and *Very remote* areas (both 40%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (40%).

It was lowest in:

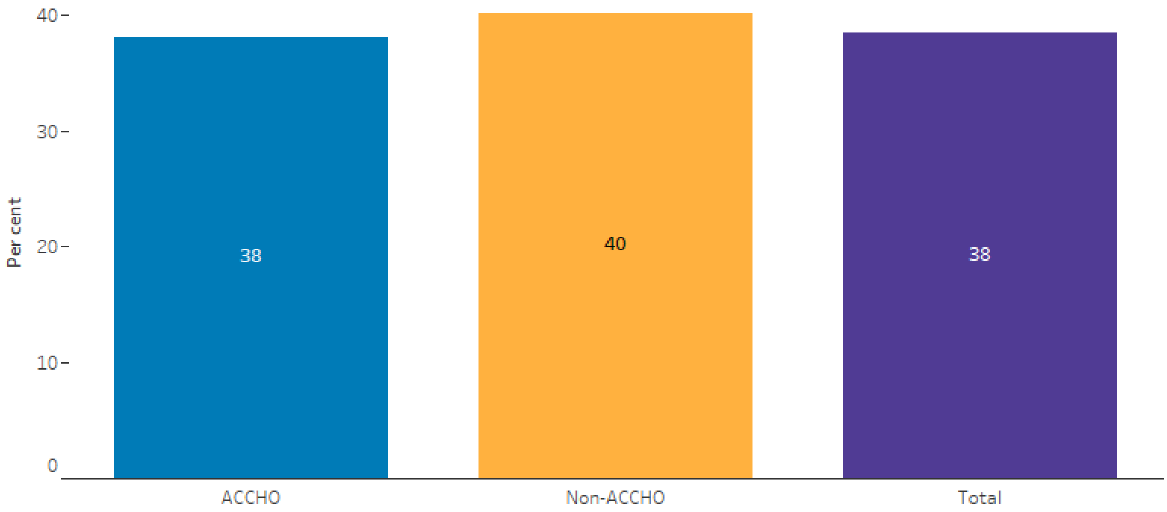
- Queensland and Western Australia (both 36%)
- *Major cities* (35%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (38%).

Select reporting period
June 2020

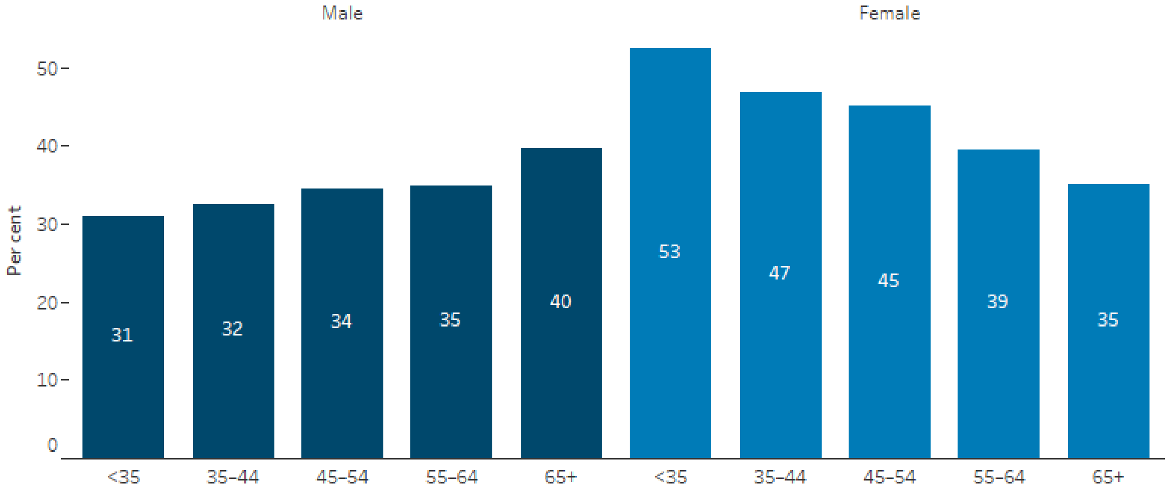
Select state/territory, remoteness or organisation type
Organisation type

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

Blood pressure result ≤130/80mmHg—type 2 diabetes, by Organisation type, June 2020



Blood pressure result ≤130/80mmHg—type 2 diabetes, by sex, age group and Organisation type (Non-ACCHO), June 2020



Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Reference

RACGP (Royal Australian College of General Practitioners) 2016. General practice management of type 2 diabetes, 2016–18. East Melbourne: RACGP and Diabetes Australia.

RACGP 2020. The Royal Australian College of General Practitioners. Management of type 2 diabetes: a handbook for general practice. East Melbourne, Vic: RACGP.

HbA1c measurement—type 2 diabetes (PI05 and PI06)

Indicators related to HbA1c in the national Key Performance Indicators (nKPI) collection are:

- the proportion of Indigenous regular clients with type 2 diabetes who had a HbA1c measurement result recorded within the previous 6 months or within the previous 12 months
- the proportion of Indigenous regular clients with type 2 diabetes who had a HbA1c measurement result recorded within the previous 6 months or within the previous 12 months that was within specified ranges.

Why HbA1c is important

The HbA1c (glycosylated haemoglobin or glycated haemoglobin) blood test gives an indication of whether blood glucose levels have been higher than normal over the preceding 6–8 weeks by looking at how much sugar (glucose) is bound in red blood cells. It is regarded as the gold standard for assessing glycaemic control.

People who have diabetes need this test regularly to see if their levels are staying within range and whether they need to adjust their diabetes management. The general glycated haemoglobin (HbA1c) target in people with type 2 diabetes is ≤53 mmol/mol (≤7%) (RACGP 2016).

HbA1c result recorded—type 2 diabetes (PI05)

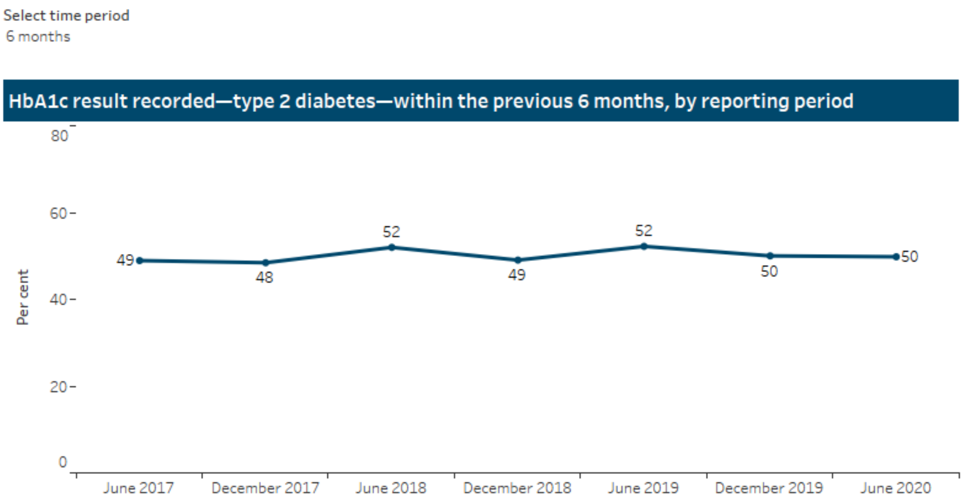
This indicator is the proportion of Indigenous regular clients with type 2 diabetes who had a HbA1c measurement result recorded within the previous 6 months or within the previous 12 months.

It is collected for males and females in age groups from 0–4 to 65 and over. It is presented here for males and females in age groups:

- under 35
- 35–44
- 45–54
- 55–64
- 65 and over.

At June 2020:

- 50% of Indigenous regular clients with type 2 diabetes had a HbA1c measurement result recorded within the previous 6 months
- 66% of Indigenous regular clients with type 2 diabetes had a HbA1c measurement result recorded within the previous 12 months.



Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Having a HbA1c measurement result recorded within the previous 6 months was highest in:

- Western Australia (53%)
- *Remote* areas (52%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (51%).

It was lowest in:

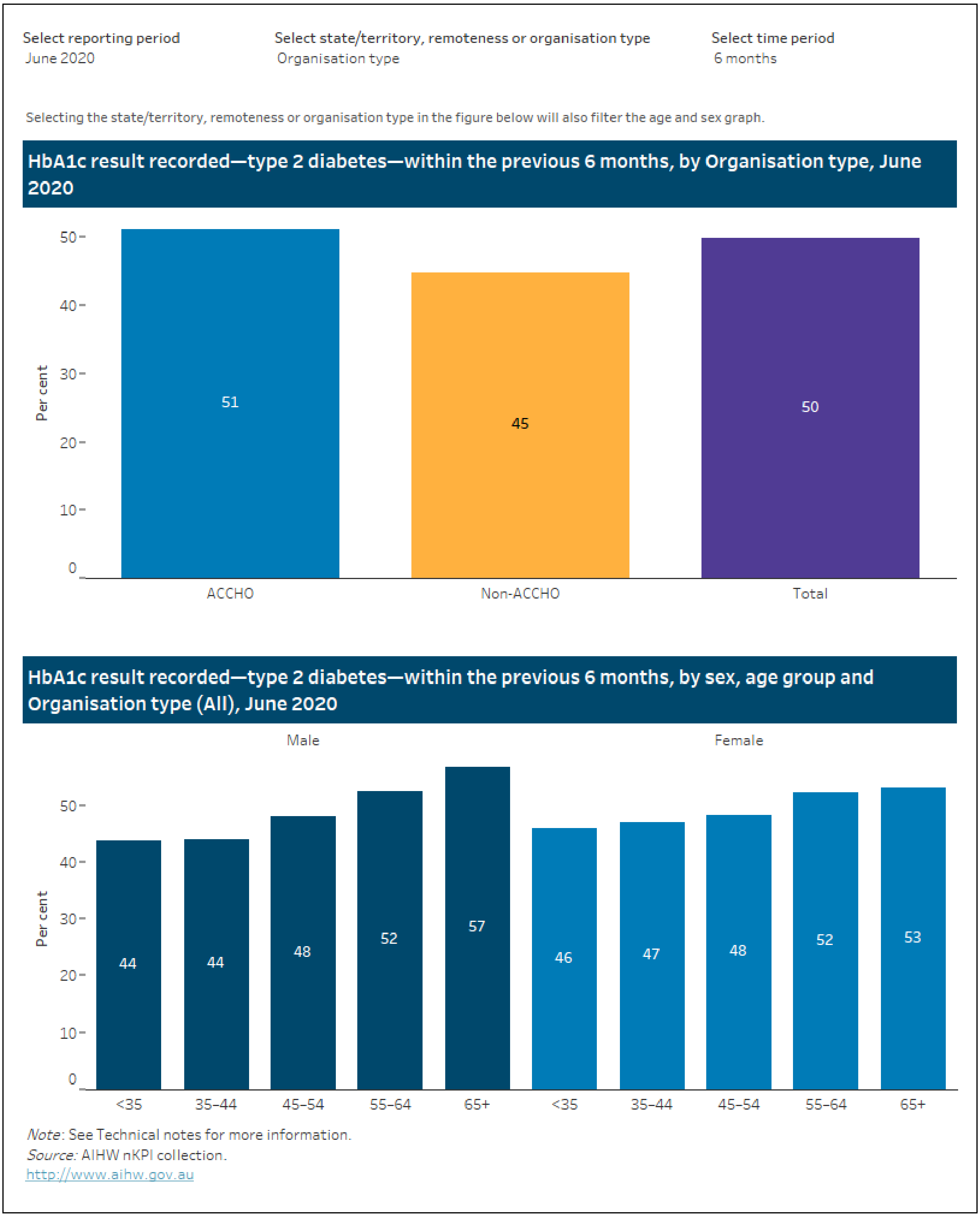
- South Australia (46%)
- *Outer regional* and *Inner regional* areas (both 49%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (45%).

Having a HbA1c measurement result recorded within the previous 12 months was highest in:

- Western Australia (71%)
- *Remote* areas (70%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (68%).

It was lowest in:

- the Northern Territory and South Australia (both 63%)
- *Inner regional* areas (62%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (57%).



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Select time period
6 months

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

HbA1c result recorded—type 2 diabetes—within the previous 6 months, by Organisation type, June 2020

HbA1c result recorded—type 2 diabetes—within the previous 6 months, by sex, age group and Organisation type (All), June 2020

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.

HbA1c result—type 2 diabetes (PI06)

This indicator is the proportion of Indigenous regular clients with type 2 diabetes who had a HbA1c measurement result recorded within the previous 6 months or within the previous 12 months (mmol/mol):

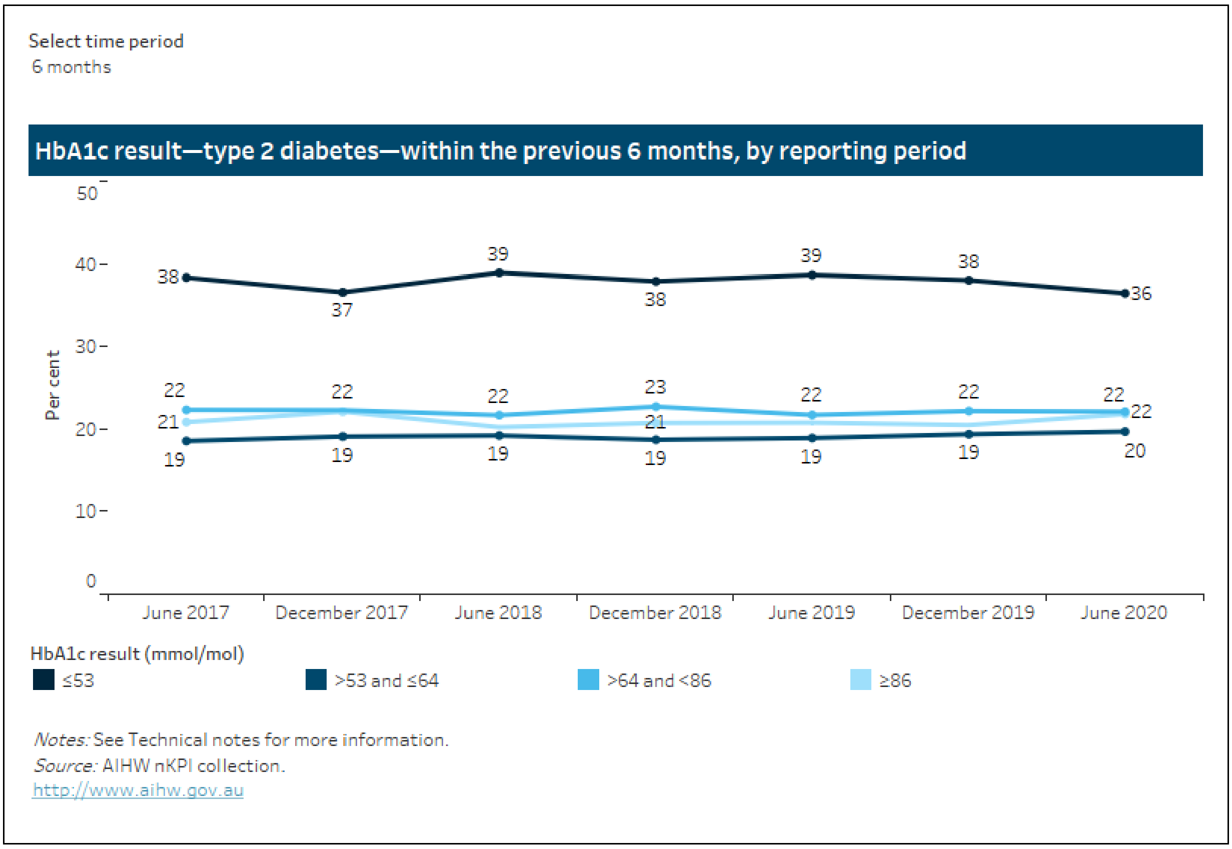
- ≤53 (≤7%)
- >53–≤64 (>7%–≤8%)
- >64–<86 (>8%–<10%)
- ≥86 (≤10%).

It is collected for males and females in age groups:

- under 35
- 35–44
- 45–54
- 55–64
- 65 and over.

At June 2020:

- 36% of Indigenous regular clients with type 2 diabetes had a HbA1c measurement result of ≤53 mmol/mol recorded within the previous 6 months
- 38% had a HbA1c measurement result of ≤53 mmol/mol recorded within the previous 12 months.



HbA1c result—type 2 diabetes—within the previous 6 months, by reporting period

Notes: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.

Having a HbA1c measurement result of ≤53 mmol/mol recorded within the previous 6 months was highest in:

- New South Wales/the Australian Capital Territory (combined) and Victoria/Tasmania (combined) (both 42%)
- *Inner regional* areas (42%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (37%).

It was lowest in:

- South Australia (32%)
- *Very remote* areas (32%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (33%).

Having a HbA1c measurement result of ≤53 mmol/mol recorded within the previous 12 months was highest in:

- New South Wales/the Australian Capital Territory (combined) (44%)
- *Inner regional* areas (44%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (39%).

It was lowest in:

- South Australia and the Northern Territory (both 34%)
- *Very remote* areas (32%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (34%).

Select reporting period
June 2020

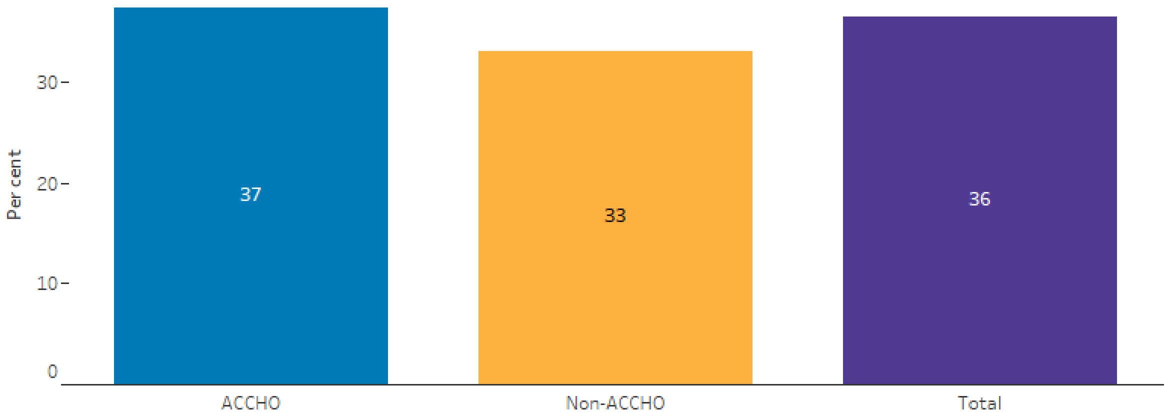
Select state/territory, remoteness or organisation type
Organisation type

Select time period
6 months

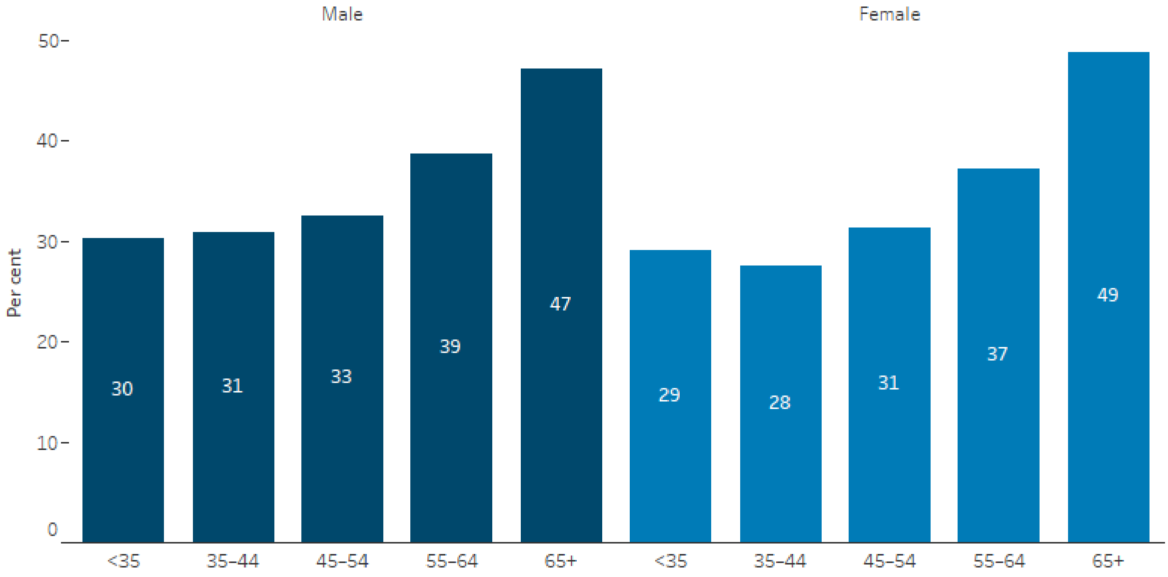
Select result level (mmol/mol)
≤53

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

HbA1c result—type 2 diabetes—within the previous 6 months, by HbA1c result (≤53 mmol/mol) and Organisation type, June 2020



HbA1c result—type 2 diabetes—within the previous 6 months, by sex, age group, HbA1c result (≤53 mmol/mol) and Organisation type (All), June 2020



Notes:
1. A result of ≤53 mmol/mol is ideal.
2. See Technical notes for more information.

Source: AIHW nKPI collection
http://www.aihw.gov.au

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.

Reference

RACGP (Royal Australian College of General Practitioners) 2016. General practice management of type 2 diabetes, 2016–18. East Melbourne: RACGP and Diabetes Australia.

Kidney function test—type 2 diabetes or CVD (PI18 and PI19)

Indicators related to kidney function tests in the national Key Performance Indicators (nKPI) collection are:

- Type 2 diabetes:
  - the proportion of Indigenous regular clients aged 15 and over with type 2 diabetes who had an estimated glomerular filtration rate (eGFR) recorded and/or an albumin/creatinine ratio (ACR) or other micro albumin test result recorded within the previous 12 months
  - the proportion of Indigenous regular clients aged 15 and over with type 2 diabetes who had an eGFR recorded within the previous 12 months within a specified range
  - the proportion of Indigenous regular clients aged 15 and over with type 2 diabetes who had an ACR recorded within the previous 12 months within a specified range.
- Cardiovascular disease (CVD):
  - the proportion of Indigenous regular clients aged 15 and over with CVD who had an eGFR recorded within the previous 12 months
  - the proportion of Indigenous regular clients aged 15 and over with CVD who had an eGFR test recorded within the previous 12 months within a specified range.

Why testing kidney function is important

Type 2 diabetes and CVD can damage the kidneys. If kidney disease is diagnosed early, appropriate treatment can be given and its effects can be closely monitored.

The Royal Australian College of General Practitioners (RACGP) guidelines recommend an annual screening of kidney function in patients with CVD and type 2 diabetes for albuminuria by ACR (spot urine sample), and annual estimation of the eGFR (RACGP 2016).

A ‘normal’ eGFR result is considered to be ≥60 mL/min/1.73 m^2 (Kidney Health Australia 2020).

Very low values for ACR (<2.5 for males or <3.5 for females) generally indicate that kidney function is normal if other tests of kidney function also show no abnormality. A moderately increased ACR indicates an early phase of developing kidney disease. Very high values indicate that kidney disease is present in a more severe form.

Indigenous Australians are far more likely to develop, and to die from, chronic kidney disease than non-Indigenous Australians (AIHW 2020; Kidney Health Australia 2020).

Kidney function test recorded—type 2 diabetes or CVD (PI18)

This indicator is:

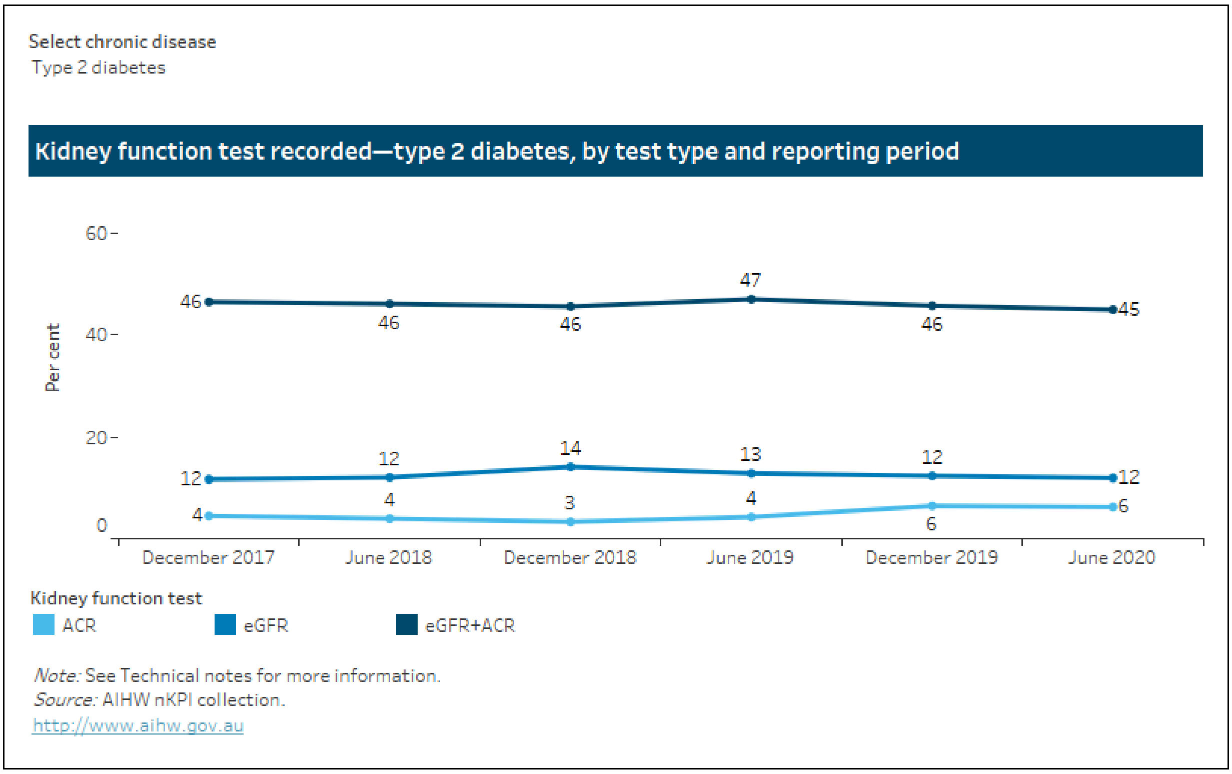
- the proportion of Indigenous regular clients aged 15 and over with type 2 diabetes who had an eGFR and/or ACR or other micro albumin test result recorded within the previous 12 months; and
- the proportion of Indigenous regular clients aged 15 and over with CVD who had an eGFR recorded within the previous 12 months.

It is collected for males and females in age groups from 15–24 to 65 and over. It is presented here for males and females in age groups:

- under 35
- 35–44
- 45–54
- 55–64
- 65 and over.

At June 2020:

- 63% of Indigenous regular clients aged 15 and over with type 2 diabetes had an eGFR recorded and/or ACR or other micro albumin test result recorded within the previous 12 months
- 62% of Indigenous regular clients aged 15 and over with CVD had an eGFR recorded test result recorded within the previous 12 months.



Select chronic disease
Type 2 diabetes

Kidney function test recorded—type 2 diabetes, by test type and reporting period

Note: See Technical notes for more information.
Source: AIHW nKPI collection.

Having an eGFR and/or ACR or other micro albumin test result recorded within the previous 12 months for clients with type 2 diabetes was highest in:

- Western Australia (69%)
- *Major cities* and *Remote* areas (both 65%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (66%).

It was lowest in:

- Victoria/Tasmania (combined), South Australia and the Northern Territory (all 59%)
- *Very remote* areas (51%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (52%).

Having an eGFR test result recorded within the previous 12 months for clients with CVD was highest in:

- Western Australia (67%)
- *Remote* areas (68%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (65%).

It was lowest in:

- South Australia (55%)
- *Inner regional* areas (58%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (47%).

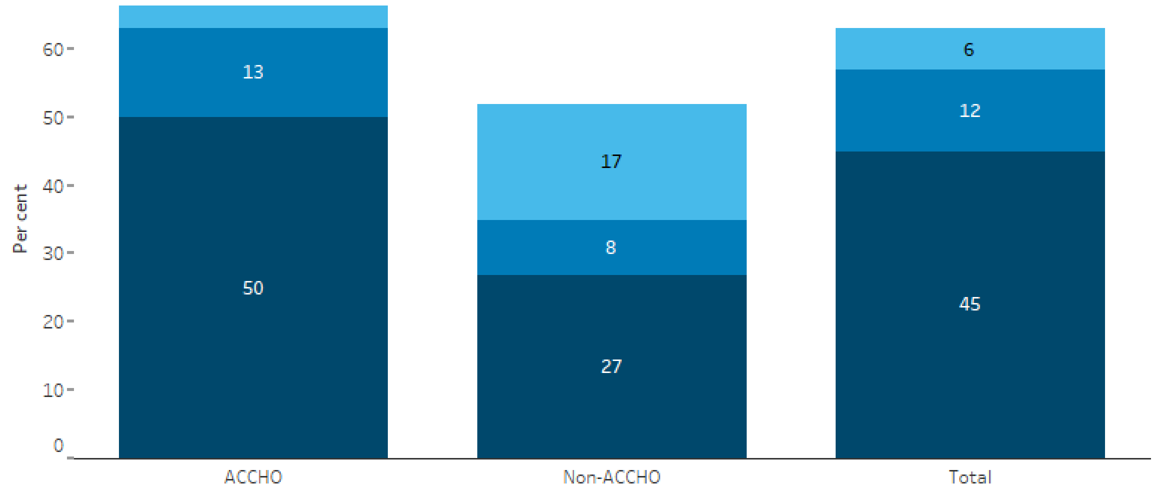
Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

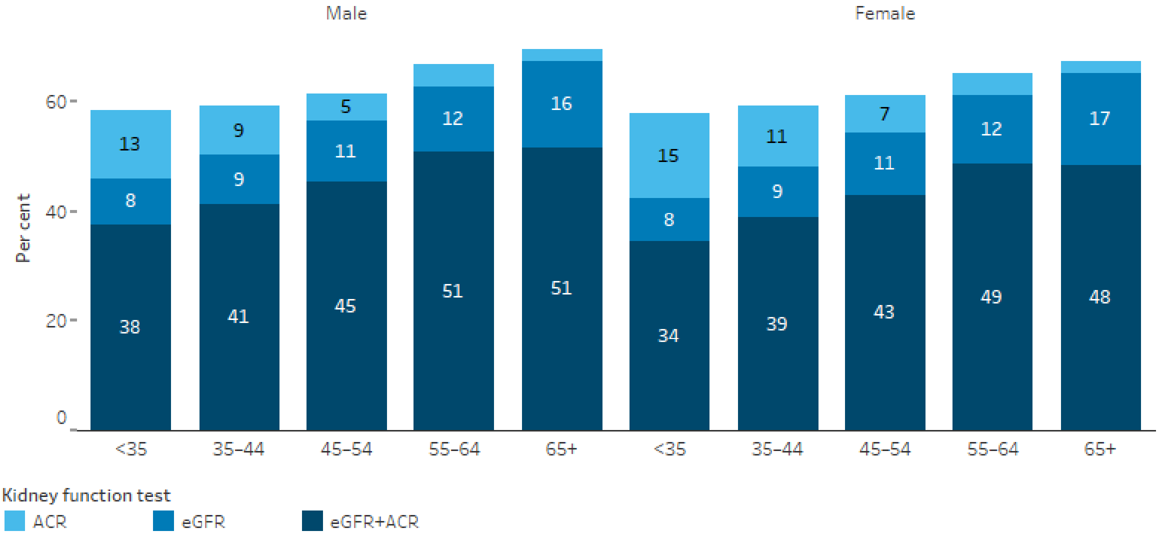
Select chronic disease
Type 2 diabetes

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

Kidney function test recorded—type 2 diabetes, by test type and Organisation type, June 2020



Kidney function test recorded—type 2 diabetes, by sex, age group, test type (All), Organisation type (All), June 2020



Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Kidney function test result (eGFR)—type 2 diabetes or CVD (PI19-A)

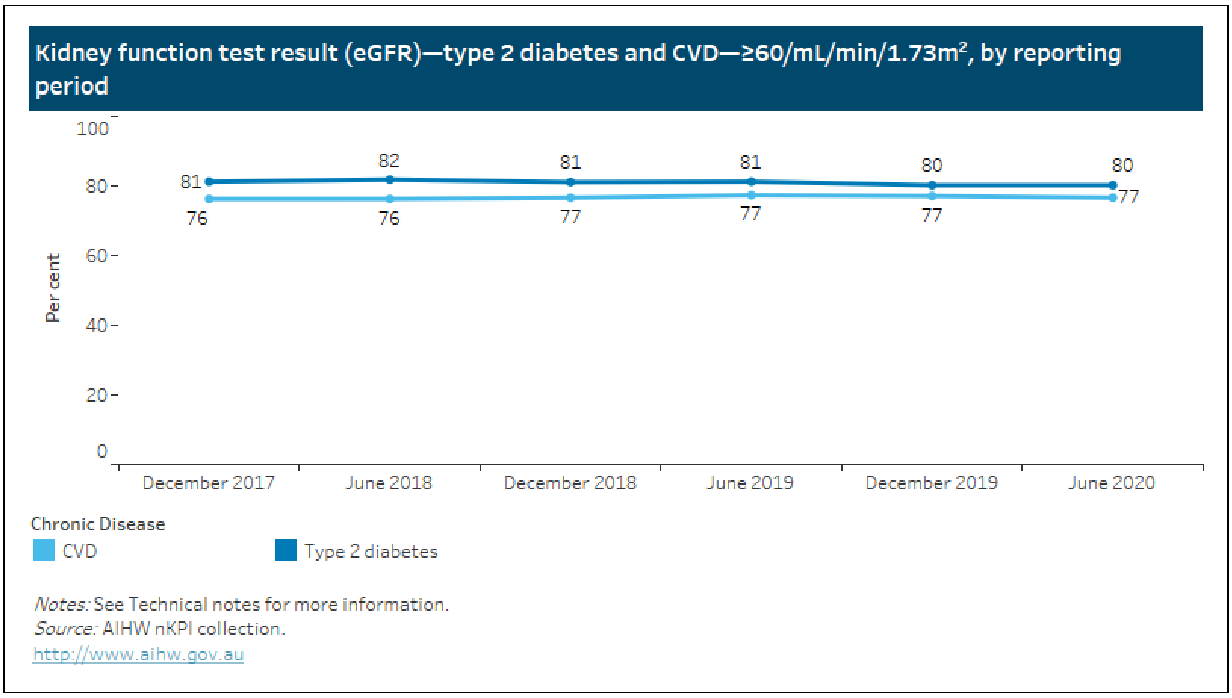
This indicator is the proportion of Indigenous regular clients aged 15 and over with type 2 diabetes or CVD who had an eGFR test result recorded within the previous 12 months of (mL/min/1.73m^2):

- ≥90
- ≥60–<90
- ≥45–<60
- ≥30–<45
- ≥15–<30
- <15.

It is collected for males and females in age groups from 15–24 to 65 and over. It is presented here for all Indigenous regular clients aged 15 and over.

At June 2020:

- 80% of Indigenous regular clients aged 15 and over with type 2 diabetes had an eGFR test result recorded within the previous 12 months of ≥60 mL/min/1.73m^2
- 77% of Indigenous regular clients aged 15 and over with CVD had an eGFR test result recorded within the previous 12 months of ≥60 mL/min/1.73m^2.



Kidney function test result (eGFR)—type 2 diabetes and CVD—≥60/mL/min/1.73m^2, by reporting period

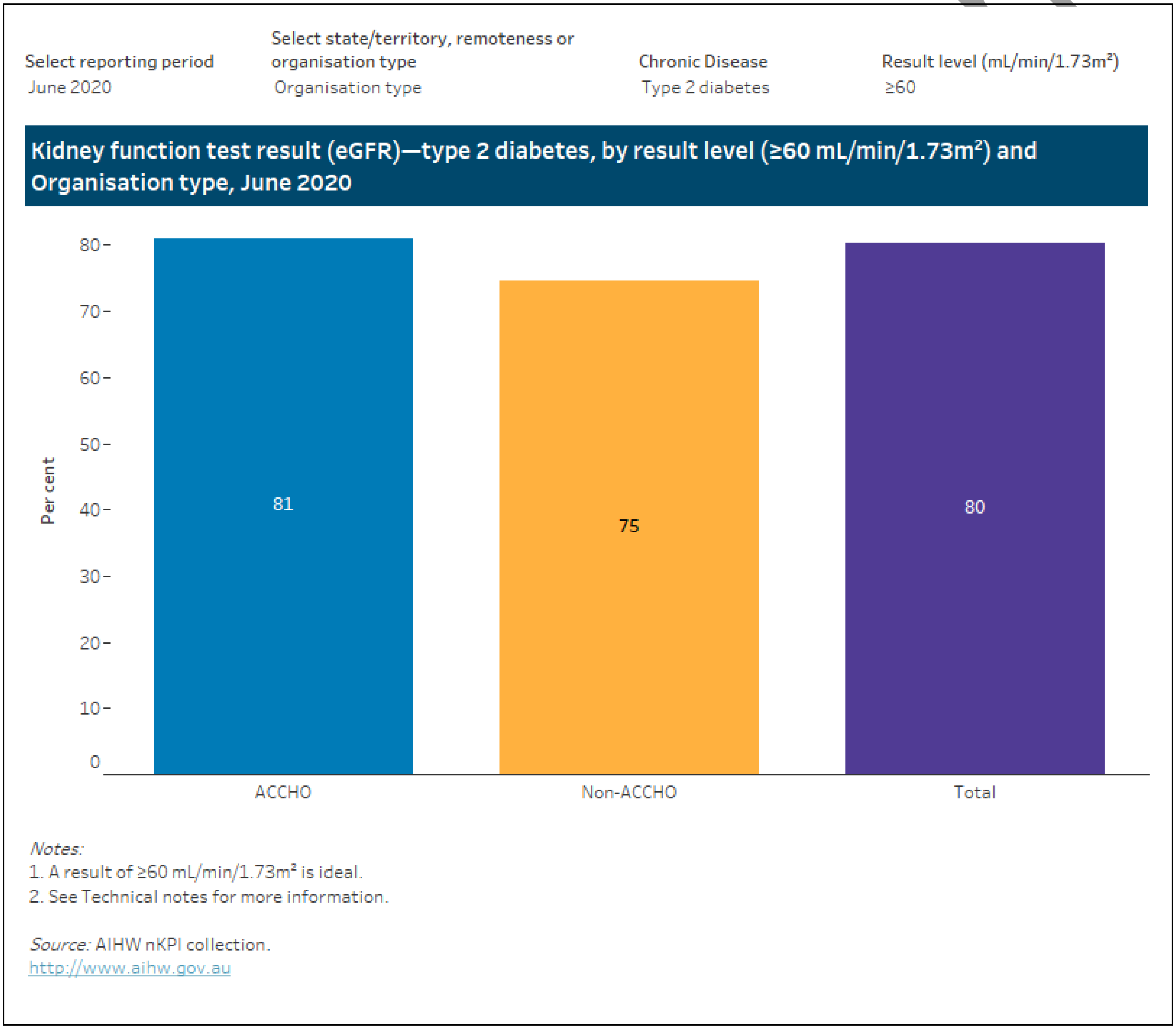
Notes: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Having an eGFR result of ≥60 mL/min/1.73m^2 within the previous 12 months for clients with type 2 diabetes ranged from:

- 84% in South Australia to 78% in Queensland
- 85% in *Major cities* to 78% in both *Remote and Very remote* areas
- 81% in Aboriginal Community Controlled Health Organisations (ACCHOs) to 75% in non-ACCHOs.

Having an eGFR result of ≥60 mL/min/1.73m^2 within the previous 12 months for clients with CVD ranged from:

- 80% in Victoria/Tasmania (combined) to 74% in Western Australian
- 81% in *Major cities* to 75% in *Outer regional*, *Remote* and *Very remote* areas
- 77% in Aboriginal Community Controlled Health Organisations (ACCHOs) to 74% in non-ACCHOs.



Select reporting period	Select state/territory, remoteness or organisation type	Chronic Disease	Result level (mL/min/1.73m²)
June 2020	Organisation type	Type 2 diabetes	≥60

Kidney function test result (eGFR)—type 2 diabetes, by result level (≥60 mL/min/1.73m²) and Organisation type, June 2020

Notes:
1. A result of ≥60 mL/min/1.73m² is ideal.
2. See Technical notes for more information.

Source: AIHW nKPI collection.
http://www.aihw.gov.au

Kidney function test result (ACR)—type 2 diabetes (PI19-B)

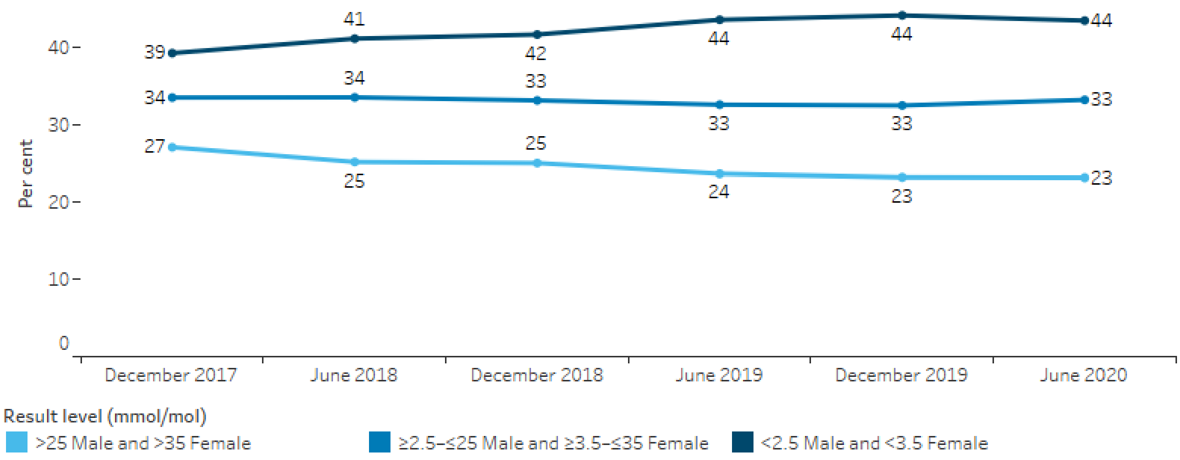
This indicator is:

- the proportion of male Indigenous regular clients aged 15 and over with type 2 diabetes who had an albumin/creatinine ratio (ACR) recorded within the previous 12 months of (mg/mmol):
  - <2.5
  - ≥2.5–≤25
  - >25; and
- the proportion of female Indigenous regular clients aged 15 and over with type 2 diabetes who had an albumin/creatinine ratio (ACR) recorded within the previous 12 months with a result of (mg/mmol):
  - <3.5
  - ≥3.5–≤35
  - >35.

It is collected for males and females in age groups from 15–24 to 65 and over. It is presented here for all Indigenous regular clients aged 15 and over.

At June 2020, 44% of Indigenous regular clients aged 15 and over with type 2 diabetes had an albumin/creatinine ratio (ACR) recorded within the previous 12 months of <2.5 for males or <3.5 for females.

Kidney function test result (ACR)—type 2 diabetes, by reporting period



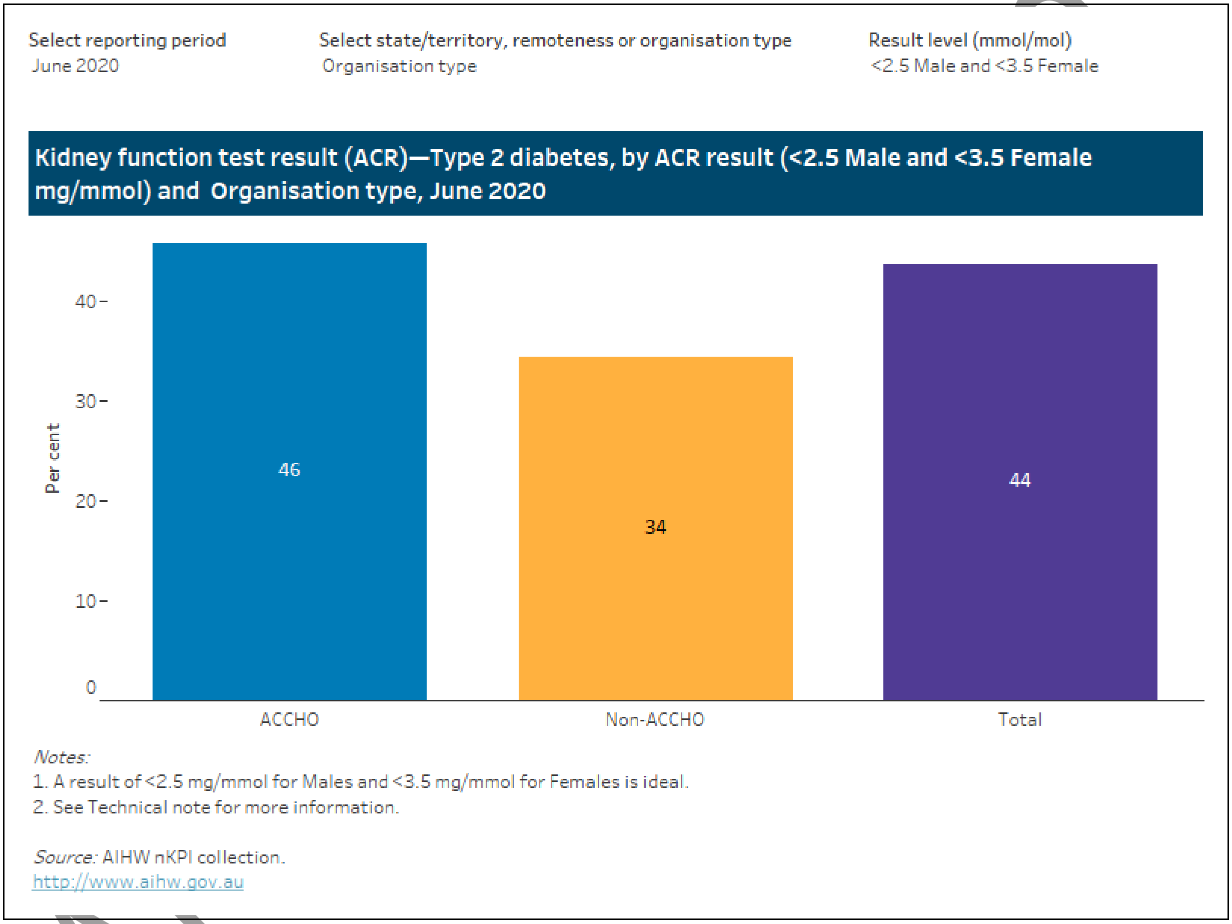
Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was highest in:

- New South Wales/the Australian Capital Territory (combined) (57%)
- *Inner regional* areas (56%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (46%).

It was lowest in:

- the Northern Territory (34%)
- *Very remote* areas (34%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (34%).



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Result level (mmol/mol)
<2.5 Male and <3.5 Female

Kidney function test result (ACR)—Type 2 diabetes, by ACR result (<2.5 Male and <3.5 Female mg/mmol) and Organisation type, June 2020

Notes:
1. A result of <2.5 mg/mmol for Males and <3.5 mg/mmol for Females is ideal.
2. See Technical note for more information.

Source: AIHW nKPI collection.
http://www.aihw.gov.au

References

AIHW (Australian Institute of Health and Welfare) 2020. Chronic kidney disease. Cat. No. CDK 16. Canberra: AIHW.

Kidney Health Australia 2020. Chronic Kidney Disease (CKD) Management in Primary Care (4th edition). Melbourne: Kidney Health Australia.

RACGP (Royal Australian College of General Practitioners) 2016. General practice management of type 2 diabetes, 2016–18. East Melbourne: RACGP and Diabetes Australia.

Immunised against influenza—type 2 diabetes or COPD (PI15)

This indicator is the proportion of Indigenous regular clients aged 15–49 with type 2 diabetes or chronic obstructive pulmonary disease (COPD) who had an influenza immunisation within the previous 12 months.

It is collected for males and females in age groups from 15–24 to 45–49. It is presented here for males and females in age groups:

- under 35
- 35–44
- 45–49.

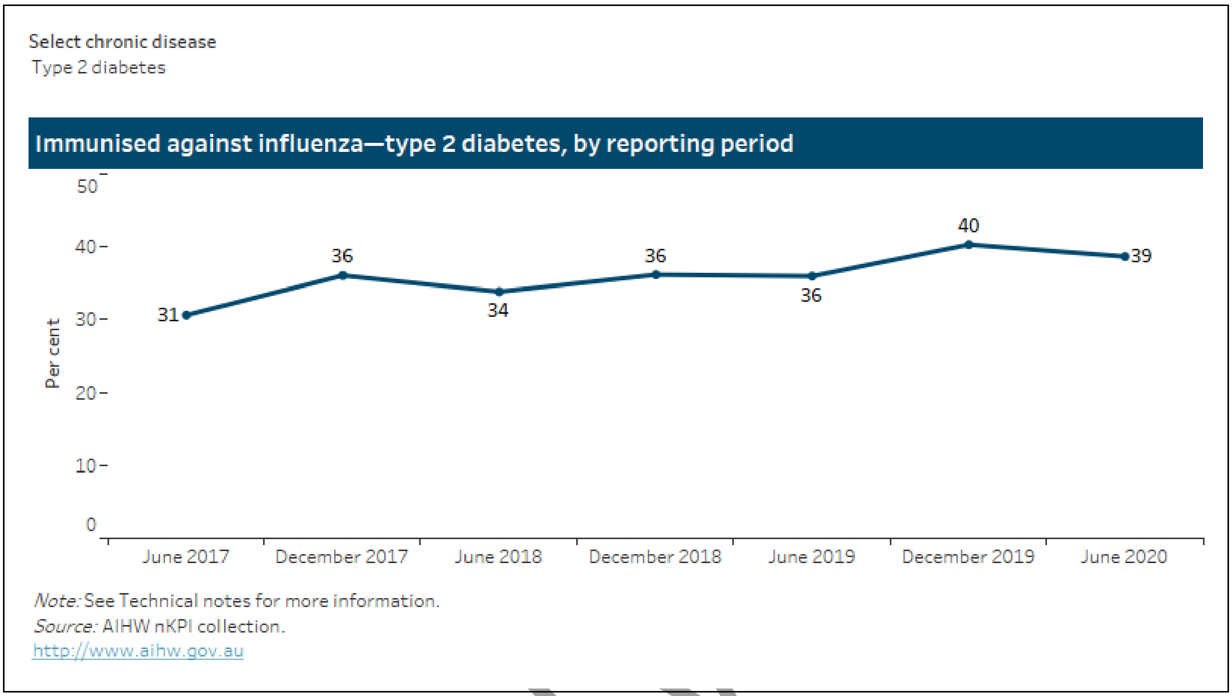
Why immunisation against influenza is important

Influenza (the flu) is a contagious respiratory disease that causes seasonal epidemics in Australia. Anyone can be infected with influenza but some people, such as Indigenous Australians, have a higher chance of serious illness and complications, such as pneumonia. Some people with influenza die as a result of their infection. Annual vaccination is the best way to prevent severe infections, hospitalisation and death due to influenza.

While immunisation against influenza is recommended for all Indigenous Australians aged 6 months and over, it is particularly important for those who are at a greater risk of complications, such as those with diabetes and COPD. Influenza vaccination substantially reduces the risk of hospitalisation and death from influenza and pneumonia for people with type 2 diabetes and COPD (AIHW 2018).

At June 2020:

- 39% of Indigenous regular clients aged 15–49 with type 2 diabetes had an influenza immunisation within the previous 12 months
- 42% of Indigenous regular clients aged 15–49 with COPD had an influenza immunisation within the previous 12 months.



Immunised against influenza—type 2 diabetes, by reporting period

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Influenza immunisation for those with type 2 diabetes was highest in:

- South Australia (45%)
- *Very remote* areas (45%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (41%).

It was lowest in:

- Queensland (32%)
- *Outer regional* areas (30%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (38%).

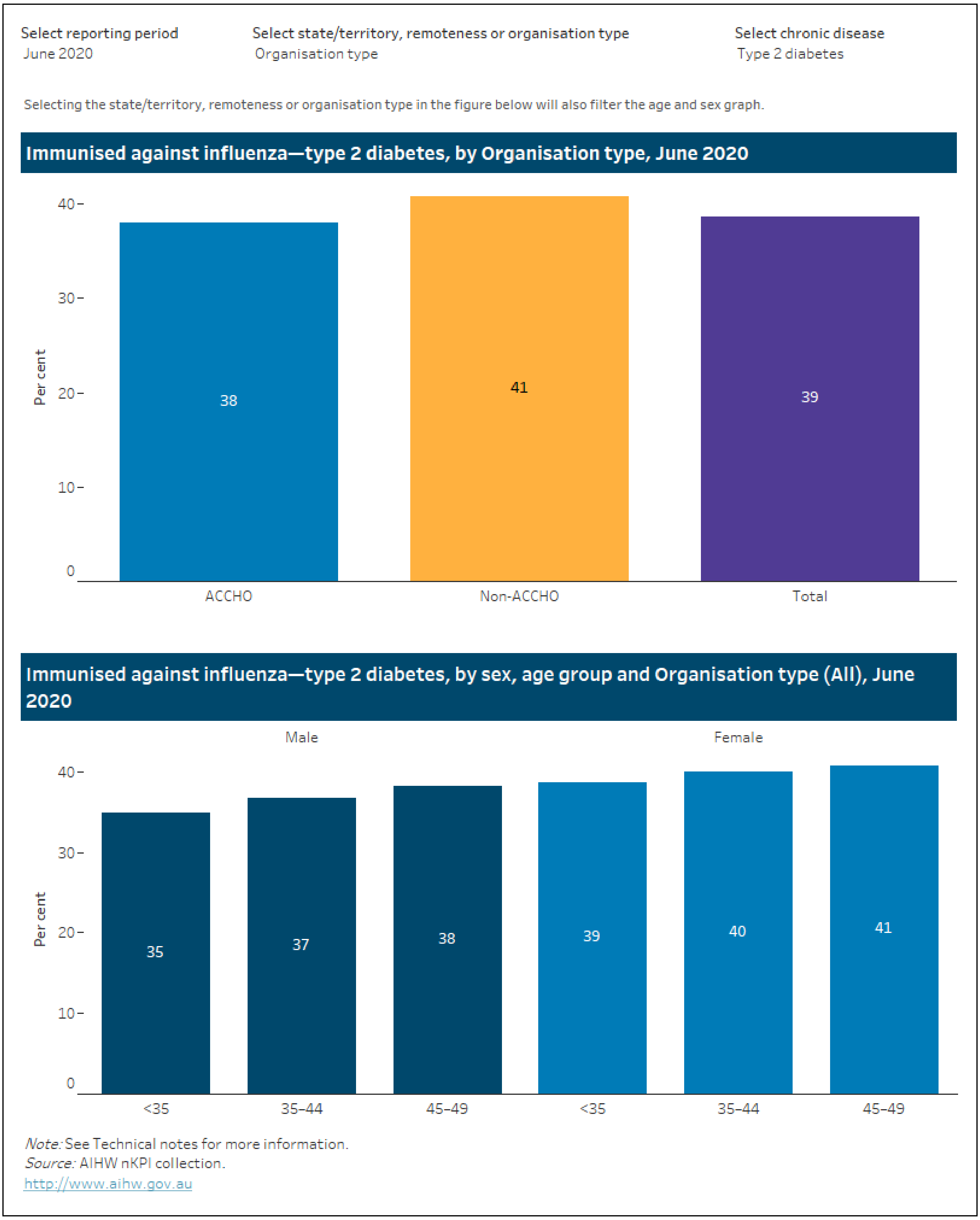
Influenza immunisation for those with COPD was highest in:

- the Northern Territory (51%)
- *Very remote* areas (52%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (46%).

It was lowest in:

- New South Wales/the Australian Capital Territory (combined, 33%)

- *Outer regional* areas (33%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (40%).



Select reporting period
June 2020

Select state/territory, remoteness or organisation type
Organisation type

Select chronic disease
Type 2 diabetes

Selecting the state/territory, remoteness or organisation type in the figure below will also filter the age and sex graph.

Immunised against influenza—type 2 diabetes, by Organisation type, June 2020

Immunised against influenza—type 2 diabetes, by sex, age group and Organisation type (All), June 2020

Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Reference

AIHW (Australian Institute of Health and Welfare) 2018. Vaccine-preventable diseases fact sheets. Cat no. PHE 236. Canberra: AIHW.

Impact of COVID-19

Analysis of the impact of COVID-19 on the activities and staffing of organisations reporting to the OSR and nKPI collections is complex because:

- the data cover periods outside of the pandemic and cannot be disaggregated into those prior to and during the pandemic, for example:
    - the 2019–20 OSR collection covers the period 1 July 2019–30 June 2020, and only the months between March and June 2020 overlap with the pandemic
    - the June 2020 nKPI collection covers various periods, depending on the indicator, and uses the regular client definition (that is 3 visits within 2 years, noting some or all visits may have occurred before the pandemic)
- some variation in results over time are normal.

However, by looking at the comments organisations include in the OSR to explain variations in their data (recorded for those with a 20% or more increase or decrease between periods), some analysis can be done on how often COVID-19 was cited as an explanation for variations in client numbers, client contacts, episodes of care, and FTEs.

To do this:

- Because not all services submit OSR data every year, a dataset was created using the 196 organisations that reported in 2019–20 and refined to only include those organisations who also reported in each of the financial years 2017–18 and 2018–19. The resulting dataset contained 157 organisations.
- The dataset was further reduced to 140 organisations to exclude organisations whose data was not considered comparable over the 3 periods. Reasons why data may not be comparable include changes to an organisation’s counting rules (for example, whether to include all clients of a large area health service or just a subset who use a particular service) or changes to clinical information systems (CIS).
- Comments recorded for organisations with a 20% or more increase or decrease between 2018–19 and 2019–20 in client numbers, client contacts, episodes of care, and total FTEs were examined.

The aggregate data from the selected 140 organisations show increases in the number of clients and workforce between the two most recent periods and decreases in client contacts and episodes of care (Table 1).

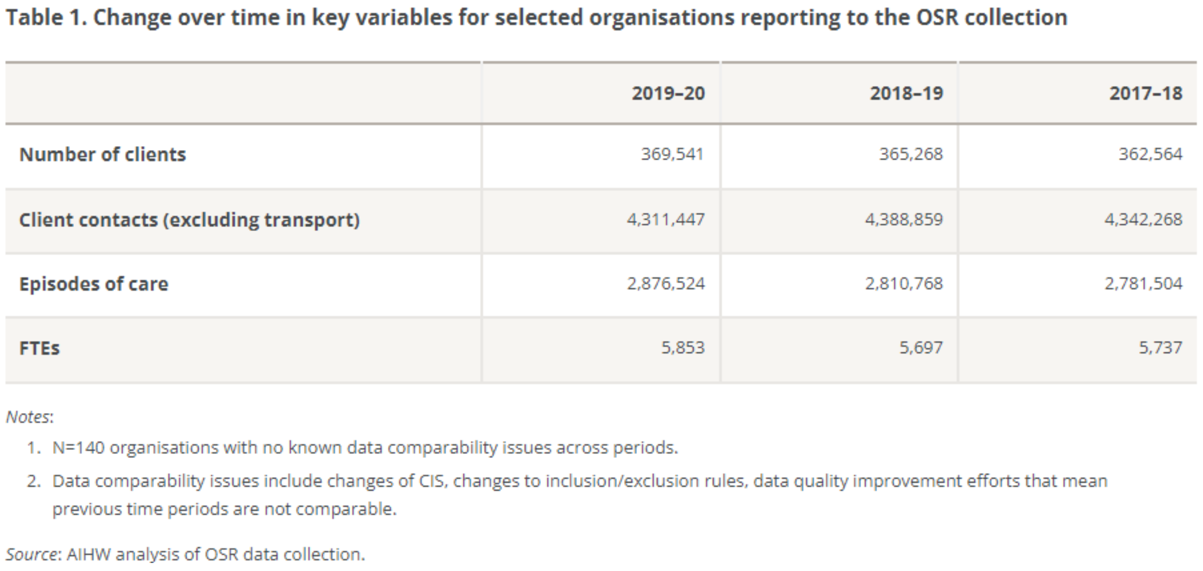


Table 1. Change over time in key variables for selected organisations reporting to the OSR collection

	2019–20	2018–19	2017–18
Number of clients	369,541	365,268	362,564
Client contacts (excluding transport)	4,311,447	4,388,859	4,342,268
Episodes of care	2,876,524	2,810,768	2,781,504
FTEs	5,853	5,697	5,737

Notes:

1. N=140 organisations with no known data comparability issues across periods.
2. Data comparability issues include changes of CIS, changes to inclusion/exclusion rules, data quality improvement efforts that mean previous time periods are not comparable.

Source: AIHW analysis of OSR data collection.

Aggregate analyses, however, can mask variations between organisations. Breaking the 2019–20 and 2018–19 data for the selected organisation down by whether there was a 20% or more decrease, a 20% or more increase or a less than 20% change shows that the numbers were relatively stable between periods for those organisations with a less than 20% change, but there were extensive changes for the other organisations (Table 2).

Table 2. Key variables for selected organisations reporting to the OSR collection, by degree of variation from previous reporting period, 2018–19 and 2019–20 (number)

2019–20

Degree of variation	Client numbers	Client contacts[(a)]	Episodes of care	Full-time equivalent (FTE) staff
<20% change	327,687	3,816,745	2,557,894	4,573
≥20% decrease	9,739	149,553	65,649	175
≥20% increase	32,115	345,149	252,981	1,105
Total	**369,541**	**4,311,447**	**2,876,524**	**5,853**

2018–19

Degree of variation	Client numbers	Client contacts[(a)]	Episodes of care	Full-time equivalent (FTE) staff
<20% change	327,485	3,826,736	2,531,145	4,567
≥20% decrease	13,404	304,642	92,087	285
≥20% increase	24,379	257,481	187,536	845
Total	**365,268**	**4,388,859**	**2,810,768**	**5,697**

(a) Excludes transport.

Notes:

1. N=140 organisations with no known data comparability issues across periods.
2. Degree of variation for 2018–19 refers to the change in numbers reported between 2017–18 and 2018–19; degree of variation for 2019–20 refers to the change in numbers reported between 2018–19 and 2019–20.
3. Data comparability issues include changes of CIS, changes to inclusion/exclusion rules, data quality improvement efforts that mean previous time periods are not comparable.

Source: AIHW analysis of OSR data collection.

Looking at the number of organisations that explicitly cited COVID-19 as a reason for the variation in key characteristics between reporting periods shows that:

- for client numbers:
  - of the organisations that reported a 20% or more decrease, the majority gave COVID-19 as the reason
  - of the organisations that reported a 20% or more increase, none gave COVID-19 as the reason
- a similar pattern was observed for client contacts and episode of care but, of those that reported a 20% or more increase, 13% and 25%, respectively, gave COVID-19 as the reason, compared with 75% and 90% that reported a 20% or more decrease
- very few organisations that reported a 20% or more increase or decrease in full-time equivalent (FTE) staff gave COVID-19 as the reason (Table 3).

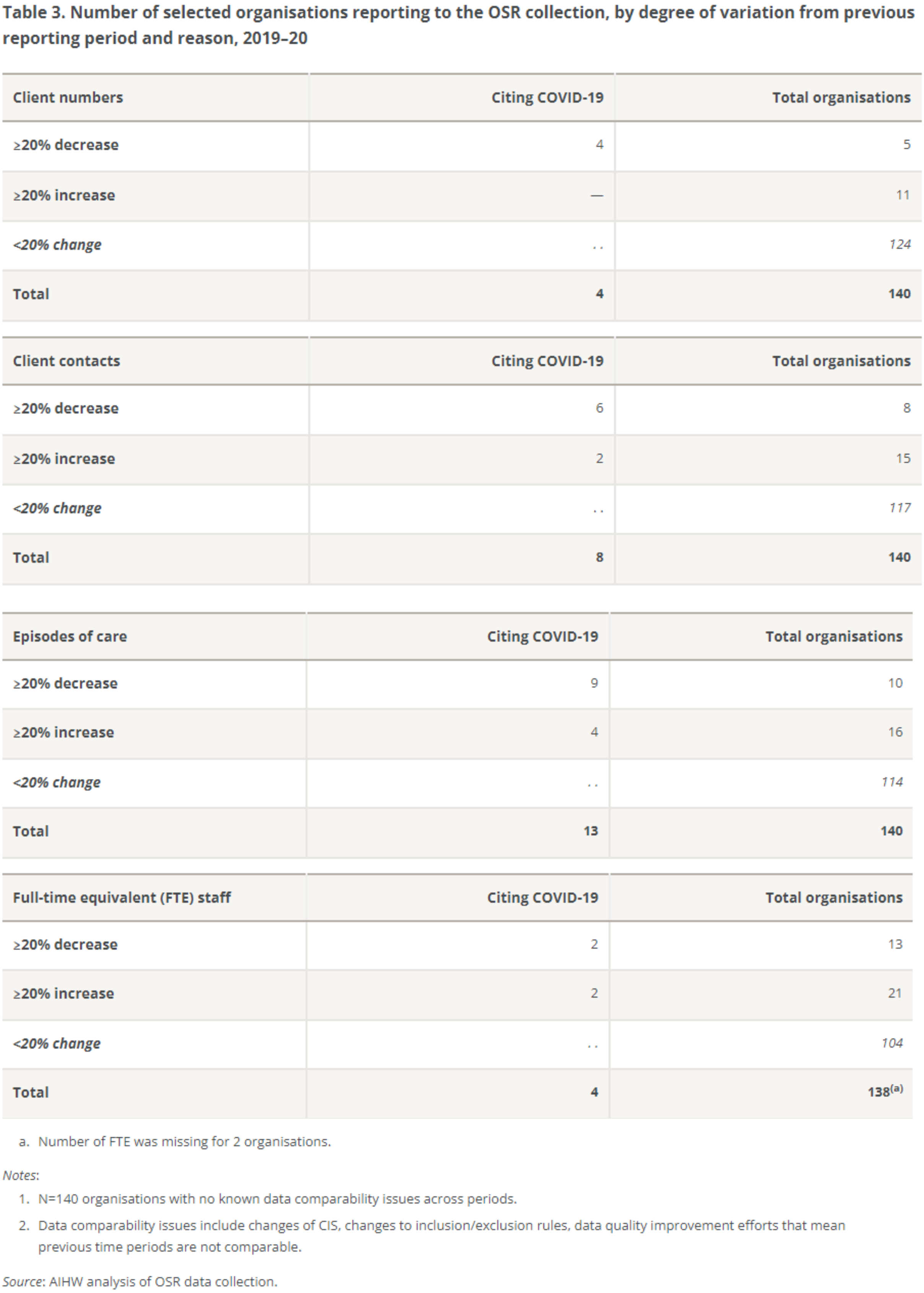


Table 3. Number of selected organisations reporting to the OSR collection, by degree of variation from previous reporting period and reason, 2019–20

Client numbers	Citing COVID-19	Total organisations
≥20% decrease	4	5
≥20% increase	—	11
<20% change	. .	*124*
Total	**4**	**140**

Client contacts	Citing COVID-19	Total organisations
≥20% decrease	6	8
≥20% increase	2	15
<20% change	. .	*117*
Total	**8**	**140**

Episodes of care	Citing COVID-19	Total organisations
≥20% decrease	9	10
≥20% increase	4	16
<20% change	. .	*114*
Total	**13**	**140**

Full-time equivalent (FTE) staff	Citing COVID-19	Total organisations
≥20% decrease	2	13
≥20% increase	2	21
<20% change	. .	*104*
Total	**4**	**138**[(a)]

a. Number of FTE was missing for 2 organisations.

Notes:

1. N=140 organisations with no known data comparability issues across periods.
2. Data comparability issues include changes of CIS, changes to inclusion/exclusion rules, data quality improvement efforts that mean previous time periods are not comparable.

Source: AIHW analysis of OSR data collection.

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.

The organisations citing COVID-19 as an explanation for a decrease came from all remoteness areas, states and territories (with the exception of Western Australia), service sizes, and organisation types.

The reasons COVID-19 caused changes in the data are difficult to generalise but the explanations given by organisations included:

- restrictions on travel for clients and staff
- reluctance of some clients to attend during the pandemic or to use telehealth
- difficulties in recording telehealth consultations
- vulnerable staff working from home
- people returning from urban areas to remote areas.

It is important to note, however, that these results are only indicative of the impact of COVID-19. Organisations whose data were not within the 20% threshold for variation may also have been affected but were not asked to provide an explanation.

Technical notes

This page contains information relevant to both the Online Services Report (OSR) and national Key Performance Indictors (nKPI) collections. Further information specific to each collection is provided in Interpreting OSR data and Interpreting nKPI data.

Where to go for more information

This page contains general information to aid interpretation of the OSR and nKPI collections. This should be used in conjunction with additional information contained in the:

- data tables accompanying this report
- OSR and nKPI data collection guides
- METeOR (AIHW's Metadata Online Registry)
- Health Data Portal.

While some organisations constitute an individual health care clinic, others have multiple clinics, and provide combined data for all their clinics. Other organisations are intermediaries (for example, Primary Health Networks), which might also combine the data for the clinics where they subcontract services.

In both collections, a client may attend more than one organisation. The extent this occurs is not known and is not adjusted for.

Data collection and submission

Each organisation reporting to the OSR and nKPI collections records service provision in their Clinical Information Systems (CIS). While the CISs contain many variables related to individual clients, only those specified as required for the OSR and nKPI collections, aggregated for each organisation, are extracted for use.

Data are aggregated using cohort definitions and specialised software and then submitted to the Australian Institute of Health and Welfare (AIHW) via the Health Data Portal (the HDP). The HDP is the Department of Health's secure web-based data submission platform.

Many CIS are able to extract, aggregate and upload the de-individualised data directly to the HDP through a direct-load process. Organisations with systems unable to complete the direct-load process can manually enter aggregate data directly into a web-based form through the HDP.

The HDP applies a series of pre-defined validation rules (originally developed by the AIHW) to the data to identify any data quality issues, for example, that the numerator is less than the denominator, that the numerator sums to the denominator and that related indicators or questions are consistent. In addition, the data are compared with data from the previous period and:

- for the OSR collection, differences of more than 20% are flagged

- for the nKPI collection, differences of 25% to 100% are flagged, depending on the size of the numerator/denominator.

If any validation rules are triggered, the organisation is asked to review their data and either amend it, or confirm that it is correct and provide an optional comment.

The data are then submitted to the AIHW for review. Where the AIHW identifies possible errors or inconsistencies in the data, a comment is added to the HDP containing a description of the issue and the organisation is invited to resubmit their data. This process is repeated until no data quality issues are identified, the relevant organisation indicates it is unable or unwilling to resupply corrected data or the collection period is closed. At this point, the data are considered to be finalised for that organisation.

Where unresolved data quality issues are identified, the AIHW excludes these data from national reporting (this may be a single data item for an organisation or all data for an organisation).

Comparisons over time

Trends over time are presented where possible, noting that the organisations reporting to the OSR and nKPI collections, and data quality, can vary over time. For example:

- While for the most part, it is the same organisations contributing to the collections, as a result of changes in funding, auspicing or reporting arrangements at the local level:
  - the organisations that are funded to provide services vary between periods
  - the funded organisations that report data each year vary (for example, an organisation may be given an exemption from reporting for specific periods).
- Some organisations may be unable to report accurate data in particular periods or for particular data items (for example, because of changes in their clinical information systems or record-keeping practices) and these data are excluded from national reporting. As such, the number of organisations submitting valid data, on the whole or for a particular data item, vary between periods.

Also, unlike in previous years where reporting to the OSR and nKPI collections was a mandatory condition of receiving funding, for 2019–20, reporting was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19. COVID-19 also affected the organisations reporting to the collections in a variety of other ways. See Impact of COVID-19 for more information.

Interpreting OSR data

This page contains general information to aid in interpreting OSR data. Further information related to both collections is provided on the main Technical notes page.

Where to go for more information

This page contains general information to aid interpretation of OSR data. This should be used in conjunction with additional information contained in the:

- data tables accompanying this report
- OSR data collection guide
- METeOR (AIHW's Metadata Online Registry)
- Health Data Portal.

Organisational participation and data exclusions

Not all organisations in-scope to report data to the OSR collection do so. This varies by year (tables 1 and 2).

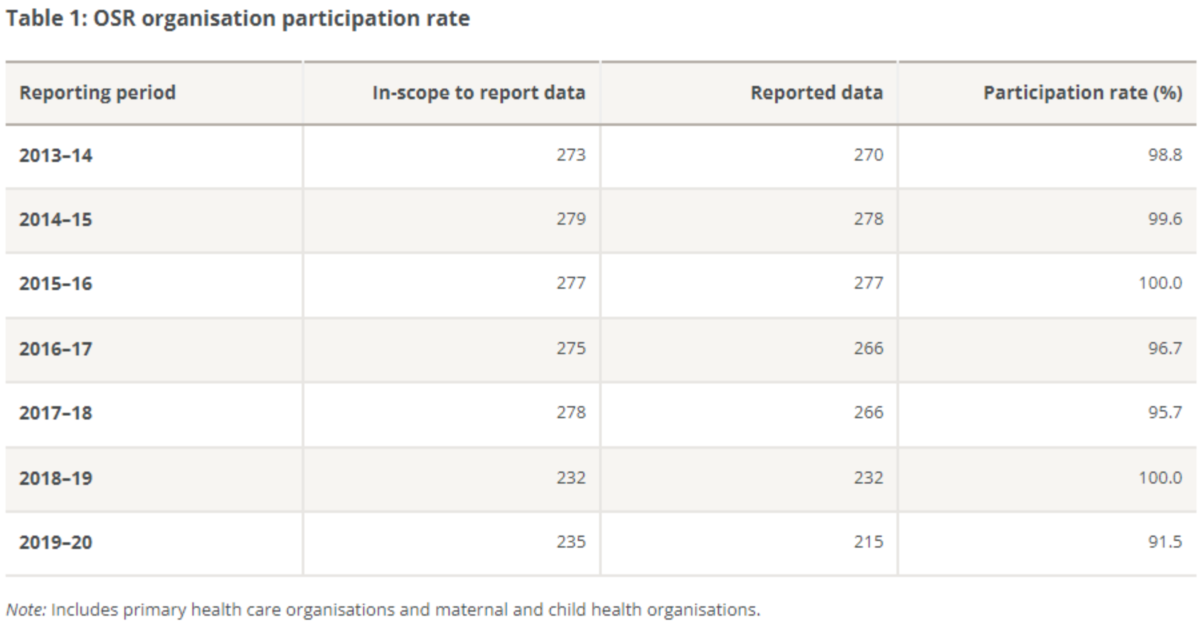


Table 1: OSR organisation participation rate

Reporting period	In-scope to report data	Reported data	Participation rate (%)
2013–14	273	270	98.8
2014–15	279	278	99.6
2015–16	277	277	100.0
2016–17	275	266	96.7
2017–18	278	266	95.7
2018–19	232	232	100.0
2019–20	235	215	91.5

Note: Includes primary health care organisations and maternal and child health organisations.

NOTE: this is not the most recent version of this report. Please visit the AIHW website for updates.

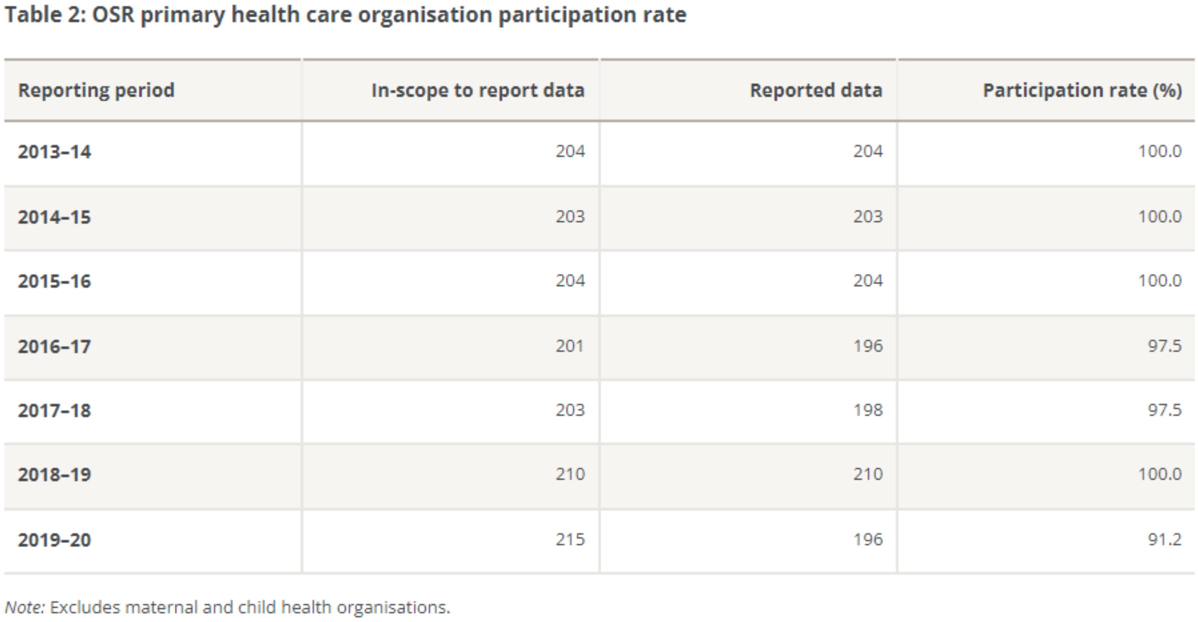


Table 2: OSR primary health care organisation participation rate

Reporting period	In-scope to report data	Reported data	Participation rate (%)
2013–14	204	204	100.0
2014–15	203	203	100.0
2015–16	204	204	100.0
2016–17	201	196	97.5
2017–18	203	198	97.5
2018–19	210	210	100.0
2019–20	215	196	91.2

Note: Excludes maternal and child health organisations.

For the organisation that do report data, particular data items may be excluded from analysis if data quality issues have not been resolved. Common data quality queries received during data submission relate to incomplete or inaccurate data (for example, workforce positions not reported or reported in terms of the number of people rather than full-time equivalent positions); data discrepancies between two or more questions (for example, the number of clients exceeding the number of episodes of care); and large increases or decreases in data items compared with previous submissions. Where significant data quality issues remain after follow-up with organisations, affected data are excluded from analyses. This varies by year and by data item (tables 3 and 4).

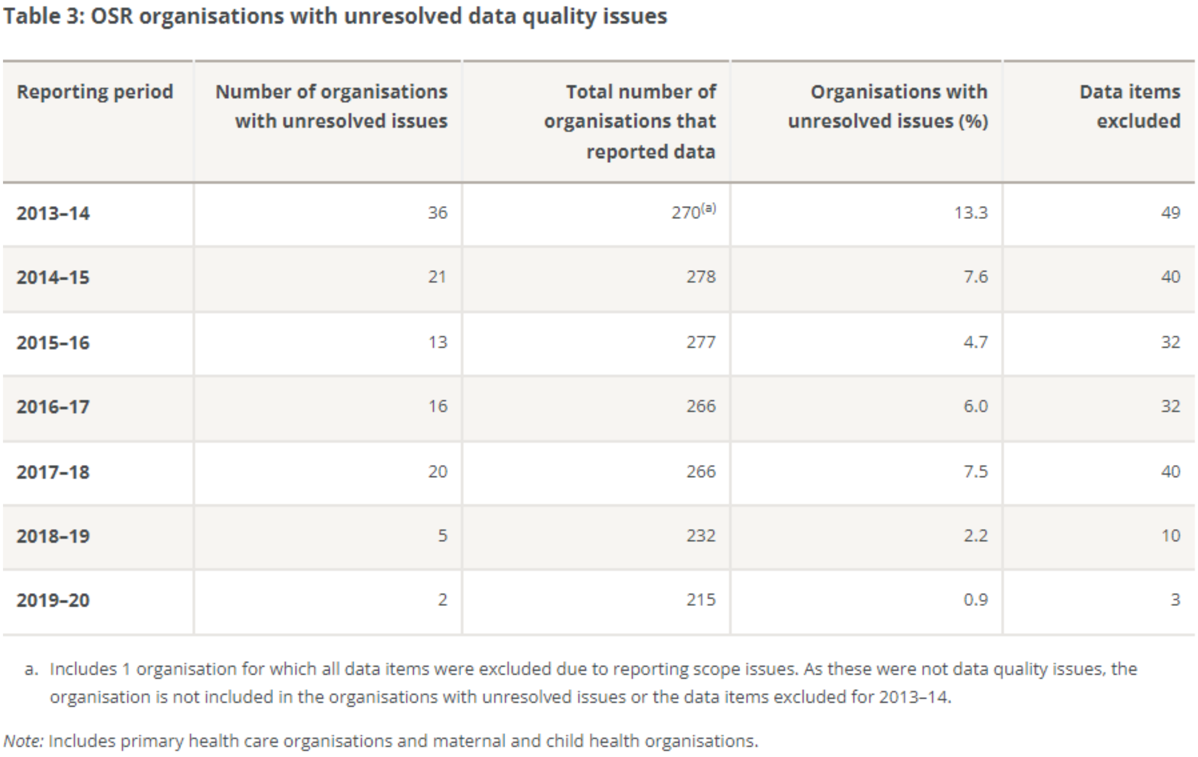


Table 3: OSR organisations with unresolved data quality issues

Reporting period	Number of organisations with unresolved issues	Total number of organisations that reported data	Organisations with unresolved issues (%)	Data items excluded
2013–14	36	270[a]	13.3	49
2014–15	21	278	7.6	40
2015–16	13	277	4.7	32
2016–17	16	266	6.0	32
2017–18	20	266	7.5	40
2018–19	5	232	2.2	10
2019–20	2	215	0.9	3

a. Includes 1 organisation for which all data items were excluded due to reporting scope issues. As these were not data quality issues, the organisation is not included in the organisations with unresolved issues or the data items excluded for 2013–14.

Note: Includes primary health care organisations and maternal and child health organisations.

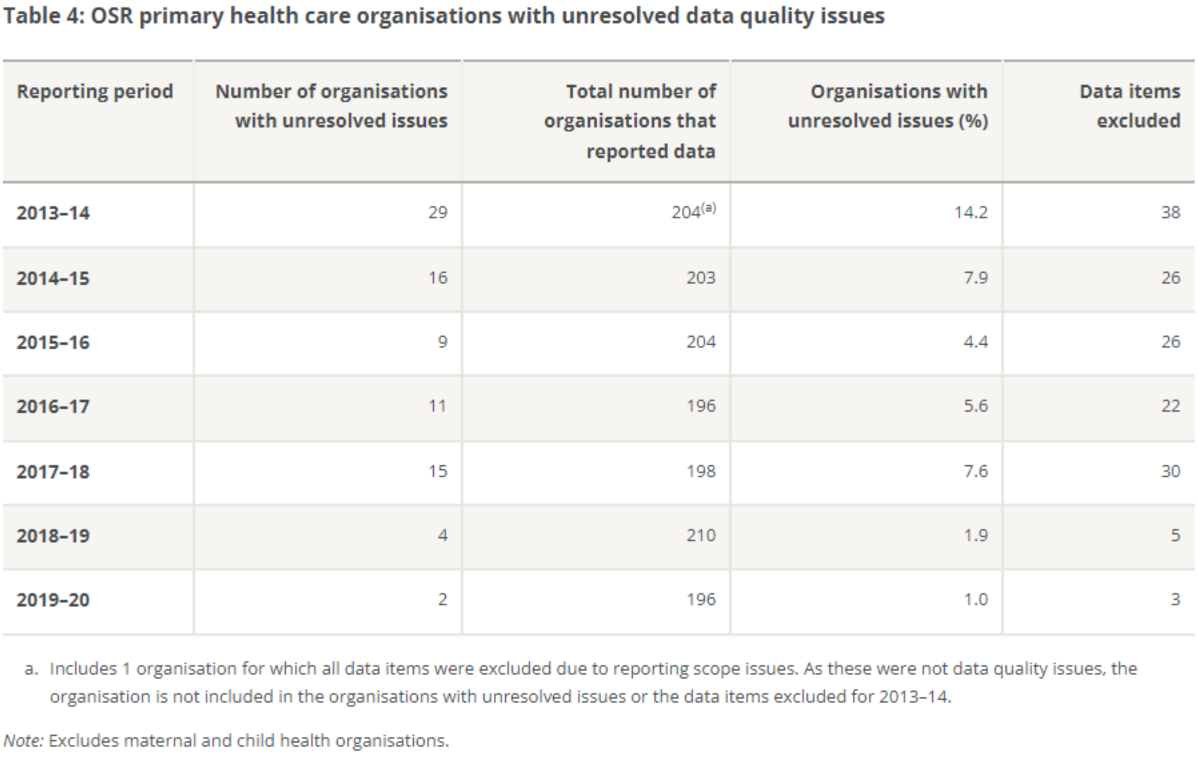


Table 4: OSR primary health care organisations with unresolved data quality issues

Reporting period	Number of organisations with unresolved issues	Total number of organisations that reported data	Organisations with unresolved issues (%)	Data items excluded
2013–14	29	204[a]	14.2	38
2014–15	16	203	7.9	26
2015–16	9	204	4.4	26
2016–17	11	196	5.6	22
2017–18	15	198	7.6	30
2018–19	4	210	1.9	5
2019–20	2	196	1.0	3

a. Includes 1 organisation for which all data items were excluded due to reporting scope issues. As these were not data quality issues, the organisation is not included in the organisations with unresolved issues or the data items excluded for 2013–14.

Note: Excludes maternal and child health organisations.

Maternal and child health organisations

While a small number of organisations that received funding only for maternal and child health services (MCH organisations) report to the OSR collection, these are excluded from the OSR data presented in this report unless otherwise noted.

MCH organisations reporting to the OSR are significantly different from organisations funded for comprehensive primary health care (PHC), both in the purpose of the funding and in what they report in the OSR. For example, MCH organisations are funded only for specific maternal and child health programs (such as those based within a hospital or health service) and only report on their funded program.

Changes to collection content in 2018–19

In 2018–19, the OSR collection underwent significant change and was scaled back to include only 'core' items. Items dropped include the substance use and social and emotional wellbeing modules, and the services provided and cultural safety items. Plans are underway to reintroduce key items in a staged approach over the next few years (see the Health Data Portal: Online Services Report).

Also, collections prior to 2018–19 had maternal and child health (MCH) questions in a separate module to preventative health. In 2018–19 these were combined but the data range MCH services were required to report was only focused on what they received MCH funding for, not through all types of PH services the health organisation offered.

Changes to episodes of care in 2016–17

While the collection and validation processes for most years have been similar, episodes of care data for 2016–17 are not comparable with other years because changes were made to the types of contacts counted as an episode of care. There were also corrections made to the counting rules used by one clinical information system which did not fully align with the episode of care definition (which had not changed since originally agreed in 2008–09). These led to lower numbers of episodes of care recorded and potential undercounts for some services in 2016–17. In 2017–18, these contact types were again included in the episodes of care count and the extraction issues around episodes of care counts were resolved. This also affected counts of client contacts.

Interpreting nKPI data

This page contains general information to aid in interpreting nKPI data. Further information related to both collections is provided on the main Technical notes page.

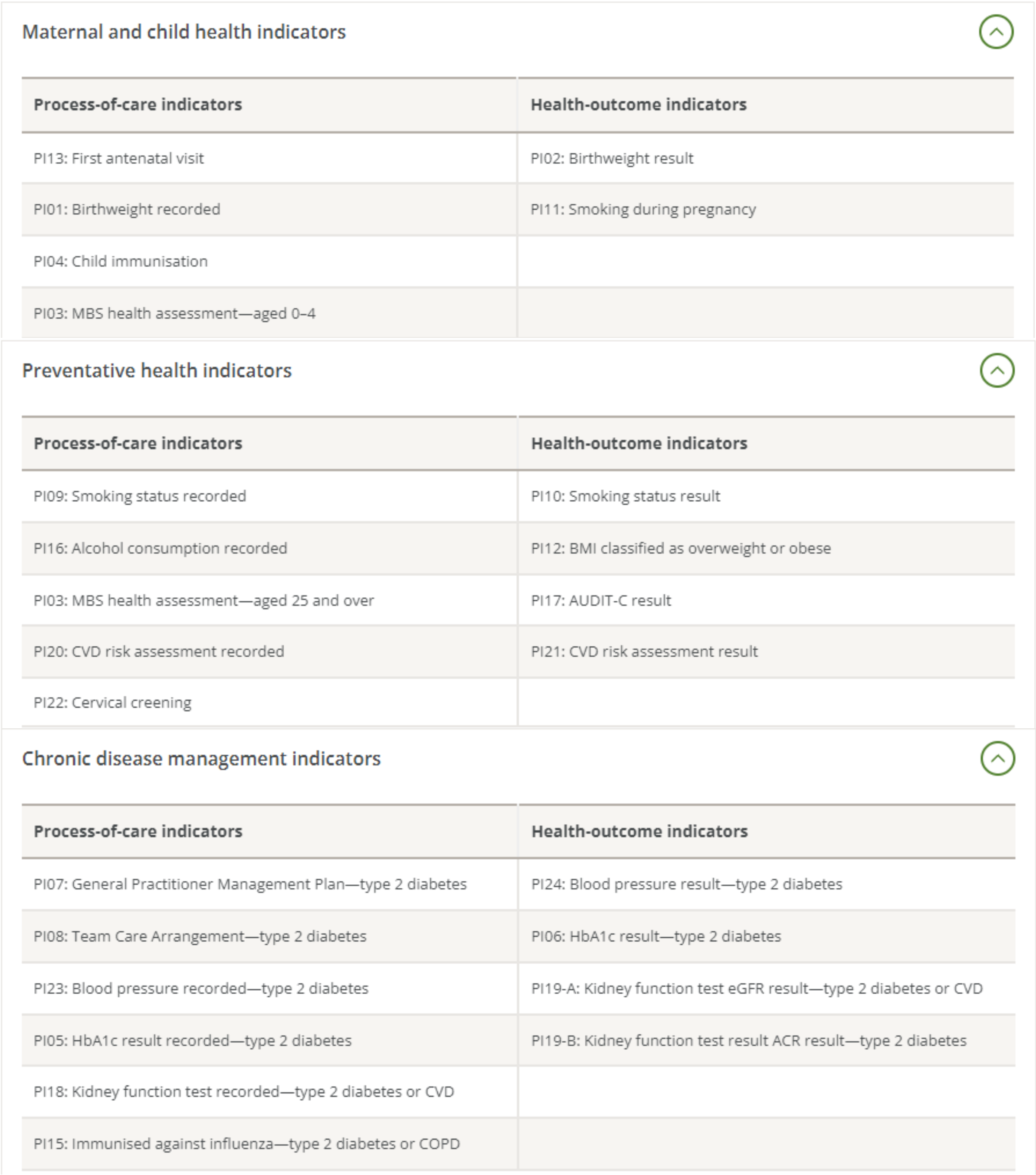
Where to go for more information

This page contains general information to aid interpretation of nKPI data. This should be used in conjunction with additional information contained in the:

- data tables accompanying this report
- nKPI data collection guide
- METeOR (AIHW's Metadata Online Registry)
- Health Data Portal.

The national Key Performance Indicators (nKPI) collection consists of 15 process-of-care and 9 health-outcome indicators organised under three domains (Table 1).

Table 1: Indicators by domain and type



Maternal and child health indicators

Process-of-care indicators	Health-outcome indicators
PI13: First antenatal visit	PI02: Birthweight result
PI01: Birthweight recorded	PI11: Smoking during pregnancy
PI04: Child immunisation	
PI03: MBS health assessment—aged 0–4	

Preventative health indicators

Process-of-care indicators	Health-outcome indicators
PI09: Smoking status recorded	PI10: Smoking status result
PI16: Alcohol consumption recorded	PI12: BMI classified as overweight or obese
PI03: MBS health assessment—aged 25 and over	PI17: AUDIT-C result
PI20: CVD risk assessment recorded	PI21: CVD risk assessment result
PI22: Cervical creening	

Chronic disease management indicators

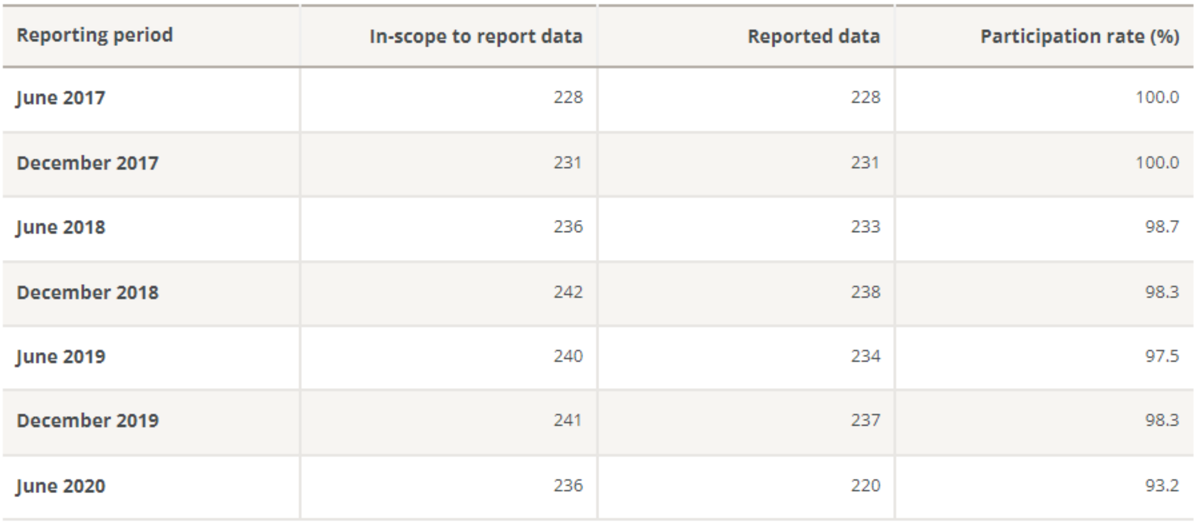
Process-of-care indicators	Health-outcome indicators
PI07: General Practitioner Management Plan—type 2 diabetes	PI24: Blood pressure result—type 2 diabetes
PI08: Team Care Arrangement—type 2 diabetes	PI06: HbA1c result—type 2 diabetes
PI23: Blood pressure recorded—type 2 diabetes	PI19-A: Kidney function test eGFR result—type 2 diabetes or CVD
PI05: HbA1c result recorded—type 2 diabetes	PI19-B: Kidney function test result ACR result—type 2 diabetes
PI18: Kidney function test recorded—type 2 diabetes or CVD	
PI15: Immunised against influenza—type 2 diabetes or COPD	

In this report, where there are small numbers of reporting organisations in a state or territory, data are presented combined with another state or territory. This is the case for Tasmania (presented combined with Victoria) and the Australian Capital Territory (presented combined with New South Wales).

Organisational participation and data exclusions

Not all organisations in-scope to report data to the nKPI collection do so. This varies by period (Table 2).

Table 2: nKPI organisation participation rate



Reporting period	In-scope to report data	Reported data	Participation rate (%)
June 2017	228	228	100.0
December 2017	231	231	100.0
June 2018	236	233	98.7
December 2018	242	238	98.3
June 2019	240	234	97.5
December 2019	241	237	98.3
June 2020	236	220	93.2

For the organisations that do report data, particular data items may be excluded from analysis if data quality issues have not been resolved (Table 3). The major reasons for data not being provided or organisations having data quality problems include a lack of complete records of data held by the organisation, insufficient data management resources at organisations to support the data collection, organisations not providing the service for which the indicator collects information, and problems with the electronic transfer of data extracted from organisations' CIS. Changes to the data extraction process were a major reason for organisations having data quality issues in their original submission from June 2017 to June 2018.

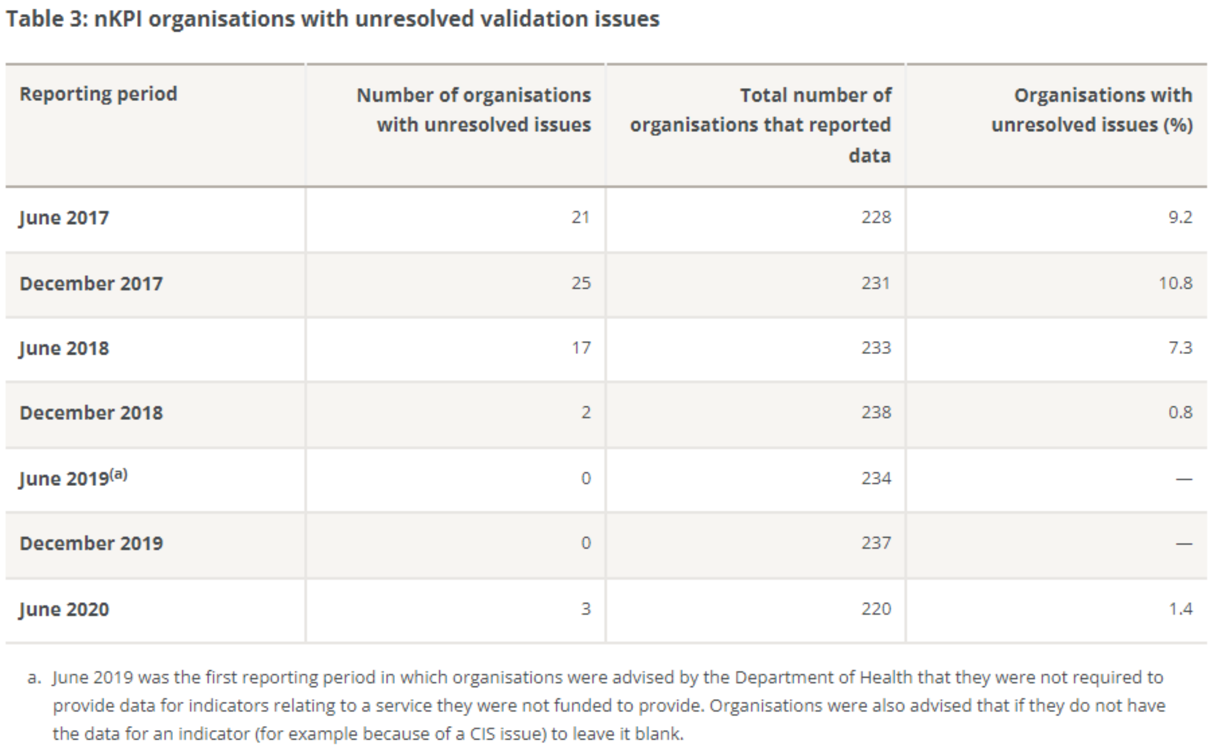


Table 3: nKPI organisations with unresolved validation issues

Reporting period	Number of organisations with unresolved issues	Total number of organisations that reported data	Organisations with unresolved issues (%)
June 2017	21	228	9.2
December 2017	25	231	10.8
June 2018	17	233	7.3
December 2018	2	238	0.8
June 2019[(a)]	0	234	—
December 2019	0	237	—
June 2020	3	220	1.4

a. June 2019 was the first reporting period in which organisations were advised by the Department of Health that they were not required to provide data for indicators relating to a service they were not funded to provide. Organisations were also advised that if they do not have the data for an indicator (for example because of a CIS issue) to leave it blank.

In addition to unresolved internal validation issues, some indicators are excluded from analysis where the organisation's data do not meet the regular client definition (for example because they were a new organisation or they had changed to a new CIS) or where issues were identified with a particular CIS. This varies by period and by data item. For example:

- Data from organisations using the MMEX Clinical Information System (CIS) were excluded from data submitted in collections from June 2019 and earlier for indicators related to smoking and alcohol.
- PI13 (antenatal visits)—data for some organisations using Communicare and Medical Director was affected by data extraction issues for June 2017, December 2017 and June 2018. This resulted in some categories being combined.
- PI20 (risk factors to enable a CVD risk assessment)—MMEX results are excluded for June 2017.
- PI21 (CVD risk assessment result)—data are only included from organisations with CISs which capture all data necessary to calculate a result (some CISs do not).
- PI22 (cervical screening)—some data quality issues were identified with the initial June 2018 submission but these have been resolved for all other periods.
- PI18 and PI19 (kidney function test recorded and result) have had ongoing data quality issues since June 2017. Affected data were excluded.

Changes to data extraction methods

Data from earlier collections are not comparable with data from June 2017 onwards. For the June 2017 collection, changes were made to the electronic data extraction method for most organisations that resulted in a break in series. For more information see AIHW 2018.

From December 2015 onwards, organisations funded by the Northern Territory Government changed the way in which data were extracted so that only tests or measurements conducted at the reporting organisation were counted.

Changes in indicators

Indicator specifications may be revised over time (for example, to reflect the latest clinical and best-practice guidelines).

- PI22 (cervical screening)—in June 2018, PI22 was adjusted to align with revised requirements under the National Cervical Screening Program (NCSP). The key changes from June 2018 are that:
  - data include clients who had either a Papanicolaou smear (Pap test) conducted prior to 1 December 2017 or a human papillomavirus (HPV test) conducted from 1 December 2017
  - the age range was revised to 20–74 to accommodate the former reporting age range (20–69) and the new age range (25–74).

In 2020, in response to issues identified during the AIHW's *Review of the two national Indigenous specific primary health care datasets: OSR and nKPI*, all indicators current as of June 2020 underwent a review by a clinical and technical working group sitting under, and convened by, the (Indigenous) Health Services Advisory Group (HS DAG). As a result, HS DAG has approved a series of changes to the indicators and these will be rolled out progressively during 2020–21.

Maternal and child health organisations

Data from a small number of organisations that received funding only for maternal and child health services (MCH organisations) are included in the nKPI data presented in this report unless otherwise noted.

While MCH organisations are generally excluded from the OSR data presented in this report (see Interpreting OSR data), they are included in the nKPI data. This is because a subset of indicators applies directly to the MCH funded programs and the aims of these programs are considered similar to the aims of antenatal/early childhood care delivered within organisations funded for primary health care.

Prior to June 2019, because MCH organisations were not limited to reporting only on the maternal and child health indicators, a small number also reported against other indicators (like alcohol or BMI).

References

AIHW (Australian Institute of Health and Welfare) 2018. National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care: results for 2017. National key performance indicators for Aboriginal and Torres Strait Islander primary health care series no. 5. Cat. no. IHW 200. Canberra: AIHW.

Glossary

Aboriginal and/or Torres Strait Islander: A person who identified themselves, or was identified by another household member, as being of Aboriginal or Torres Strait Islander origin. See also **Indigenous**.

Aboriginal Community Controlled Health Organisation (ACCHO): Health services operated by local Indigenous communities to deliver comprehensive, holistic and culturally appropriate health care to their communities. They range from large services with several medical practitioners who provide a range of services, to small services that rely on nurses and/or Aboriginal health workers to provide most services, and are controlled through a locally elected board of management. For more information see the National Aboriginal Community Controlled Health Organisation (NACCHO) website.

Aboriginal and Torres Strait Islander health worker: An Aboriginal and/or Torres Strait Islander person with a minimum qualification in the field of primary health-care work or clinical practice. Aboriginal and Torres Strait Islander health practitioners are one speciality stream of health worker. Health workers liaise with patients, clients and visitors to hospitals and health clinics, and work as a team member to arrange, coordinate and provide health-care delivery in community health clinics.

Aboriginal and Torres Strait Islander health practitioner: A person who has completed Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) and is registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. The practitioner may undertake higher levels of clinical assessment and care within their agreed scope of practice. This role became nationally registered from 1 July 2012 under the National Registration and Accreditation Scheme for health professions.

Accessibility/Remoteness Index of Australia (ARIA): ARIA measures the remoteness of a point based on the physical road distances to the nearest urban centre in each of 5 size classes. Therefore, not all remoteness areas are represented in each state or territory.

There are 6 remoteness areas in this structure:

- *Major cities*—collection districts (CDs) with an average ARIA index value between 0 and less than or equal to 0.2
- *Inner regional areas*—CDs with an average ARIA index value greater than 0.2 and less than or equal to 2.4

- *Outer regional areas*—CDs with an average ARIA index value greater than 2.4 and less than or equal to 5.92
- *Remote areas*—CDs with an average ARIA index value greater than 5.92 and less than or equal to 10.53
- *Very remote areas*—CDs with an average ARIA index value greater than 10.53
- *Migratory*—composed of offshore, shipping and migratory CDs.

albumin/creatinine ratio (ACR): A measure of renal function that assesses albumin in the urine.

allied health professionals: Includes professionals working as an audiologist/audiometrist, diabetes educator, dietitian, optometrist, pharmacist, physiotherapist, podiatrist, speech pathologist and 'other' allied health professionals not already specified.

AUDIT-C: An Alcohol Use Disorders Identification Test screening tool, which is sensitive to the early detection of risky and high-risk (or hazardous and harmful) drinking.

birthweight: The first weight of the fetus or baby obtained after birth.

body mass index (BMI): A measure of an adult's weight (body mass) relative to height, used to assess the extent of weight deficit or excess, where height and weight have been measured. BMI is the weight in kilograms divided by the square of the height in metres.

cardiovascular disease (CVD): Any disease of the circulatory system, namely the heart (cardio) or blood vessels (vascular).

chronic obstructive pulmonary disease (COPD): Serious, progressive and disabling long-term lung disease where damage to the lungs—usually because of both emphysema and chronic bronchitis—obstructs oxygen intake, and causes increasing shortness of breath.

client numbers: Refers to how many individuals receive health care from an organisation during the period. For the OSR, this refers to Indigenous and non-Indigenous clients. For the nKPI, this refers to only Indigenous **regular clients**. Each individual is counted once only within an organisation, regardless of how many times they are seen. See also Clients and Technical notes pages.

client contact: In the OSR collection, this refers to contacts made by clients of an organisation during the collection period. See also Clients and Technical notes pages.

clinical information system (CIS): A computer system used to manage client records.

episodes of care: In the OSR collection, this refers to contacts between an individual client and 1 or more staff of the organisation within 1 calendar day during the collection period. All contacts with the same client on the same day are treated holistically as 1 episode of care. See also Clients and Technical notes pages.

estimated glomerular filtration rate (eGFR): A measure of how well the kidneys filter waste from the blood.

first antenatal visit: The contact at which the initial antenatal check-ups are done—for example, to confirm pregnancy, establish history, and conduct blood tests.

full-time equivalent (FTE) staff: FTE is a standard measure of the size of a workforce that takes into account both the number of workers and the hours that each works. For example, if a workforce comprises 2 people working full-time 40 hours a week and 2 working half-time, this is the same as 3 working full-time—an FTE of 3.

General Practitioner Management Plan (GPMP): Chronic disease management plan carried out according to the MBS Schedule (item 721).

haemoglobin A1c (HbA1c or glycated haemoglobin): A measurement that acts as an indicator of time-averaged blood glucose levels (over the previous 2–3 months).

health staff: The following positions are counted as 'health' staff in this report: Aboriginal and Torres Strait Islander health workers; Aboriginal and Torres Strait Islander health practitioners; doctors/GPs; nurses and midwives; substance misuse and drug and alcohol workers; tobacco workers and coordinators; dentists or dental therapists; dental support workers; sexual health workers; outreach workers; traditional healers; environmental health workers and officers; medical specialists; social and emotional wellbeing staff and counsellors; allied health professionals; health promotion or prevention workers; training or trainee health positions; other health workers (not reported elsewhere).

indicator: See definition for national Key Performance Indicators.

Indigenous: Used interchangeably with **Aboriginal and/or Torres Strait Islander**.

influenza: An acute contagious viral respiratory infection marked by fever, muscle aches, headache, cough, and sore throat.

MBS health assessment: Health assessment which are done according to the MBS Schedule (item 715).

medical specialists: Medical practitioners who are registered as specialists under a law of state or territory or recognised as specialists or consultant physicians by a specialist recognition advisory committee, such as paediatricians, ophthalmologists, cardiologists, ear, nose and throat specialists, obstetricians and surgeons.

non-Indigenous: A person who has indicated they are not of **Aboriginal and/or Torres Strait Islander** origin.

other staff: The following positions are counted as 'other' staff in this report: chief executive officers (CEOs); managers and supervisors; drivers and field officers; finance and accounting staff; administrative and clerical staff; information technology (IT) and data management staff; cleaners, security and other support staff; administrative and support trainees.

regular client: A client who has visited a particular primary health care provider 3 or more times in the previous 2 years.

remoteness areas: The remoteness areas divide Australia into broad geographic regions that share common characteristics of remoteness for statistical purposes. Each state and territory is divided into several regions based on their relative accessibility to goods and services (such as GPs, hospitals and specialist care) as measured by road distance. These regions are based on the **Accessibility/Remoteness Index of Australia (ARIA)**. The main categories are *Major cities*, *Inner regional*, *Outer regional*, *Remote*, and *Very remote*. Individual states and territories may not contain areas of every class: for example, the Northern Territory does not contain a Major city or an Inner regional classification.

service delivery site: In the OSR collection, this refers to all service delivery sites owned, leased or otherwise controlled by an organisation. It does not include outlets or sites only visited by mobile services.

social and emotional wellbeing (SEWB) staff: These include (but are not limited to) psychologists, counsellors, mental health workers, social workers and welfare workers.

Team Care Arrangement (TCA): Chronic disease management plan carried out according to the MBS Schedule (item 723).

type 2 diabetes: The most common form of diabetes, occurring mostly in people aged 40 or over, and marked by reduced or less effective insulin.