Steering Committee for the Review of Government Service Provision

Report on Government Services 2024

Health (part E)

Produced by the Productivity Commission on behalf of the Steering Committee for the Review of Government Service Provision.

The Productivity Commission acknowledges the Traditional Owners of Country throughout Australia and their continuing connection to land, waters and community. We pay our respects to their Cultures, Country and Elders past and present.

ISSN 2205-5703 (online version)

This work should be attributed as follows, *Source: Steering Committee for the Review of Government Service Provision, Report on Government Services 2024.*

If you have adapted, modified or transformed this work in anyway, please use the following, *Source: based on Steering Committee for the Review of Government Service Provision data, Report on Government Services 2024.*

An appropriate reference for this publication is:

SCRGSP (Steering Committee for the Review of Government Service Provision) 2024, Report on Government Services 2024, Productivity Commission, Canberra.

The Productivity Commission acts as the Secretariat for the Steering Committee.

Publication enquiries:
Phone 03 9653 2244 | email publications@pc.gov.au

Report on Government Services 2024

PART E: RELEASED ON 31 JANUARY 2024

Produced by the Productivity Commission for the Steering Committee for Review of Government Service Provision. The content for this PDF is generated from the online, interactive publication. Data below are the most recent at the time of preparing the report. In some cases, charts and tables may present data for a single jurisdiction. To access data for all jurisdictions and the most current data available, go to: www.pc.gov.au/rogs

E Health

Data downloads

These data tables relate to the sector as a whole. Data specific to individual service areas is in the data tables under the relevant service area.

Health data tables (XLSX 439.3 KB)

Health dataset (CSV 1.1 MB)

Refer to the Sector overview text and corresponding table number in the data tables for detailed definitions, caveats, footnotes and data source(s).

Note: Data tables are referenced by table xA.1, xA.2, etc, with x referring to the section or overview. For example, table EA.1 refers to data table 1 for this sector overview.

Main aims of services within the sector

The main objective of the health sector is that Australians are born and remain healthy. To this end, health sector services seek to promote, restore and maintain a healthy society through the delivery of services that prevent illness, promote health, detect and treat illness and injury, rehabilitate and provide palliative care.

Services included in the sector

Primary and community health >

Includes general practice, pharmaceutical services, dentistry, allied health services, maternal and child health, alcohol and drug treatment and other services.

Ambulance services >

Includes responding to and treating out-of-hospital medical emergencies.

Public hospitals >

Includes care provided to admitted and non-admitted patients, including acute and non-acute care and mental health services.

Services for mental health >

Includes MBS-subsidised mental health services provided by primary and community health providers, state and territory government specialised mental health services and non-government services providing community-based support.

Other major areas of government involvement in health provision not covered in the health sections, or elsewhere in the report, include public health programs (other than those for mental health) and funding for specialist medical practitioners (although data on patient out-of-pocket costs for

specialist services are provided as contextual information in the Primary and community health section).

Detailed information on the equity, effectiveness and efficiency of service provision and the achievement of outcomes for primary and community health, ambulance, public hospital and services for mental health are contained in service-specific sections.

Government expenditure in the sector

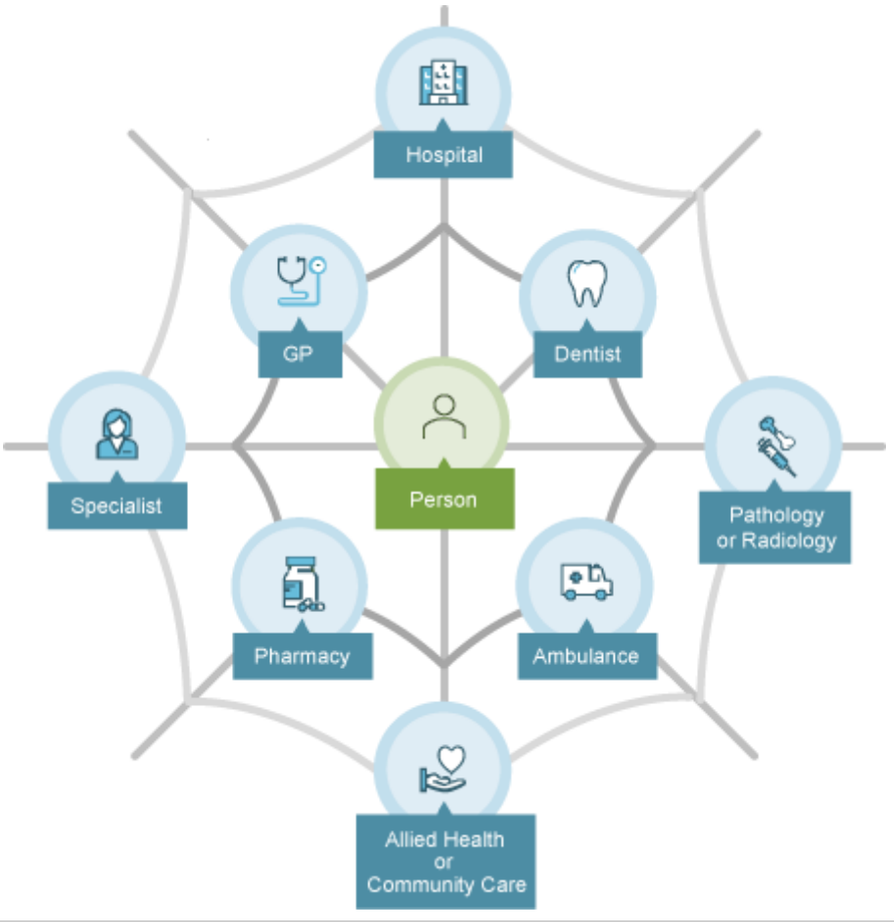
Total government recurrent expenditure for health services for the latest years covered in this report was $150.9 billion. Public hospitals was the largest contributor ($90.0 billion in 2021-22, table 12A.1), followed by primary and community health ($55.4 billion in 2021-22, table 10A.1) and ambulance services ($5.5 billion in 2022-23, table 11A.11). Expenditure on services for mental health was $11.6 billion in 2021-22 (table 13A.1); however, as much of this expenditure is already captured in public hospital and primary and community health expenditure, it is not included in the health sector expenditure total to avoid double counting. For the 2021-22 financial year (the most recent financial year for which data is available across all sections) this represented 43.1% of total government expenditure covered in this report.

When expenditure by local government and for health services outside the scope of this report are added, government expenditure in 2021-22 was estimated at $176.0 billion (AIHW 2023).

Flows in the sector

Health services in Australia are delivered by a variety of government and non-government providers in a range of service settings that do not have a clearly defined path (figure E.1). Primary and community health services are the most common entry points to the health system in Australia. Ambulance services and public hospital emergency departments can also be first points of contact. Some patients may then progress through the system to become non-admitted or admitted hospital patients (including specialist mental health care) or medical specialist patients. Patients might cycle through various points in the health system for treatment of a particular condition. Finally, some patients will require rehabilitation provided by hospitals or primary and community health services.

Figure E.1 Client flow within the Australian health care system



Nationally in 2022, nurses and midwives made up the largest group of FTE health workers (339,883), followed by allied health practitioners (169,526) and medical practitioners (114,815). This trend was also evident for Aboriginal and Torres Strait Islander health care workers, where nurses and midwives were the largest workforce group (5,183). Medical practitioners had the highest proportion of the workforce aged 60 years or older (15.2%), while allied health practitioners had the highest proportion aged under 30 years (26.6%) (EA.36–40).

Sector-wide indicators

This overview reports on four sector-wide indicators of governments' objective that Australians are born and remain healthy:

- babies born of low birthweight
- selected potentially preventable diseases
- life expectancy
- mortality rates.

Data on key risk factors affecting outcomes for these indicators (including overweight/obesity, smoking and risky alcohol consumption) are available in tables EA.3, EA.7 and EA.9.

Babies born of low birthweight

In 2021, 4.9% of babies born in Australia were of low birthweight (table EA.1). The proportion of babies born of low birthweight to Aboriginal and Torres Strait Islander mothers was more than twice that for babies born to non-Indigenous mothers (table EA.2; figure E.2). Data on the Aboriginal and Torres Strait Islander status of the baby are available in table EA.1.

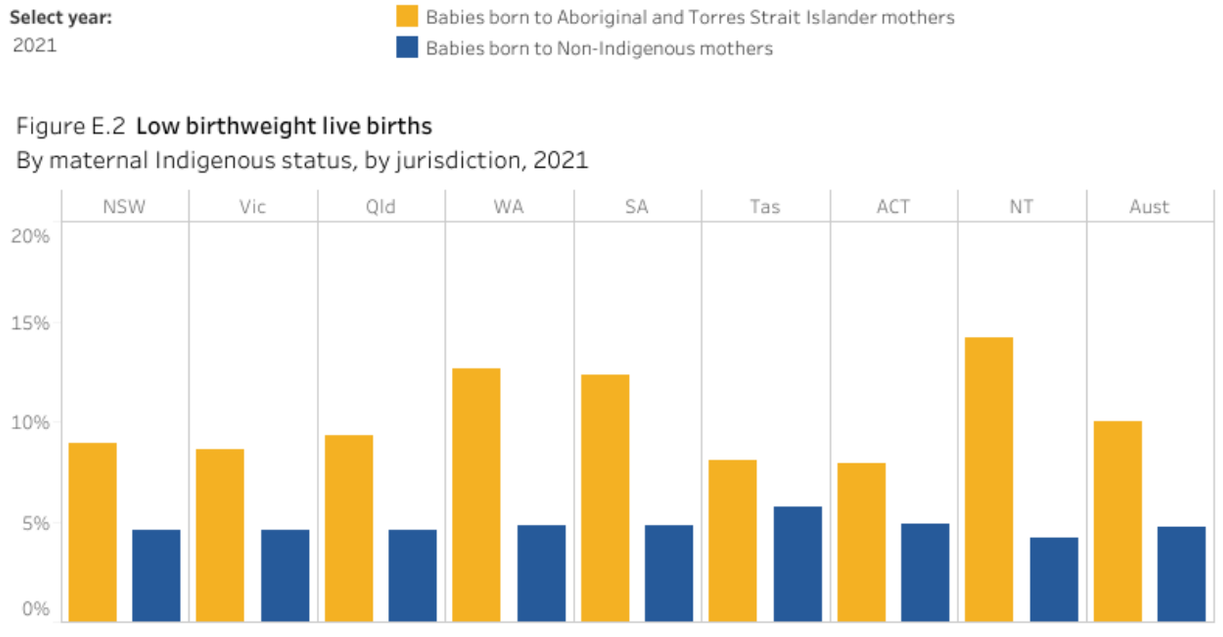


Figure E.2 **Low birthweight live births**
By maternal Indigenous status, by jurisdiction, 2021

Source: table EA.2

Data tables are referenced above by a 'EA' prefix and all data (footnotes and data sources) is available for download from above (in Excel and CSV format).

Selected potentially preventable diseases

Selected potentially preventable diseases are diseases that could potentially have been prevented through the provision of health interventions and early disease management. Diseases covered in this report include selected cancers, heart attacks and type 2 diabetes.

Nationally in 2020, the age standardised rate of new cases of selected cancers was highest for female breast cancer (119.5 per 100,000 females), followed by melanoma, bowel cancer, and lung cancer (49.1, 47.4 and 41.7 per 100,000 people respectively) and lowest for cervical cancer (7.5 per 100,000 females) (table EA.11). More recent data for 2021 are available for two jurisdictions (Victoria and Queensland) in table EA.11.

Nationally in 2021, the age standardised rate of heart attacks (acute coronary events) was 274.0 cases per 100,000 people (table EA.14). The national rate has decreased each year over the 10 years included in this report. The rate for females is less than half the rate for males.

Nationally in 2011-12 (the only year of data available), an estimated 4.3% of adults had type 2 diabetes, with rates higher for males compared with females (table EA.16).

Life expectancy

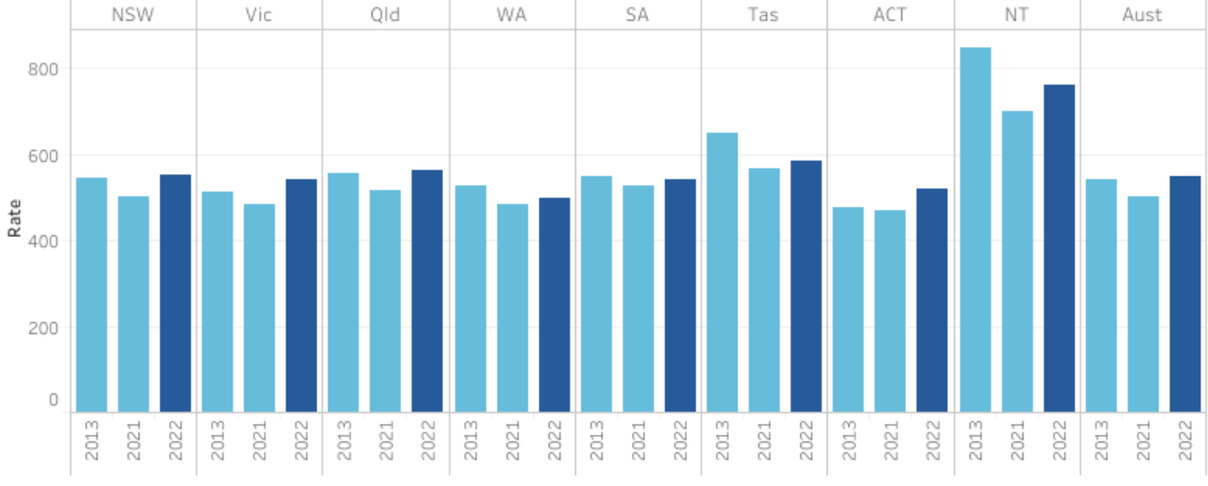
The average life expectancy at birth in the period 1901–1910 was 55.2 years for males and 58.8 years for females (ABS 2010). Historically, life expectancy has risen steadily each decade since, however both males (81.2 years) and females (85.3 years) reported a slight decrease in 2020–2022 (table EA.22). The life expectancy of Aboriginal and Torres Strait Islander people is considerably lower than that of other people, with a life expectancy at birth of 71.9 years for Aboriginal and Torres Strait Islander males and 75.6 years for Aboriginal and Torres Strait Islander females born between 2020–22. For the same reference period, the life expectancy at birth for non-Indigenous males was 80.6 years and for non-Indigenous females was 83.8 years (table EA.23). An increase in 2022 Aboriginal and Torres Strait Islander deaths is influenced by the use of information from a second source for the first time when deriving the indigenous status of deaths registered in NSW (for more detail refer to the Technical notes (ABS, 2023)).

Mortality rates

The national age standardised mortality rate, measured in deaths per 100,000 people, was 547.6 in 2022 – an increase from 2021 (table EA.24; figure E.3). In line with life expectancy data, mortality rates are higher for Aboriginal and Torres Strait Islander people compared to non-Indigenous people (table EA.25).

Select year(s):
Multiple values

Figure E.3 **Mortality rates**
Per 100,000 people, age standardised, by jurisdiction, by year



Source: table EA.24

Data tables are referenced above by a 'EA' prefix and all data (footnotes and data sources) is available for download from above (in Excel and CSV format).

Perinatal and children

Mortality data is separately reported for children for perinatal deaths (fetal deaths [still births] and neonatal deaths [death of an infant within 28 days of birth]), infant deaths (children aged 0<1 year) and infant and child deaths (children aged 0<5 years).

There were 8.1 perinatal deaths per 1,000 births (table EA.34) in 2022, of which around 72% were fetal deaths and the remainder neonatal deaths (tables EA.32).

In 2022, the average infant mortality rate was 3.2 deaths per 1,000 live births (table EA.28). Over the past 10 years, the average infant mortality rate has ranged from 3.1 deaths per 1,000 live births (2016 and 2018) to 3.6 deaths per 1,000 live births (2013). The Australian infant and child combined mortality rate (3-year average) has decreased over time from 91.5 deaths per 100,000 population in 2010-12 to 74.4 deaths per 100,000 population in 2019-21 (table EA.30).

Causes and prevention

The most common causes of death among all Australians in 2022 were neoplasms (cancer) and circulatory diseases (including heart disease, heart attack and stroke) (table EA.26). Data by Indigenous status is available in table EA.27.

There is potential to prevent some deaths through individualised care and/or to treat health conditions through existing primary or hospital care. Nationally, there were 100.1 potentially avoidable deaths per 100,000 people in 2022 – an increase on 2021 (96.9 per 100,000 people) (table EA.19). The rate of potentially avoidable deaths in 2018–22 for Aboriginal and Torres Strait Islander people (324.1 per 100,000 people) was the highest rate since 2011-15 and more than three times the rate for other Australians (95.2) (table EA.20).

References

AIHW (Australian Institute of Health and Welfare) 2023, *Health Expenditure Australia 2021-22,* https://www.aihw.gov.au/getmedia/b464ddb8-ccb4-4093-acd4-3655176599dc/health-expenditure-australia-2021-22.pdf?v=20231025081735&inline=true.

ABS (Australian Bureau of Statistics) 2010, *Deaths Australia 2009,* https://www.abs.gov.au/ausstats/abs@.nsf/Products/16B1031FC87A6A8CCA2577D600109F8A.

ABS (Australian Bureau of Statistics) 2023, *Causes of Death, Australia 2022, methodology* https://www.abs.gov.au/methodologies/causes-death-australia-methodology/2022#.

Report on Government Services 2024

PART E, SECTION 10: RELEASED ON 31 JANUARY 2024

10 Primary and community health

This section reports on the performance of primary and community health services which include general practice, pharmaceutical services, dentistry, allied health services, community health services, maternal and child health and alcohol and other drug treatment. This section does not include:

- public hospital emergency departments and outpatient services (reported in section 12, 'Public hospitals')
- community mental health services (reported in section 13, 'Services for mental health')
- home and community care services (reported in section 14, 'Aged care' and section 15, 'Services for people with disability').

The **Indicator results** tab uses data from the data tables to provide information on the performance for each indicator in the **Indicator framework.** The same data is also available in CSV format.

Data downloads

10 Primary and community health data tables (XLSX 934.7 KB)

10 Primary and community health dataset (CSV 2.8 MB)

Refer to the corresponding table number in the data tables for detailed definitions, caveats, footnotes and data source(s).

Guide: How to find what you need in RoGS (PDF 288.5 KB)

Context

Objectives for primary and community health

Primary and community health services aim to promote health, prevent illness and support people to manage their health issues in the community, by providing services that are:

- timely, affordable and accessible to all
- appropriate and responsive to meet the needs of individuals throughout their lifespan and communities
- well coordinated to ensure continuity of care where more than one service type, and/or ongoing service provision is required
- sustainable.

Governments aim for primary and community health services to meet these objectives in an equitable and efficient manner.

Service overview

Primary and community health services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Definitions for common health terms are provided in the 'Explanatory material' tab.

General practice

General practice is a major provider of primary healthcare in Australia. General practice services include preventative care and the diagnosis and treatment of illness and injury, through direct service provision and/or referral to acute (hospital) or other healthcare services, as appropriate.

The Australian Government provides the majority of general practice income, through Services Australia – mainly as fee for service payments via the Medicare Benefits Schedule (MBS) – and the Department of Veterans' Affairs (DVA). Additional funding is provided to influence the supply, regional distribution and quality of general practice services, and support engagement of the health workforce in primary health care settings, through initiatives such as the Practice Incentives Program (PIP), the Workforce Incentive Program (WIP), and Primary Health Networks (PHNs) (Services Australia 2021). State and territory governments also provide some funding for such programs, mainly to influence the availability of GPs in rural and remote areas. The remainder comes primarily from insurance schemes (for example, workers compensation schemes and traffic accident schemes that cover medical expenses in certain circumstances) and patient contributions.

Pharmaceutical services

The Commonwealth funds the Pharmaceutical Benefits Scheme (PBS), which subsidises the cost of many medicines in Australia. The PBS schedule sets a price for listed medicines and a maximum co-payment amount that people contribute towards the cost of these medicines. The Commonwealth incurs the expense of any difference where the listed price exceeds the patient co-contribution (whether for general or concessional patients).

Around 69% of PBS prescriptions dispensed in 2022-23 were above the co-payment threshold, meaning patients paid the relevant co-payment and the remaining cost was subsidised by the Australian Government. Around 31% of PBS prescriptions dispensed in 2022-23 were under the co-payment threshold, meaning the patient paid the full cost with no government subsidy (AIHW unpublished). Co-payments contribute to a patient's safety net threshold that, once reached, provides eligibility to receive PBS medicines at a lower cost or free of charge (Department of Health and Aged Care 2021).

The Repatriation Pharmaceutical Benefits Scheme (RPBS) provides subsidised pharmaceutical medicines, dressings and other items to war veterans and war widows. The RPBS is administered by the DVA.

Dental services

Australia has a mixed system of public and private dental services. State and territory governments deliver public dental services, which are primarily available to children and disadvantaged adults. The Australian Government works with state and territory governments to fund dental services. Since 2013, the Australian Government has increased funding for public dental services via National Partnership Agreements and Federal Funding Agreements with states and territories and the Child Dental Benefits Schedule. The private sector receives funding to provide some public dental services, from the Australian Government through the DVA and the Child Dental Benefits Schedule, and from state and territory governments through dental voucher systems. Under the COAG Health

Council, Australian governments developed the *National Oral Health Plan 2015 to 2024* that sets out priorities to improve dental health across Australia (COAG 2015). Data on dental service expenditure in 2021-22 is presented in table 10A.6.

Allied health services

Allied health services include, but are not limited to, physiotherapy, psychology, occupational therapy, podiatry and osteopathy. They are delivered mainly in the private sector. Some government funding of private allied health services is provided through insurance schemes and the private health insurance rebate. The Australian Government makes some allied health services available under the MBS to patients with particular needs – for example, people with chronic conditions and complex care needs. The Australian Government also funds the Workforce Incentive Program (WIP) – Practice Steam, which supports general practices, Aboriginal Medical Services and Aboriginal Community Controlled Health Services with the cost of engaging eligible allied health professionals. Data on the number of Medicare rebated allied health services used per person and the availability of public allied health professionals by region is presented in tables 10A.10 and 10A.22, respectively.

Community health services

Community health services generally comprise multidisciplinary teams of health and allied health professionals who provide targeted health promotion, prevention and management services. Their aim is to protect the health and wellbeing of local populations, particularly people who have or are at risk of the poorest health and/or have the greatest economic and social needs, while taking pressure off the acute care health system. Governments (including local governments) provide community health services directly or indirectly by funding local health services and community organisations. There is no national strategy for community health services and there is considerable variation in the services provided across jurisdictions.

State and territory governments are responsible for most community health services. Those serving Aboriginal and Torres Strait Islander communities are mainly the responsibility of the Australian Government (state and territory governments provide some funding).

Maternal and child health services

Maternal and child health services are funded by state and territory governments. They provide services including: parenting support (including antenatal and postnatal programs); early childhood nursing programs; disease prevention programs (including childhood immunisations); and early intervention and treatment programs related to child health and development. Some jurisdictions also provide specialist programs through child health services, including hearing screening programs, and mothers and babies residential programs.

Alcohol and other drug treatment

Alcohol and other drug treatment activities range from a brief intervention to long term residential treatment. Types of treatment include withdrawal management, pharmacological treatment, counselling and rehabilitation. Selected data on these services is available in table 10A.13.

Funding

In 2021-22, of the $55.4 billion government recurrent expenditure on primary and community health services, almost three-quarters was funded by the Australian Government and one-quarter by state, territory and local governments (table 10A.1). This included:

- $11.4 billion for community health services (36.1% by the Australian Government and 63.9% by state, territory and local governments)
- $2.3 billion for dental services (57.5% by the Australian Government and 42.5% by state, territory and local governments) (table 10A.6).

Where more recent data is available, for 2022-23, Australian Government expenditure was:

- $11.0 billion on general practice (table 10A.2)
- $11.9 billion through the PBS and RPBS on Section 85 prescription medicines filled at pharmacies (table 10A.3)
- $53.9 million on funding of PBS medicines to Aboriginal and Torres Strait Islander primary health services in remote and very remote areas (table 10A.5)
- $903.2 million on Aboriginal and Torres Strait Islander primary health services (table 10A.7).

Size and scope

Nationally in 2022, there were 38,881 GPs – 29,921 on a full-time equivalent (FTE) basis, equating to 115.2 per 100,000 people (table 10A.8), a decrease from 120.9 in 2021 (table 10A.8).

Nationally, rates of GP-type services used per person decreased between 2021-22 (7.6 services per person) and 2022-23 (6.6 services per person) (table 10A.9). GP-type services disaggregated by in-person attendances and telehealth appointments are reported in table 10A.9. Nationally in 2022-23, 1.2 telehealth GP-type services were used per person (figure 10.1).

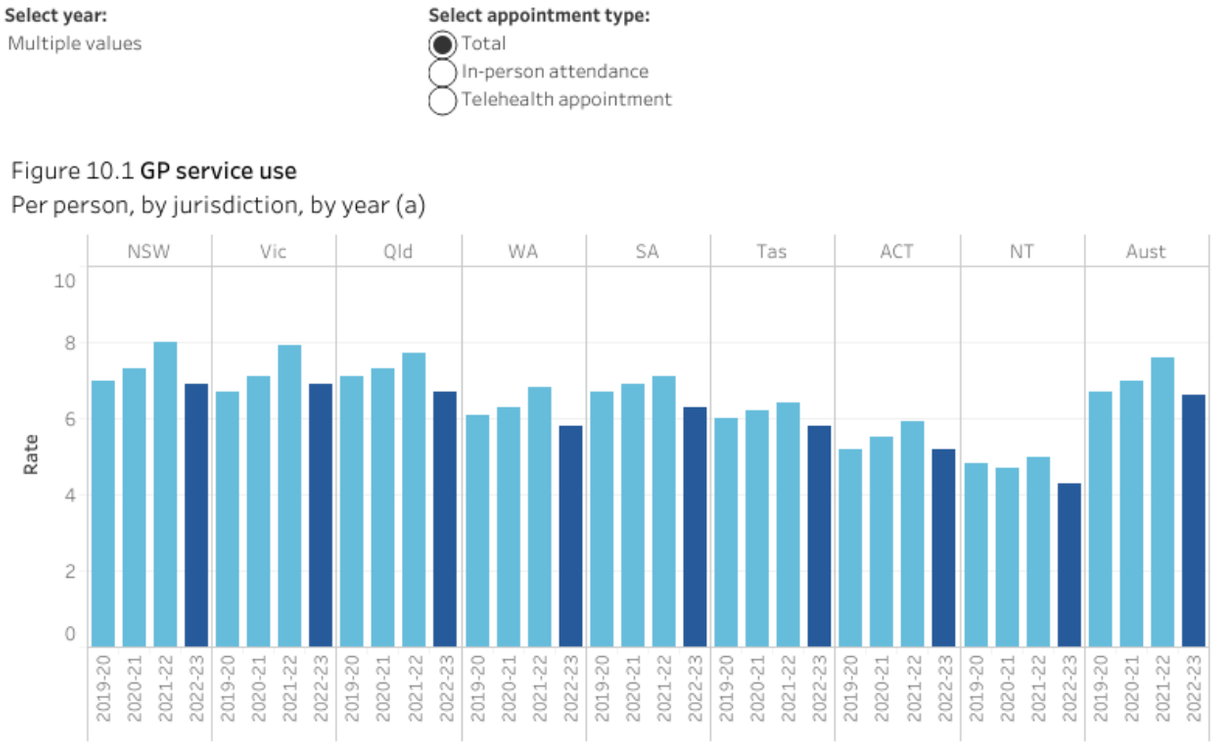


Figure 10.1 **GP service use**
Per person, by jurisdiction, by year (a)

Source: table 10A.9

(a) Data disaggregated by in-person attendances and telehealth appointments is not available prior to 2019-20.

Data tables are referenced above by a '10A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Around 220 million services (8.3 per person) were subsidised under Section 85 of the PBS in 2022-23 – with 89.6% concessional. A further 7.1 million services were subsidised under the RPBS (tables 10A.11-12).

Nationally in 2021-22 there were:

- 211 Aboriginal and Torres Strait Islander primary health services which provided 4.0 million episodes of healthcare (table 10A.14). Data by remoteness is presented in table 10A.15 and health service staffing numbers are provided in table 10A.16.
- 1,274 alcohol and other drug treatment agencies (31.6% identified as government providers) with a reported 228,451 closed treatment episodes (27.1% identified as government provided) (table 10A.13).

The most recent available data on public dental service usage is for 2013 and showed that nationally, around 97.8 per 1,000 people accessed public dental services that year (AIHW unpublished).

Indicator framework

The performance indicator framework provides information on equity, effectiveness and efficiency, and distinguishes the outputs and outcomes of primary and community health services.

The performance indicator framework shows which data is complete and comparable in this report. For data that is not considered directly comparable, text includes relevant caveats and supporting commentary. Section 1 discusses data comparability and completeness from a report-wide perspective. In addition to the contextual information for this service area (see Context tab), the report's statistical context (section 2) contains data that may assist in interpreting the performance indicators presented in this section.

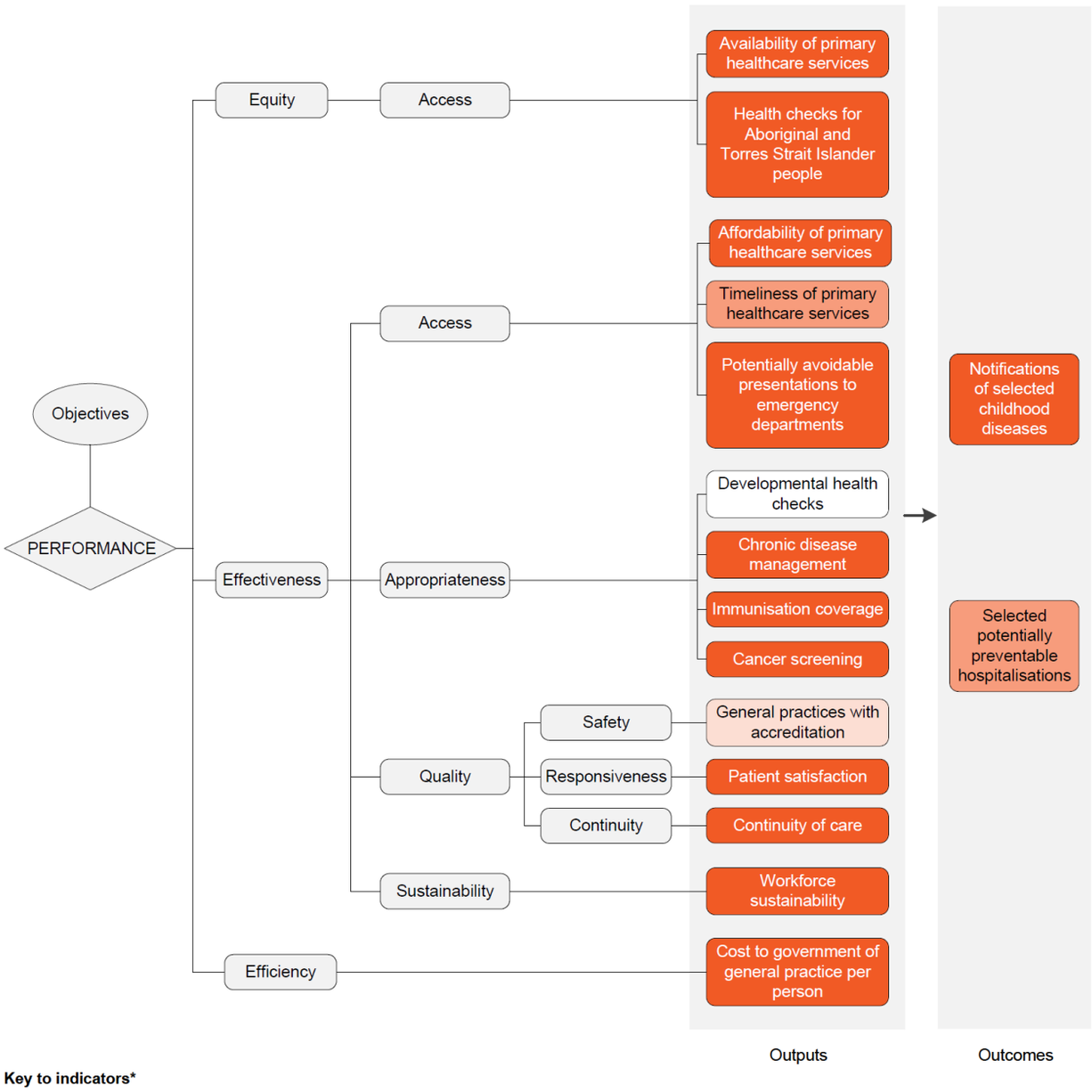
Improvements to performance reporting for primary and community health services are ongoing and include identifying data sources to fill gaps in reporting for performance indicators and measures, and improving the comparability and completeness of data.

Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (see section 1). Output information is also critical for equitable, efficient and effective management of government services.

Outcomes

Outcomes are the impact of services on the status of an individual or group (see section 1).



Text version of indicator framework

Performance – linked to Objectives

Outputs

Equity – Access

- Availability of primary healthcare services – most recent data for all measures is comparable and complete
- Health checks for Aboriginal and Torres Strait Islander people – most recent data for all measures is comparable and complete

Effectiveness – Access

- Affordability of primary healthcare services – most recent data for all measures is comparable and complete
- Timeliness of primary healthcare services – most recent data for at least one measure is comparable and complete
- Potentially avoidable presentations to emergency departments – most recent data for all measures is comparable and complete

Effectiveness – Appropriateness

- Developmental health checks – no data reported and/or no measures yet developed
- Chronic disease management – most recent data for all measures is comparable and complete
- Immunisation coverage – most recent data for all measures is comparable and complete
- Cancer screening – most recent data for all measures is comparable and complete

Effectiveness – Quality – Safety

- General practices with accreditation – most recent data for all measures is either not comparable and/or not complete

Effectiveness – Quality – Responsiveness

- Patient satisfaction – most recent data for all measures is comparable and complete

Effectiveness – Quality – Continuity

- Continuity of care – most recent data for all measures is comparable and complete

Effectiveness – Sustainability

- Workforce sustainability – most recent data for all measures is comparable and complete

Efficiency

- Cost to government of general practice per person – most recent data for all measures is comparable and complete

Outcomes

- Notifications of selected childhood diseases – most recent data for all measures is comparable and complete
- Selected potentially preventable hospitalisations – most recent data for at least one measure is comparable and complete

A description of the comparability and completeness is provided under the Indicator results tab for each measure.

Indicator results

This section presents an overview of 'Primary and community health' performance indicator results. Different delivery contexts, locations and types of clients can affect the equity, effectiveness and efficiency of primary and community health services.

Information to assist the interpretation of this data can be found with the indicators below and all data (footnotes and data sources) is available for download above as an excel spreadsheet and as a CSV dataset. Data tables are identified by a '10A' prefix (for example, table 10A.1).

Specific data used in figures can be downloaded by clicking in the figure area, navigating to the bottom of the visualisation to the grey toolbar, clicking on the 'Download' icon and selecting 'Data' from the menu. Selecting 'PDF' or 'Powerpoint' from the 'Download' menu will download a static view of the performance indicator results.

1. Availability of primary healthcare services

'Availability of primary healthcare services' is an indicator of governments' objective to provide access to primary healthcare services in an equitable manner.

'Availability of primary healthcare services' is defined by four measures:

- PBS medicines by region, defined as the ABS census population divided by the number of approved suppliers of PBS medicines, by metropolitan/rural and remote location under the Modified Monash Model (MMM) classification
- General Practitioners (GPs) by region, defined as the number of FTE GPs per 100,000 people, by region
- GPs by sex, defined as the number of FTE GPs per 100,000 population, by sex
- Public dentists by region, defined as the number of full time equivalent (FTE) public dentists per 100,000 people based on clinical hours worked in the public sector, by region.

A similar rate across regions is desirable as it indicates equity of access by location. A similar rate by sex is desirable as it means patients who prefer to visit GPs of their own sex are more likely to have their preference met. A low rate of GPs of either sex could be associated with increased waiting times to see a GP, for patients who prefer to visit GPs of their own sex.

Measures on GPs by region and sex, and public dentists by region do not provide information on whether people are accessing services or whether the services are appropriate for the needs of the people receiving them.

> Measure 1: Nationally, at 30 June 2023, there were 4,106 people per approved PBS provider in metropolitan areas and 3,263 people per approved PBS supplier in rural and remote areas (figure 10.2a). These numbers have decreased in metropolitan and rural and remote areas following a peak in 2017 (table 10A.18). Data is also available for pharmacy suppliers only (table 10A.18) and by MMM area (table 10A.17).

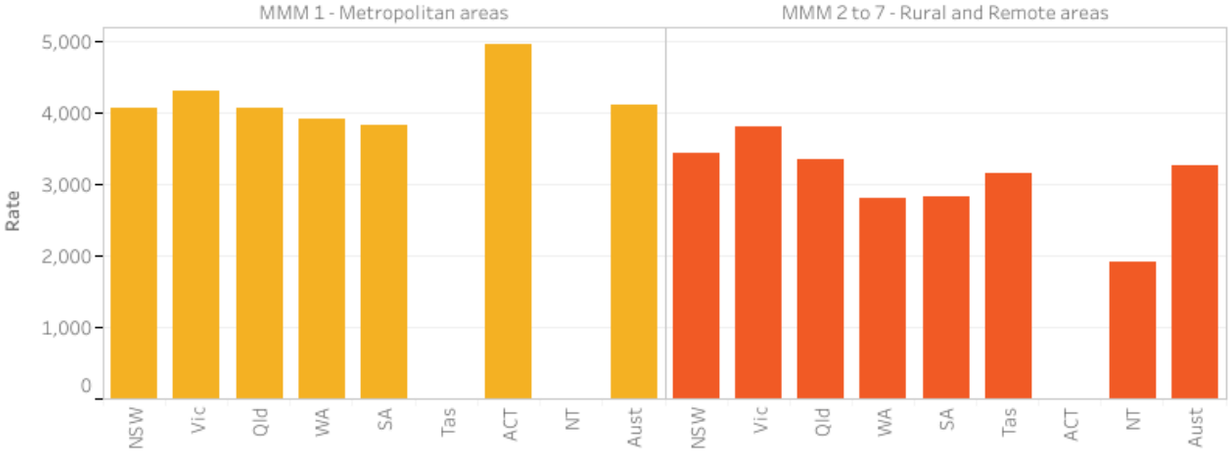
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year:
2023

MMM 1 - Metropolitan areas
MMM 2 to 7 - Rural and Remote areas

Figure 10.2a Measure 1: **Availability of primary healthcare services (PBS medicines)**
Number of people per approved PBS supplier, by MMM area, by jurisdiction, 2023 (a)



Source: table 10A.18

(a) Tasmania and the NT have no metropolitan areas under the classification used. The ACT has no rural and remote areas under the classification used.

Measures 2-3: Nationally in 2022, the number of FTE GPs per 100,000 people decreased as remoteness increased (118.1 GPs per 100,000 people in major cities compared to 88.9 GPs per 100,000 people in outer regional, remote and very remote areas) (table 10A.19). Nationally in 2022, there were 95.1 FTE female GPs per 100,000 females and 135.6 FTE male GPs per 100,000 males (figure 10.2b).

Data is comparable (subject to caveats) across jurisdictions and over time.

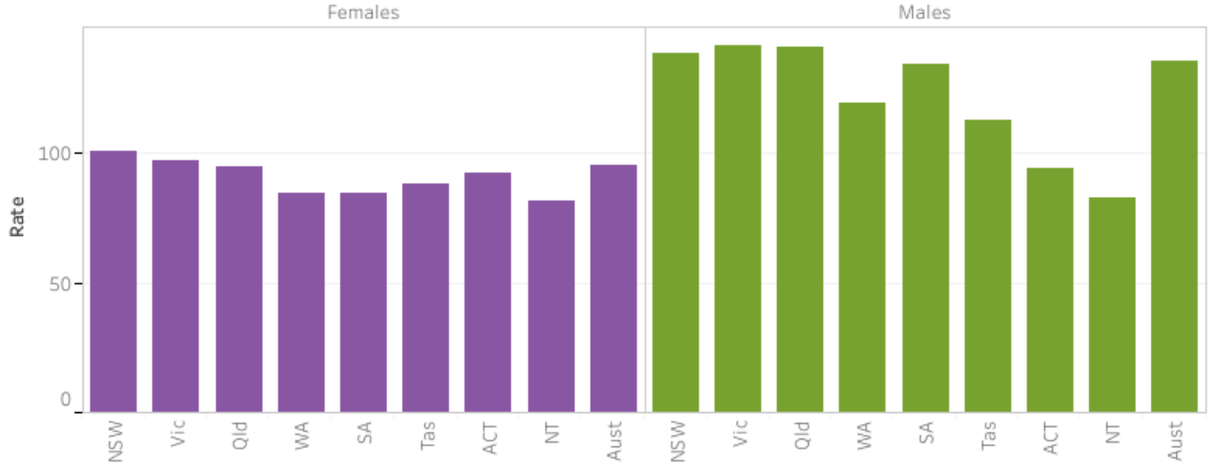
Data is complete (subject to caveats) for the current reporting period.

Select year:
2022

Select measure:
Sex
Region

Females
Males

Figure 10.2b Measures 2-3: **Full-time equivalent GPs**
Per 100,000 population, by Sex, by jurisdiction, 2022 (a)



Source: table(s) 10A.20 & 10A.21

(a) There are no major cities in Tasmania; no outer regional or remote areas in the ACT; no major cities or inner regional areas in the NT.

Measure 4: Nationally in 2022, the rate of FTE public dentists per 100,000 people was higher in outer regional areas (5.8 per 100,000 people) compared to other areas (4.9 – 5.5 per 100 people) (figure 10.2c). Data on FTE public dentists and allied dental practitioners are presented in table 10A.22.

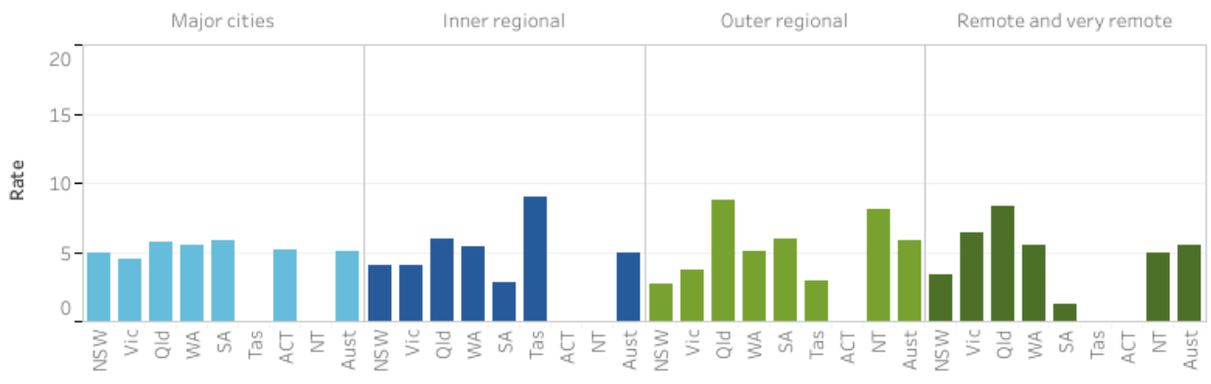
Data is comparable (subject to caveats) across jurisdictions and over time (from 2014).

Data is complete (subject to caveats) for the current reporting period.

Select year:
2022

Major cities
Inner regional
Outer regional
Remote and very remote

Figure 10.2c Measure 4: **Full time equivalent public Dentists** per 100,000 people, by Region, by jurisdiction, 2022 (a)



Source: table 10A.22

(a) Victoria has no very remote areas; Tasmania has no major cities; the ACT has no inner regional, outer regional, remote or very remote areas, and the NT has no major cities or inner regional areas.

2. Health checks for Aboriginal and Torres Strait Islander people

'Health checks for Aboriginal and Torres Strait Islander people' is an indicator of governments' objective to provide access to primary and community healthcare in an equitable manner.

'Health checks for Aboriginal and Torres Strait Islander people' is defined as the number of Aboriginal and Torres Strait Islander people who had an MBS health check that is Aboriginal and Torres Strait Islander-specific, by assessment location divided by the number of Aboriginal and Torres Strait Islander people, and is presented as a *rate per 1,000 people*.

An increase over time in the proportion of Aboriginal and Torres Strait Islander people who received a health check is desirable as it indicates improved access to these services.

This indicator provides no information about health checks provided outside Medicare (predominantly used by Aboriginal and Torres Strait Islander people in remote and very remote areas). Accordingly, this indicator understates the proportion of Aboriginal and Torres Strait Islander people who received health check services.

> Nationally in 2022-23, 269.7 per 1,000 Aboriginal and Torres Strait Islander people had an Indigenous-specific health check, reversing the downward trend from the peak in 2018-19 (287.7 per 1,000 people) (figure 10.3). Nationally in 2022-23, Aboriginal and Torres Strait Islander people mainly received Indigenous-specific health checks at health facilities or residential aged care (99%), with 1% obtaining checks via telehealth.

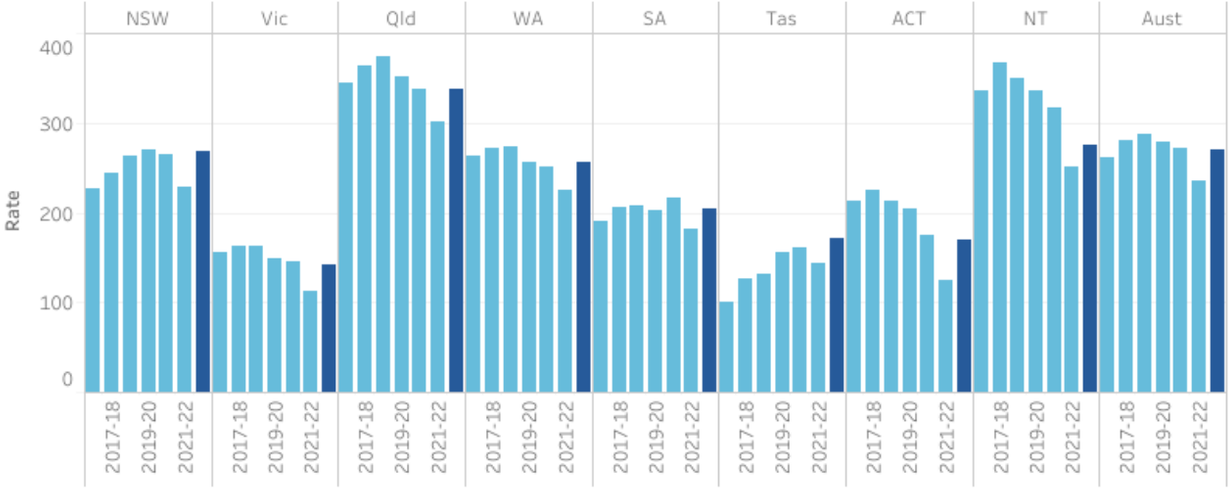
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year:
All

Select location:
All locations
Health facility and residential aged care
Telehealth

Figure 10.3 **Aboriginal and Torres Strait Islander people who had Aboriginal and Torres Strait Islander-specific health checks or assessments**
Rate per 1,000 people, by location, by jurisdiction, by year



Source: table 10A.23

Data by age group is reported in table 10A.25.

3. Affordability of primary healthcare services

'Affordability of primary healthcare services' is an indicator of governments' objective to provide primary healthcare services that are affordable.

'Affordability of primary healthcare' is defined by two measures:

- People delaying or not seeing a GP due to cost, defined as the proportion of people who delayed seeing or did not see a GP when needed at any time in the previous 12 months due to cost.
- People delaying or not filling prescription medication due to cost, defined as the proportion of people who delayed filling or did not fill a prescription when needed at any time in the previous 12 months due to cost.

A low or decreasing proportion of people deferring visits to GPs or filling prescription medication due to cost indicates more widely affordable access to GPs and medicines.

Data is sourced from the ABS Patient Experience Survey (PEx) of people aged 15 years and over. The PEx does not include people living in discrete Indigenous communities, which affects the representativeness of the Northern Territory results. Approximately 20% of the resident population of the Northern Territory live in discrete Indigenous communities as of 2020-21.

Measure 1: Nationally in 2022-23, 7.0% of respondents who needed to see a GP reported that they delayed or did not see a GP in the last 12 months due to cost, double the proportion of respondents in 2021-22 (3.5%) and the highest over the reported time series (figure 10.4a).

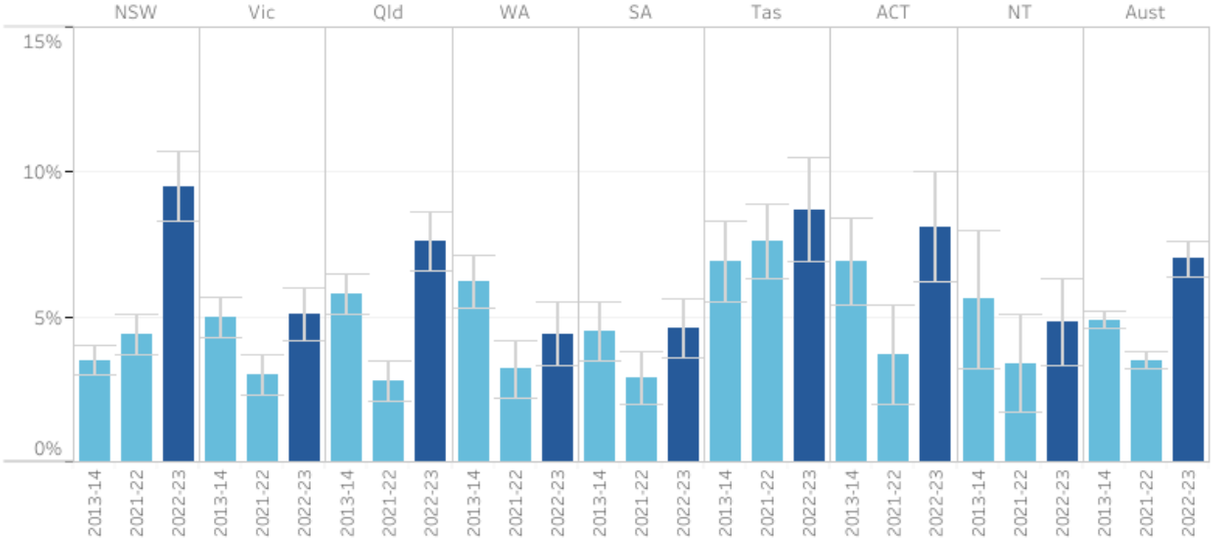
Contextual information on bulk billing and out-of-pocket costs are provided to assist interpretation of this indicator. Bulk billing information is available for both patients and services (one patient may have more than one service in a given year). Bulk billing rates for non-referred GP and specialist services, by jurisdiction, region and age are available in tables 10A.27-30. Nationally in 2022-23, 80.2% of non-referred GP services and 30.2% of specialist services were bulk billed. Information on the proportion of non-referred GP patients who were fully bulk billed are available in table 10A.31. Nationally in 2022-23, 51.7% of patients were fully bulk billed, a decrease from 65.8% in 2021-22. Data on average patient out-of-pocket costs are reported in table 10A.32. Nationally in 2022-23, out-of-pocket costs were highest for specialists ($108), followed by allied health services ($65) and non-referred GPs ($43).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 10.4a Measure 1: **People who delayed or did not see a GP due to cost**
By jurisdiction, by year



Source: table 10A.26

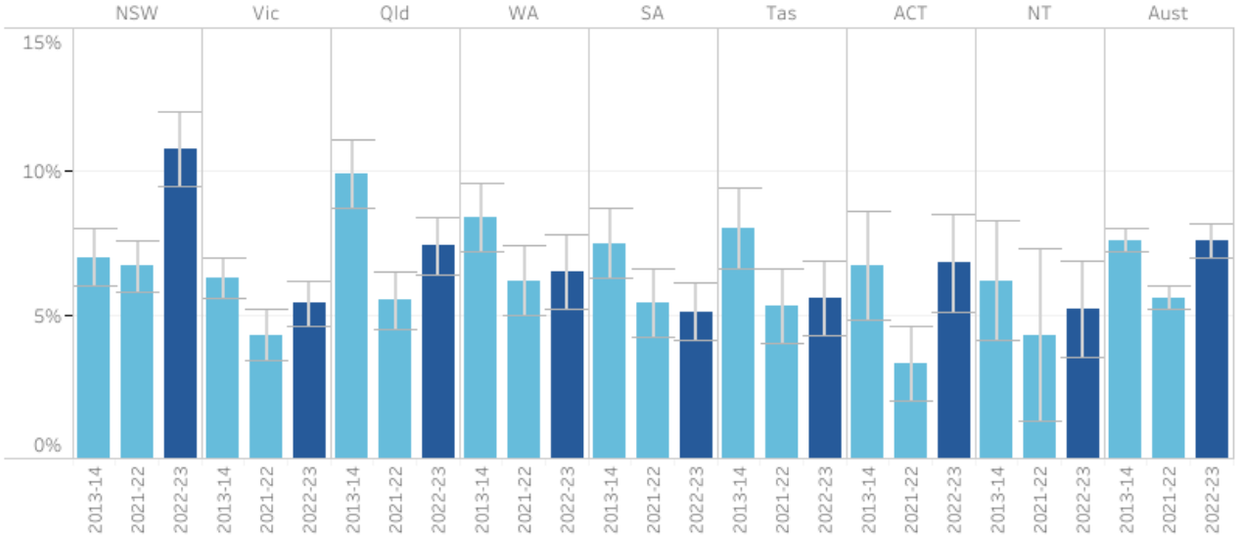
Measure 2: Nationally in 2022-23, 7.6% of respondents who needed a prescription for medication reported that they delayed filling or did not fill a prescription in the last 12 months due to cost, an increase from 2021-22 (5.6%) (figure 10.4b).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 10.4b Measure 2: **People who delayed or did not get prescription medication when needed due to cost**
By jurisdiction, by year



Source: table 10A.33

4. Timeliness of primary healthcare services

'Timeliness of primary healthcare services' is an indicator of governments' objective to ensure primary healthcare services are provided in a timely manner.

'Timeliness of primary healthcare services' is defined by two measures:

- Public dentistry waiting times, defined as the number of days waited at the 50th (median) and 90th percentiles between being placed on a selected public dentistry waiting list and either being offered dental care or receiving dental care
- GP waiting times for urgent medical care, defined as the proportion of people who, in the previous 12 months, saw a GP for urgent medical care within specified times from making the appointment. Specified waiting times are less than 4 hours, 4 to less than 24 hours, 24 hours or more.

A shorter time waited to see a dental professional indicates more timely access to public dental services. A high or increasing proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs.

Public dental waiting times only include records on persons eligible for public dental services who were aged 18 years or over. It excludes those on jurisdictional priority client schemes and those who access the service but pay full price. Data is reported by Aboriginal and Torres Strait Islander status, remoteness area of residence, and Socio-Economic Indexes for Areas (SEIFA) of residence.

The ABS Patient Experience Survey of people aged 15 years and over does not include people living in discrete Indigenous communities, which affects the representativeness of the Northern Territory results for the GP waiting times measure. Approximately 20% of the estimated resident population of the Northern Territory live in discrete Indigenous communities as of 2020-21.

> Measure 1: Data for the time waited at the 50th and 90th percentiles by people on selected public dental waiting lists are presented for states and territories (figure 10.5a).

Data is not comparable across jurisdictions, but is comparable (subject to caveats) within jurisdictions over time.

Data is not complete for the current reporting period. Data for the Australian Capital Territory for 2022-23 is not available.

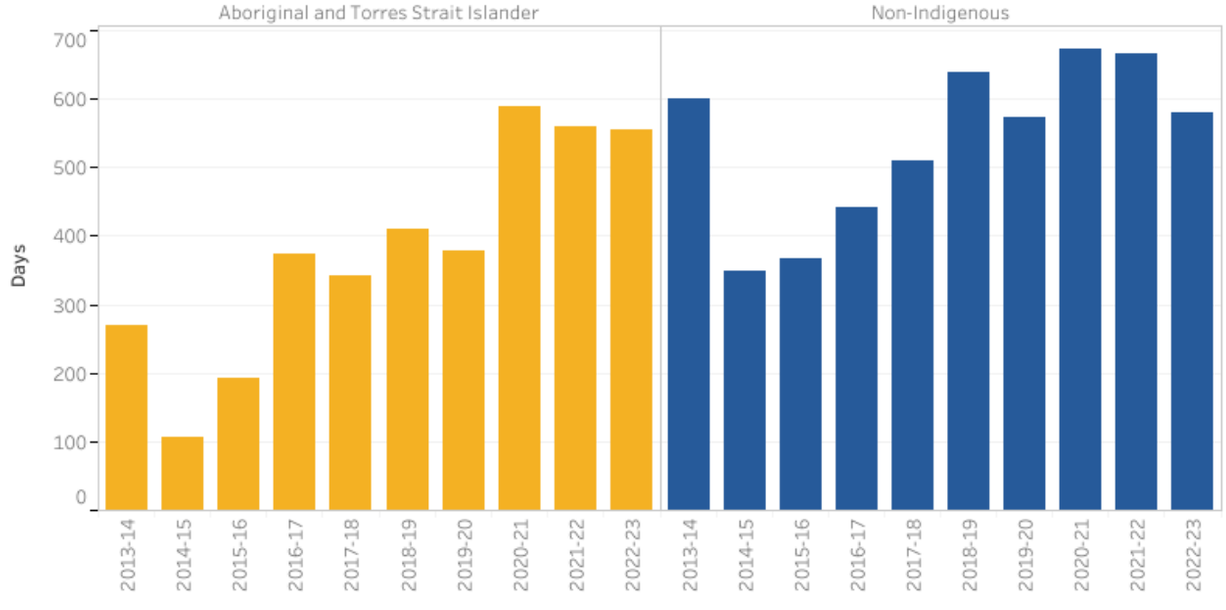
Select jurisdiction:
Qld

Select measure:
(●) Days waited at the 50th percentile
( ) Days waited at the 90th percentile

Select equity group:
(●) Indigenous status
( ) Remoteness area of residence
( ) SEIFA of residence

Aboriginal and Torres Strait Islander
Non-Indigenous

Figure 10.5a Measure 1: **Public dentistry waiting times**
General dental care, Days waited at the 50th percentile (for first visit), by Indigenous status, by year, Qld (a), (b)



Source: tables 10A.35-10A.42

(a) Data are not available for NSW (all years prior to 2020-21), Vic (for 2016-17), the ACT (for 2022-23, 2014-15 and 2013-14) and the NT (all years except 2020-21, 2019-20 and 2017-18). (b) See data tables 10A.34-41 for information on non-publication of data on Indigenous status, remoteness or Socio-Economic Indexes for Areas (SEIFA) for individual jurisdictions.

Measure 2: Nationally in 2022-23, for people who saw a GP for urgent care:

- 41.5% waited less than 4 hours, down from 49.7% in 2021-22
- 12.7% waited from 4 to less than 24 hours, up from 10.9% in 2021-22
- 45.6% waited for 24 hours or more, up from 39.1% in 2021-22 (figure 10.5b).

Overall, 29.6% of people who saw a GP for their own health waited longer than they felt was acceptable to get an appointment, an increase on 2021-22 (23.4%) and the highest proportion over the reported time series (table 10A.44).

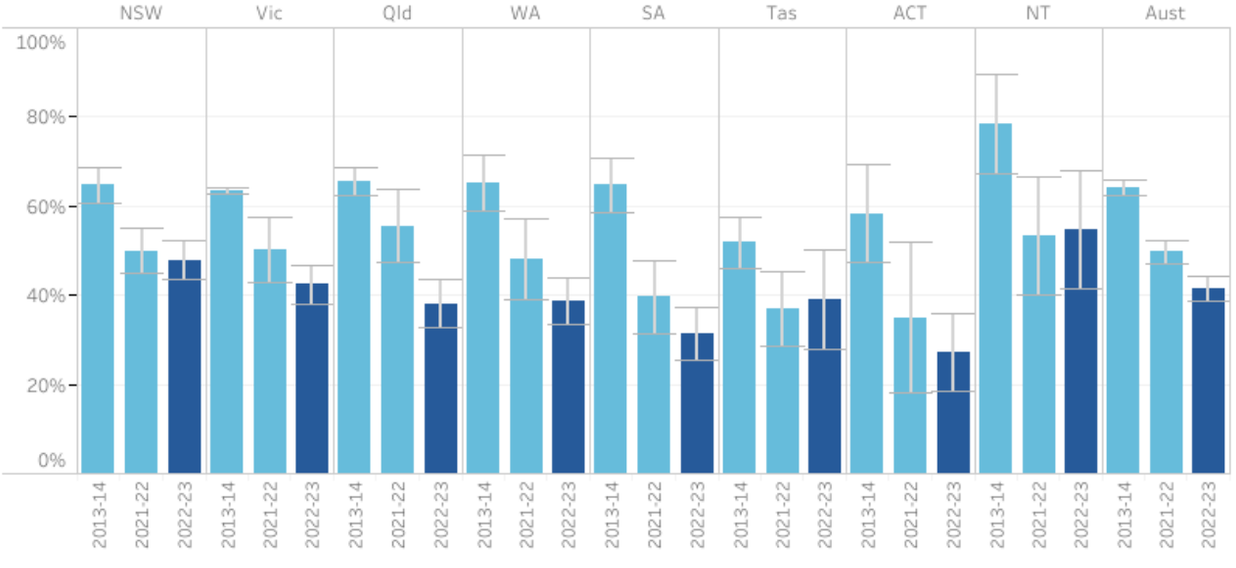
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Waiting times:
- (●) Less than four hours
- ( ) Four to less than 24 hours
- ( ) 24 hours or more

Figure 10.5b Measure 2: **GP waiting times for urgent medical care**
Less than four hours, by jurisdiction, by year



Source: table 10A.43

5. Potentially avoidable presentations to emergency departments

'Potentially avoidable presentations to emergency departments' (also known as 'GP-type presentations') is an indicator of governments' objective for primary and community healthcare to be accessible.

Potentially avoidable presentations to emergency departments (interim measure) are defined as the number of selected 'GP-type presentations' to emergency departments, where selected GP-type presentations are emergency presentations:

- allocated to triage category 4 (semi-urgent) or 5 (non-urgent); and

- not arriving by ambulance, with police or corrections; and
- not admitted or referred to another hospital; and
- who did not die.

Potentially avoidable presentations to emergency departments are presentations for conditions that could be appropriately managed in the primary and community health sector. In some cases, this can be determined only retrospectively and presentation to an emergency department is appropriate. Factors contributing to GP-type presentations at emergency departments include perceived or actual lack of access to GP services, the proximity of emergency departments and trust in emergency department staff.

Once a suitable denominator for this measure is agreed, a low or decreasing rate/proportion of potentially avoidable presentations to emergency departments can indicate better access to primary and community health care. Currently, the *number* of potentially avoidable presentations to emergency departments are reported for this indicator. In future, this indicator will be reported as a *proportion* (for example, the number of potentially avoidable GP-type presentations to emergency departments, as a proportion of all presentations to emergency departments), subject to the identification of a suitable denominator.

> Nationally in 2022-23, there were around 2.8 million GP-type presentations to public hospital emergency departments, a decrease of 7.2% from 2021-22 (table 10.1). Results varied across jurisdictions.

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Table 10.1 **Selected potentially avoidable GP-type presentations to emergency departments**
By jurisdiction, by year (number)

	2014-15	2021-22	2022-23
NSW	1,060,202	1,197,620	1,153,836
Vic	615,857	569,613	564,886
Qld	435,856	579,315	418,250
WA	331,795	373,189	357,442
SA	166,003	177,489	184,519
Tas	61,079	58,274	54,742
ACT	55,753	49,887	46,025
NT	54,832	63,293	67,452
Aust	2,781,377	3,068,680	2,847,152

Source: table 10A.34

6. Developmental health checks

‘Developmental health checks’ is an indicator of governments’ objective to ensure that services are appropriate and responsive to the needs of children.

‘Developmental health checks’ are defined as the proportion of preschool-aged children who received a developmental health assessment.

A high or increasing proportion of preschool-aged children receiving developmental health checks is desirable.

This indicator is currently under development for reporting in the future.

7. Chronic disease management

‘Chronic disease management’ is an indicator of governments’ objective to ensure that primary and community health services are appropriate and responsive to meet the needs of individuals throughout their lifespan.

‘Chronic disease management’ is defined by two measures:

- Rate of chronic disease care services (under Team Care Arrangements (TCAs) and GP Management Plans (GPMPs))
- Management of asthma, defined as the proportion of people with asthma who have a written asthma action plan.

A high or increasing proportion for each measure is desirable.

Measure 1 focuses on patients who had a GP Management Plan (GPMP) prepared or a Team Care Arrangements (TCA) co-ordination service. These are the two most highly used chronic disease management services available on the Medicare Benefits Schedule (MBS) for people with a chronic or terminal medical condition.

Claiming patterns of chronic disease management services vary by demographic characteristics, jurisdiction, remoteness and socioeconomic areas. MBS data does not give a comprehensive picture of actual service delivery and data does not include chronic disease care services provided under other arrangements that do not attract an MBS claim.

The ABS National Health Survey does not include people living in very remote areas and discrete Indigenous communities, which affects the representativeness of the Northern Territory results for the asthma measure. Approximately 20% of the estimated resident population of the Northern Territory live in very remote areas and discrete Indigenous communities as of 2020-21.

> Measure 1: Nationally in 2022-23, the rate of patients claiming for GPMP services was 122.3 per 1,000 people. The rate of patients claiming for TCAs was 104.3 per 1,000 people (Figure 10.6a).

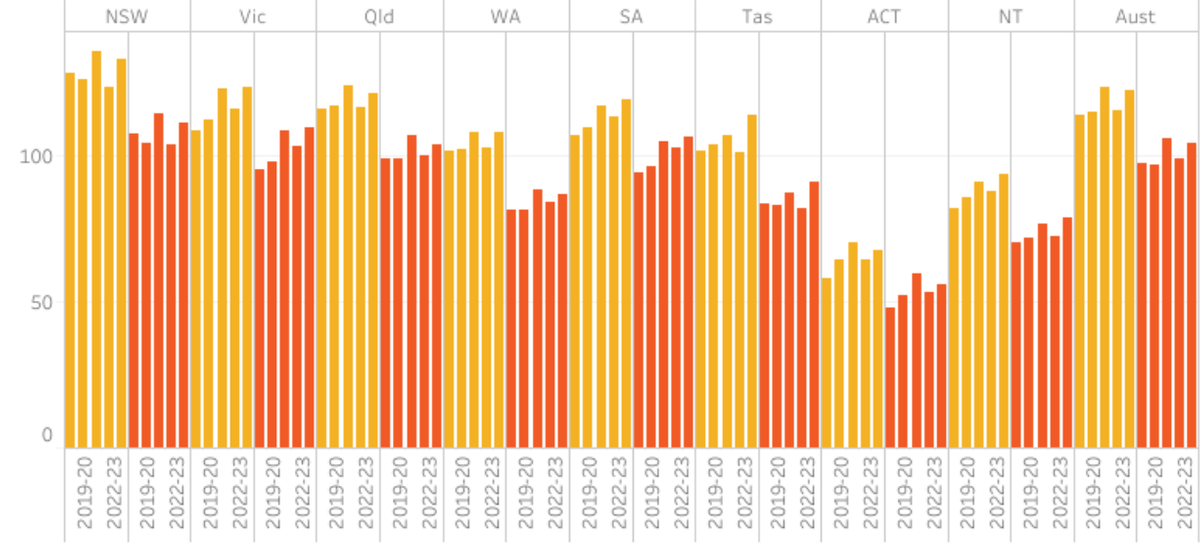
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
All

GP management plans
Team care arrangements

Figure 10.6a Measure 1: **Chronic disease care services**
Per 1,000 people, GP management plans & Team care arrangements, by jurisdiction, by year



Source: table 10A.45

Measure 2: Nationally in 2022, the age-standardised proportion of people with asthma reporting that they have a written asthma action plan was 35.4% (figure 10.6b), compared to 32.3% in 2017-18. In all jurisdictions, the proportion was higher for children aged 0–14 years than for other age groups (nationally, 71.5%) (table 10A.46).

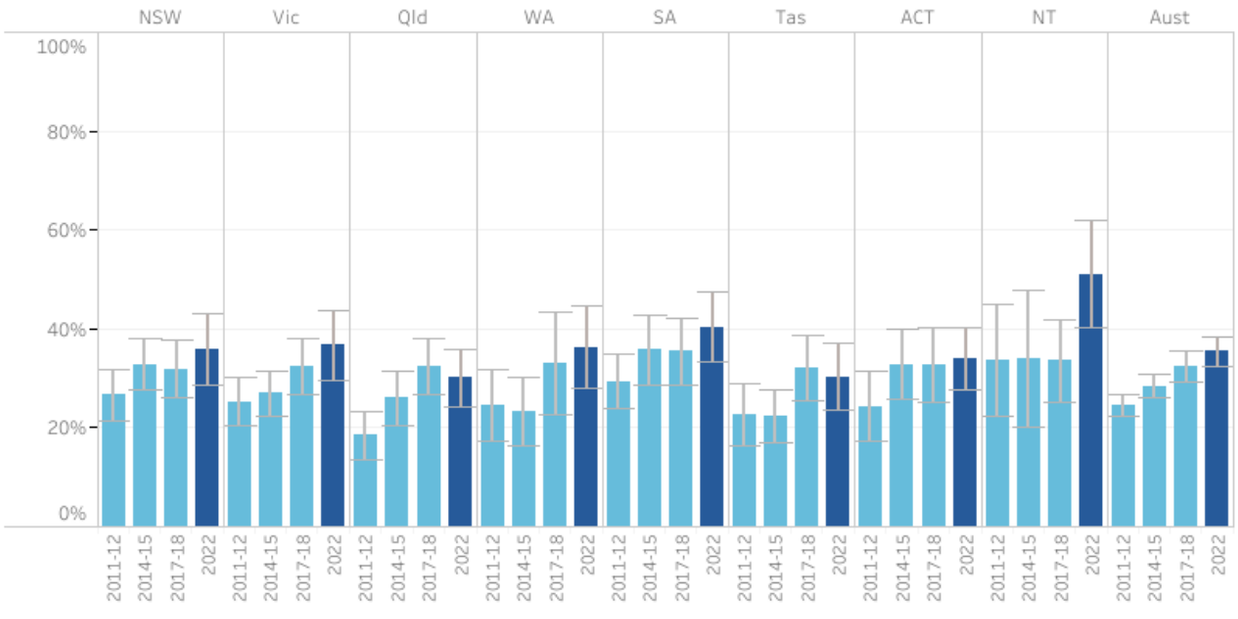
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
All

Select age group:
All ages

Figure 10.6b Measure 2: **People with asthma with a written asthma action plan**
All ages, by jurisdiction, by year (a), (b)



Source: table 10A.46

(a) Data is not published for some age groups for some jurisdictions. (b) Data for 'all ages' is age-standardised.

Biomedical data on the management of diabetes is available in earlier reports.

8. Immunisation coverage

'Immunisation coverage' is an indicator of governments' objective to ensure primary and community health services are appropriate and responsive to meet the needs of individuals throughout their lifespan and communities.

'Immunisation coverage' is defined by four measures:

- Proportion of children aged 12<15 months who are fully immunised (at this age, against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis b, *Haemophilus influenzae* type b and pneumococcal)
- Proportion of children aged 24<27 months who are fully immunised (at this age, against diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type b, hepatitis B, measles, mumps and rubella (MMR), meningococcal C and varicella)
- Proportion of children aged 60<63 months who are fully immunised (at this age, against diphtheria, tetanus, pertussis (whooping cough), polio, and to the quarter ending 31 December 2017, including measles, mumps and rubella (MMR))

- Proportion of people aged 65 years and over who have been vaccinated against seasonal influenza.

High or increasing proportions of immunisation coverage are desirable.

Measures 1-3: Nationally, the proportion of children fully immunised in 2022-23 was: 93.4% for children aged 12 to less than 15 months; 91.3% for children aged 24 to less than 27 months; and 94.1% for children aged 60 to less than 63 months (figure 10.7a). Contextual data on vaccinations supplied to children under seven years of age, by type of provider is reported in table 10A.47.

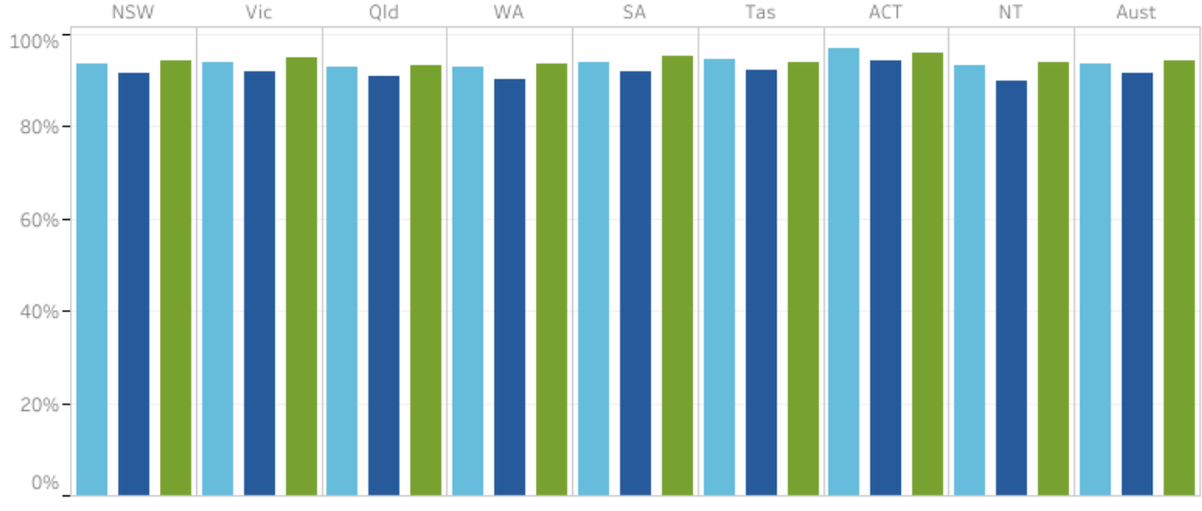
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year:
2022-23

12 months to less than 15 months
24 months to less than 27 months
60 months to less than 63 months

Figure 10.7a Measures 1-3: **Children fully immunised**
By jurisdiction, by age (months), 2022-23



Source: table 10A.48

Measure 4: Nationally, in 2023, 61.0% of people aged 65 years and over were vaccinated against seasonal influenza, with the proportion slightly higher for non-Indigenous people (61.1%) compared to Aboriginal and Torres Strait Islander people (58.4%) (figure 10.7b).

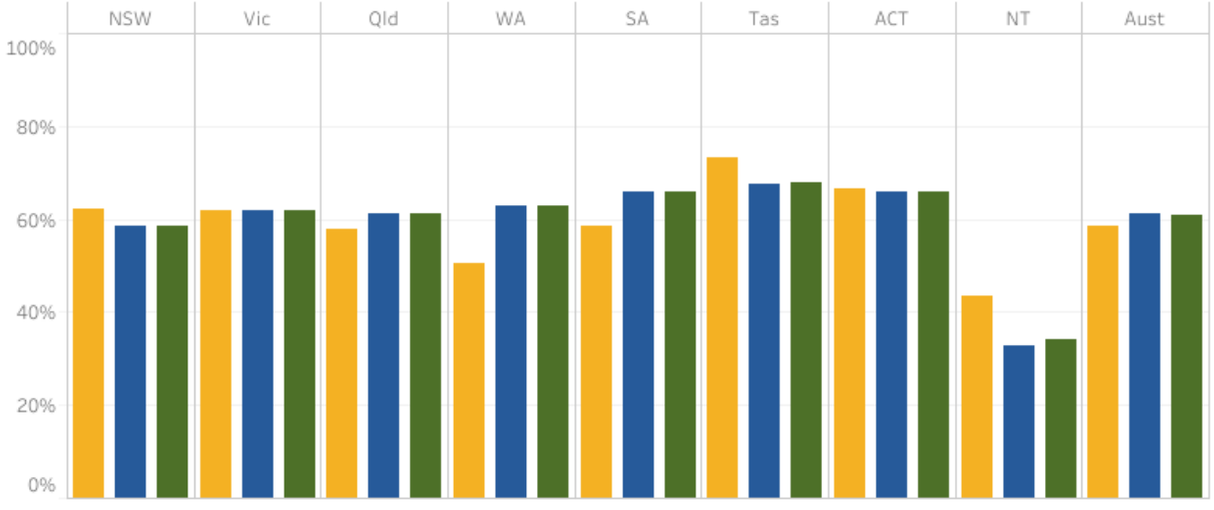
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year:
2023

Aboriginal and Torres Strait Islander people
Non-Indigenous people
All people

Figure 10.7b Measure 4: **Population 65+ years old vaccinated against influenza**
By jurisdiction, by Indigenous status, 2023



Source: table 10A.49

9. Cancer screening

'Cancer screening' is an indicator of governments' objective to ensure primary and community health services are appropriate and responsive to meet the needs of individuals throughout their lifespan and communities.

'Cancer screening' is defined by three measures:

- Participation in breast cancer screening, defined as the proportion of women aged 50–74 years who are screened in the BreastScreen Australia Program over a 24-month period
- Participation in cervical screening, is defined as the number of people aged 25–74 years screened in a five-year period as a percentage of females in the population.
    - A new National Cervical Screening Program commenced in December 2017, at which time cervical screening changed from two-yearly Pap tests to five-yearly Cervical Screening Tests. Participation data for 2018-2022 is the first to show a five-year participation rate in the new program.
- Participation in bowel cancer screening, defined as people aged 50–74 years who were invited to participate in the National Bowel Cancer Screening Program over a 24-month period and returned a completed test kit within six months of the end of that period, divided by the number of invitations issued minus those people who opted out or suspended without completing their screening test.

High or increasing screening participation rates are desirable.

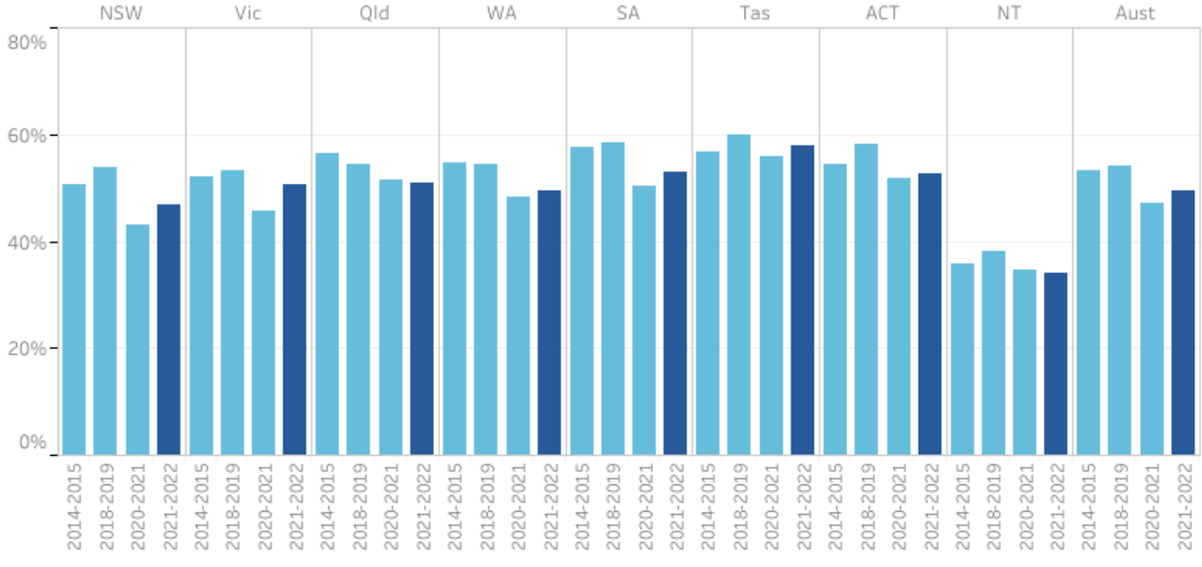
Measure 1: The national age-standardised BreastScreen participation rate for women aged 50–74 years for 2021–2022 was 49.6% (figure 10.8a), an increase from 2020–2021 (47.0%). While screening rates have increased, they have not returned to pre-pandemic levels (54.2% in 2018-19). For 2021–2022, the participation rate for Aboriginal and Torres Strait Islander women aged 50–74 years was 36.7%, also an increase from 2020–2021 (35.1%) (table 10A.51).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 10.8a Measure 1: **Participation of women in BreastScreen Australia**
50-74 years old, 24-month period, by jurisdiction, by year (a)



Source: table 10A.50

Measure 2: For the five-year period 2018-2022, the national aged-standardised participation rate for people aged 25-74 years in cervical cancer screening was 68.4% (table 10.3).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Table 10.3 Measure 2: **Participation of people in the National Cervical Screening Program** 25-74 years old, by jurisdiction, 2018-2022

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
%	67.2	69.0	67.5	68.6	69.4	67.7	70.9	67.9	68.3
% (AS)	67.3	69.1	67.6	68.6	70.0	68.5	70.8	66.4	68.4

Source: table 10A.52
AS = Age Standardised

+ a b | e a u

Data collected under the previous cervical cancer screening program (to June 2017) is available in earlier reports.

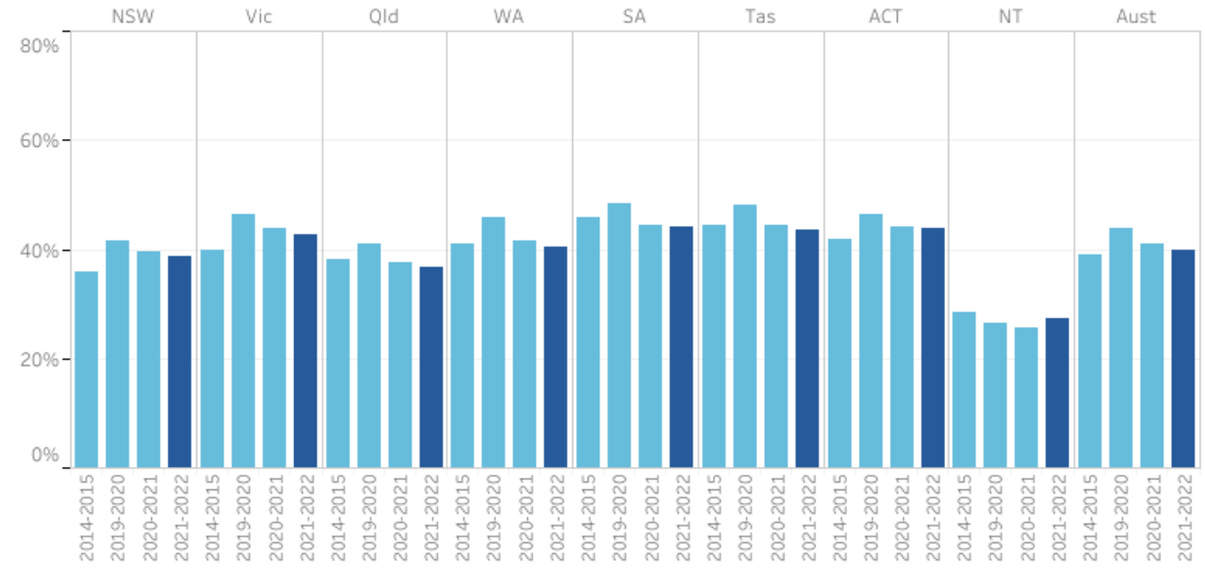
> Measure 3: For 2021-2022, the national participation rate for people aged 50–74 years in bowel cancer screening was 40.0%, a decrease from 40.9% in 2020–2021, a continued downward trend from 2019-2020 (43.8%) (figure 10.8b).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 10.8b Measure 3: **Participation of people in the National Bowel Cancer Screening Program**
50-74 years old, 24-month period, by jurisdiction, by year



Source: table 10A.53

+ a b | e a u

10. General practices with accreditation

‘General practices with accreditation’ is an indicator of governments’ objective to ensure primary and community health services are high quality and safe.

‘General practices with accreditation’ is defined as the number of general practices in Australia that are accredited as a rate per 100 general practices. Accreditation is a voluntary process of independent third-party peer review that assesses general practices against a set of standards developed by the Royal Australasian College of General Practitioners.

A high or increasing rate of practices with accreditation can indicate an improvement in the capability of general practice to deliver high quality services. However, general practices without accreditation may deliver services of equally high quality. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards.

> Nationally in 2019, 83.8 general practices were accredited per 100 general practices (figure 10.9).

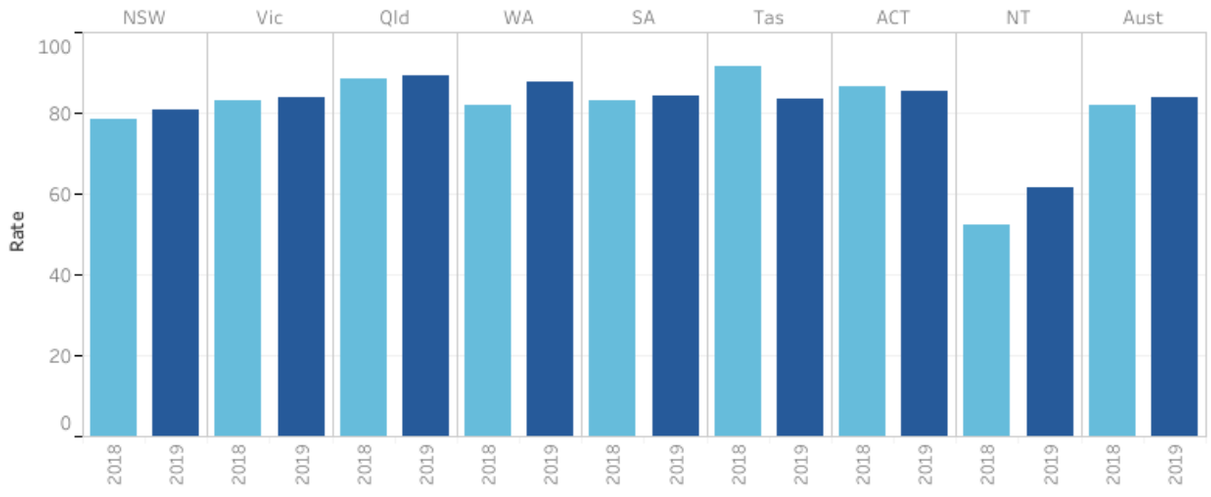
While rates are not available from 2020 onwards (as the total number of general practices (denominator) was not available), the number of accredited general practices at 30 June 2023 was 7,135, a decrease from 7,219 at 30 June 2022 (table 10A.54). The Australian Government is developing a method to source the total number of general practices. Data is expected to be available for the 2025 Report.

Data is comparable (subject to caveats) across jurisdictions and over time (from 2018).

Data is not complete for the current reporting period. All required 2021 data for the number of general practices (denominator) is not available and therefore an accreditation rate cannot be calculated.

Select year(s):
All

Figure 10.9 **Accreditation of general practices**
Per 100 general practices, by jurisdiction, by year



Source: table 10A.54

11. Patient satisfaction

'Patient satisfaction' is an indicator of governments' objective that primary and community health services are high quality.

'Patient satisfaction' is defined as the quality of care as perceived by the patient. It is measured as patient experience of aspects of care that are key factors in patient outcomes and can be readily modified. Two measures of patient experience of communication with health professionals – a key aspect of care – are reported:

- the proportion of people who needed to and saw a GP in the previous 12 months who reported the GP always or often:
  - listened carefully to them
  - showed respect
  - spent enough time with them
- the proportion of people who needed to and saw a dental professional in the previous 12 months who reported the dental professional always or often:
  - listened carefully to them
  - showed respect
  - spent enough time with them.

High or increasing proportions can indicate improved satisfaction with the quality of care from the patient's perspective.

The ABS Patient Experience Survey of people aged 15 years and over does not include people living in discrete Indigenous communities, which affects the representativeness of the Northern Territory results. Approximately 20% of the resident population of the Northern Territory live in discrete Indigenous communities as of 2020-21.

Measure 1: Nationally in 2022-23, the majority of respondents who needed to and saw a GP reported that the GP always or often:

- listened carefully (90.7%)
- showed respect (94.1%)
- spent enough time with them (87.5%) (figure 10.10a) (tables 10A.55-56).

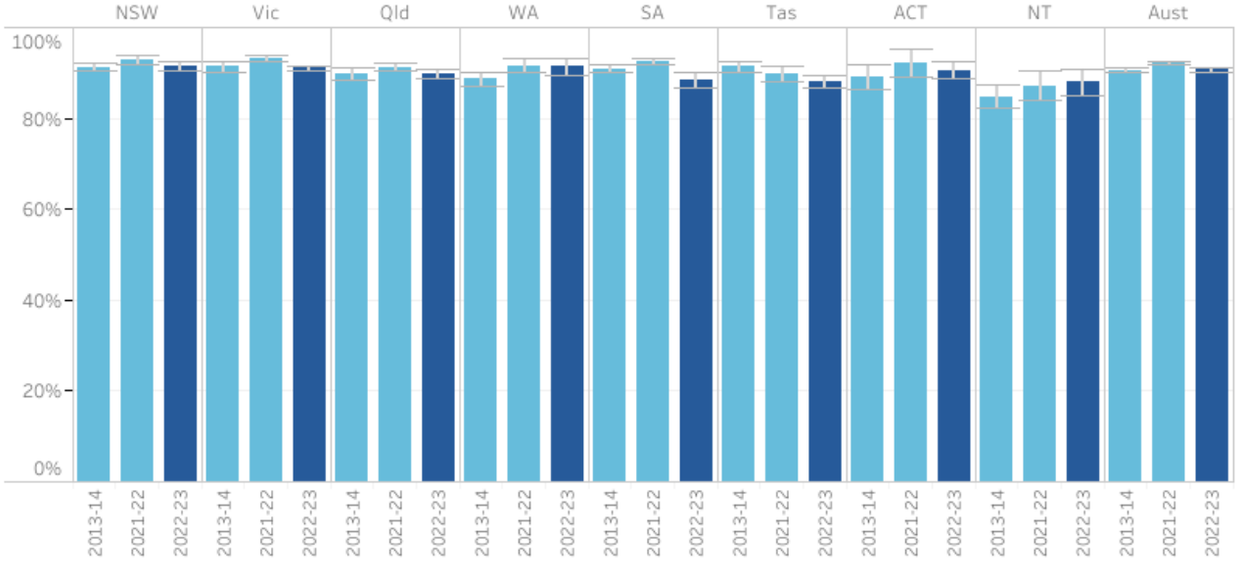
(all measures) Data is comparable (subject to caveats) across jurisdictions and over time.

(all measures) Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Select disaggregation:
(●) GP always or often listened carefully
( ) GP always or often showed respect
( ) GP always or often spent enough time with person

Figure 10.10a Measure 1: **Patient experience of GPs: GP always or often listened carefully**
By jurisdiction, by year



Source: tables 10A.55-10A.56

Measure 2: Nationally in 2022-23, the majority of respondents who needed to and saw a dental professional reported that the dental professional always or often:

- listened carefully (96.3%) (figure 10.10b)
- showed respect (97.1%).
- spent enough time with them (96.9%) (tables 10A.57-58).

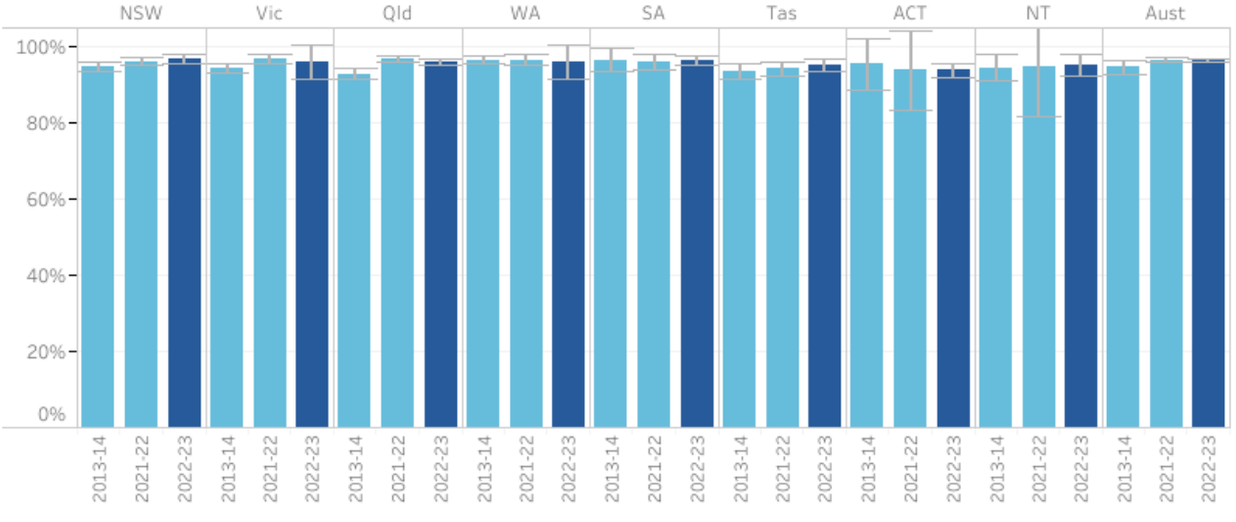
(all measures) Data is comparable (subject to caveats) across jurisdictions and over time.

(all measures) Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Select disaggregation:
Dental professional always or often listened carefully
Dental professional always or often showed respect
Dental professional always or often spent enough time with person

Figure 10.10b Measure 2: **Patient experience of dental professionals: Dental professional always or often listened carefully**
By jurisdiction, by year



Source: tables 10A.57-10A.58

Data by remoteness for measures 1 and 2 is presented in tables 10A.55-58.

12. Continuity of care

'Continuity of care' is an indicator of governments' objective to ensure that services are well co-ordinated when more than one service type and/or ongoing service provision is required.

'Continuity of care' is defined by three measures:

- the proportion of GP management plans and team care assessment plans that have been reviewed in the last 12 months
- the proportion of people who saw three or more health professionals in the last 12 months for the same condition and who reported that a health professional helped coordinate their care and that this coordination of care helped to a large extent

- the proportion of people who saw three or more health professionals in the last 12 months for the same condition and who reported that issues were caused by a lack of communication between the health professionals.

For the first measure, proportions are calculated by dividing the number of MBS subsidised GP management plans and team care assessment plans reviewed (Medicare item no. 732), by the total number of MBS subsidised GP management plans (Medicare item no. 721) and team care assessment plans (Medicare item no. 723), multiplied by 100.

A high or increasing proportion of GP management and team care assessment plans reviewed is desirable.

The second and third measures are enumerated using data from the ABS Patient Experience Survey (PEx) of people aged 15 years and over. The PEx does not include people living in discrete Indigenous communities, which affects the representativeness of the Northern Territory results for both measures. Approximately 20% of the estimated resident population of the Northern Territory live in discrete Indigenous communities as of 2020-21.

For the second measure, a high or increasing proportion of patients who saw three or more different health professionals in the past 12 months for the same condition and who reported that a health professional helped coordinate their care and that this coordination of care helped to a large extent is desirable.

For the third measure, a low or decreasing proportion of patients who saw three or more different health professionals in the past 12 months for the same condition and who reported that issues were caused by a lack of communication between health professionals is desirable.

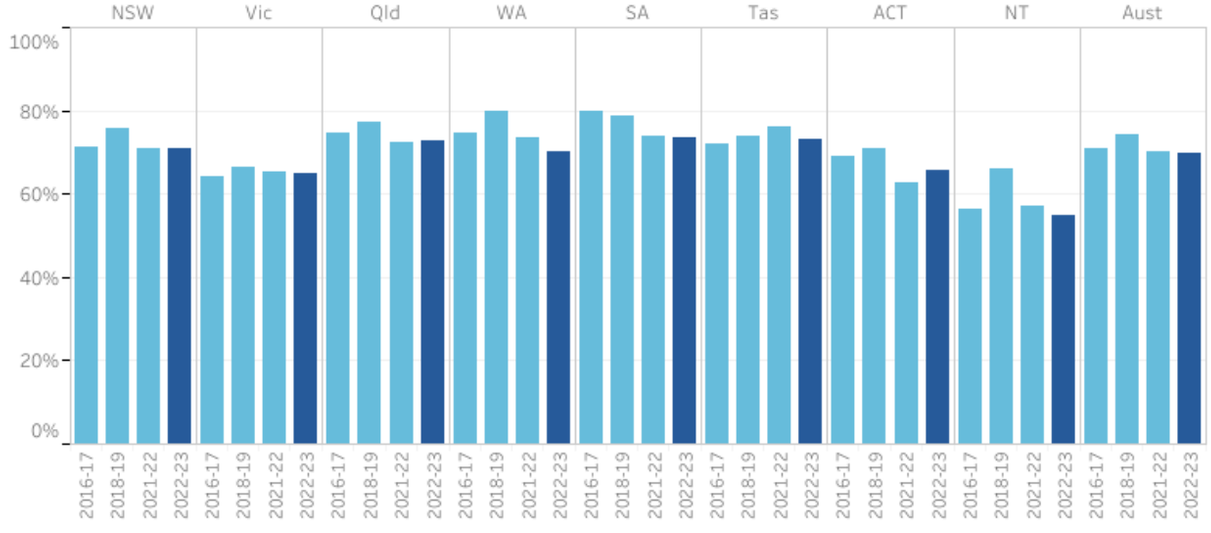
> Measure 1: Nationally in 2022-23, 69.8% of MBS subsidised GP management plans and team care assessment plans were reviewed. This is lowest for the seven years of reported data and reflects a continuing decrease since the peak in 2018-19 (74.1%) (figure 10.11a).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 10.11a Measure 1: **GP management and team care assessment plans reviewed in the past 12 months**
By jurisdiction, by year



Source: table 10A.59

Measures 2-3: Nationally in 2022-23, the proportion of people who saw three or more health professionals in the last 12 months for the same condition and who reported that:

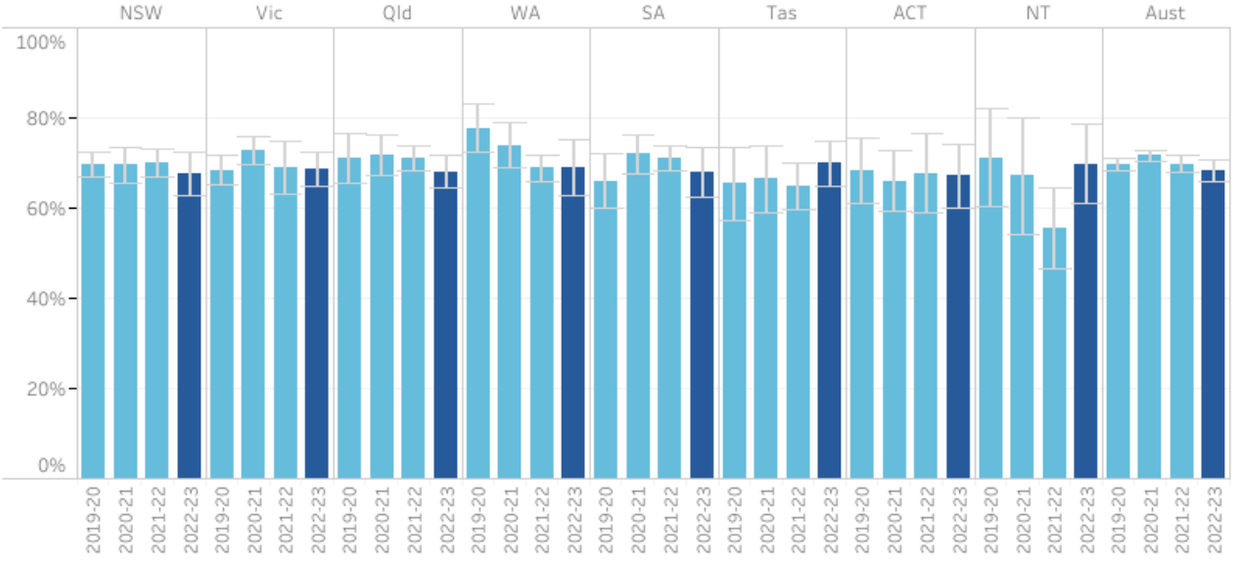
- a health professional helped coordinate their care and that this coordination of care helped to a large extent was 68.4% (figure 10.11b)
- issues were caused by a lack of communication between the health professionals was 14.5% (figure 10.11c).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
All

Figure 10.11b Measure 2: **People who saw three or more health professionals in the last 12 months for the same condition and who reported that a health professional helped coordinate their care and that this coordination of care helped to a large extent**
By jurisdiction, by year



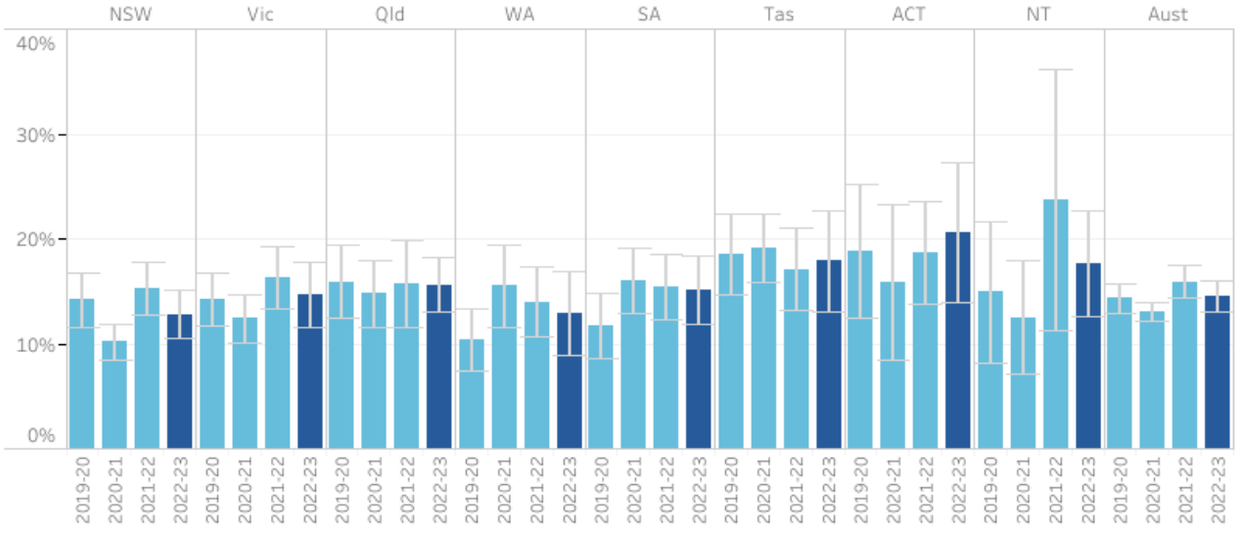
Source: table 10A.60

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
All

Figure 10.11c Measure 3: **People who saw three or more health professionals in the last 12 months for the same condition and who reported that issues were caused by a lack of communication between the health professionals**
By jurisdiction, by year



Source: table 10A.61

13. Workforce sustainability

'Workforce sustainability' is an indicator of governments' objective to provide sustainable primary and community healthcare services.

'Workforce sustainability' is defined by two measures:

- the proportion of full-time equivalent (FTE) GPs in ten-year age brackets
- the attrition rate of FTE GPs who exit the workforce as a proportion of the number of FTE GPs by age bracket.

A high or increasing percentage of the workforce that are new entrants and/or low or decreasing proportions of the workforce that are close to retirement is desirable. A low or decreasing rate of workforce attrition is desirable.

Health workforce sustainability relates to the capacity of the health workforce to meet current and projected future service demand. These measures are not a substitute for a full workforce analysis that allows for training, migration, changing patterns of work and expected future demand. They can, however, indicate that further attention should be given to workforce planning for primary and community health services.

The attrition rate is measured as the proportion of GPs who were in scope in 2021, but not in scope in 2022. In scope is defined as Primary Care GPs, being GPs working in the treatment of non-admitted patients in the community. GPs who 'exited' (i.e., were no longer in scope) in 2022

might still be in the medical workforce and practicing as a GP but are classified as an exit as they are no longer Primary Care GPs.

> Measure 1: Nationally in 2022, 26.6% of FTE general practitioners were aged 60 years or older, compared to 2.4% who were less than 30 years of age (figure 10.12). This is the highest proportion of GPs aged 60 years or older and the lowest proportion of GPs who were less than 30 years old across the reported eight-year time series.

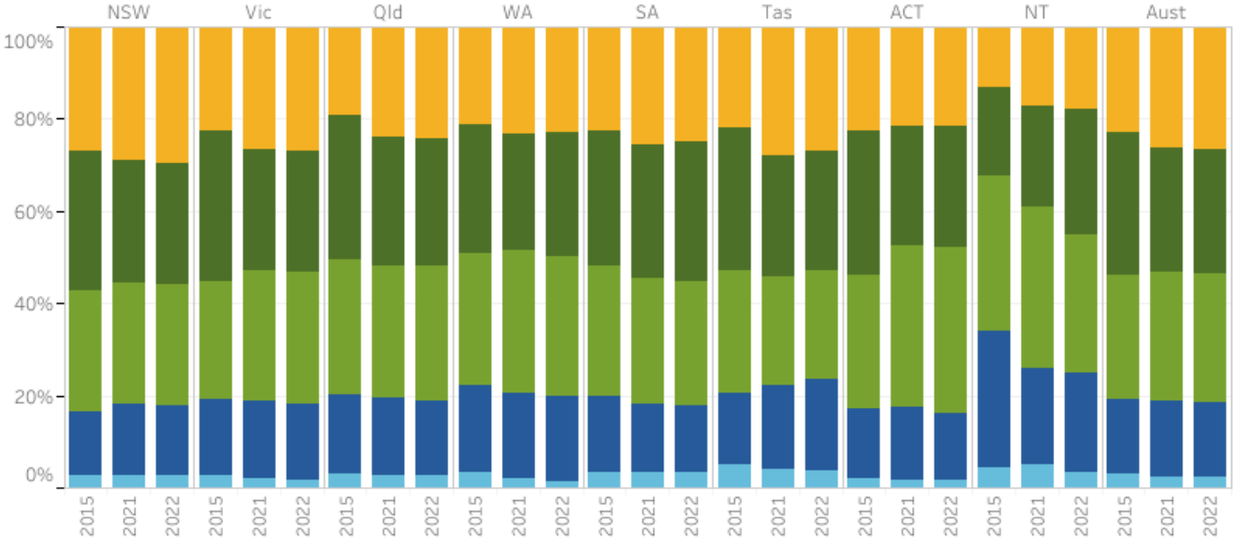
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year:
Multiple values

60+ years old
50-59 years old
40-49 years old
30-39 years old
<30 years old

Figure 10.12 Measure 1: **Full-time equivalent proportions of the General practitioner workforce**
By age group, by jurisdiction, by year



Source: table 10A.62

+ableau

> Measure 2: Nationally in 2022, the proportion of general practitioners who exited the GP workforce was 1.3%, with the proportion highest for those 60 years and over (2.5%) (table 10.4).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year:
- (●) 2022
- ( ) 2021
- ( ) 2020
- ( ) 2019

Table 10.4 Measure 2: **General practitioner workforce workforce attrition rate**
By age group, by jurisdiction, 2022

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
<30 years old	3.2	0.7	2.8	1.0	0.8	1.9	–	4.8	2.2
30-39 years old	1.4	1.6	1.5	2.3	1.2	3.0	2.8	2.4	1.6
40-49 years old	0.6	0.5	0.9	0.6	0.9	0.9	0.7	3.6	0.7
50-59 years old	0.3	0.5	0.7	0.8	0.5	0.8	0.6	2.5	0.5
60+ years old	2.2	2.0	3.0	2.7	2.7	5.8	2.6	5.1	2.5
Total	1.2	1.1	1.5	1.5	1.3	2.7	1.4	3.4	1.3

Source: table 10A.63

14. Cost to government of general practice per person

‘Cost to government of general practice per person’ is an indicator of governments’ objective to provide primary and community health services in an efficient manner.

‘Cost to government of general practice per person’ is defined as the cost to government of general practice per person in the population.

This indicator should be interpreted with care. A low or decreasing cost per person can indicate higher efficiency, provided services are equally or more effective. It can also reflect service substitution between primary healthcare and hospital or specialist services – potentially at greater expense.

Cost to government of general practice does not capture the costs of salaried GP service delivery models, used particularly in rural/remote areas. Salaried GP service models involve the delivery of primary healthcare services by salaried GPs in community health settings, emergency departments, and Aboriginal and Torres Strait Islander primary healthcare services. Therefore, costs are understated for jurisdictions where a larger proportion of the population live in rural and remote areas.

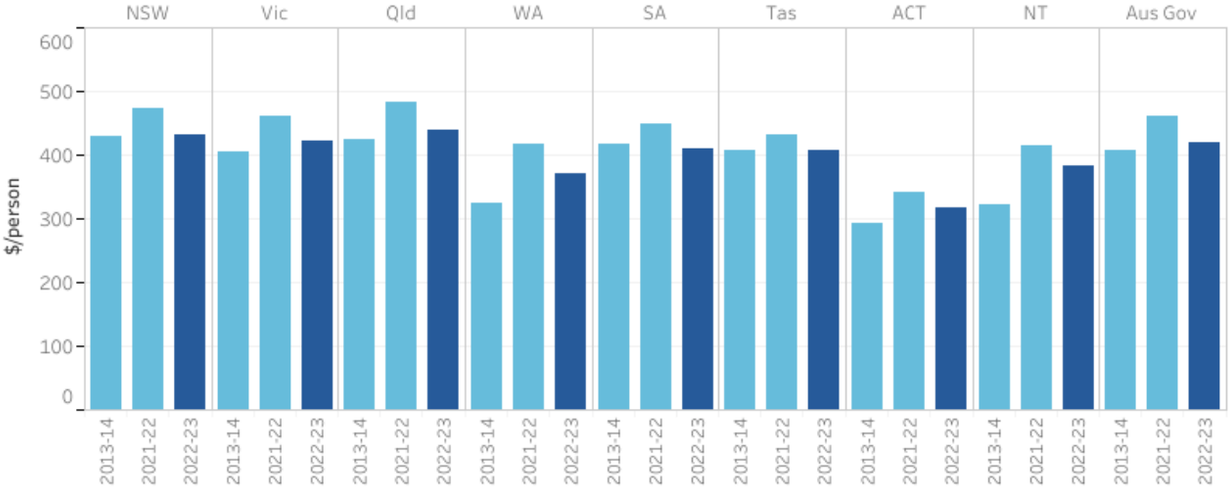
> Nationally in 2022-23, total expenditure per person on general practice was $420 per person, a decrease in real terms from $461 in 2021-22 (figure 10.13).

Data is comparable (subject to caveats) across jurisdictions, and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 10.13 **Australian Government expenditure on GPs**
By jurisdiction, by year (2022-23 dollars)



Source: table 10A.2

15. Notifications of selected childhood diseases

'Notifications of selected childhood diseases' is an indicator of governments' objective for primary and community health services to promote health and prevent illness.

'Notifications of selected childhood diseases' is defined as the number of notifications of measles, pertussis and invasive *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System by state and territory health authorities for children aged 0–14 years, per 100,000 children in that age group.

A low or reducing notification rate for the selected diseases indicates that the immunisation program is more effective.

Measles, pertussis (whooping cough) and invasive *Haemophilus influenzae* type b are nationally notifiable vaccine preventable diseases, and notification to the relevant state or territory authority is required on diagnosis.

Nationally in 2022-23, the rate of notifications for children aged 0–14 years was:

- 0.2 per 100,000 children for Haemophilus influenzae type b
- 0.2 per 100,000 children for measles
- 3.6 per 100,000 children for pertussis (whooping cough) (figure 10.14 and table 10A.64).

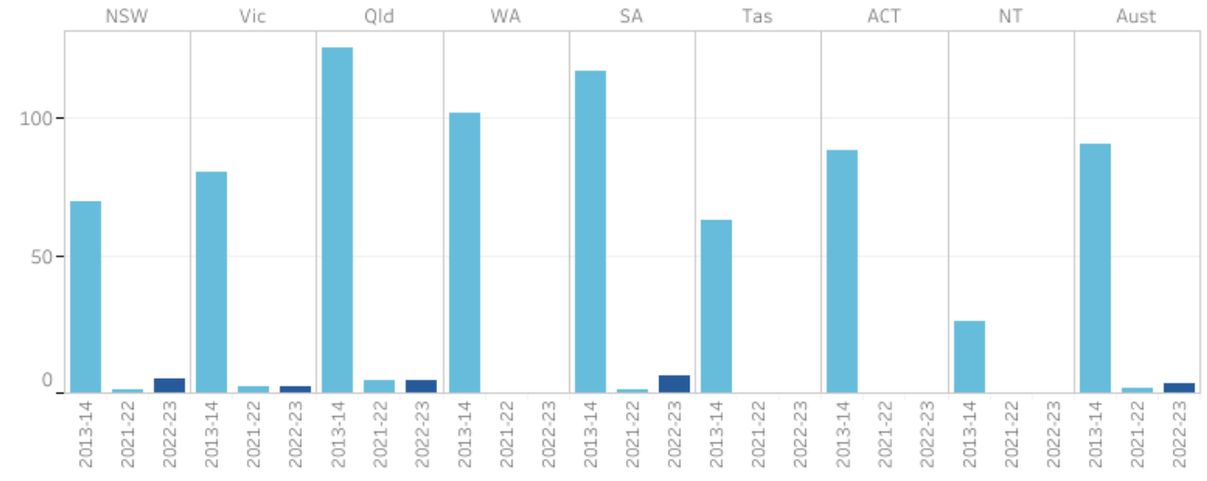
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Select disease:
- Invasive haemophilus influenzae type b
- Measles
- Pertussis (whooping cough)

Figure 10.14 **Notifications of selected childhood diseases: Pertussis (whooping cough)**
Per 100,000 children, by jurisdiction, by year (a)



Source: table 10A.64

(a) Some rates are suppressed where the numerator is less than 5.

tableau

16. Selected potentially preventable hospitalisations

'Selected potentially preventable hospitalisations' is an indicator of governments' objective for primary and community health services to promote health, prevent illness and to support people to manage their health issues in the community.

'Selected potentially preventable hospitalisations' is defined as hospital admissions that may be avoided by effective management of illness and injury in the primary and community healthcare sector or, in some cases, by preventing illness and injury altogether. Two measures of selected potentially preventable hospitalisations are reported by jurisdiction of residence:

- Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions
- Potentially preventable hospitalisations for diabetes (Type 2 diabetes mellitus as principal diagnosis).

Low or decreasing separation rates for selected potentially preventable hospitalisations can indicate more effective management of selected conditions in the primary and community healthcare sector and/or more effective preventative programs. Factors outside the control of the primary and community healthcare sector also influence hospitalisation rates for these conditions. For example, the underlying prevalence of conditions, patient compliance with management and older people's access to aged care services and other support.

Measure 1: Nationally in 2021-22, the age-standardised hospital separation rate for selected vaccine preventable, acute and chronic conditions was 23.1 per 1,000 people, the lowest rate reported over the past ten years (table 10.5). Rates were higher for Aboriginal and Torres Strait Islander people (65.4 per 1,000 people) than other Australians (22.0 per 1,000 people).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year:
2021-22

Select Indigenous status:
(●) All people
( ) Aboriginal and Torres Strait Islander people
( ) Non-Indigenous people and unknown Indigenous status

Table 10.5 Measure 1: **Separations for selected potentially preventable hospitalisations**
Rate per 1,000 people (age-standardised), All people, by condition, by jurisdiction, 2021-22

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Vaccine preventable	1.6	1.5	1.6	1.3	1.1	0.8	0.9	9.0	1.5
Acute	9.9	9.6	16.5	11.9	12.5	9.6	10.3	22.4	11.7
Chronic	8.0	10.9	12.2	8.8	9.5	13.4	6.7	18.4	10.0
Total	19.2	21.9	30.2	21.8	23.0	23.7	17.8	48.3	23.1

Source: tables 10A.65 and 10A.66

Measure 2: Nationally in 2021-22, the age-standardised hospital separation rate for diabetes was 124.2 separations per 100,000 people (table 10.6).

The age-standardised separation rate for Aboriginal and Torres Strait Islander people (excluding separations for diabetes complications as an additional diagnosis) was 2.7 times the rate for all Australians (table 10A.72).

The most serious complication of Type 2 diabetes most commonly leading to hospitalisation in 2021-22 was circulatory complications, with an age standardised rate of 17.1 per 100,000 people (table 10A.73). Serious circulatory complications of diabetes can necessitate lower limb amputation. In 2021-22, there were 20.1 age-standardised hospital separations per 100,000 people for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (table 10A.75).

Data is comparable (subject to caveats) across jurisdictions.

Data is complete (subject to caveats) for the current reporting period.

Table 10.6 Measure 2: **Separations for Type 2 diabetes mellitus as principal diagnosis**
Rate per 100,000 people (age-standardised), by complication, by jurisdiction, 2021-22

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Circulatory	17.1	14.1	16.7	25.2	15.8	12.9	28.6	26.8	17.1
Multiple	26.6	76.6	46.4	45.1	41.9	75.4	26.3	149.5	48.6
No complications	4.6	7.0	5.2	4.0	4.6	4.3	3.2	3.8	5.2
Ophthalmic	4.4	6.9	21.1	30.8	8.9	19.1	12.1	3.2	11.9
Other specified	33.8	35.6	48.8	36.7	40.4	34.7	30.0	63.2	38.3
Renal	2.7	2.6	4.3	3.0	2.0	2.7	3.6	2.8	3.0
Total	89.2	142.9	142.5	144.8	113.6	149.1	103.8	249.4	124.2

Source: table 10A.73

Indigenous data

Performance indicator data for Aboriginal and Torres Strait Islander people in this section is available in the data tables listed below. Further supporting information can be found in the Indicator results tab and data tables.

Primary and community health data disaggregated for Aboriginal and Torres Strait Islander people

Table number	Table title
Table 10A.17	Approved suppliers of PBS medicines by MMM area, at 30 June (number)
Table 10A.18	Approved suppliers of PBS medicines by remoteness area, at 30 June (number)
Table 10A.23	Aboriginal and Torres Strait Islander people who had Aboriginal and Torres Strait Islander-specific health checks or assessments, by location of assessment (per 1,000 people)
Table 10A.24	Aboriginal and Torres Strait Islander-specific health checks or assessments, by location of assessment (per 1,000 people)
Table 10A.25	Aboriginal and Torres Strait Islander people who had Aboriginal and Torres Strait Islander-specific health checks or assessments, by age (per cent)
Table 10A.34	Median waiting time for public dental care, NSW (days)
Table 10A.35	Median waiting time for public dental care, Victoria (days)
Table 10A.36	Median waiting time for public dental care, Queensland (days)
Table 10A.37	Median waiting time for public dental care, WA (days)
Table 10A.38	Median waiting time for public dental care, SA (days)

Table number	Table title
Table 10A.39	Median waiting time for public dental care, Tasmania (days)
Table 10A.40	Median waiting time for public dental care, ACT (days)
Table 10A.41	Median waiting time for public dental care, NT (days)
Table 10A.49	Influenza vaccination coverage for people aged 65 years and over (per cent)
Table 10A.51	Participation rates for Aboriginal and Torres Strait Islander women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 10A.66	Separations for selected potentially preventable hospitalisations by Indigenous status (per 1,000 people)
Table 10A.68	Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia (per 1,000 people)
Table 10A.69	Separations for selected vaccine preventable conditions by Indigenous status (per 1,000 people)
Table 10A.70	Separations for selected acute conditions by Indigenous status (per 1,000 people)
Table 10A.71	Separations for selected chronic conditions by Indigenous status (per 1,000 people)
Table 10A.72	Selected potentially preventable hospitalisations, ratio of separations for Aboriginal and Torres Strait Islander people to all Australians, diabetes

Explanatory material

Key terms

Terms	Definition
Age-standardised	Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution.
Annual cycle of care for people with diabetes mellitus within general practice	The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice based on RACGP guidelines. MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines.
Asthma action plan	The National Asthma Council Australia recommends people with asthma should have their own individual written action plan that includes instructions on what to do when asthma symptoms worsen. Source: National Asthma Council Australia, 2022, *Australian Asthma Handbook,* Version 2.2. National Asthma Council Australia, Melbourne, accessed 15 December 2023: https://www.asthmahandbook.org.au/management/action-plans
Australian classification of health interventions (ACHI)	Developed by the National Centre for Classification in Health, the ACHI comprises a tabular list of health interventions and an alphabetic index of health intervention.
Cervical screening test	A cervical screening test consists of a human papillomavirus (HPV) test with partial genotyping and, if the HPV test detects oncogenic HPV, liquid based cytology (LBC).
Closed treatment episode	A closed treatment episode is a period of contact between a client and an alcohol and other drug treatment agency. It has defined dates of commencement and cessation, during which the principal drug of concern, treatment delivery setting and main treatment type did not change. Reasons for cessation of a treatment episode include treatment completion, and client non-participation in treatment for three months or more. Clients may have more than one closed treatment episode in a data collection period.

Terms	Definition
Community health services	Health services for individuals and groups delivered in a community setting, rather than in hospitals or private facilities.
Comparability	Data is considered comparable if (subject to caveats) it can be used to inform an assessment of comparative performance. Typically, data is considered comparable when it is collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data.
Completeness	Data is considered complete if all required data is available for all jurisdictions that provide the service.
Consultations	Periods of service provided by GPs. Professional attendance by a GP can include any of the following that are clinically relevant: taking a patient history; performing a clinical examination; arranging any necessary investigation; implementing a management plan; and providing appropriate preventive health care.
Cost to government of general practice per person	Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person.
General practice	The organisational structure with one or more general practitioners (GPs) and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Aboriginal and Torres Strait Islander health.
General practitioner (GP)	To be recognised as a specialist general practitioner for the purposes of Medicare, medical practitioners must either: • hold specialist registration as a general practitioner with the Australian Health Practitioner Regulation Agency (Ahpra) • participate in an approved workforce or training program (commonly known as 3GA programs). To be registered as a specialist general practitioner by the Ahpra, general practitioners must hold fellowship of the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM). Medical practitioners who were on the vocational register on 16 June 2021 maintain their access to general practice items in the Medicare Benefits Schedule.

Terms	Definition
General practitioner full time equivalent (GP FTE)	GP FTE is a workforce specific method to estimate the workload of GPs. The method calculates a GP's workload based on the MBS services claimed as well as patient and doctor factors that affect the duration of a consultation. One GP FTE represents a 40 hour week per week for 46 weeks of the year. For each Medicare provider, the measure attributes an estimate of the amount of time they have spent on their claims compared to what would be worked by a full-time GP, including billable time, non-billable time, and non-clinical time.
General practitioner (GP) Headcount	GP Headcount is a workforce specific method of headcount for GPs working in Australia (number of GPs). The method uses elements from the MBS data set to count when, where and by what type of practitioner GP services are being delivered. The number of GPs is based on the following aspects of MBS data: • MBS items within GP's scope of practice as agreed by Commonwealth Medical Advisors and GPs (Some MBS items reviewed by Commonwealth Medical Advisors and GPs have been restricted in MM 1–2 to account for the difference in the scope of GP activity across metropolitan, regional, rural and remote areas.) • A review of a GPs services over a whole year to determine their Main Derived Major Speciality (MDMS) • A unique identifier to enable distinct counts by MDMS.
GP-type services	Non-referred attendances by vocationally registered GPs and OMPs, and practice nurses.
***Haemophilus influenzae* type b**	A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (Department of Health 2018).
Human papillomavirus (HPV) test	An HPV test uses a sample of cervical cells to determine whether the cells are infected with a high-risk strain of HPV, which could cause changes to cervical cells leading to cervical cancer.
ICD-10-AM	The International Statistical Classification of Diseases and Related Health Problems - 10th Revision - Australian modification (ICD-10-AM) is the current classification of diagnoses in Australia.
Modified Monash Model	The Modified Monash Model (MMM) is a geographical classification that categorises areas in Australia into seven remoteness categories. The model measures remoteness and population size on a scale of Modified Monash (MM) category MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote.

Terms	Definition
Non-referred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be 'referred' to receive Services Australia Medicare reimbursement.
Nationally notifiable disease	A communicable disease that is on the Communicable Diseases Network Australia's endorsed list of diseases to be notified nationally (Department of Health 2013). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority.
Other medical practitioner (OMP)	A medical practitioner other than a vocationally registered GP who has at least half of the schedule fee value of his/her Services Australia Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 Services Australia Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs.
Pap smear	A procedure used to detect pre-cancerous abnormalities of the cervix.
PBS doctor's bag	Emergency drug supplies provided without charge to prescribers for use in medical emergencies in the clinic or community at no charge to the patient.
Per person benefits paid for GP ordered pathology	Total benefits paid under Services Australia Medicare for pathology tests requested by GPs, divided by the population.
Per person benefits paid for GP referred diagnostic imaging	Total benefits paid for diagnostic imaging services performed on referral by GPs, divided by the population.
Primary healthcare	The primary and community healthcare sector includes services that: • provide the first point of contact with the health system • have a particular focus on illness prevention or early intervention • are intended to maintain people's independence and maximise their quality of life through care and support at home or in local community settings.

Terms	Definition
Primary Health Networks	Primary Health Networks (PHNs) are a national network of independent primary health care organisations (replacing Medicare Locals from 1 July 2015) designed to improve the efficiency and effectiveness of medical services for patients at risk of poor health outcomes and improve care coordination, particularly for those with chronic and complex conditions.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services.
Recognised immunisation provider	A general practitioner or an individual, or body, endorsed by the Commonwealth, a State or Territory to administer vaccines in Australia.
Recognised specialist	A medical practitioner classified as a specialist by the Medical Board of Australia and on the Services Australia Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of a test or tests on apparently well people to detect a medical condition earlier than would otherwise be possible.
Socio-Economic Indexes for Areas (SEIFA)	Socio-Economic Indexes for Areas (SEIFA) quintiles are based on the ABS Index of Relative Socio-Economic Disadvantage (IRSD), with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. Each SEIFA quintile represents approximately 20% of the national population, but does not necessarily represent 20% of the population in each state or territory.

Terms	Definition
Triage category	The urgency of the patient's need for medical and nursing care: • category 1 – resuscitation (immediate within seconds) • category 2 – emergency (within 10 minutes) • category 3 – urgent (within 30 minutes) • category 4 – semi-urgent (within 60 minutes) • category 5 – non-urgent (within 120 minutes).

References

AIHW (unpublished), *Australia's health 2024* (to be published in 2024).

AIHW (unpublished), *National Dental Telephone Interview Survey* .

COAG Health Council 2015, *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024,* https://www.health.gov.au/resources/publications/healthy-mouths-healthy-lives-australias-national-oral-health-plan-2015-2024 (accessed 9 June 2022).

Department of Health and Aged Care 2021, *PBS expenditure and prescriptions 1 July 2020 to 30 June 2021,* https://www.pbs.gov.au/statistics/expenditure-prescriptions/2020-2021/PBS_Expenditure_and_Prescriptions_Report_1-July-2020_to_30-June-2021.pdf (accessed 7 October 2022).

—— 2018, *Questions about vaccination,* https://www.health.gov.au/resources/publications/questions-about-vaccination (accessed 16 November 2018).

—— 2013, *Australian national notifiable diseases list and case definitions,* https://www.health.gov.au/diseases (accessed 8 January 2014).

—— (unpublished), *MBS Statistics.*

Services Australia 2021, *Practice Incentives Program (PIP),* https://www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/practice-incentives-program (accessed 5 October 2021).

Report on Government Services 2024

PART E, SECTION 11: RELEASED ON 31 JANUARY 2024

11 Ambulance services

The focus of performance reporting in this section is on ambulance service organisations, which are the primary agencies involved in providing emergency medical care, pre-hospital and out-of-hospital care, and transport services.

The **Indicator results** tab uses data from the data tables to provide information on the performance for each indicator in the **Indicator framework**. The same data in the data tables is also available in CSV format.

Data downloads

11 Ambulance services data tables (XLSX 170.9 KB)

11 Ambulance services dataset (CSV 263.6 KB)

Refer to the corresponding table number in the data tables for detailed definitions, caveats, footnotes and data source(s).

Guide: How to find what you need in RoGS (PDF 288.5 KB)

Context

Objectives for ambulance services

Ambulance services aim to promote health and reduce the adverse effects of emergency events on the community. Governments' involvement in ambulance services is aimed at providing emergency medical care, pre-hospital and out-of-hospital care, and transport services that are:

- accessible and timely
- meet patients' needs through delivery of appropriate health care
- high quality – safe, co-ordinated and responsive health care
- sustainable.

Governments aim for ambulance services to meet these objectives in an equitable and efficient manner.

Service overview

Ambulance services comprise:

- emergency and non-emergency pre-hospital and out-of-hospital patient care and transport
- inter-hospital patient transport including the movement of critical patients
- specialised rescue services
- responding to multi-casualty events

- community capacity building to respond to emergencies (for example, cardiopulmonary resuscitation (CPR) and first aid training).

Roles and responsibilities

Ambulance service organisations are the primary agencies involved in providing services for ambulance events. State and territory governments provide ambulance services in most jurisdictions. In Western Australia and the Northern Territory, St John Ambulance is contracted by government to be the primary provider of ambulance services.

Across jurisdictions, ambulance service organisations are an integral part of the health system. The role of paramedics has expanded over the past decade to include assessment and management of patients with minor illnesses and injuries to avoid hospitalisation.

Funding

In 2022-23, total ambulance service organisation revenue was $5.5 billion, an increase of 9.3% from 2021-22 and representing an average annual growth rate over the past five years of 6.7% (table 11.1).

Select year(s):
Multiple values

Table 11.1 **Revenue of ambulance service organisations**
By jurisdiction, by year ($m) (2022-23 dollars)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2022-23	1,515.8	1,614.4	1,140.8	436.4	483.2	152.8	80.8	51.5	5,475.7
2021-22	1,350.2	1,538.8	1,067.8	387.5	380.6	152.6	78.6	52.3	5,008.4
2018-19	1,189.0	1,257.5	890.9	333.9	345.8	96.5	65.6	40.1	4,219.2
2013-14	947.8	783.3	691.6	286.2	280.1	70.7	47.7	30.2	3,137.7

Source: table 11A.1

Data tables are referenced above by an '11A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Jurisdictions have different funding models to resource ambulance service organisations. Nationally in 2022-23, state and territory government grants and indirect government funding formed the greatest source of ambulance service organisation funding (80.4%), followed by transport fees (from public hospitals, private citizens and insurance) (15.4%), and subscriptions and other income (4.1%) (table 11A.1).

Size and scope

Human resources

Nationally in 2022-23, for ambulance services reported in this section there were:

- 23,096 full time equivalent salaried personnel (83.0% were ambulance operatives)
- 6,052 volunteer personnel (90.2% were ambulance operatives)
- 974 paramedic community first responders. Community first responders are trained volunteers that provide an emergency response (with no transport capacity) and first aid care before ambulance arrival (table 11A.2).

Registered paramedics

Paramedics must be registered with the Paramedicine Board of Australia and meet the Board's registration standards to practise in Australia (Australian Health Practitioner Regulation Agency (AHPRA) Paramedicine Board of Australia, 2022).

In 2022-23, there were 24,110 registered paramedics in Australia (including 558 non-practising registered paramedics) (table 11A.3).

'Qualified ambulance officers' must be registered paramedics (table 11A.2). It is possible some registered paramedics are employed by an ambulance service to work in a different role, such as other clinical or communication roles. Some registered paramedics work in other (non-ambulance) organisations.

Demand for ambulance services

Nationally in 2022-23, there were:

- 4.2 million incidents (events that resulted in demand for ambulance services) reported to ambulance service organisations (161.7 incidents per 1,000 people)
- 5.5 million responses where an ambulance was sent to an incident (209.9 responses per 1,000 people). There can be multiple responses sent to an incident. There can also be responses to incidents where people do not require treatment and/or transport
- 4.0 million patients assessed, treated or transported by ambulance service organisations (153.9 patients per 1,000 people) (figure 11.1).

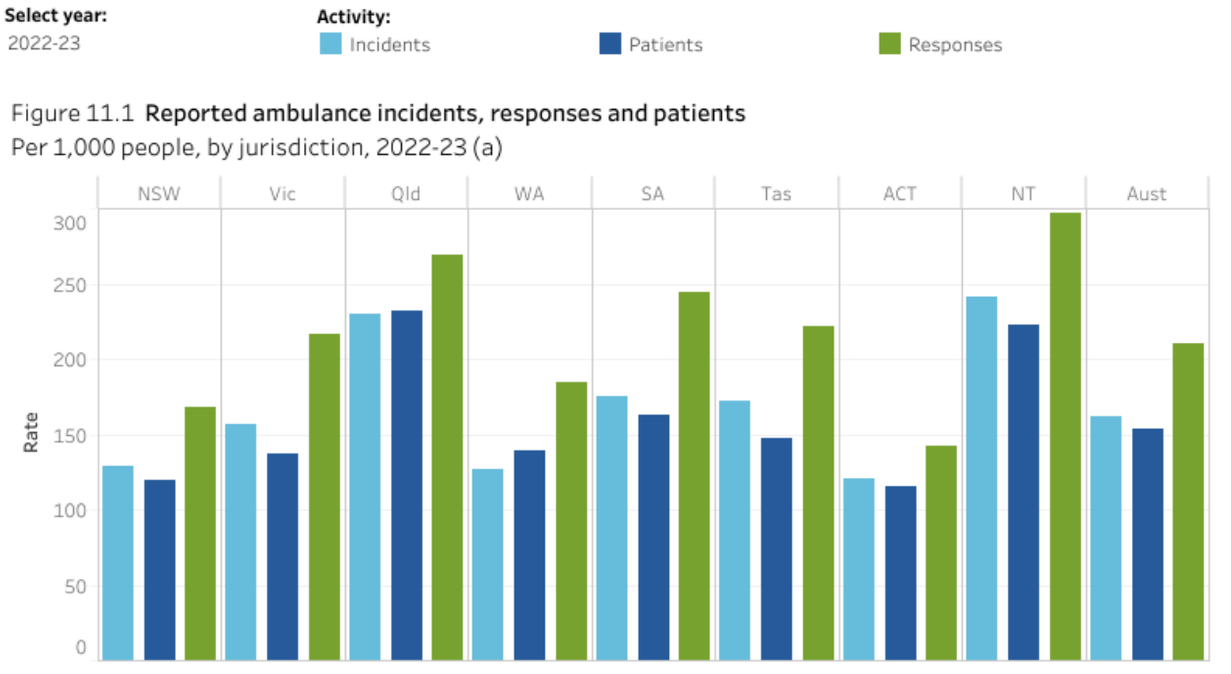


Figure 11.1 **Reported ambulance incidents, responses and patients**
Per 1,000 people, by jurisdiction, 2022-23 (a)

Source : table 11A.4

(a) Data for incidents and patients prior to 2014-15 is not available for the NT.

Data tables are referenced above by an '11A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Ambulance service organisations prioritise incidents as:

- emergency – immediate response required under lights and sirens (code 1)
- urgent – undelayed response required without lights and sirens (code 2)
- non-emergency – non-urgent response required (codes 3, 4)
- casualty room attendance.

Nationally in 2022-23, 43.5% of the 4.2 million incidents reported to ambulance service organisations were prioritised as emergency incidents, followed by 31.4% prioritised as urgent and 25.1% prioritised as non-emergency (table 11A.4).

Indicator framework

The performance indicator framework provides information on equity, effectiveness and efficiency, and distinguishes the outputs and outcomes of ambulance services.

The performance indicator framework shows which data is complete and comparable in this report. For data that is not considered directly comparable, text includes relevant caveats and supporting commentary. Section 1 discusses data comparability and completeness from a report-wide perspective. In addition to the contextual information for this service area (see Context tab), the report's statistical context (section 2) contains data that may assist in interpreting the performance indicators presented in this section.

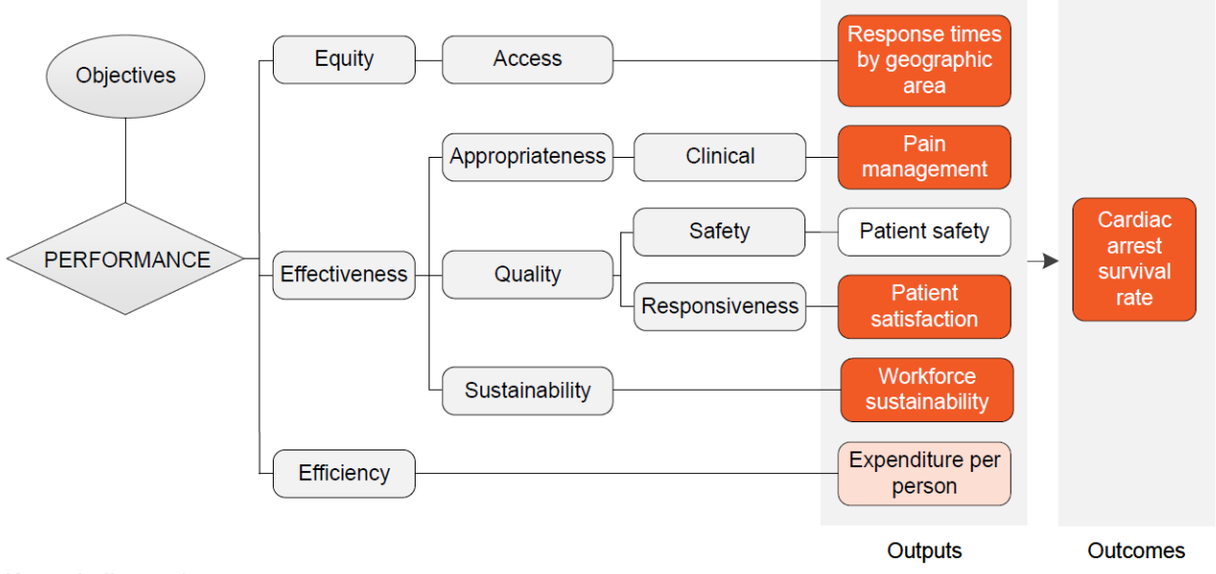
Improvements to performance reporting for ambulance services are ongoing and include identifying data sources to fill gaps in reporting for performance indicators and measures, and improving the comparability and completeness of data.

Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (see section 1). Output information is also critical for equitable, efficient and effective management of government services.

Outcomes

Outcomes are the impact of services on the status of an individual or group (see section 1).



Key to indicators*

Text — Most recent data for all measures is comparable and complete

Text — Most recent data for at least one measure is comparable and complete

Text — Most recent data for all measures is either not comparable and/or not complete

Text — No data reported and/or no measures yet developed

* A description of the comparability and completeness is provided under the Indicator results tab for each measure

Text version of indicator framework

Performance – linked to Objectives

Outputs

Equity – Access

- Response times by geographic area – most recent data for all measures is comparable and complete

Effectiveness – Appropriateness – Clinical

- Pain management – most recent data for all measures is comparable and complete

Effectiveness – Quality – Safety

- Patient safety – no data reported and/or no measures yet developed

Effectiveness – Quality – Responsiveness

- Patient satisfaction – most recent data for all measures is comparable and complete

Effectiveness – Sustainability

- Ambulance workforce – most recent data for all measures is comparable and complete

Efficiency

- Expenditure per person – most recent data for all measures is either not comparable and/or not complete

Outcomes

- Cardiac arrest survived event rate – most recent data for all measures is comparable and complete

A description of the comparability and completeness is provided under the Indicator results tab for each measure.

Indicator results

This section presents an overview of 'Ambulance services' performance indicator results. Different delivery contexts, locations and types of clients can affect the equity, effectiveness and efficiency of ambulance services.

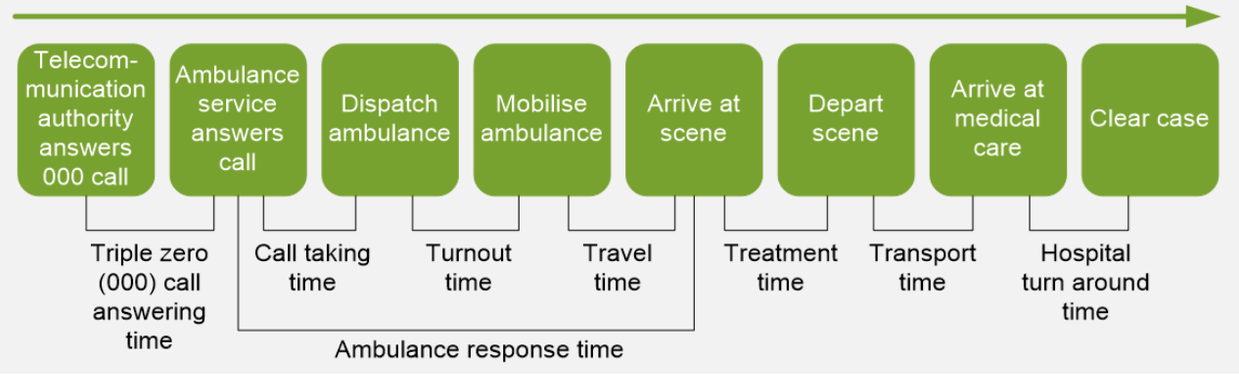
Information to assist the interpretation of these data can be found with the indicators below and all data (footnotes and data sources) is available for download above as an excel spreadsheet and as a CSV dataset. Data tables are identified by a '11A' prefix (for example, table 11A.1).

Specific data used in figures can be downloaded by clicking in the figure area, navigating to the bottom of the visualisation to the grey toolbar, clicking on the 'Download' icon and selecting 'Data' from the menu. Selecting 'PDF' or 'Powerpoint' from the 'Download' menu will download a static view of the performance indicator results.

1. Response times by geographic area

'Response times by geographic area' is an indicator of governments' objective to provide ambulance services in an accessible manner.

'Response times by geographic area' is defined as the time taken between the initial receipt of the call for an emergency at the communications centre, and the arrival of the first responding ambulance resource at the scene of an emergency code 1 incident (illustrated below), by geographic area (capital city and state-wide), for the 90th and 50th percentile.



Capital city response times are currently measured by the response times within each jurisdictions' capital city – boundaries are based on the ABS Greater Capital City Statistical Areas.

Response times are calculated for the 90th and 50th percentile – the time (in minutes) within which 90% and 50% of the first responding ambulance resources arrive at the scene of an emergency code 1 incident.

Many factors influence response times by geographic location including:

- land area
- population size and density
- dispersion of the population (particularly rural/urban population proportions), topography, road/transport infrastructure and traffic densities

- crew configurations, response systems and processes, and travel distances – for example, some jurisdictions include responses from volunteer stations (often in rural areas) where turnout times are generally longer because volunteers are on call as distinct from being on duty.

Short or decreasing response times are desirable. Short response times potentially minimise adverse effects on patients and the community of delayed emergency responses. Similar response times across geographic areas indicate equity of access to ambulance services.

> In 2022-23, the time within which 90% of first responding ambulance resources arrived at the scene of an emergency in code 1 situations ranged from:
>
> - 16.8 minutes (Australian Capital Territory) to 55.6 minutes (South Australia) in capital cities
> - 16.8 minutes (Australian Capital Territory) to 50.9 minutes (South Australia) state-wide (figure 11.2).

> In 2022-23, the time within which 50% of first responding ambulance resources arrived at the scene of an emergency in code 1 situations ranged from:
>
> - 10.0 minutes (Western Australia and Australian Capital Territory) to 15.9 minutes (South Australia) in capital cities
> - 10.0 minutes (Australian Capital Territory) to 15.1 minutes (South Australia) state-wide.

Supporting data on triple zero call answering times are available in table 11A.6. Nationally, in 2022-23, 93.4% of calls from triple zero emergency call services were answered by ambulance services communication staff in 10 seconds or less. This is an increase from 82.2% in 2021-22 and is the highest proportion of calls answered in 10 seconds or less over the ten years of available data (table 11A.6). These data do not measure the time taken for triple zero calls to be answered by emergency services telecommunication staff prior to re-direction to ambulance services communication staff.

Data is comparable (subject to caveats) across jurisdictions and over time.

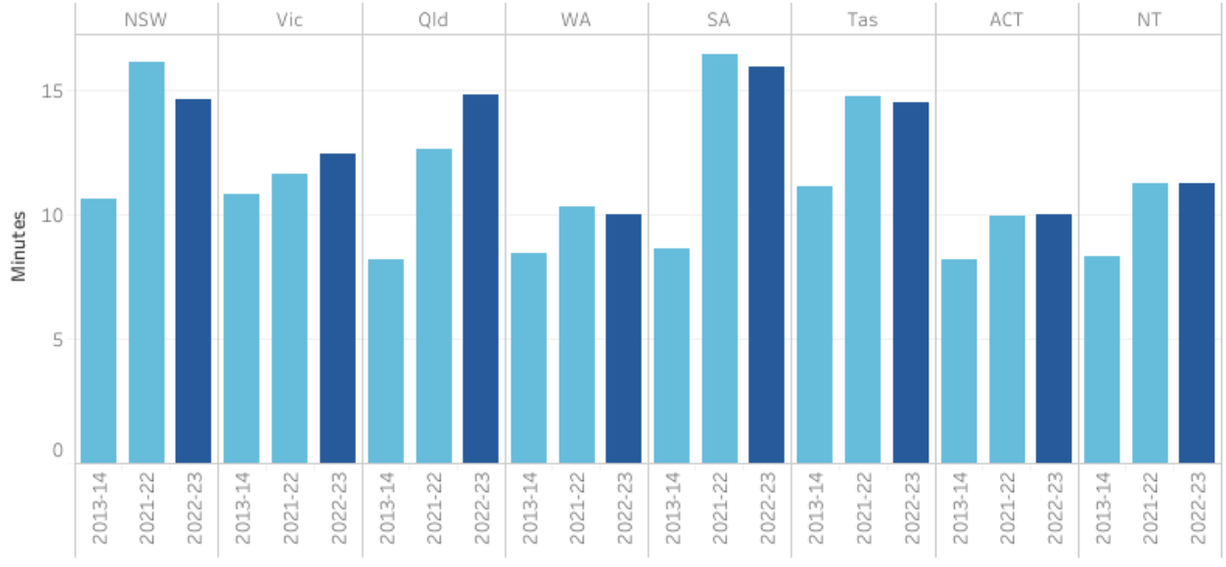
Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Select geographic area:
Capital city
Statewide

Select percentile:
50th percentile
90th percentile

Figure 11.2 **Ambulance services Response times**
Capital city, 50th percentile, by jurisdiction, by year



Source: table 11A.5

2. Pain management

'Pain management' is an indicator of governments' objective to provide pre-hospital and out-of-hospital care and patient transport services that meet patients' needs through delivery of appropriate health care.

'Pain management' is defined as the proportion of patients who report a clinically meaningful reduction in pain severity. Clinically meaningful pain reduction is defined as a minimum 2-point reduction in pain score from first to final recorded measurement (based on a 1–10 numeric rating scale of pain intensity).

This indicator includes patients who:

- are aged 16 years or over and received care from the ambulance service, which included the administration of pain medication (analgesia)
- recorded at least 2 pain scores (pre- and post-treatment)
- recorded an initial pain score of 7 or above (referred to as severe pain).

Patients who refuse pain medication for whatever reason or have an unrecorded/missing date of birth are excluded.

A high or increasing proportion of patients who report a clinically meaningful reduction in pain severity at the end of ambulance service treatment is desirable. It suggests ambulance services are

appropriately meeting patient needs.

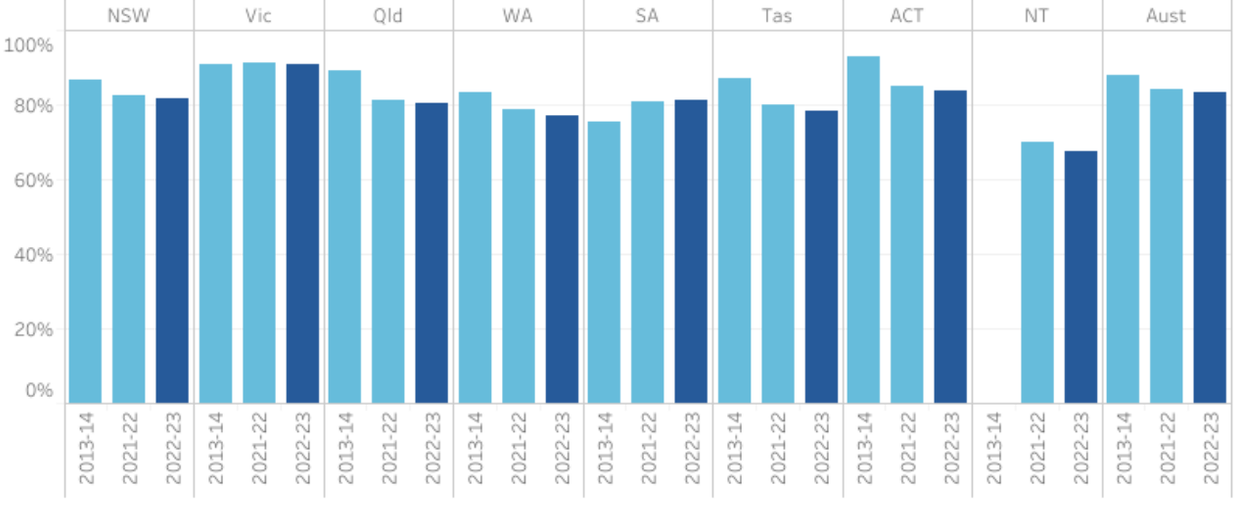
> Nationally in 2022-23, the proportion of patients who reported clinically meaningful pain reduction at the end of ambulance service treatment was 83.2%. All jurisdictions except South Australia reported a decrease from 2021-22 (figure 11.3).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 11.3 **Patients who reported a clinically meaningful pain reduction**
By jurisdiction, by year (a)



Source : table 11A.7

(a) Data is not available for the NT for 2013-14.

3. Patient safety

'Patient safety' is an indicator of governments' objective to deliver ambulance services that are high quality and safe.

A measure of patient safety is under development. Data is not yet available for reporting.

A patient safety incident is an event or circumstance that could have resulted, or did result, in unnecessary harm to a person receiving healthcare. Ambulance services have policies and systems in place to manage patient safety incidents.

Table 11.2 provides an overview of the incident management policies that apply to ambulance services in each state and territory. The requirements for notification, escalation and reporting can vary based on the severity of the incident.

High levels of service safety are desirable, as evidenced by low and decreasing rates of patient safety incidents. However, high or increasing rates of reported incidents might reflect more effective incident reporting mechanisms and organisational cultural change.

The feasibility and suitability of an additional measure for this indicator related to notifications about qualified ambulance officers is being investigated. Information about notifications made to Ahpra is available at: www.ahpra.gov.au/Notifications/Concerned-about-a-health-practitioner.aspx

Table 11.2 Overview of ambulance patient safety incident policy settings

Jurisdiction	What incidents are reported, how and to whom?
NSW	NSW Health's Incident Management Policy Directive applies to the NSW Ambulance Service. An incident is an unplanned event that results in, or has the potential for: injury, damage or loss, including near misses. A harm score (HS) from 1 to 4 applies to clinical incidents based on the patient outcome and additional treatment or resources required: • HS1 - Unexpected death or sentinel event (defined by the Australian sentinel events list, version 2) • HS2 – Major harm • HS3 – Minor harm • HS4 – No harm or near miss. Staff must notify all clinical incidents by recording them in the NSW Health incident management system. Serious incidents are escalated and reviewed.
Vic	Safer Care Victoria's (SCV) 'Adverse patient safety events' policy applies to Ambulance Victoria. Adverse patient safety events are defined as incidents that result in harm to a person receiving care. Incident Severity Ratings (ISR) are defined according to degree of impact: • ISR1 – Severe impact or death • ISR2 – Moderate • ISR3 – Mild • ISR4 – No harm or near miss. Sentinel events must be notified to SCV within three days. Sentinel events are defined as adverse patient safety events resulting in serious harm or death, including all events on the Australian sentinel events list (version 2). SCV publishes the total number of health service sentinel events each year, although data are not disaggregated by ambulance sentinel events.

Qld	A 'reportable event' in the provision of ambulance services is defined in section 36A of the Ambulance Service Act 1991 (ASA) to mean: • the death of the person, or permanent injury suffered by the person, while giving birth • the death of the person caused by the incorrect management of the person's medication • the death of the person, or neurological damage suffered by the person, caused by an intravascular gas embolism • the death of the person, or permanent loss of function suffered by the person, unrelated to the natural course of the person's medical condition for which he or she was receiving the ambulance service • the death of the person, or permanent injury suffered by the person, contributed to by an unreasonable delay in the provision of the ambulance service or a failure to meet recognised standards for providing the ambulance service • the wrong procedure being performed on the person or a procedure being performed on the wrong part of the person's body. The Queensland Ambulance Service (QAS) is obligated to comply with the *Health Ombudsman Act 2013* (Qld), which requires employers of health practitioners to notify the Health Ombudsman of certain events. Further, the QAS also notifies the State Coroner of deaths that meet the definition of 'reportable deaths', defined under the *Coroners Act 2008* (Qld). The QAS is currently rewriting the clinical incident management systems as part of the draft Patient Safety Strategy. A Pilot of these initiatives is planned for Metro South and Metro North regions. Currently, the QAS defines a clinical incident as '*an event or circumstance that could have resulted, or did result, in unintended harm to a patient during the course of clinical care is considered a clinical incident*'. Clinical incidents are then assigned a Severity Assessment Code (SAC), being one of the following: • SAC 1 – where a clinical incident results in death or permanent harm • SAC 2 – where a clinical incident results in temporary harm • SAC 3 – where a clinical incident results in minimal harm • SAC 4 – where a clinical incident resulted in no harm but raised a potential for harm as a 'near miss'.

WA

WA Department of Health's Clinical Incident Management Policy and associated guidelines apply to St John Ambulance WA, as part of its contract. Health services must ensure they maintain systems and processes that provide a consistent approach to clinical incident management, including managing data quality.

A clinical incident is as an event or circumstance that could have or did lead to unintended or unnecessary physical or psychological harm to a patient. Clinical incidents are those events or circumstances where the harm is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.

The WA health system Severity Assessment Codes (SACs) include three categories of clinical incidents:

- SAC 1 – clinical incident that has or could have (near miss) caused serious harm or death, defined as:
    - Sentinel events according to version 2 of the Australian sentinel events list.
    - Patient harm during an episode of care resulting in injury/illness requiring hospitalisation >7 days OR surgical intervention.
    - Unrecognised patient deterioration during ab episode of care requiring hospitalisation >7 days OR death.
    - Incorrect prehospital triage/differential diagnosis resulting in significant harm or death.
    - Unauthorised clinical care provision resulting in harm to the patient.
    - Clinical care provision outside of scope of practice that causes significant harm OR potential to cause significant harm or death (e.g. lack of administration of defibrillation shock when indicated; not providing ventilation to patient in respiratory arrest).
    - Death or serious harm of a patient who was discharged within the community following St John WA attendance within 12 hours (e.g. patient was left at home and subsequently deteriorates into a cardiac arrest six hours later).
    - Delayed care provision inclusive of response time to a patient that leads to identifiable clinical deterioration with actual or potential serious harm or death as per current contractual response time KPIs.
    - Critical equipment failure leading to identifiable or potential serious harm or death (e.g. defibrillation failure).
    - Significant harm or death as a result of administration of sedation in St John WA care.
    - Inappropriate termination of resuscitation efforts outside the approved clinical practice guideline.
    - Inappropriate priority allocation of 000 calls leading to extended response time, which results in serious harm or death.
    - Provision of clinical advice or recommendations leading to serious harm or death.
- SAC 2– clinical incident that has or could have (near miss) caused moderate harm

	• SAC 3 – clinical incident that has or could have (near miss) caused minor or no harm. When a clinical incident or near miss has occurred, staff must notify the incident in the approved clinical incident management system by the end of the workday and allocate a SAC rating within 48 hours of notification. Health services are required to report SAC 1 clinical incidents to the Department of Health.
SA	SA Health's Patient Incident Management and Open Disclosure Policy Directive applies to the SA Ambulance Service. A patient incident is defined as any event or circumstance which could have (near miss) or did lead to unintended or unnecessary psychological or physical harm that occurs during an episode of health care to a person or patient. The Incident Severity Rating (ISR) is a numerical score applied to patient incidents that considers the direct outcome and follow up treatment required following an incident: • ISR1: patient outcome is death or sentinel event (as defined by version 2 of the Australian sentinel events list) • ISR2: major harm. When patient outcome is either: harm, injury or expected permanent loss of function and treatment required is determined as either: immediate emergency or palliative treatment for life-threatening condition, expected long-term high-level care or an unplanned procedure resulting in higher level of care or therapy. • ISR3: Minor harm. Defined as either: ◦ patient outcome is harm, injury or expected permanent loss of function requiring clinical review, additional treatment or therapies ◦ patient outcome is harm or injury and treatment required is determined as either increased monitoring or assessment only or no change in treatment. • ISR4: no harm or injury, or near miss (incident avoided). Services must record all patient related incidents, including near misses, in SA Health's Safety Learning System.
Tas	All patient safety events are required to be reported, categorised and managed through the Department of Health Safety Reporting and Learning System (SRLS), which is oversighted internally by an Ambulance Tasmania management and review committee. The SRLS is subject to required commencement of management and completion KPIs. Version 2 of the Australian sentinel events list applies to all health services in Tasmania, including Ambulance Tasmania. Ambulance Tasmania must provide a brief to the Tasmanian Department of Health within 2 business days of any sentinel event being reported in its safety event reporting system.

ACT	ACT Ambulance Service (ACTAS) manages adverse and near miss events using its own policy and procedure. Patient safety incidents are categorised according to the following Severity Assessment Code (SAC) scale: • SAC1 – clinical incidents/near misses where serious harm or death is/could be specifically caused by health care rather than the patient's underlying condition. • SAC2 – clinical incidents/near misses where moderate harm is/could be specifically caused by health care rather than the patient's underlying condition of illness. • SAC3 – clinical incidents/near misses where minimal harm is/could be specifically caused by health care rather than the patient's underlying condition or illness. • SAC4 – clinical incidents/near misses where no harm occurs but the health care had the potential to cause harm rather than the patient's underlying condition/illness. ACTAS is not required to notify patient safety incidents or sentinel events to the ACT Government.
NT	Version 2 of the Australian sentinel events list applies to all health services in the NT, including St John Ambulance NT. The NT Health annual report includes the number of sentinel events in NT health services, although data are not disaggregated by ambulance sentinel events.

Source: State and Territory governments (unpublished).

4. Patient satisfaction

'Patient satisfaction' is an indicator of governments' objective to provide emergency medical care, pre-hospital and out-of-hospital care, and transport services that are responsive to patients' needs.

'Patient satisfaction' is defined as the quality of ambulance services, as perceived by the patient. It is measured as patient experience of aspects of response and treatment that are key factors in patient outcomes.

Patients are defined as people who were transported under an emergency event classified as code 1 (an emergency event requiring one or more immediate ambulance responses under lights and sirens where the incident is potentially life threatening) or code 2 (urgent incidents requiring an undelayed response by one or more ambulances without warning devices, with arrival desirable within 30 minutes).

The following measures of patient experience of ambulance services are reported:

- proportion of patients who reported that the length of time they waited to be connected to an ambulance service call taker was much quicker or a little quicker than they thought it would be
- proportion of patients who reported that the length of time they waited for an ambulance was much quicker or a little quicker than they thought it would be
- proportion of patients who reported that the level of care provided to them by paramedics was very good or good
- proportion of patients whose level of trust and confidence in paramedics and their ability to provide quality care and treatment was very high or high

- proportion of patients who were very satisfied or satisfied with the ambulance services they received.

High or increasing proportions for these measures are desirable as they indicate improved responsiveness to patient needs.

> Nationally in 2022-23, the majority of respondents (97.0%) reported they were satisfied or very satisfied with ambulance services received in the previous 12 months (table 11.3).

> Nationally, the proportions of respondents in 2022-23 who reported a quicker than expected phone answer time (64.0%) and ambulance arrival time (60.0%) increased from 2021-22 (table 11.3). The proportions of respondents who indicated a slower than expected phone answer time (5.0%) and ambulance arrival time (13.0%) both decreased from 2021-22 data (table 11A.8).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Table 11.3 **Patient satisfaction**
By jurisdiction, by year (%) (a)

			NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Phone answer time	Much quicker or a little quicker than I thought it would be	2022-23	66.0	69.0	63.0	71.0	65.0	63.0	58.0	59.0	64.0
		2021-22	65.0	63.0	59.0	61.0	62.0	66.0	61.0	64.0	63.0
		2016-17	64.0	66.0	65.0	65.0	68.0	60.0	62.0	64.0	65.0
Ambulance arrival time	Much quicker or a little quicker than I thought it would be	2022-23	61.0	64.0	57.0	69.0	62.0	57.0	54.0	58.0	60.0
		2021-22	61.0	60.0	54.0	55.0	60.0	61.0	57.0	61.0	58.0
		2016-17	56.0	62.0	63.0	63.0	67.0	50.0	61.0	57.0	61.0
Level of care provided by paramedics	Very good or good	2022-23	97.0	98.0	96.0	97.0	98.0	98.0	96.0	97.0	97.0
		2021-22	98.0	97.0	97.0	94.0	98.0	98.0	94.0	99.0	97.0
		2016-17	96.0	98.0	98.0	98.0	98.0	98.0	97.0	95.0	97.0
Level of trust and confidence in paramedics and their ability to provide quality care and treatment	Very high or high	2022-23	91.0	95.0	93.0	93.0	94.0	91.0	91.0	93.0	93.0
		2021-22	93.0	92.0	90.0	88.0	91.0	95.0	90.0	93.0	92.0
		2016-17	91.0	91.0	93.0	94.0	92.0	93.0	92.0	89.0	92.0
Overall satisfaction	Very satisfied or satisfied	2022-23	97.0 ±1.6	98.0 ±1.6	97.0 ±1.5	98.0 ±1.7	97.0 ±1.8	97.0 ±1.6	96.0 ±2.5	99.0 ±3.6	97.0 ±0.6
		2021-22	97.0 ±1.7	97.0 ±1.6	95.0 ±1.7	95.0 ±1.9	96.0 ±1.8	97.0 ±1.4	96.0 ±2.0	96.0 ±3.7	96.0 ±0.6
		2016-17	97.0 ±4.9	97.0 ±4.9	98.0 ±5.0	99.0 ±5.9	98.0 ±5.2	97.0 ±4.7	97.0 ±5.4	97.0 ±7.6	97.0 ±1.8

Source : table 11A.8

(a) Some percentages reported in these tables include 95% confidence intervals (for example, 80% ± 2.7 percentage points).

5. Workforce sustainability

'Workforce sustainability' is an indicator of governments' objective to provide emergency medical care, pre-hospital and out-of-hospital care, and transport services that are sustainable.

Health workforce sustainability concerns the capacity of the health workforce to meet current and projected demand.

'Workforce sustainability' is defined by two measures:

- 'workforce by age group' – the proportion of the operational salaried workforce in 10-year age groups (under 30, 30–39, 40–49, 50–59 and 60 and over)
- 'operational workforce attrition' – the proportion of full time equivalent salaried staff who exited the organisation. This includes staff in operational positions where paramedic qualifications are either essential or desirable to the role.

A low or decreasing proportion of the workforce in younger age groups and/or a high or increasing proportion of the workforce in older age groups suggest potential workforce sustainability problems as older age workers enter retirement. High and increasing levels of staff attrition also suggest potential workforce sustainability problems.

The workforce by age group and staff attrition measures should be considered together. Each provides a different perspective on the changing profile of the ambulance workforce. These data should also be considered in conjunction with data on the:

- number of students enrolled in accredited paramedic training courses (table 11A.10)
- availability of paramedics and response locations, which show that for some jurisdictions, there can be a large proportion of volunteers or volunteer ambulance locations (tables 11A.2 and 11A.4).

These measures are not a substitute for a full workforce analysis that allows for migration, trends in full-time work and expected demand increases. They can, however, indicate that further attention should be given to workforce sustainability.

> Nationally in 2022-23, the proportion of the ambulance workforce aged under 50 years was 78.6% (figure 11.4 and table 11A.9). This is a decrease from 2021-22 when the proportion was 79.1%, however it is the equal second highest proportion over the past 10 years (with 2013-14) (figure 11.4 and table 11A.9).

Supporting data on student enrolments in accredited paramedic training courses are available in table 11A.10. Enrolments peaked in 2019 with 342.3 enrolments nationally per million people, while there were 292.4 enrolments per million in 2022-23.

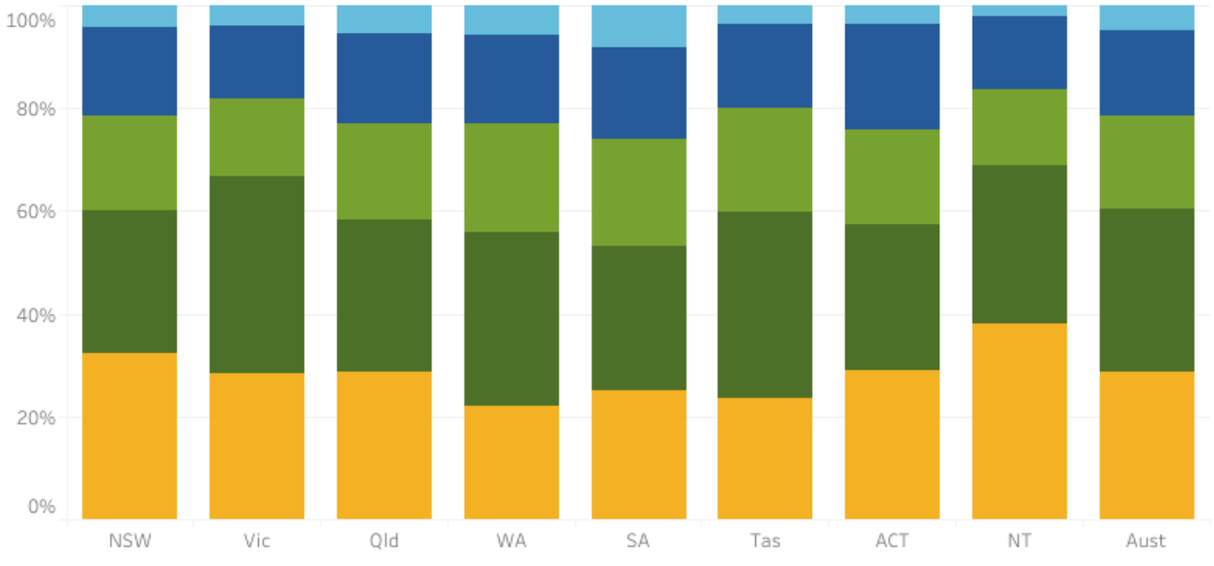
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year:
2022-23

60+ years old
50-59 years old
40-49 years old
30-39 years old
<30 years old

Figure 11.4 Measure 1: **Ambulance workforce**
By age group, by jurisdiction, 2022-23



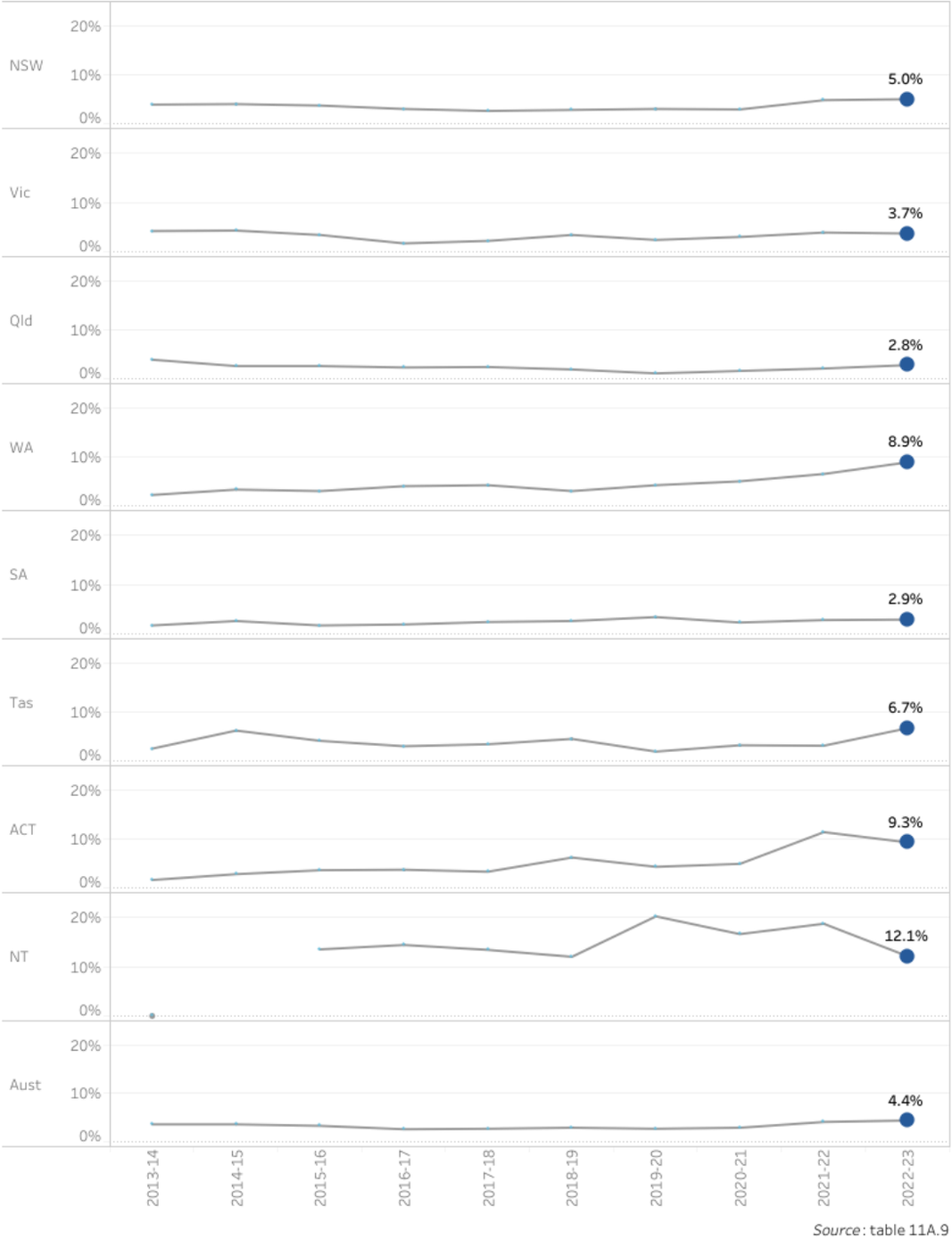
Source: table 11A.9

Nationally in 2022-23, the attrition rate was 4.4%, an increase from 4.1% in 2021-22 and the highest rate in the 10 years reported (figure 11.5 and 11A.9).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Figure 11.5 Measure 2: **Ambulance workforce Attrition rate**
By jurisdiction, by year (a)



Source: table 11A.9

(a) Data for the NT is not available for some years.

6. Expenditure per person

'Expenditure per person' is a proxy indicator of governments' objective to provide emergency medical care, pre-hospital and out-of-hospital care, and transport services in an efficient manner.

'Expenditure per person' is defined as total ambulance service organisation expenditure per person in the population.

All else being equal, lower expenditure per person represents greater efficiency. However, efficiency data should be interpreted with caution.

- High or increasing expenditure per person may reflect deteriorating efficiency. Alternatively, it may reflect changes in: aspects of the service (such as improved response); resourcing for first aid and community safety; or the characteristics of events requiring an ambulance service response, such as more serious medical presentations requiring complex clinical interventions.
- Differences in geographic size, terrain, climate, and population dispersal may affect costs of infrastructure and numbers of service delivery locations per person.

> Nationally, total expenditure on ambulance service organisations was $210 per person in 2022-23, an increase of 6.3% from the previous year (figure 11.6).

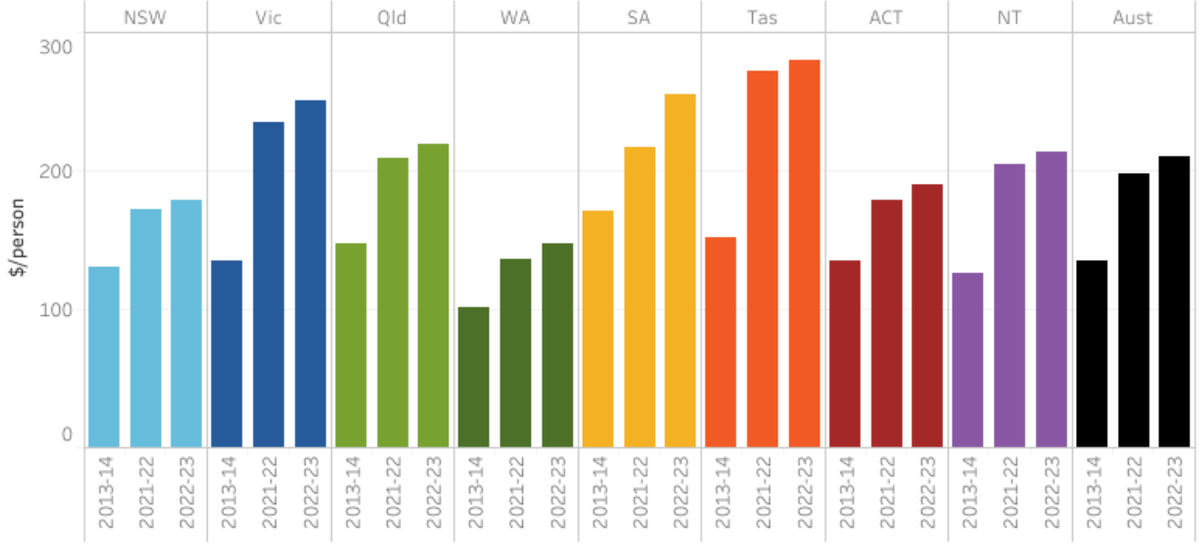
Data is not comparable across jurisdictions, but is comparable (subject to caveats) within jurisdictions over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Jurisdiction:
NSW Vic Qld WA SA Tas ACT NT Aust

Figure 11.6 **Expenditure per person**
By jurisdiction, by year (2022-23 dollars)



Source : table 11A.11

7. Cardiac arrest survival rate

'Cardiac arrest survival rate' is an indicator of governments' objective to provide emergency medical care, pre-hospital and out-of-hospital care, and transport services that reduce the adverse effects of emergency events on the community.

'Cardiac arrest survival rate' is defined as the proportion of adult patients (aged 16 years and over) who were in out-of-hospital cardiac arrest and returned to spontaneous circulation (that is, the patient had a pulse) on arrival at hospital.

Three measures are reported:

- Paramedic witnessed adult cardiac arrests where resuscitation was attempted by ambulance or emergency medical services personnel.
- Non-paramedic witnessed adult cardiac arrests where non-paramedic resuscitation was attempted.
- Non-paramedic witnessed adult Ventricular Fibrillation or Ventricular Tachycardia cardiac arrests where non-ambulance resuscitation was attempted.

Ventricular Fibrillation (VF) is a heart rhythm problem that occurs when the heart beats with rapid, erratic electrical impulses. Ventricular Tachycardia (VT) is a type of regular and fast heart beat that arises from improper electrical activity in the ventricles of the heart.

Cardiac arrests that are treated immediately by a paramedic have a better likelihood of survival due to immediate and rapid intervention. Patients who suffer a VF or VT cardiac arrest are more likely to have better outcomes compared with other causes of cardiac arrest as these conditions are primarily correctable through defibrillation.

This indicator measures survival rates to hospital, not survival rates in or post-hospital. A high or increasing cardiac arrest survived event rate is desirable.

Nationally in 2022-23, the survival rates for patients in VF or VT cardiac arrest or paramedic witnessed cardiac arrest were higher than for non-paramedic witnessed cardiac arrest where resuscitation was attempted:

- the cardiac arrest survival rate for paramedic witnessed cardiac arrests was 45.8% nationally
- the cardiac arrest survival rate for non-paramedic witnessed cardiac arrests where resuscitation was attempted was 23.5%
- the VF/VT cardiac arrest survival rate for non-paramedic witnessed cardiac arrests was 45.0% (figure 11.7).

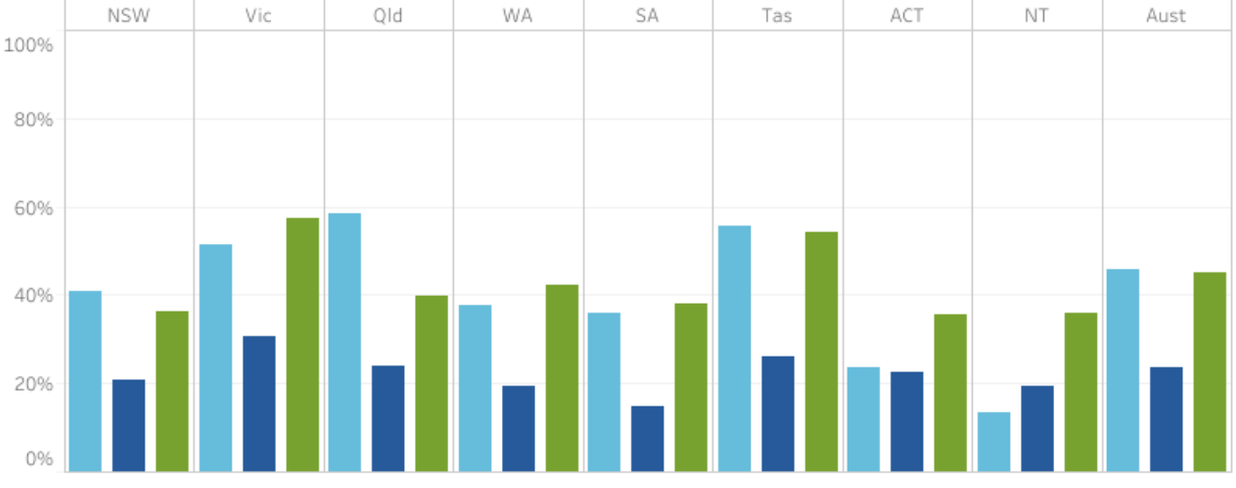
(all measures) Data is comparable (subject to caveats) across jurisdictions from 2018-19 onwards and over time for all jurisdictions except NSW (NSW changed in 2018-19 bringing it in line with national counting rules but creating a break with its historical reporting).

(all measures) Data is complete (subject to caveats) for the current reporting period.

Select year:
2022-23

Event type:
- Paramedic witnessed, Adult cardiac arrest survival rate
- Non-paramedic witnessed, Adult cardiac arrest survival rate where resuscitation attempted
- Non-paramedic witnessed, Adult VF/VT cardiac arrest survival rate

Figure 11.7 **Cardiac arrest survival rate**
By jurisdiction, 2022-23 (a), (b)



Source: table 11A.12

(a) The NT recorded no Paramedic witnessed adult cardiac arrests for 2019-20. (b) Paramedic witnessed adult cardiac arrest data is not available for Tasmania for 2014-15 and 2013-14.

Explanatory material

Key terms

Terms	Definition
Estimated resident population (ERP)	The official Australian Bureau of Statistics estimate of the Australian population. The ERP is derived from the 5-yearly Census counts and is updated quarterly between censuses. It is based on the usual residence of the person.
Expenditure	Includes: • salaries and payments in the nature of salaries to ambulance personnel • capital expenditure (such as the user cost of capital) • other operating expenditure (such as running expenditure, contract expenditure, training expenditure, maintenance expenditure, communications expenditure, provision for losses and other recurrent expenditure). Excludes the user cost of capital for land, payroll tax and interest on borrowings.
Human resources	Human resources refers to any person delivering a service, or managing the delivery of this service, including: • salaried ambulance personnel, remunerated volunteer and non-remunerated volunteer ambulance personnel • support personnel (any paid person or volunteer directly supporting operational providers, including administrative, technical and communications personnel).
Locations	Initial assistance can come from two locations: • First responder locations- staffed by non-remunerated individuals who offer immediate assistance without transport capacity before ambulance services arrive. First responder locations are sites where these teams are based and dispatched. Third Party First Responders are third-party organisations who collaborate with the ambulance service. • Response locations- includes all sites operated by the ambulance service, whether owned, leased, or occupied. These locations maybe be serviced by a combination of salaried and volunteer ambulance operatives with a variety of general purpose and special operations resources.

Terms	Definition
Revenue	Revenue received directly or indirectly by ambulance service organisations on an accrual accounting basis, including: • Government grants (grant funding, as established in legislation, from the Australian, State/Territory and Local governments) • Transport fees (Transport fees for the use of ambulances and other ambulance vehicles received directly and indirectly by ambulance agencies. It also includes treatment without transport. Subscriptions and other income (subscriptions and benefit funds received from the community; donations, industry contributions and fundraising received; other income).
User cost of capital	The opportunity cost of funds tied up in the capital used to deliver services. Calculated as 8% of the current value of non-current physical assets (including land, plant and equipment).

References

Australian Health Practitioner Regulation Agency (AHPRA) Paramedicine Board of Australia, 2022, *Registration,* https://www.paramedicineboard.gov.au/Registration.aspx (accessed 7 October 2022).

Report on Government Services 2024

PART E, SECTION 12: RELEASED ON 31 JANUARY 2024

12 Public hospitals

This section reports on the performance of governments in providing public hospitals, with a focus on acute care services.

The **Indicator results** tab uses data from the data tables to provide information on the performance for each indicator in the **Indicator framework.** The same data is also available in CSV format.

Data downloads

12 Public hospitals data tables (XLSX 924.4 KB)

12 Public hospitals dataset (CSV 3.4 MB)

Refer to the corresponding table number in the data tables for detailed definitions, caveats, footnotes and data source(s).

Guide: How to find what you need in RoGS (PDF 288.5 KB)

Context

Objectives for public hospitals

Public hospitals aim to alleviate or manage illness and the effects of injury by providing acute, non and sub-acute care along with emergency and outpatient care that is:

- timely and accessible to all
- appropriate and responsive to the needs of individuals throughout their lifespan and communities
- high quality and safe
- well coordinated to ensure continuity of care where more than one service type, and/or ongoing service provision is required
- sustainable.

Governments aim for public hospital services to meet these objectives in an equitable and efficient manner.

Service overview

Public hospitals provide a range of services, including:

- acute care services to admitted patients
- subacute and non-acute services to admitted patients (for example, rehabilitation, palliative care and long stay maintenance care)
- emergency, outpatient and other services to non-admitted patients

- mental health services, including services provided to admitted patients by designated psychiatric/psychogeriatric units
- public health services
- teaching and research activities.

This section focuses on services (acute, subacute and non-acute) provided to admitted patients and services provided to non-admitted patients in public hospitals. These services comprise the bulk of public hospital activity.

In some instances, data for stand-alone psychiatric hospitals are included in this section. The performance of psychiatric hospitals and psychiatric units of public hospitals is examined more closely in the 'Services for mental health' section of this report (section 13).

Funding

Total recurrent expenditure on public hospitals (excluding depreciation) was $90.0 billion in 2021-22 (table 12A.1), with 97% funded by the Australian, State and Territory governments and 3% funded by non-government sources (including depreciation) (AIHW 2023).

Government real recurrent expenditure (all sources) on public hospitals per person was $3,483 in 2021-22; an increase of 7.3% from 2020-21 ($3,247) (table 12A.2).

Size and scope

Hospitals

In 2021-22, there were 697 public hospitals in Australia – the same number as in 2020-21 (table 12A.3). Although 68.4% of hospitals had 50 or fewer beds (figure 12.1), these smaller hospitals represented only 12.5 % of total available beds (table 12A.3).

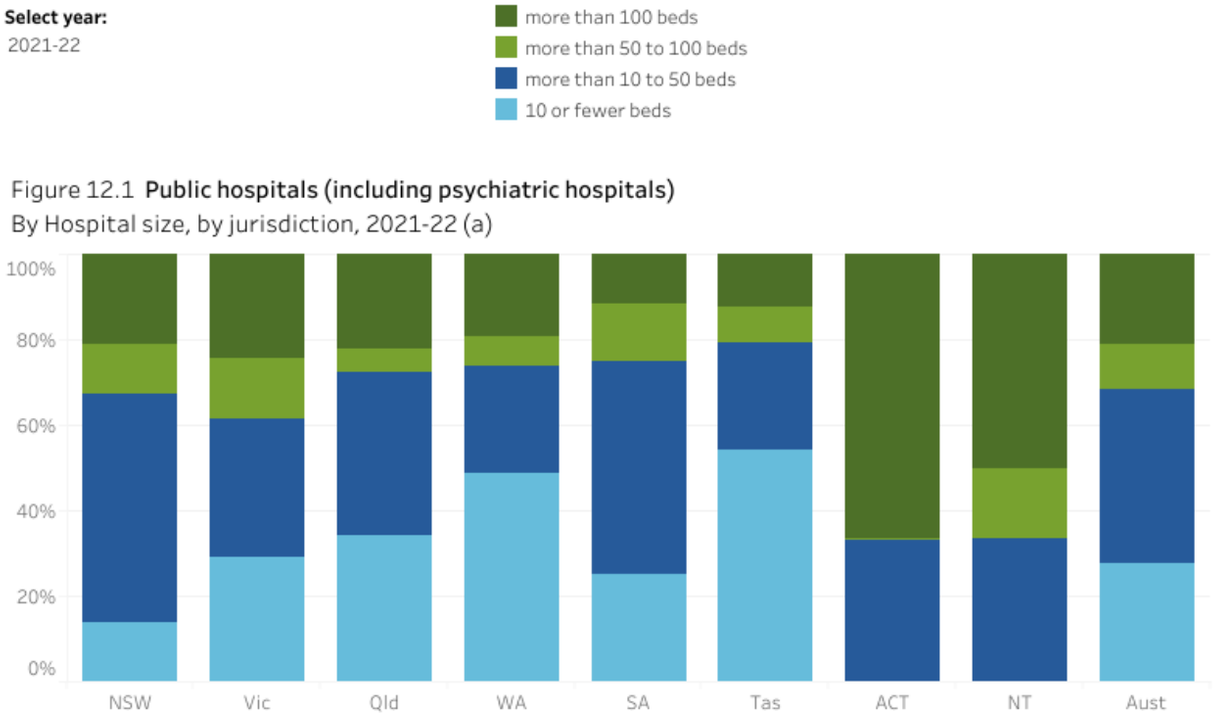


Figure 12.1 **Public hospitals (including psychiatric hospitals)**
By Hospital size, by jurisdiction, 2021-22 (a)

Source: table 12A.3

(a) The ACT did not have hospitals with 10 or fewer beds or more than 50 to 100 beds. The NT did not have hospitals with 10 or fewer beds or more than 500 beds.

Data tables are referenced above by a '12A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Hospital beds

There were 63,444 public hospital beds available for admitted patients in public hospitals in 2021-22, equivalent to 2.5 beds per 1,000 people (table 12.1 and tables 12A.3–4). Information on the availability of hospital beds in relation to the population provides some information about the accessibility of public hospital services. However, the concept of an available bed is becoming less important in the overall context of hospital activity, particularly given the extent to which hospitals provide services for patients who usually reside in other areas of the state or territory, in other jurisdictions, or who receive services through different modes of care (such as virtual care or 'hospital in the home' care models) (AIHW 2023a). Nationally, the number of beds available per 1,000 people increased as remoteness increased (table 12A.4). The patterns of bed availability across regions may reflect the availability of other health-care services and patterns of disease and injury (AIHW 2023a).

Select year:
2021-22

Table 12.1 **Available beds, Public hospitals (including psychiatric hospitals)**
Per 1,000 people, by jurisdiction, 2021-22

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
no.	20,623	14,871	13,142	6,356	4,517	1,656	1,207	1,072	63,444
rate	2.6	2.3	2.5	2.3	2.5	2.9	2.7	4.3	2.5

Source: tables 12A.3 and 12A.4

Data tables are referenced above by a '12A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

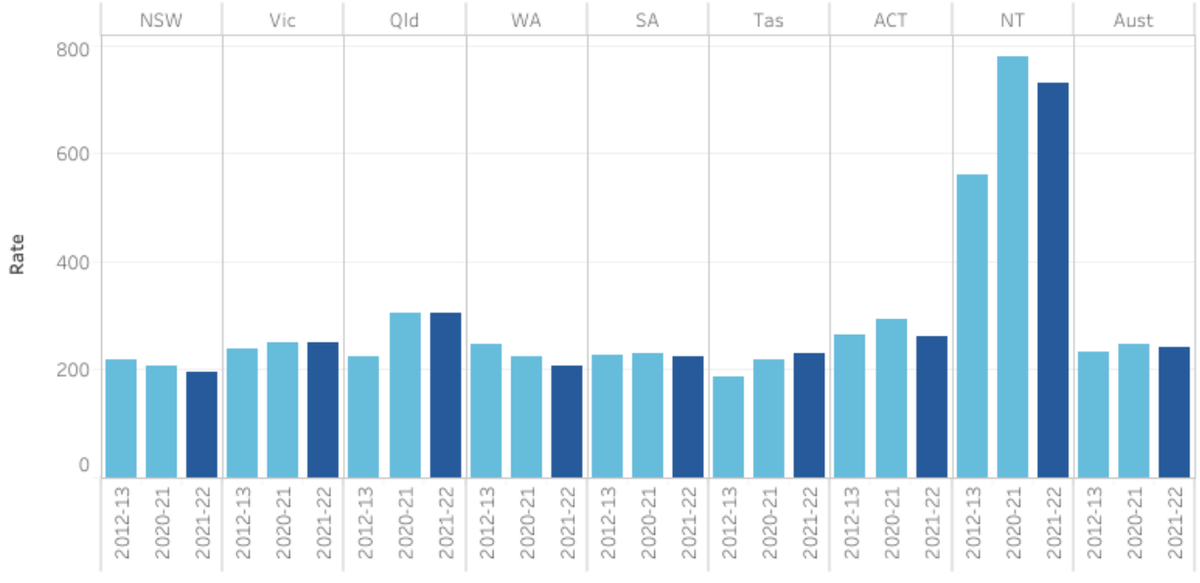
tableau

Admitted patient care

There were approximately 6.8 million separations from public (non-psychiatric) hospitals in 2021-22, of which just over half (55.3%) were same day patients (table 12A.5). Nationally, this equates to 241.4 separations per 1,000 people (figure 12.2). Acute care separations accounted for 93.9% of separations from public hospitals (table 12A.10).

Select year(s):
Multiple values

Figure 12.2 **Separations, Public acute hospitals**
Per 1,000 people, by jurisdiction, by year



Source: table 12A.6

Data tables are referenced above by a '12A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Variations in admission rates can reflect different practices in classifying patients as either admitted same day patients or non-admitted outpatients. The extent of differences in classification practices can be inferred from the variation in the proportion of same day separations across jurisdictions for certain conditions or treatments. This is particularly true of medical separations, where there was significant variation across jurisdictions in the proportion of same day medical separations in 2021-22 (table 12A.7).

In 2021-22, on an age-standardised basis, public hospital separation rates for Aboriginal and Torres Strait Islander people were markedly higher than the corresponding rates for all people. For private hospital separations, rates were higher for all people compared to Aboriginal and Torres Strait Islander people (though separations are lower for private hospitals compared to public hospitals) (table 12A.8).

Non-admitted patient services

Non-admitted patient services include outpatient services, which may be provided on an individual or group basis, and emergency department services. Nationally in 2021-22, 55.4 million non-admitted patient care service events were provided for public patients. Of these, 53.0 million individual service events were provided to outpatients in public hospitals (a 14.8% increase on 2020-21) and 680,531 group service events were provided (a 6.8% increase on 2020-21) (table 12A.11). Differing admission practices across states and territories lead to variation among jurisdictions in the services reported (AIHW 2023b).

There were 8,800,919 million presentations to emergency departments in 2022-23 (table 12A.12).

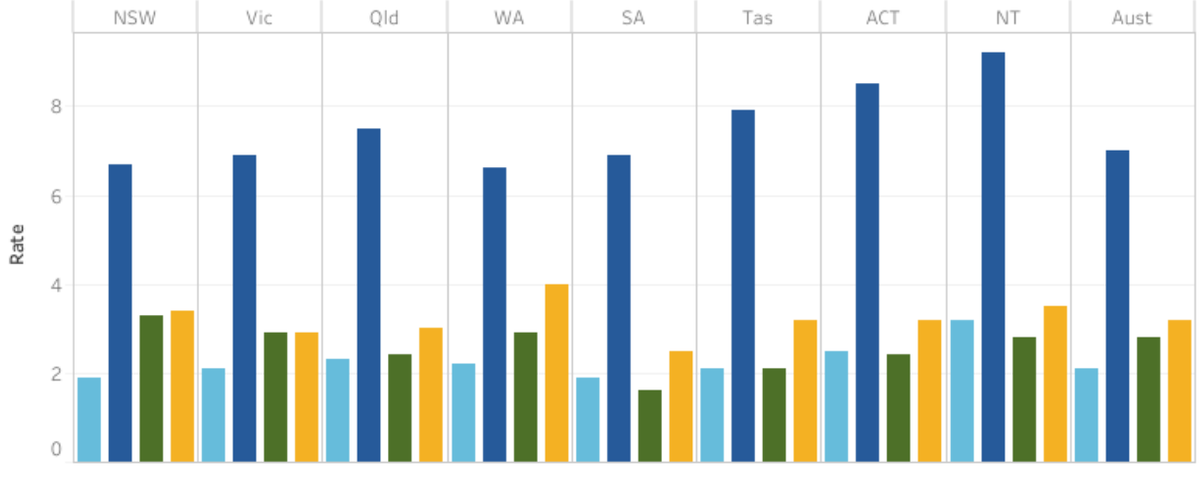
Staff

In 2021-22, nurses comprised the single largest group of full-time equivalent (FTE) staff employed in public hospitals (figure 12.3). Comparing data on FTE staff across jurisdictions should be undertaken with care, as this data is affected by jurisdictional differences in recording and classifying staff.

Select year:
2021-22

Salaried medical officers
Nurses
Diagnostic and allied health
Administrative and clerical

Figure 12.3 **Average full-time equivalent (FTE) staff, Public hospitals (including psychiatric hospitals)**
Per 1,000 people, by staff category, by jurisdiction, 2021-22



Source: table 12A.9

Data tables are referenced above by a '12A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Indicator framework

The performance indicator framework provides information on equity, effectiveness and efficiency, and distinguishes the outputs and outcomes of public hospital services.

The performance indicator framework shows which data is complete and comparable in this report. For data that is not considered directly comparable, text includes relevant caveats and supporting commentary. Section 1 discusses data comparability and completeness from a report-wide perspective. In addition to the contextual information for this service area (see Context tab), the report's statistical context (section 2) contains data that may assist in interpreting the performance indicators presented in this section.

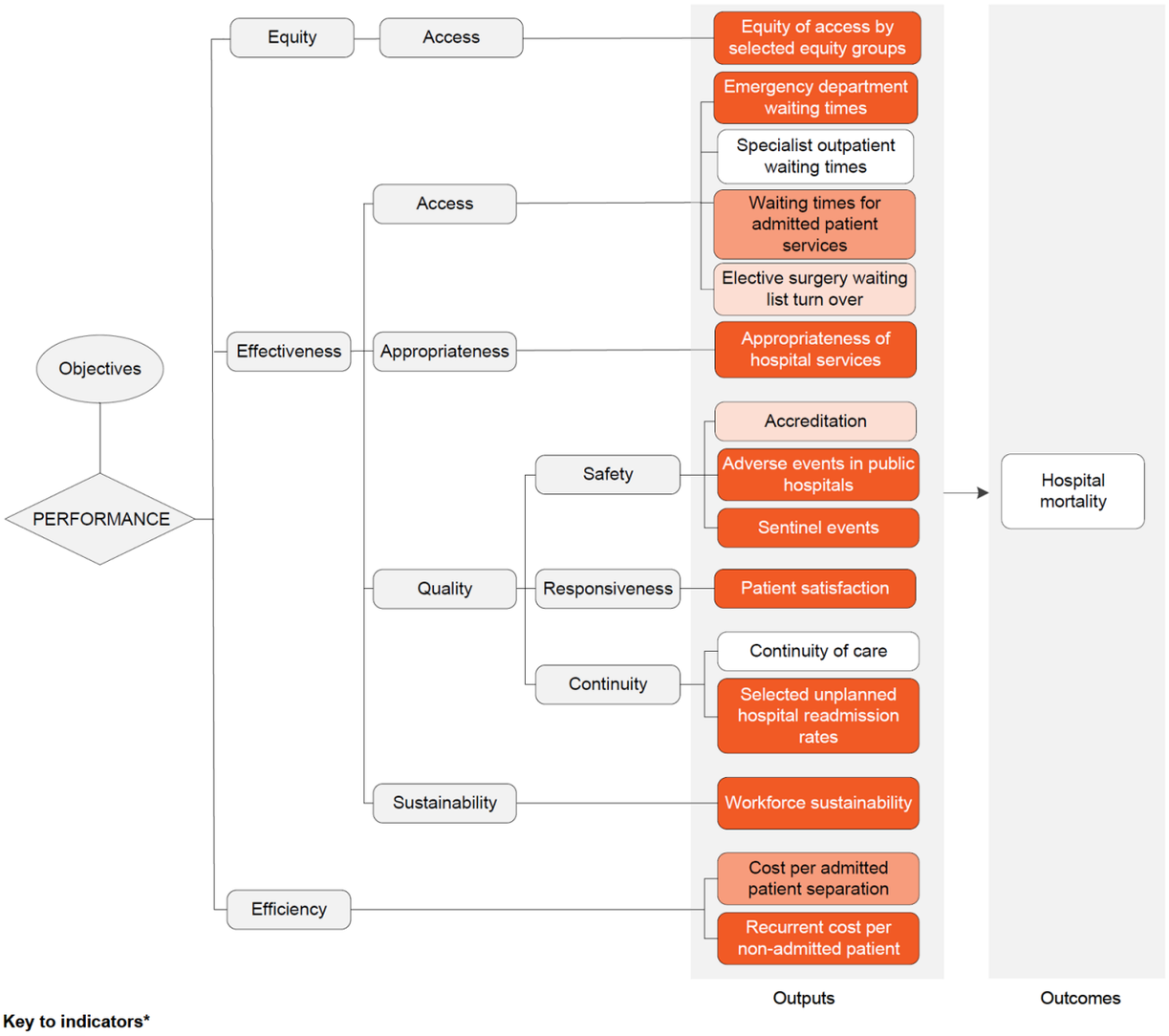
Improvements to performance reporting for public hospital services are ongoing and include identifying data sources to fill gaps in reporting for performance indicators and measures, and improving the comparability and completeness of data.

Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (see section 1). Output information is also critical for equitable, efficient and effective management of government services.

Outcomes

Outcomes are the impact of services on the status of an individual or group (see section 1).



Key to indicators*

Text	Most recent data for all measures is comparable and complete
Text	Most recent data for at least one measure is comparable and complete
Text	Most recent data for all measures is either not comparable and/or not complete
Text	No data reported and/or no measures yet developed

* A description of the comparability and completeness is provided under the Indicator results tab for each measure

Text version of indicator framework

Performance – linked to Objectives

Outputs

Equity – Access

- Equity of access by selected equity groups – most recent data for all measures is comparable and complete.

Effectiveness – Access

- Emergency department waiting times – most recent data for all measures is comparable and complete
- Specialist outpatient waiting times – no data reported and/or no measures yet developed
- Waiting times for admitted patient services – most recent data for at least one measure is comparable and complete
- Elective surgery waiting list turn over – most recent data for all measures is either not comparable and/or not complete

Effectiveness – Appropriateness

- Appropriateness of hospital services – most recent data for all measures is comparable and complete

Effectiveness – Quality – Safety

- Accreditation – most recent data for all measures is either not comparable and/or not complete
- Adverse events in public hospitals – most recent data for all measures is comparable and complete
- Sentinel events – most recent data for all measures is comparable and complete

Effectiveness – Quality – Responsiveness

- Patient satisfaction – most recent data for all measures is comparable and complete

Effectiveness – Quality – Continuity

- Continuity of care – no data reported and/or no measures yet developed
- Selected unplanned hospital readmission rates – most recent data for all measures is comparable and complete

Effectiveness – Sustainability

- Workforce sustainability – most recent data for all measures is comparable and complete

Efficiency

- Cost per admitted patient separation – most recent data for at least one measure is comparable and complete
- Recurrent cost per non-admitted patient – most recent data for all measures is comparable and complete

Outcomes

- Hospital mortality – no data reported and/or no measures yet developed

A description of the comparability and completeness is provided under the Indicator results tab for each measure.

Indicator results

This section presents an overview of 'Public hospital services' performance indicator results. Different delivery contexts, locations and types of clients can affect the equity, effectiveness and efficiency of public hospital services.

Information to assist the interpretation of this data can be found with the indicators below and all data (footnotes and data sources) is available for download above as an excel spreadsheet and as a CSV dataset. Data tables are identified by a ‘12A’ prefix (for example, table 12A.1).

Specific data used in figures can be downloaded by clicking in the figure area, navigating to the bottom of the visualisation to the grey toolbar, clicking on the 'Download' icon and selecting 'Data' from the menu. Selecting 'PDF' or 'Powerpoint' from the 'Download' menu will download a static view of the performance indicator results.

1. Equity of access by selected equity groups

‘Equity of access by selected equity groups’ is an indicator of governments’ objective to provide hospital services in an equitable manner. 'Equity of access by selected equity groups is defined by three measures:

- Emergency department waiting times by triage category, defined as the proportion of patients seen within the benchmarks set by the Australasian Triage Scale
- Presentations to public hospital emergency departments where the time from presentation to admission, transfer or discharge is less than or equal to four hours
- Overall elective surgery waiting times.

The measures are disaggregations of existing emergency department and elective surgery waiting times indicators. Selected equity groups include people:

- who are Aboriginal and Torres Strait Islander
- from regional and remote areas (based on the ABS Australian Statistical Geography Standard remoteness area structure)
- from low socio-economic areas (based on the ABS Index of Relative Socio-economic Disadvantage, with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged).

Results for this indicator should be interpreted with caution:

- See PI 2 'Emergency department waiting times’ for further information on the Australasian Triage Scale and triage categories.
- See PI 4 ‘Waiting times for admitted patient services’ for further information on the scope and calculation of presentations to emergency departments with a length of stay of 4 hours or less ending in admission, overall elective surgery waiting times and elective surgery waiting times by clinical urgency category.

- See PI 5 'Elective surgery waiting list turn over'. This indicator reports the number of additions to, and removals from, public hospital elective surgery waiting lists. Waiting list turn over data is relevant to understanding the extent to which public hospitals are keeping pace with demand for elective surgery.
- See PI 6 ‘Appropriateness of hospital services’. This indicator reports the extent to which emergency department and admitted patients did not wait, left at own risk and discharged against medical advice, rates of which are consistently higher for Aboriginal and Torres Strait Islander people than non-Indigenous people.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

> Measure 1: In 2022-23, all category 1 Aboriginal and Torres Strait Islander patients were seen within clinically appropriate timeframes, except in Western Australia, the Australian Capital Territory and the Northern Territory, similar to the results observed for other Australians. Proportions were similar for category 1 patients across remoteness categories and socio-economic areas (table 12.2 and tables 12A.15-17).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year:
2022-23

Select equity group:
(●) Indigenous status
( ) Remoteness area
( ) SEIFA

Table 12.2 Measure 1: **Emergency department waiting times, patients seen on time**
By triage category, by Indigenous status, by jurisdiction, 2022-23 (%)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
1 - Resuscitation	Aboriginal and Torres Strait Islander people	100.0	100.0	100.0	98.0	100.0	100.0	96.0	97.0	99.0
	Other Australians	100.0	100.0	100.0	99.0	99.0	100.0	98.0	99.0	100.0
2 - Emergency	Aboriginal and Torres Strait Islander people	72.0	55.0	66.0	66.0	54.0	47.0	67.0	55.0	65.0
	Other Australians	75.0	57.0	64.0	68.0	43.0	49.0	66.0	52.0	64.0
3 - Urgent	Aboriginal and Torres Strait Islander people	70.0	57.0	64.0	50.0	49.0	42.0	39.0	50.0	60.0
	Other Australians	69.0	62.0	62.0	30.0	38.0	44.0	41.0	38.0	58.0
4 - Semi-urgent	Aboriginal and Torres Strait Islander people	75.0	68.0	75.0	65.0	67.0	58.0	52.0	52.0	69.0
	Other Australians	75.0	70.0	74.0	48.0	60.0	60.0	51.0	46.0	68.0
5 - Non-urgent	Aboriginal and Torres Strait Islander people	90.0	86.0	91.0	89.0	83.0	79.0	75.0	83.0	89.0
	Other Australians	91.0	87.0	91.0	81.0	81.0	79.0	76.0	81.0	88.0

Source: tables 12A.15-17

Measure 2: Nationally, in 2022-23, the proportion of patients with a length of stay in an emergency department of four hours or less was:

- higher for Aboriginal and Torres Strait Islander patients than other Australians
- higher for patients in outer regional, remote and very remote areas compared to inner regional and major cities
- similar for patients across socio-economic areas (figure 12.4) (tables 12A.19-21).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select equity group:

- (●) Indigenous status
- ( ) Remoteness area of residence
- ( ) SEIFA

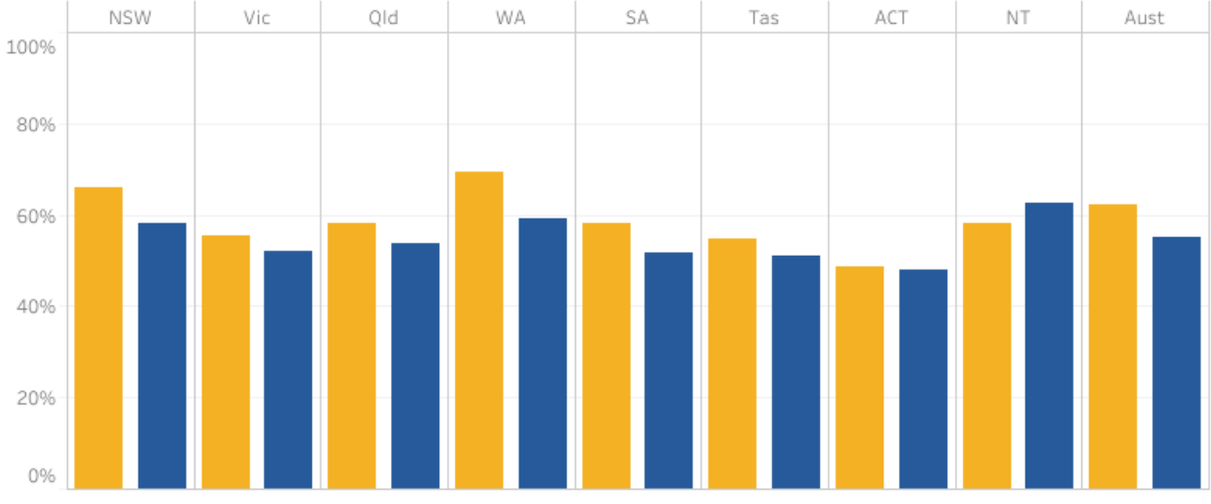
Aboriginal and Torres Strait Islander people

Other Australians

Select year:

2022-23

Figure 12.4 Measure 2: **Emergency department waiting times: ED stay length is within four hours**
By Indigenous status, by jurisdiction, 2022-23 (a), (b), (c)



Source: tables 12A.19-21

(a) Data for the ACT for very remote areas is not published. (b) Disaggregation by remoteness area is by the patient's usual residence, not the location of hospital. (c) Disaggregation by SEIFA is based on the patient's usual residence, not the location of the hospital.

tableau

Measure 3: In 2021-22, the time within which 50% of patients were admitted for their awaited procedure varied by remoteness area from 48 days for people in outer regional areas to 34 days for people in remote areas. The time within which 50% of patients were admitted across socio-economic areas ranged from 30 days for people in the highest socio-economic status area to 44 days for people in the lowest socio-economic status area. Newer data (2022-23) is available for Indigenous status. In 2022-23, overall, the time within which 50% of Aboriginal and Torres Strait Islander Australians were admitted for their awaited procedure was greater than that for other Australians (56 days and 49 days, respectively) (figure 12.5 and tables 12A.24-26).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

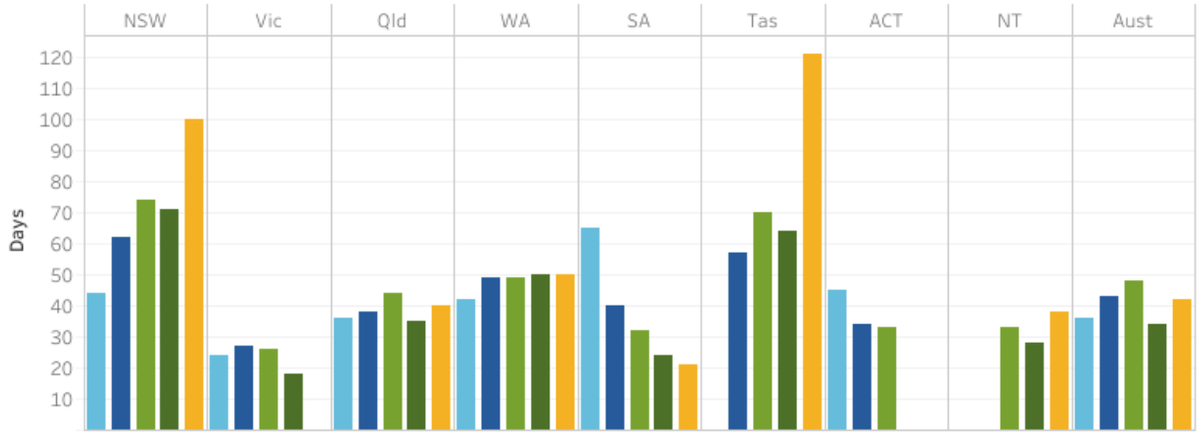
Select equity group:
- Indigenous status
- Remoteness area of residence
- SEIFA

Select percentile:
- 50th percentile
- 90th percentile

- Major cities
- Inner regional
- Outer regional
- Remote
- Very remote

Select year(s):
2021-22

Figure 12.5 Measure 3: **Elective surgery: waiting times**
50th percentile, by Remoteness area of residence, by jurisdiction, 2021-22 (a), (b), (c), (d)



Source: tables 12A.24-26

(a) The most recent year of data available for Remoteness area of residence and SEIFA is for 2021-22 and for Indigenous status is for 2022-23. (b) There are no very remote areas in Victoria; no major cities in Tasmania; no outer regional or remote areas in the ACT; no major cities or inner regional areas in the NT. (c) Disaggregation by remoteness area is by the patient's usual residence, not the location of hospital. (d) Disaggregation by SEIFA is based on the patient's usual residence, not the location of the hospital.

2. Emergency department waiting times

'Emergency department waiting times' is an indicator of governments' objective to provide timely and accessible services to all.

'Emergency department waiting times' is defined by the following two measures:

- Emergency department waiting times by triage category, defined as the proportion of patients seen within the benchmarks set by the Australasian Triage Scale. The Australasian Triage Scale is a scale for rating clinical urgency, designed for use in hospital-based emergency services in Australia and New Zealand. The benchmarks, set according to triage category, are as follows:
  - triage category 1: need for resuscitation – patients seen immediately
  - triage category 2: emergency – patients seen within 10 minutes
  - triage category 3: urgent – patients seen within 30 minutes
  - triage category 4: semi-urgent – patients seen within 60 minutes
  - triage category 5: non-urgent – patients seen within 120 minutes.

- Proportion of patients staying for four hours or less, defined as the proportion of presentations to public hospital emergency departments where the time from presentation to admission, transfer or discharge is less than or equal to four hours. It is a measure of the duration of the emergency department service rather than a waiting time for emergency department care.

High or increasing proportions for both measures are desirable.

The comparability of emergency department waiting times data across jurisdictions can be influenced by differences in data coverage and clinical practices – in particular, the allocation of cases to urgency categories. The proportion of patients in each triage category who were subsequently admitted can indicate the comparability of triage categorisations across jurisdictions and thus the comparability of the waiting times data (table 12A.13).

> Measure 1: In 2022-23, all category 1 patients were seen within clinically appropriate timeframes in New South Wales, Victoria, Queensland and Tasmania, but not in Western Australia, South Australia, the Australian Capital Territory and the Northern Territory. For all triage categories combined, an estimated 65% of patients were seen within triage category timeframes (table 12.3).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Table 12.3 Measure 1: **Emergency department waiting times, Patients seen on time**
By triage category, by jurisdiction, by year (per cent)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
1 - Resuscitation	2022-23	100	100	100	99	99	100	98	98	100
	2021-22	100	100	100	100	99	99	100	100	100
	2013-14	100	100	100	100	100	100	100	100	100
2 - Emergency	2022-23	75	57	64	67	44	49	66	53	64
	2021-22	77	55	62	69	53	49	73	59	65
	2013-14	83	84	80	86	74	85	83	61	82
3 - Urgent	2022-23	69	61	62	32	39	44	41	44	58
	2021-22	72	58	60	33	45	43	36	49	58
	2013-14	76	73	67	58	65	66	50	51	70
4 - Semi-urgent	2022-23	75	70	74	50	60	60	51	48	68
	2021-22	77	69	76	52	64	61	46	58	70
	2013-14	80	71	75	71	77	71	57	53	75
5 - Non-urgent	2022-23	91	87	91	83	81	79	76	82	88
	2021-22	94	89	95	85	86	83	73	88	92
	2013-14	94	88	92	94	92	90	86	89	92
Total excluding unknown triage category	2022-23	74	65	67	48	50	52	51	50	65
	2021-22	77	63	68	50	55	53	48	57	67
	2013-14	81	75	73	70	73	72	61	57	75

Source: table 12A.13
na Not available.

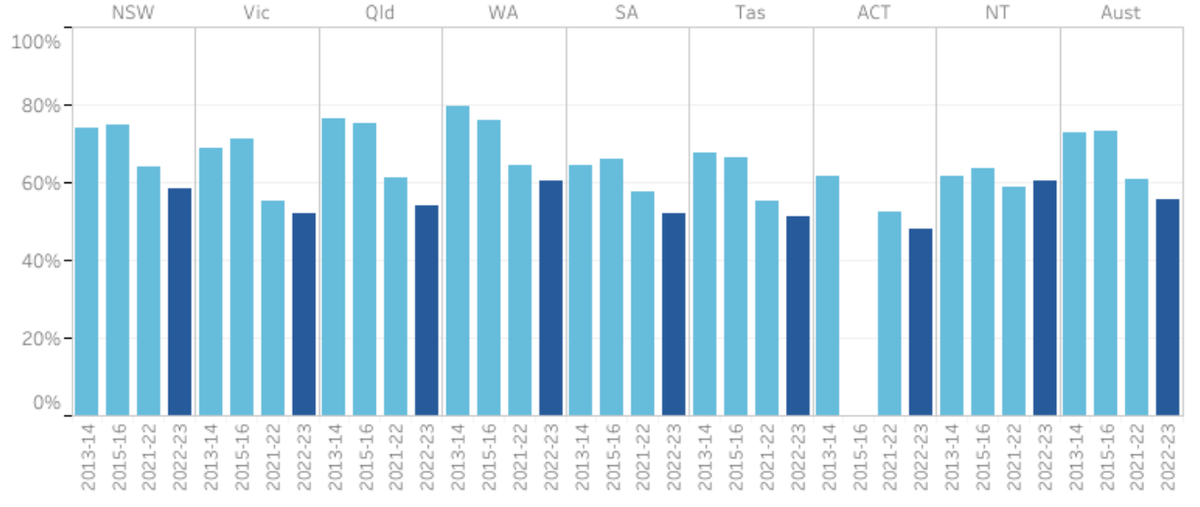
Measure 2: Nationally, in 2022-23, the proportion of patients staying for four hours or less in an emergency department was 55.8%, continuing an annual decrease from 73.2% in 2015-16 (figure 12.6).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 12.6 Measure 2: **Patients staying for four hours or less, ED stay length is within four hours**
By jurisdiction, by year (a)



Source: table 12A.18

(a) Data were not available for the ACT for 2015-16 and have not been included in the Australian total for that year.

3. Specialist outpatient waiting times

'Specialist outpatient waiting times' is an indicator of governments' objective to provide timely and accessible hospital services.

'Specialist outpatient waiting times' are defined as the period of time (days or months) between the date a specialist outpatient clinic receives a patient referral, and the date that patient is first seen by the specialist outpatient clinic.

A low or decreasing number of days waited is desirable.

This indicator is currently under development for reporting in the future.

4. Waiting times for admitted patient services

'Waiting times for admitted patient services' is an indicator of governments' objective to provide timely and accessible services to all.

'Waiting times for admitted patient services' is defined by the following three measures:

- Overall elective surgery waiting times

- Elective surgery waiting times by clinical urgency category
- Presentations to emergency departments with a length of stay of four hours or less ending in admission.

Overall elective surgery waiting times

'Overall elective surgery waiting times' are calculated by comparing the date patients are added to a waiting list with the date they were admitted. Days on which the patient was not ready for care are excluded. Overall waiting times are presented as the number of days within which 50% of patients are admitted and the number of days within which 90% of patients are admitted. Patients on waiting lists who were not subsequently admitted are excluded.

For overall elective surgery waiting times, a low or decreasing number of days waited is desirable. Comparisons across jurisdictions should be made with caution, due to differences in clinical practices and classification of patients across Australia. The measures are also affected by variations across jurisdictions in the method used to calculate waiting times for patients who transferred from a waiting list managed by one hospital to a waiting list managed by another hospital, with the time waited on the first list included in the waiting time reported in New South Wales, Western Australia, South Australia and the Northern Territory. This approach can have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions.

> Measure 1: Nationally, in 2022-23, 50% of patients were admitted within 49 days (up from 40 days in 2021-22) and 90% of patients were admitted within 361 days (up from 323 days in 2021-22) (figure 12.7). Data is available on elective surgery waiting times by hospital peer group and procedure, by Aboriginal and Torres Strait Islander status, remoteness area of residence and socio-economic status (tables 12A.23-26).

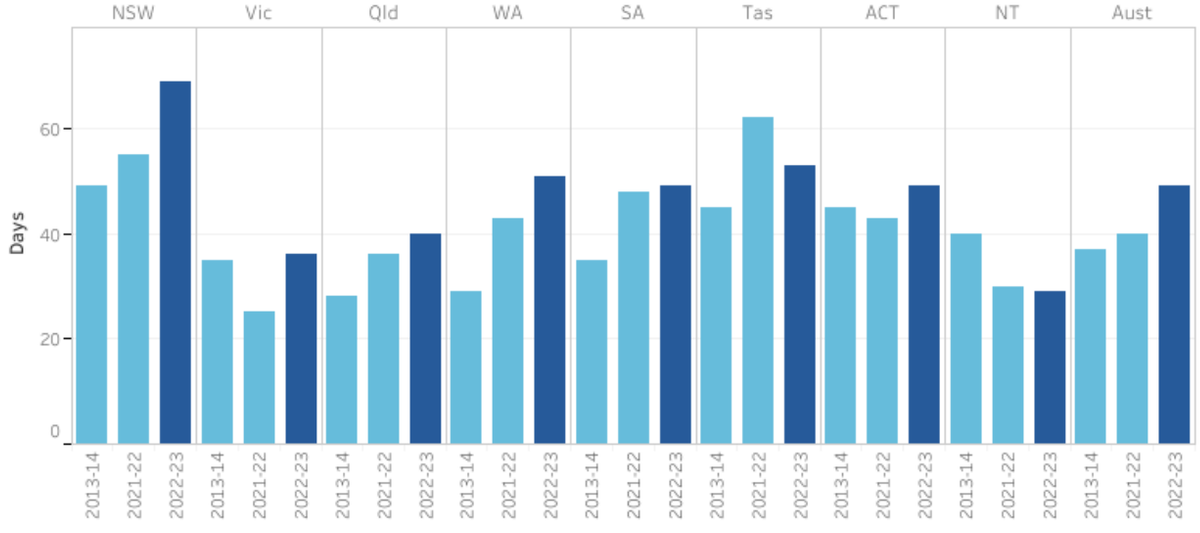
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Select percentile:
50th percentile
90th percentile

Figure 12.7 Measure 1: **Elective surgery: waiting times (days), 50th percentile**
By jurisdiction, by year



Source: table 12A.23

Elective surgery waiting times by clinical urgency category

'Elective surgery waiting times by clinical urgency category' reports the proportion of patients who were admitted from waiting lists after an extended wait. When patients are placed on public hospital waiting lists, clinical assessments are made on how urgently they require elective surgery. The clinical urgency categories are:

- Category 1 – procedures that are clinically indicated within 30 days
- Category 2 – procedures that are clinically indicated within 90 days
- Category 3 – procedures that are clinically indicated within 365 days.

The term 'extended wait' is used for patients in categories 1, 2 and 3 waiting longer than specified times (30 days, 90 days and 365 days respectively).

For elective surgery waiting times by clinical urgency category, a low or decreasing proportion of patients who experienced extended waits at admission is desirable. However, variation in the way patients are classified to urgency categories should be considered. Rather than comparing jurisdictions, the results for individual jurisdictions should be viewed in the context of the proportions of patients assigned to each of the three urgency categories.

Measure 2: Jurisdictional differences in the classification of patients by urgency category are shown in table 12.4a. The proportions of patients on waiting lists who already had an extended wait at the date of assessment are reported in tables 12A.28–35.

Data is not comparable across jurisdictions, but is comparable (subject to caveats) within jurisdictions over time.

Data is complete (subject to caveats) for the current reporting period.

Select year:
2022-23

Table 12.4a Measure 2: **Patients with extended waits admitted from waiting lists during the year**
By clinical urgency category, by jurisdiction, 2022-23 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Clinical urgency category 1	1.0	–	12.6	18.8	15.2	37.4	16.1	24.9
Clinical urgency category 2	26.7	44.7	29.8	31.3	38.0	47.6	51.4	37.6
Clinical urgency category 3	32.3	25.7	27.8	22.1	22.0	26.6	27.8	43.3
All patients	22.7	24.9	22.3	24.0	25.9	38.3	30.8	31.8

Source: tables 12A.28-12A.35
– Nil or rounded to zero. **na** Not available.

tableau

Presentations to emergency departments with a length of stay of four hours or less ending in admission

'Presentations to emergency departments with a length of stay of four hours or less ending in admission' is defined as the proportion of presentations to public hospital emergency departments where the time from presentation to admission to hospital is less than or equal to four hours.

A high or increasing proportion of presentations to emergency departments with a length of stay of four hours or less ending in admission is desirable.

Measure 3: Nationally in 2022-23, 31% of people who presented to an emergency department and were admitted, waited four hours or less to be admitted to a public hospital (table 12.4b). This proportion has declined each year over the five years of reported data.

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year:
2022-23

Table 12.4b Measure 3: **Emergency department presentations, ED stay length is within four hours ending in admission, All public hospitals**
By triage category, by jurisdiction, 2022-23 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
1 - Resuscitation	35	44	44	47	46	46	40	55	42
2 - Emergency	25	34	38	36	35	28	40	45	33
3 - Urgent	22	32	32	24	28	17	29	38	28
4 - Semi-urgent	27	36	34	28	35	19	30	35	31
5 - Non-urgent	51	49	55	42	45	44	40	53	50
Total	25	34	35	30	32	22	32	40	31

Source: table 12A.22
na Not available.

5. Elective surgery waiting list turn over

‘Elective surgery waiting list turn over’ is an indicator of governments' objective to provide timely and accessible services to all.

‘Elective surgery waiting list turn over’ is defined as the number of additions to, and removals from, public hospital elective surgery waiting lists. It is measured as the number of people removed from public hospital elective surgery waiting lists following admission for surgery during the reference year, divided by the number of people added to public hospital elective surgery waiting lists during the same year, multiplied by 100.

The number of people removed from public hospital elective surgery waiting lists following admission for surgery includes elective and emergency admissions. For context, the total number of removals from elective surgery waiting lists are also reported. Other reasons for removal include patient not contactable or died, patient treated elsewhere, surgery not required or declined, transferred to another hospital's waiting list, and not reported.

When interpreting this data, 100% indicates that an equal number of patients were added to public hospital elective surgery waiting lists as were removed following admission for surgery during the reporting period (therefore the number of patients on the waiting list will be largely unchanged). A figure less than 100% indicates that more patients were added to public hospital elective surgery waiting lists than were removed following admission for surgery during the reporting period (therefore the number of patients on the waiting list will have increased).

A higher and increasing proportion of patient turn over is desirable as it indicates the public hospital system is keeping pace with demand for elective surgery.

> Nationally in 2022-23, 855,528 people were added to public hospital elective surgery waiting lists, while 735,460 people were removed following admission for surgery, resulting in a national public hospital elective surgery waiting list turn over of 86.0% (table 12.5). Results varied across jurisdictions.

6. Appropriateness of hospital services

'Appropriateness of hospital services' is an indicator of governments' objective to provide care that is appropriate and responsive to the needs of individuals throughout their lifespan and communities.

'Appropriateness of hospital services' is defined as the proportion of patients who discharge against medical advice and is measured as:

- Emergency department presentations:
  - patients who did not wait, as a proportion of all emergency department presentations
  - patients who left at their own risk, as a proportion of all emergency department presentations
- Admitted patient care separations:
  - patients who left or were discharged against medical advice, as a proportion of all hospital separations.

'Did not wait' refers to patients who did not wait for clinical care to commence or medical assessment following triage in the emergency department. 'Left at own risk' refers to patients who left against advice after treatment had commenced. This includes patients who were planned for admission but who did not physically leave the emergency department prior to departing. 'Discharge against medical advice' refers to patients who were admitted to hospital and left against the advice of their treating physician.

Patients who do not wait, leave at own risk and discharge against medical advice are at an increased risk of complications, readmission and mortality. Low or decreasing proportions of patients who do not wait, leave at own risk and discharge against medical advice are desirable.

Broader, system-level definitions of appropriate health care include dimensions such as evidence-based care, variations in clinical practice and resource use. Additional measures for this indicator will be considered for inclusion in future editions of this report.

> Nationally in 2021-22, 4.5% of emergency department presentations did not wait, while 2.8% of emergency department presentations left at their own risk. Additionally, 1.2% of admitted patients left or were discharged against medical advice (table 12.6). Proportions for all measures were higher for Aboriginal and Torres Strait Islander people than for non-Indigenous people (table 12A.37).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select patient status:

- (●) Patients who did not wait
- ( ) Patients who left at their own risk
- ( ) Patients who left or were discharged against medical advice

Table 12.6 **Discharge against medical advice: Patients who did not wait as a Proportion of all emergency department presentations**

By jurisdiction, by Indigenous status, 2021-22

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Aboriginal and Torres Strait Islander people	%	5.7	10.0	6.1	9.6	6.0	5.3	9.2	8.4	7.0
Non-Indigenous people	%	3.4	6.4	3.4	5.1	4.0	3.2	5.8	5.2	4.3
All people	%	3.6	6.5	3.6	5.6	4.1	3.4	6.0	6.6	4.5

Source: table 12A.37

tableau

7. Accreditation

'Accreditation' is an indicator of governments' objective to provide public hospital services that are high quality and safe.

'Accreditation' is defined as public hospitals accredited to the National Safety and Quality Health Service (NSQHS) Standards (the Standards) and is measured as:

- the number of public hospitals accredited, as a proportion of all public hospitals with completed accreditation assessments in the same calendar year
- the number of public hospitals accredited during the calendar year that required remedial actions to achieve accreditation, as a proportion of all public hospitals accredited during the same calendar year.

It is mandatory for all Australian hospitals and day procedure services to be accredited to the NSQHS Standards. Health service organisations must demonstrate that they meet all requirements in the NSQHS Standards to achieve accreditation. Health service organisations are assessed to the NSQHS Standards every three years. The NSQHS Standards are:

- Clinical governance
- Partnering with consumers
- Preventing and controlling infections

- Medication safety
- Comprehensive care
- Communicating for safety
- Blood management
- Recognising and responding to acute deterioration.

A high or increasing rate of accreditation is desirable. Accreditation against the NSQHS Standards is evidence that a hospital has been able to demonstrate that safety and quality systems and processes are in place to prevent or minimise patient harm. It does not mean that an accredited hospital will always provide high quality and safe care.

There are differences across jurisdictions in: (1) the proportion of public hospitals opting for announced or short-notice assessments (from July 2023, short-notice assessments will be mandatory for all hospitals); and (2) the mix of hospitals that were assessed (for example, large metropolitan hospitals and small rural services). This indicator should be interpreted in conjunction with other indicators of public hospital quality and safety.

> Nationally in 2022, 40.0% of public hospitals that were accredited during the year required remedial actions to achieve accreditation (table 12.7). This is slightly lower than the proportion in 2021 (41.0%). However, due to the temporary suspension of the national accreditation program between March 2020 and October 2021 as a result of COVID-19, fewer hospitals were accredited in 2021 (209 hospitals) compared to 2022 (258 hospitals) (table 12A.38). During this period of temporary program suspension, hospitals and day procedure services maintained their existing accreditation status (ACSQHC 2020) and were required to continue to comply with the NSQHS Standards.

Data is not comparable across jurisdictions, but is comparable (subject to caveats) within jurisdictions over time.

Data is complete (subject to caveats) for the current reporting period.

Select year:
2022

Table 12.7 **National Safety and Quality Health Service Standards (NSQHSS) accreditation, All public hospitals**
By jurisdiction, 2022 (a)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Number of public hospitals that were accredited	no.	124	59	37	29	–	5	4	–	258
Proportion of accredited public hospitals that required remedial actions to achieve accreditation	%	43	12	59	59	..	60	–	..	40

Source: table 12A.38
– Nil or rounded to zero.

(a) Total includes hospitals in external territories.

8. Adverse events in public hospitals

'Adverse events in public hospitals' is an indicator of governments' objective to provide public hospital services that are high quality and safe. Sentinel events, which are a subset of adverse events that result in death or very serious harm to the patient, are reported as a separate output indicator.

'Adverse events in public hospitals' is defined by three measures:

- Selected healthcare-associated infections
- Adverse events treated in hospitals
- Falls resulting in patient harm in hospitals.

Selected healthcare-associated infections

'Selected healthcare-associated infections' is the number of *Staphylococcus aureus* (including Methicillin-resistant *Staphylococcus aureus* [MRSA]) bacteraemia (SAB) patient episodes associated with public hospitals (admitted and non-admitted patients), expressed as a rate per 10,000 patient days for public hospitals.

A patient episode of SAB is defined as a positive blood culture for SAB. Only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded.

SAB is considered to be healthcare-associated if the first positive blood culture is collected more than 48 hours after hospital admission or less than 48 hours after discharge, or if the first positive blood culture is collected less than or equal to 48 hours after admission to hospital and the patient episode of SAB meets at least one of the following criteria:

- SAB is a complication of the presence of an indwelling medical device
- SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site
- SAB was diagnosed within 48 hours of a related invasive instrumentation or incision
- SAB is associated with neutropenia contributed to by cytotoxic therapy. Neutropenia is defined as at least two separate calendar days with values of absolute neutrophil count (ANC) or total white blood cell count <500 cell/mm^3 (0.5 × 10^9/L) on or within a seven-day time period which includes the date the positive blood specimen was collected (Day 1), the three calendar days before and the three calendar days after.

Cases where a known previous positive test was obtained within the past 14 days are excluded. Patient days for unqualified newborns, hospital boarders and posthumous organ procurement are excluded.

A low or decreasing rate of selected healthcare-associated infections is desirable.

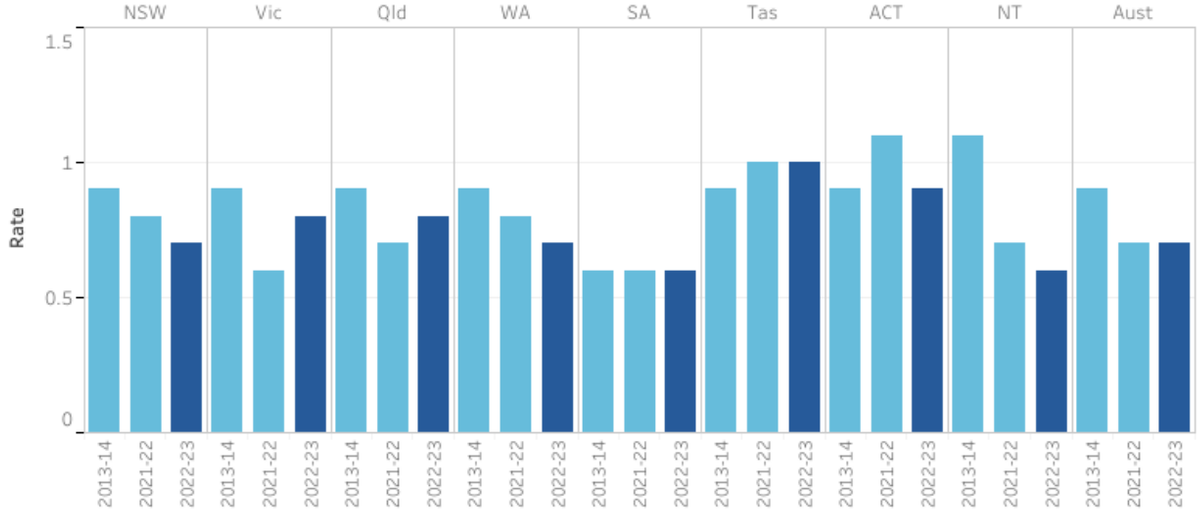
> Measure 1: Nationally in 2022-23, the rate of selected healthcare-associated infections was 0.7 per 10,000 patient days (figure 12.8a).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 12.8a Measure 1: **Selected healthcare-associated infections: Episodes of Staphylococcus aureus (including MRSA) bacteraemia (SAB) in acute care hospitals**
Per 10,000 patient days, by jurisdiction, by year



Source: table 12A.39

Adverse events treated in hospitals

'Adverse events treated in hospitals' are incidents in which harm resulted to a person during hospitalisation and are measured by separations that had an adverse event (including infections, falls resulting in injuries and problems with medication and medical devices) that occurred during hospitalisation. Hospital separations data includes information on diagnoses and place of occurrence that can indicate that an adverse event was treated and/or occurred during the hospitalisation, but some adverse events are not identifiable using these codes.

Low or decreasing adverse events treated in hospitals are desirable.

> Measure 2: Nationally in 2021-22, 6.4% of separations in public hospitals had an adverse event reported during hospitalisation (table 12.8). Results by category (diagnosis, external cause and place of occurrence of the injury or poisoning) are in table 12A.40.

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Table 12.8 Measure 2: **Adverse events treated in hospitals, Public hospitals (including psychiatric hospitals)**
Per 100 separations, by jurisdiction, by year

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2021-22	7.1	5.4	6.2	7.9	7.5	7.1	7.0	3.1	6.4
2020-21	7.0	5.7	6.5	7.8	7.7	7.2	6.8	3.3	6.6
2012-13	6.3	6.8	6.3	6.4	7.2	8.2	7.4	3.4	6.5

Source: table 12A.40

Falls resulting in patient harm in hospitals

'Falls resulting in patient harm in hospitals' is defined as the number of separations with an external cause code for fall and a place of occurrence of health service area, expressed as a rate per 1,000 hospital separations. It is not possible to determine if the place of occurrence was exclusively within a hospital, only that it was a health service area, which alongside hospitals include day procedure centres, health centres, hospices and outpatient clinics.

A low or decreasing rate of falls resulting in patient harm in hospitals is desirable.

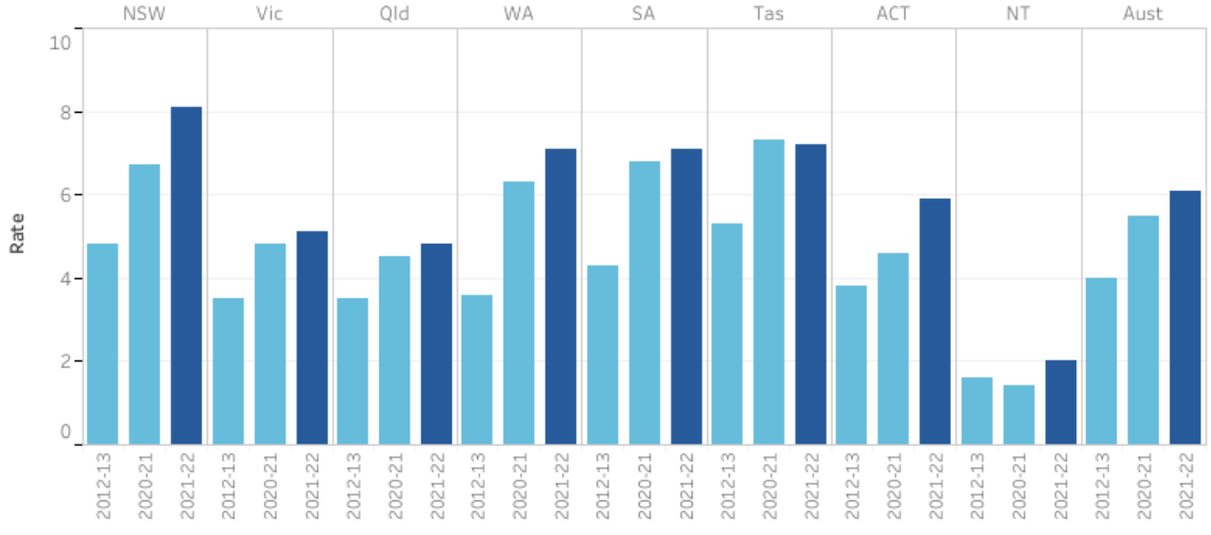
Measure 3: Nationally in 2021-22, the rate of falls resulting in patient harm was 6.1 per 1,000 hospital separations (public hospitals); results varied across states and territories (figure 12.8b). Data is reported by Indigenous status and remoteness in table 12A.41.

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 12.8b Measure 3: **Falls resulting in patient harm in hospitals, All public hospitals**
Per 1,000 separations, by jurisdiction, by year



Source: table 12A.41

9. Sentinel events

'Sentinel events' is an indicator of governments' objective to deliver public hospital services that are high quality and safe. Sentinel events are a subset of adverse events that result in death or very serious harm to a patient. Adverse events are reported as a separate output indicator.

'Sentinel events' is defined as the number of reported adverse events that occur because of hospital system and process deficiencies, and which result in the death of, or serious harm to, a patient. Sentinel events occur relatively infrequently and are independent of a patient's condition.

Australian health ministers agreed version 2 of the Australian sentinel events list in December 2018. All jurisdictions implemented these categories on 1 July 2019. The national sentinel events are:

- Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death
- Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death
- Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death

- Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death
- Haemolytic blood transfusion reaction resulting from ABO blood type incompatibility resulting in serious harm or death
- Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward
- Medication error resulting in serious harm or death
- Use of physical or mechanical restraint resulting in serious harm or death
- Discharge or release of an infant or child to an unauthorised person
- Use of an incorrectly positioned oro-or naso-gastric tube resulting in serious harm or death.

A low or decreasing number of sentinel events is desirable.

All state and territory governments have implemented sentinel event reporting programs. The purpose of these programs is to facilitate a safe environment for patients by reducing the frequency of these events. The programs are not punitive and are designed to facilitate self-reporting of errors so that the underlying causes of events can be examined, and action taken to reduce the risk of these events re-occurring.

Changes in the number of sentinel events reported over time do not necessarily mean that Australian public hospitals have become more or less safe, but might reflect improvements in incident reporting mechanisms, organisational cultural change, and/or an increasing number of hospital admissions (this data is reported as numbers rather than rates). Sentinel event should be monitored over time to identify trends and establish underlying reasons.

> Nationally in 2021-22, there was a total of 64 sentinel events, 18 fewer than in 2020-21 (table 12.9). As larger states and territories will tend to have more sentinel events than smaller jurisdictions, the number of separations is also presented to provide context. Data disaggregated by the type of sentinel event is reported in table 12A.42.

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
All

Table 12.9 **Sentinel events and hospital separations**
By jurisdiction, by year (number)

	Total events			Separations		
	2021-22	2020-21	2019-20	2021-22	2020-21	2019-20
NSW	12	19	9	1,768,912	1,898,959	1,809,760
Vic	24	30	23	1,814,006	1,822,038	1,834,131
Qld	7	12	8	1,720,372	1,685,357	1,596,532
WA	11	12	6	616,935	644,476	612,154
SA	5	4	5	466,236	466,248	446,766
Tas	1	2	4	157,344	140,192	130,473
ACT	2	1	1	121,079	129,547	118,737
NT	2	2	–	172,211	182,370	181,489
Aust	64	82	56	6,837,095	6,969,187	6,730,042

Source: tables 12A.5 and 12A.42
– Nil or rounded to zero...

10. Patient satisfaction

'Patient satisfaction' provides a proxy measure of governments' objective to deliver services that are responsive to individuals throughout their lifespan and communities.

'Patient satisfaction' is defined by two measures:

- Proportion of people who visited a hospital emergency department in the last 12 months for their own health reporting that the emergency department doctors, specialists or nurses 'always' or 'often':
  - listened carefully to them
  - showed respect to them
  - spent enough time with them
- Proportion of people who were admitted to hospital in the last 12 months reporting that the hospital doctors, specialists or nurses 'always' or 'often':
  - listened carefully to them
  - showed respect to them
  - spent enough time with them.

A high or increasing proportion of patients who were satisfied is desirable, as it suggests high quality hospital care that meets patient needs and expectations.

The ABS Patient Experience Survey of people aged 15 years and over does not include people living in discrete Indigenous communities, which affects the representativeness of the Northern Territory results. Approximately 20% of the resident population of the Northern Territory live in discrete Indigenous communities as of 2020-21.

Measure 1: Nationally in 2022-23, the proportion of respondents across all areas reporting that emergency department doctors, specialists or nurses always or often listened carefully and showed respect was above 83%. The proportion of respondents who reported that emergency department doctors or specialists always or often spent enough time with them was 78.6% compared to 83.9% who reported that emergency department nurses always or often spent enough time with them (figure 12.9a).

Data is comparable (subject to caveats) across jurisdictions and over time.

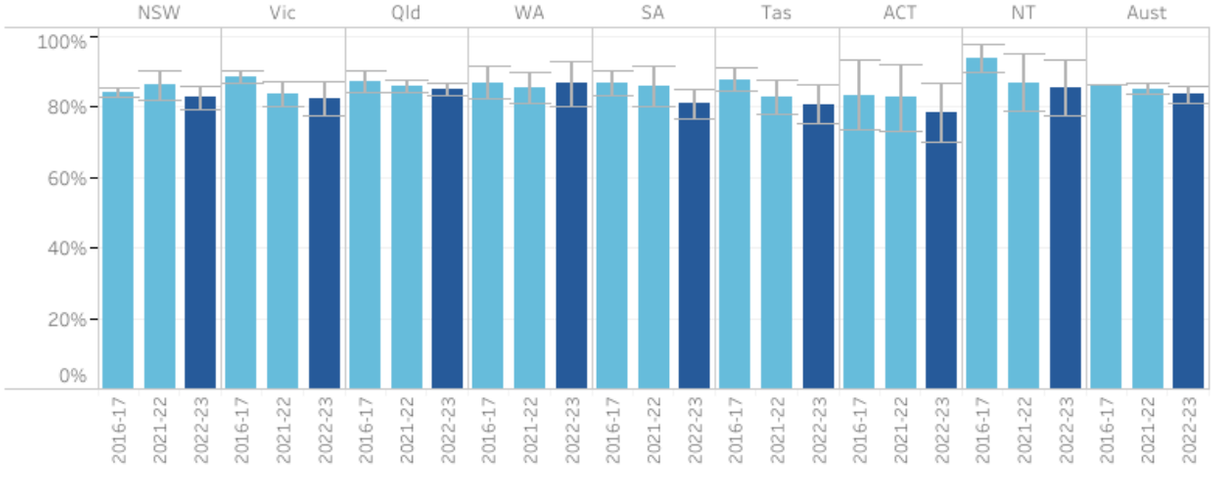
Data is complete (subject to caveats) for the current reporting period.

Select health professional:
- (●) ED doctors or specialists
- ( ) ED nurses

Select disaggregation:
- (●) always or often listened carefully
- ( ) always or often showed respect
- ( ) always or often spent enough time with person

Select year(s):
Multiple values

Figure 12.9a Measure 1: **Patient satisfaction with ED doctors or specialists — always or often listened carefully**
By jurisdiction, by year



Source: table 12A.43

Measure 2: Nationally in 2022-23, the proportion of respondents across all areas reporting that hospital doctors, specialists or nurses listened carefully, showed respect and spent enough time with them was above 86% (figure 12.9b).

Data is comparable (subject to caveats) across jurisdictions and over time.

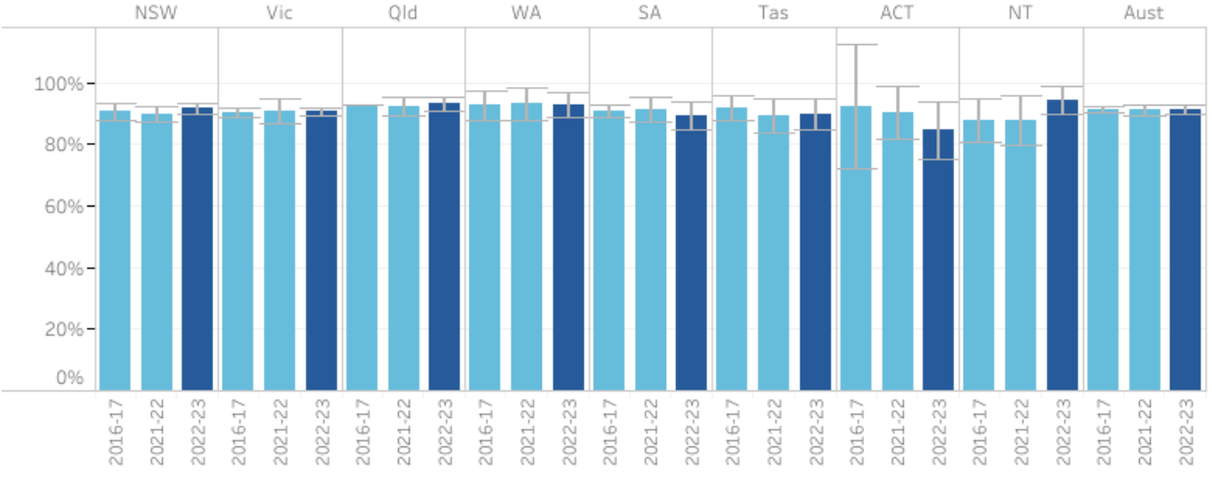
Data is complete (subject to caveats) for the current reporting period.

Select health professional:
- (●) hospital doctors or specialists
- ( ) hospital nurses

Select disaggregation:
- (●) always or often listened carefully
- ( ) always or often showed respect
- ( ) always or often spent enough time with person

Select year(s):
Multiple values

Figure 12.9b Measure 2: **Patient satisfaction with hospital doctors or specialists — always or often listened carefully**
By jurisdiction, by year



Source: table 12A.45

+ a b | e a u

11. Continuity of care

'Continuity of care' is an indicator of governments' objective to provide care that is well co-ordinated where more than one service type, and/or ongoing service provision is required.

'Continuity of care' is defined as the proportion of patients who reported that arrangements were not made by their hospital for any services needed after leaving hospital when last admitted.

A low or decreasing proportion of patients reporting that arrangements were not made by their hospital for any services needed after leaving hospital when last admitted is desirable.

This indicator is currently under development for reporting in the future. Summary data from the 2016 ABS survey of health care for people aged 45 years and over is available as contextual information for this indicator in table 12A.47.

12. Selected unplanned hospital readmission rates

‘Selected unplanned hospital readmission rates’ is an indicator of governments’ objective to provide public hospital services that are of high quality and well-coordinated to ensure continuity of care.

‘Selected unplanned hospital readmission rates’ is defined as the rate at which patients unexpectedly return to the same hospital within 28 days for further treatment where the original admission involved one of a selected set of procedures, and the readmission is identified as a post-operative complication. It is expressed as a rate per 1,000 separations in which one of the selected surgical procedures was performed. The indicator is an underestimate of all possible unplanned/unexpected readmissions.

The selected surgical procedures are knee replacement, hip replacement, tonsillectomy and adenoidectomy, hysterectomy, prostatectomy, cataract surgery and appendectomy. Unplanned readmissions are those having a principal diagnosis of a post-operative adverse event for which a specified ICD-10-AM diagnosis code has been assigned.

Low or decreasing rates of unplanned readmissions are desirable. Conversely, high or increasing rates suggest the quality of care provided by hospitals, or post-discharge care or planning, should be examined, because there may be scope for improvement.

States and territories have elected to pause reporting on this indicator while data specifications are reviewed to address data quality concerns. Data for 2021-22 was not provided, however reporting is expected to resume in time for inclusion in the 2025 report. This may be on the basis of either updated specifications or a suitable alternative data source, for example, the Australian Commission on Safety and Quality in Health Care’s ‘Avoidable hospital readmissions’ indicator.

> Of the selected surgical procedures in 2020-21, readmission rates were highest nationally, and for most jurisdictions, for tonsillectomy and adenoidectomy, with the rate increasing from 27.8 to 47.9 readmissions per 1,000 separations over the past 10 years (table 12.10). Selected unplanned hospital readmission rates are reported by hospital peer group, Indigenous status, remoteness and socioeconomic status in table 12A.49.

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year:
2020-21

Table 12.10 **Unplanned hospital readmissions, All public hospitals**
Per 1,000 separations, by selected surgical procedure, by jurisdiction, 2020-21

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Appendicectomy	21.6	18.1	24.6	26.7	22.3	17.8	20.0	51.2	21.8
Cataract surgery	2.1	2.4	5.9	2.0	2.7	4.4	1.9	np	2.8
Hip replacement	21.0	20.8	28.2	10.1	18.3	30.0	11.5	np	22.0
Hysterectomy	26.0	24.7	37.3	32.3	31.9	42.0	50.0	80.4	30.5
Knee replacement	15.6	17.7	36.3	18.1	23.3	25.9	5.7	np	20.6
Prostatectomy	26.1	27.5	40.3	39.0	34.3	45.2	7.3	np	30.7
Tonsillectomy and Adenoidectomy	47.1	29.6	69.0	54.9	51.6	79.7	33.1	83.3	47.9

Source: table 12A.48
np Not published. **–** Nil or rounded to zero.

tableau

13. Workforce sustainability

‘Workforce sustainability’ is an indicator of governments’ objective to provide sustainable public hospital services.

‘Workforce sustainability’ reports age profiles for the nursing and midwifery workforce and the medical practitioner workforce. It shows the proportions of registered nurses and midwives, and medical practitioners in ten year age brackets, by jurisdiction and by region.

High or increasing proportions of the workforce that are new entrants and/or low or decreasing proportions of the workforce that are close to retirement are desirable.

All nurses, midwives and medical practitioners are included in these measures, as a crude indication of the potential nursing, midwifery and medical practitioner workforces for public hospitals.

Health workforce sustainability relates to the capacity of the health workforce to meet current and projected future service demand. These measures are not a substitute for a full workforce analysis that allows for training, migration, changing patterns of work and expected future demand. They can, however, indicate that further attention should be given to workforce planning for public hospital services.

Nationally across all areas in 2022, 8.9% of the full-time equivalent nursing workforce were aged 60 years and over (figure 12.10a). This proportion has increased from 7.7% in 2013 but may be partially offset by a corresponding increase in the proportion of the nursing workforce aged under 40 years (table 12A.50).

Data is comparable (subject to caveats) across jurisdictions and over time.

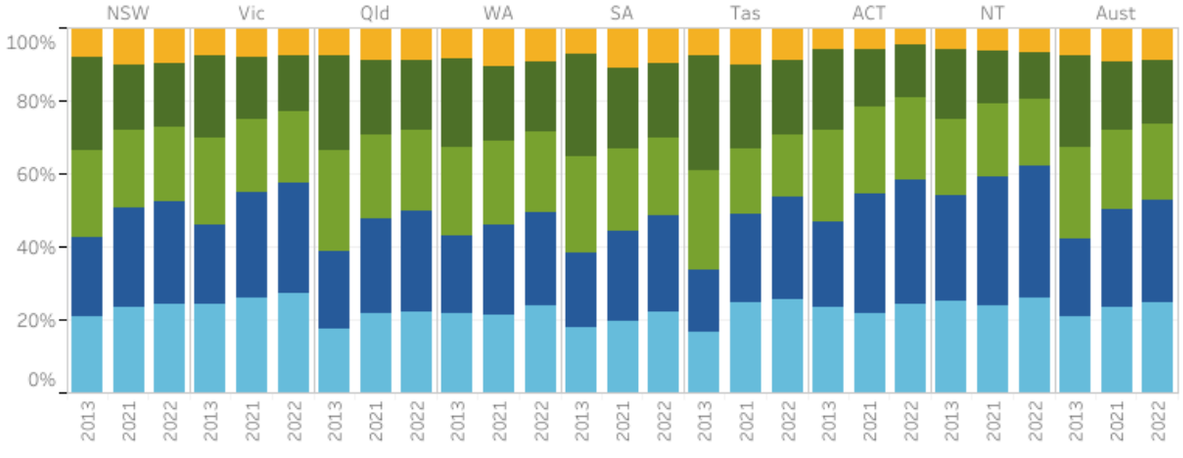
Data is complete (subject to caveats) for the current reporting period.

Select year:
Multiple values

Select remoteness area:
- Major cities
- Inner regional
- Outer regional
- Remote and very remote
- All areas

60+ years old | 50-59 years old | 40-49 years old | 30-39 years old | <30 years old

Figure 12.10a **Nurses (registered and enrolled) and midwives, All areas**
By age group, by jurisdiction, by year (a)



Source: tables 12A.50

(a) There are no major cities in Tasmania, no outer regional or remote areas in the ACT, and no inner regional or major cities in the NT.

For the medical practitioner workforce, the proportion aged 60 years and over across all areas was 5.9% in 2022 (figure 12.10b). Similar to the nursing workforce, the proportion of the medical practitioner workforce aged under 40 years (30-39 years age group) has increased since 2013 (table 12A.51).

Data is comparable (subject to caveats) across jurisdictions and over time.

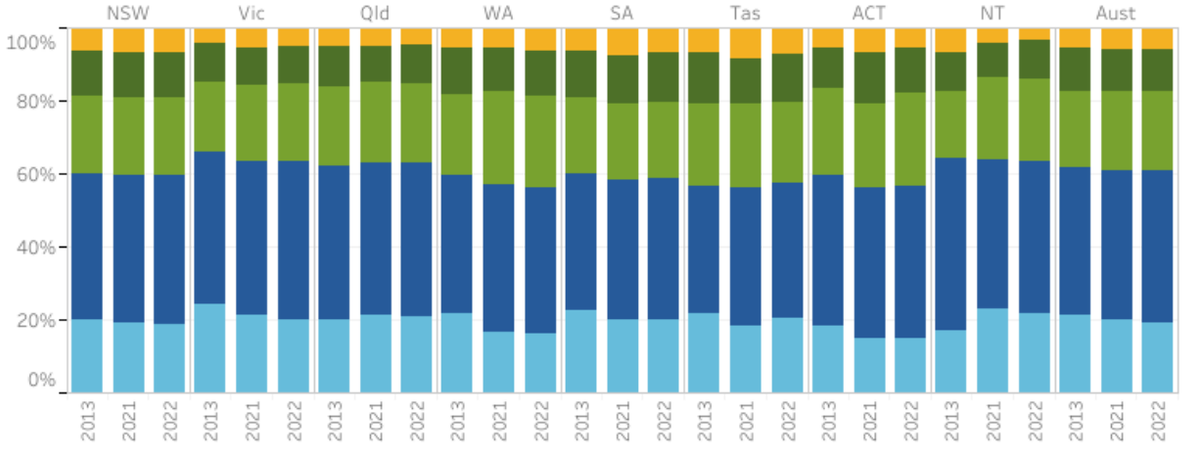
Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Select remoteness area:
- Major cities
- Inner regional
- Outer regional
- Remote and very remote
- All areas

60+ years old | 50-59 years old | 40-49 years old | 30-39 years old | <30 years old

Figure 12.10b **Medical practitioners, All areas**
By age group, by jurisdiction, by year (a)



Source: tables 12A.51

(a) There are no major cities in Tasmania, no outer regional or remote areas in the ACT, and no inner regional or major cities in the NT.

+ a b | e a u

For both the nursing and medical practitioner workforce, the proportion aged 60 years and over is higher in remote areas compared to non-remote areas (tables 12A.50 and 12A.51).

14. Cost per admitted patient separation

'Cost per admitted patient separation' is an indicator of governments' objective to deliver services in an efficient manner.

'Cost per admitted patient separation' is defined by the following two measures:

- Recurrent cost per weighted separation
- Capital cost per weighted separation.

A low or decreasing recurrent cost per weighted separation or capital cost per weighted separation can reflect more efficient service delivery in public hospitals. However, this indicator should be viewed in the context of the performance indicator framework as a whole, as decreasing cost could also be associated with decreasing quality and effectiveness.

Recurrent cost per weighted separation

'Recurrent cost per weighted separation' is the average cost of providing care for an admitted patient (overnight stay or same day) adjusted for casemix. Casemix adjustment takes account of variation in the relative complexity of a patient's clinical condition and of the hospital services provided, but not other influences on length of stay.

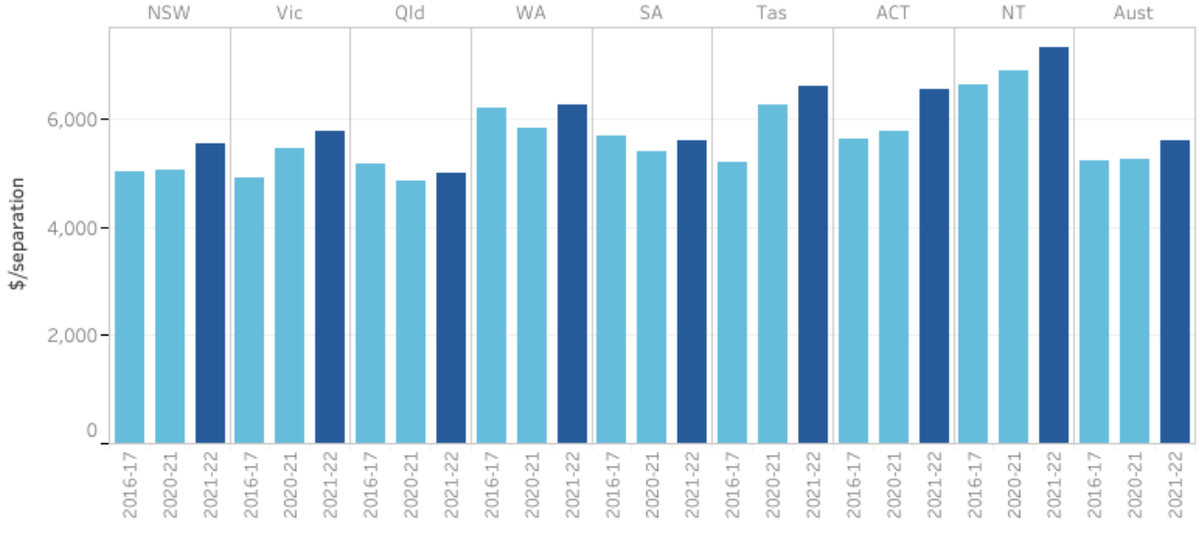
> Measure 1: Nationally in 2021-22, the recurrent cost per weighted separation was $5,614, an increase from $5,272 in 2020-21 (figure 12.11a). Data on the average cost per admitted patient separation is available on the subset of presentations that are acute emergency department presentations (table 12A.52).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 12.11a Measure 1: **Recurrent cost per weighted separation, All public hospitals**
By jurisdiction, by year (2021-22 dollars)



Source: table 12A.52

Capital cost per weighted separation

'Capital cost per weighted separation' is defined as the user cost of capital (calculated as 8% of the value of non-current physical assets including buildings and equipment but excluding land) plus depreciation, divided by the number of weighted separations.

This measure allows the full cost of hospital services to be considered. Depreciation is defined as the cost of consuming an asset's services. It is measured by the reduction in value of an asset over the financial year. The user cost of capital is the opportunity cost of the capital invested in an asset, and is equivalent to the return foregone from not using the funds to deliver other services or to retire debt. Interest payments represent a user cost of capital, so are deducted from capital costs to avoid double counting.

Measure 2: Costs associated with non-current physical assets are important components of the total costs of many services delivered by government agencies. Nationally in 2021-22, the total capital cost (excluding land) per weighted separation was $1,441 (figure 12.11b).

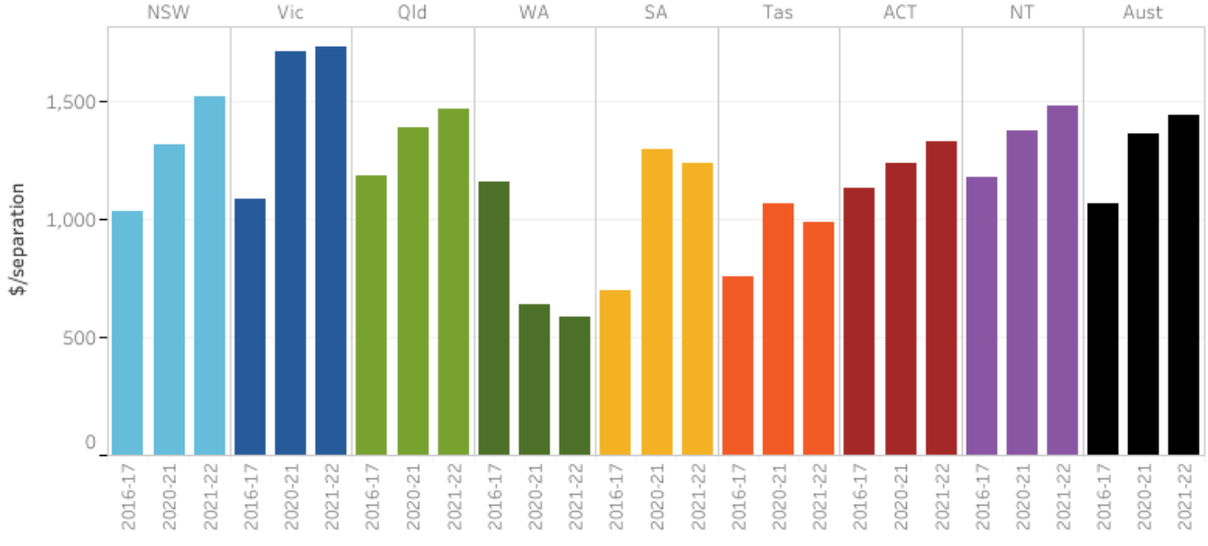
Data is not comparable across jurisdictions, but is comparable (subject to caveats) within jurisdictions over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Jurisdiction:
NSW Vic Qld WA SA Tas ACT NT Aust

Figure 12.11b Measure 2: **Capital cost per weighted separation, All public hospitals**
By jurisdiction, by year (2021-22 dollars)



Source: table 12A.53

+ a b | e a u

15. Recurrent cost per non-admitted patient

'Recurrent cost per non-admitted patient' is an indicator of governments' objective to deliver services in an efficient manner.

'Recurrent cost per non-admitted patient' is defined by the following two measures:

- Average cost per non-admitted acute emergency department presentation
- Average cost per non-admitted service event.

A low or decreasing recurrent cost per non-admitted patient can reflect more efficient service delivery in public hospitals. However, this indicator should be viewed in the context of the set of performance indicators as a whole, as decreasing cost could also be associated with decreasing quality and effectiveness. This indicator does not adjust for the complexity of service.

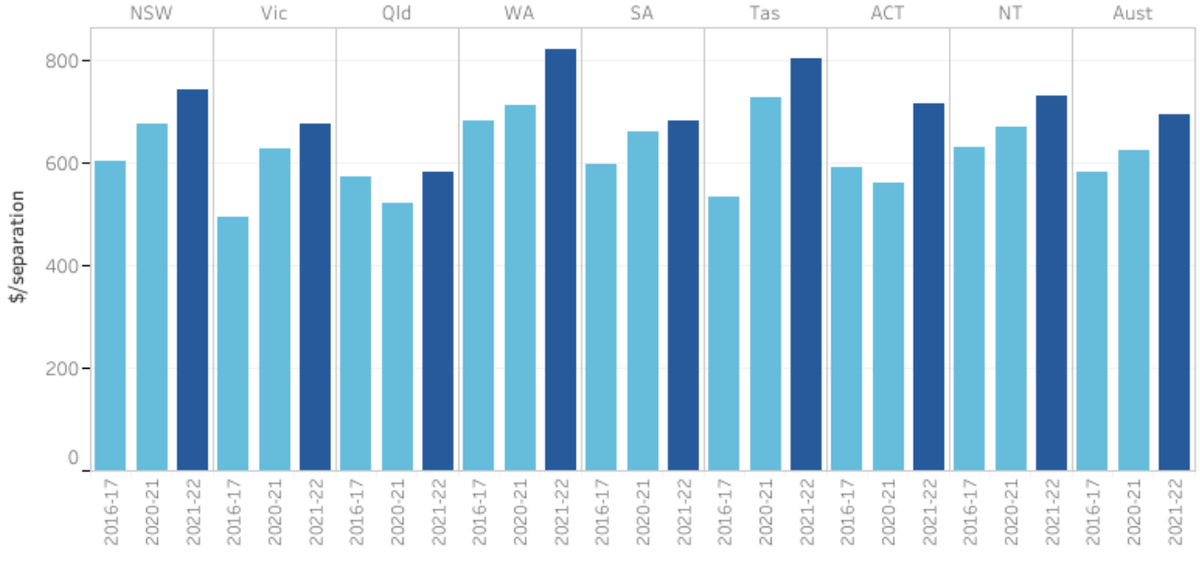
Measure 1: Nationally in 2021-22, the average cost per non-admitted emergency department presentation was $692 (figure 12.12a). Costs per non-admitted emergency department presentation have increased over the six years of reported data.

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 12.12a Measure 1: **Average cost per presentation, Emergency department (non-admitted)**
By jurisdiction, by year (2021-22 dollars)



Source: table 12A.54

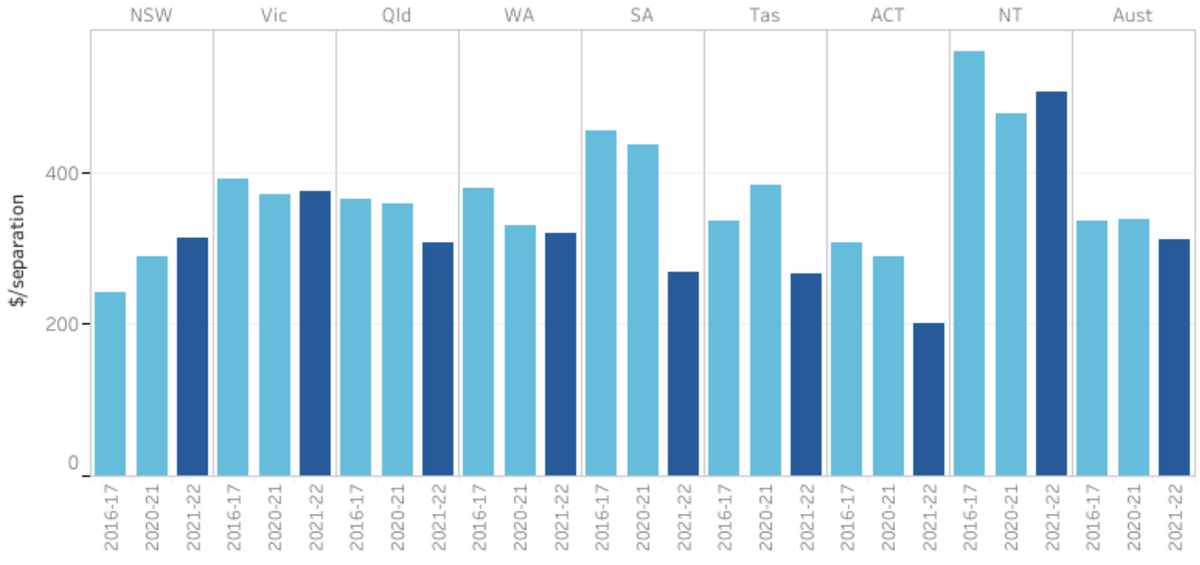
Measure 2: Nationally in 2021-22, the average cost per non-admitted service event was $312, down from $338 in 2020-21 (figure 12.12b).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 12.12b Measure 2: **Recurrent cost per non-admitted patient, Average cost per service event**
By jurisdiction, by year (2021-22 dollars)



Source: table 12A.55

+ a b | e a u

16. Hospital mortality

‘Hospital mortality’ is an indicator of governments’ objective to alleviate or manage illness and the effects of injury and provide high quality and safe care.

‘Hospital mortality’ is defined as death in low-mortality diagnostic related groups (DRGs) expressed as a rate. Low-mortality DRGs comprise diagnoses that have a very low chance of death (for example, headache, hand procedures, arthroscopy).

Low or decreasing rates of death in low-mortality DRGs can indicate more effective management of illness and the effects of injury.

In 2009, Australian Health Ministers agreed state and territory hospital mortality data should be gathered and presented to hospitals for regular review. The hospital mortality indicators endorsed by Health Ministers include 'death in low mortality DRGs', 'hospital-standardised mortality ratios' and 'in-hospital mortality for four specified conditions' (acute myocardial infarction, stroke, fractured neck of femur and pneumonia) (ACSQHC 2014).

Hospital mortality indicators can act as screening tools to flag potential issues for further clinical review. Hospital mortality data should be considered as part of a suite of patient safety metrics including hospital-acquired infection, patient experience data and readmission rates.

This indicator is currently under development for reporting in the future. Table 12.11 provides an overview of the review mechanisms in place across states and territories for examining in-hospital deaths.

Table 12.11 Overview of review mechanisms across states and territories for in-hospital deaths

NSW	NSW reports publicly on selected mortality in hospitals data. The report 'Mortality following hospitalisation for seven clinical conditions' provides information on patient deaths within 30 days of admission across 73 public hospitals for seven clinical conditions during the period July 2015 to June 2018 http://www.bhi.nsw.gov.au/__data/assets/pdf_file/0007/557827/BHI_Mortality_2015-2018_REPORT.pdf). The seven clinical conditions are: acute myocardial infarction, ischaemic stroke, haemorrhagic stroke, congestive heart failure, pneumonia, chronic obstructive pulmonary disease, and hip fracture surgery. Together these conditions account for approximately 11% of acute emergency hospitalisations for people aged 15 years and over in NSW, and approximately 28% of in-hospital deaths following acute emergency hospitalisation. The NSW Bureau of Health Information uses 30-day risk-standardised mortality ratios (RSMRs) to assess mortality in hospital. The RSMRs take into account the volume of patients treated and key patient risk factors beyond the control of a hospital. However, not all relevant risk factors are recorded, such as sociological and environmental factors, so while results are useful for trend analysis and a guide for further investigation, they are not suitable for direct performance comparisons. A ratio of less than 1.0 indicates that mortality is lower than expected in a given hospital, while a ratio of greater than 1.0 indicates that mortality is higher than expected in a given hospital. Three years of data is used to create stable, reliable estimates of performance. Rates are also reported per 100 hospitalisations for each of the seven clinical conditions.
Vic	Victoria does not report publicly on this data. However, Victoria reports internally on three indicators based on the Core Hospital-Based Outcome Indicator (CHBOI) specifications published by the Australian Commission on Safety and Quality in Health Care (ACSQHC) In-hospital Mortality for Fractured Neck-of-Femur, Acute Myocardial Infarction and Pneumonia, as well as two locally developed mortality indicators for ischaemic and haemorrhagic stroke and a Gestationally Standardised Perinatal Mortality Ratio. Outliers for these indicators are reviewed on a regular basis by Safer Care Victoria, the Department of Health and respective health services as part of the performance monitoring process. In addition, the Victorian Perioperative Consultative Council oversees, reviews and analyses cases of perioperative mortality and morbidity in Victoria and the Consultative Council for Obstetric and Perinatal Morbidity and Mortality (CCOPMM) reviews and reports on all child deaths in Victoria, including in-hospital deaths. Victoria also reports internally on four in-hospital mortality indicators (for Stroke, Fractured Neck of Femur, Acute Myocardial Infarction and Pneumonia) via the Victorian Agency for Health Information Private Hospitals Quality and Safety Report.
Qld	Queensland does not report publicly on this data. Queensland Hospital and Health Services undertake 'outlier' reviews of in-hospital deaths which are reviewed by a statewide committee to ensure the review is thorough and actions are identified for any issues found. The need for review is identified through monitoring condition or procedure specific indicators (AMI, Heart Failure, Stroke, Fractured Neck of Femur and Pneumonia) and system-wide mortality indicators i.e. low-mortality DRG and hospital standard mortality ratio (HSMR). In addition, morbidity and mortality meetings are held at a local level. Further, Quality Assurance Committees (QAC) identify common issues across the state to identify lessons learnt and/or recommendations for consideration statewide and locally. Other QACs e.g. Queensland Audit of Surgical Mortality provide individual feedback to practitioners to improve individual performance.

WA	WA does not report publicly on this data. WA Health currently reports six indicators internally that are based on the Core Hospital Based Outcome Indicator (CHBOI) specifications published by the Australian Commission on Safety and Quality in Health Care (ACSQHC); Hospital Standardised Mortality Ratio, In-hospital Mortality (for Stroke, Fractured Neck-of-Femur, Acute Myocardial Infarction and Pneumonia) and Death in Low Mortality Diagnosis-Related Groups. Outliers for these indicators are reviewed on a regular basis through the WA Health system Quality Surveillance Group (QSG). Note that the results of mortality reviews as undertaken by local Mortality Committees are publicly available from the annual WA Health *Your safety in our hands in hospital* patient safety report.
SA	SA does not report publicly on this data. For internal mortality analysis, SA uses national Core hospital based outcome indicators (CHBOI) developed by the ACSQHC. Examples include: monitoring Hospital standardised mortality ratios (HSMR) (included as a key performance indicator in service agreements) and monitoring CHBOI condition-specific mortality measures (fractured neck of femur, stroke, AMI and pneumonia).
Tas	Tasmania does not report publicly on this data. Hospital mortality is reported internally using the Hospital Diagnosis Standardised Mortality Ratio, provided by the Health Roundtable (https://home.healthroundtable.org/), and hospital-wide and condition/procedure specific mortality as per the Core Hospital-Based Outcome Indicator (CHBOI) specifications developed by the ACSQHC. Morbidity and Mortality reviews are undertaken across the health service to promote safety and quality improvement. Tasmania also uses CHBOI-based outcome indicators of safety and quality. This reporting system has included in-hospital mortality and unplanned/unexpected hospital re-admissions, as developed by the ACSQHC. These indicators are designed as screening tools for internal safety and quality improvement, and they are not intended to be used as performance measures.
ACT	The ACT does not report publicly on these data. Mortality information from Canberra Health Services (CHS) is collated by the Health Round Table (HRT) and includes deaths in low mortality DRGs and is defined by the ACSQHC and adopted by the Independent Health and Aged Care Pricing Authority (IHACPA). These may not necessarily be avoidable when investigated. Sentinel events are reported to ACT Health Directorate for inclusion in IHACPA reporting. In addition, Morbidity and Mortality meetings are held at a local level. The ACT Children and Young People Death Review Committee reviews all deaths of children and young people aged from birth to 18 years. This committee reports annually to the Minister for Children, Youth and Families and the statistics are published here: https://www.childdeathcommittee.act.gov.au/publications. The ACT Maternal and Perinatal Mortality Committee reviews all deaths of women who died while pregnant or up to 42 days post-partum and all deaths of fetuses from 20 weeks gestation and babies up to 28 days of life. Maternal death information is included in national reports but is not published specifically for the ACT due to the very small number of deaths in the ACT. The perinatal death rate is published annually here: https://health.act.gov.au/about-our-health-system/data-and-publications/healthstats/statistics-and-indicators/perinatal and a detailed report is provided by the Committee to the ACT Chief Health Officer and published every five years https://health.act.gov.au/about-our-health-system/data-and-publications/healthstats/epidemiology-publications.

NT	The NT does not report publicly on this data. The NT uses national Core hospital based outcome indicators (CHBOIs) developed by the ACSQHC. CHBOI 1 - Hospital Standardised Mortality Ratio (HSMR); CHBOI 2 - Death in low-mortality Diagnosis Related Groups (DRGs); CHBOI 3: Condition Specific Mortality Measures. This data is included in the internal NT Health Patient Quality and Safety Surveillance Quarterly Report. The NT also provides data on coronial recommendations, Incident Severity Rating 1 events (ISR1s), and national sentinel events.

Sources: State and Territory governments (unpublished).

Indigenous data

Performance indicator data for Aboriginal and Torres Strait Islander people in this section is available in the data tables listed below. Further supporting information can be found in the Indicator results tab and data tables.

Public hospitals data disaggregated for Aboriginal and Torres Strait Islander people

Table number	Table title
Table 12A.15	Patients treated within national benchmarks for emergency department waiting time, by Indigenous status
Table 12A.19	Length of stay for emergency department care, proportion of patients staying for four hours or less, by Indigenous status
Table 12A.24	Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days)
Table 12A.37	Patients who did not wait, left or were discharged against medical advice, by Indigenous status (public hospitals)
Table 12A.41	Separations for falls resulting in patient harm in hospitals, per 1,000 separations
Table 12A.49	Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles

Explanatory material

Key terms

Terms	Definition
Accreditation	Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals can seek accreditation through the Australian Council on Healthcare Standards Evaluation and Quality Improvement Program, the Australian Quality Council (now known as Business Excellence Australia), the Quality Improvement Council, the International Organisation for Standardization 9000 Quality Management System or other equivalent programs.
Acute care	Clinical services provided to admitted patients, including managing labour, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures.
Admitted patient	A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).
Allied health (non-admitted)	Occasions of service to non-admitted patients at units/clinics providing treatment/counselling to patients. These include units providing physiotherapy, speech therapy, family planning, dietary advice, optometry and occupational therapy.
Australian classification of health interventions (ACHI)	Developed by the National Centre for Classification in Health, the ACHI comprises a tabular list of health interventions and an alphabetic index of health intervention.
AR-DRG	Australian Refined Diagnosis Related Group - a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 6.0x is based on the ICD-10-AM classification.
Casemix adjusted	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted by AR-DRG into categories of patients with similar clinical conditions and requiring similar hospital services. Casemix adjustment is an important step to achieving comparable measures of efficiency across hospitals and jurisdictions.
Casemix adjusted separations	The number of separations adjusted to account for differences across hospitals in the complexity of episodes of care.

Terms	Definition
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Comparability	Data is considered comparable if (subject to caveats) it can be used to inform an assessment of comparative performance. Typically, data is considered comparable when it is collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data.
Completeness	Data is considered complete if all required data is available for all jurisdictions that provide the service.
Cost of capital	The return foregone on the next best investment, estimated at a rate of 8% of the depreciated replacement value of buildings, equipment and land. Also called the 'opportunity cost' of capital.
Elective surgery waiting times	Elective surgery waiting times are calculated by comparing the date on which patients are added to a waiting list with the date on which they are admitted for the awaited procedure. Days on which the patient was not ready for care are excluded.
Emergency department waiting time to commencement of clinical care	The time elapsed for each patient from presentation to the emergency department (that is, the time at which the patient is clerically registered or triaged, whichever occurs earlier) to the commencement of service by a treating medical officer or nurse.
Emergency department waiting times to admission	The time elapsed for each patient from presentation to the emergency department to admission to hospital.
ICD-10-AM	The International Statistical Classification of Diseases and Related Health Problems - 10th Revision - Australian modification (ICD-10-AM) is the current classification of diagnoses in Australia.
Hospital boarder	A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.

Terms	Definition
Length of stay	For an episode of care, the period from admission to separation less any days spent away from the hospital (leave days).
Medicare	Australian Government funding of private medical and optometrical services (under the Medicare Benefits Schedule). Sometimes defined to include other forms of Australian Government funding such as subsidisation of selected pharmaceuticals (under the Pharmaceutical Benefits Scheme) and public hospital funding (under the Australian Health Care Agreements), which provides public hospital services free of charge to public patients.
Newborn qualification status	A newborn qualification status is assigned to each patient day within a newborn episode of care. A newborn patient day is qualified if the infant meets at least one of the following criteria: • is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient • is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care • is admitted to, or remains in hospital without its mother. A newborn patient day is unqualified if the infant does not meet any of the above criteria. The day on which a change in qualification status occurs is counted as a day of the new qualification status. If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day.
Nursing and midwifery workforce	Registered nurses, enrolled nurses and midwives registered with the Australian Health Practitioner Regulation Agency and who are employed in nursing and/or midwifery in Australia excluding those on extended leave.
Medical practitioner workforce	Medical practitioners registered with the Australian Health Practitioner Regulation Agency and who are employed in medicine in Australia excluding those on extended leave.
Non-acute care	Includes maintenance care and newborn care (where the newborn does not require acute care).

Terms	Definition
Non-admitted occasions of service	Occasion of examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service establishment. Services can include emergency department visits, outpatient services (such as pathology, radiology and imaging, and allied health services, including speech therapy and family planning) and other services to non-admitted patients. Hospital non-admitted occasions of service are not yet recorded consistently across states and territories, and relative differences in the complexity of services provided are not yet documented.
Non-admitted patient	A patient who has not undergone a formal admission process, but who may receive care through an emergency department, outpatient or other non-admitted service.
Peer group(s)	Peer groups are used to categorise similar hospitals with shared characteristics. Categorising hospitals in peer groups allows for valid comparisons to be made across similar hospitals providing similar services. The peer groups are: • Acute public hospitals • Acute private hospitals • Very small hospitals • Women's and children's hospitals • Early parenting centres • Drug and alcohol hospitals • Psychiatric hospitals • Other acute specialised hospitals • Same day hospitals • Sub- and non-acute hospitals • Outpatient hospitals • Unpeered hospitals For further details on hospital peer groups, see AIHW (2015) *Australian hospital peer groups.* Health services series no. 66. Cat. no. HSE 170. Canberra: AIHW (https://www.aihw.gov.au/reports/hospitals/australian-hospital-peer-groups/data)
Posthumous organ procurement	An activity undertaken by hospitals in which human tissue is procured for the purpose of transplantation from a donor who has been declared brain dead.

Terms	Definition
Public hospital	A hospital that provides free treatment and accommodation to eligible admitted persons who elect to be treated as public patients. It also provides free services to eligible non-admitted patients and can provide (and charge for) treatment and accommodation services to private patients.
Real expenditure	Actual expenditure adjusted for changes in prices.
Relative stay index	The actual number of patient days for acute care separations in selected AR–DRGs divided by the expected number of patient days adjusted for casemix. Includes acute care separations only. Excludes: patients who died or were transferred within 2 days of admission, or separations with length of stay greater than 120 days, AR-DRGs which are for 'rehabilitation', AR-DRGs which are predominantly same day (such as R63Z chemotherapy and L61Z admit for renal dialysis), AR-DRGs which have a length of stay component in the definition, and error AR-DRGs.
Same day patients	A patient whose admission date is the same as the separation date.
Sentinel events	Adverse events that cause serious harm to patients and that have the potential to undermine public confidence in the healthcare system.
Separation	A total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change in the type of care for an admitted patient (for example, acute to rehabilitation). Includes admitted patients who receive same day procedures.
Service event	An interaction between one or more health-care provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in dated entry in the patient's medical record.
Subacute care	Specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction. Subacute care comprises the defined care types of rehabilitation, palliative care, geriatric evaluation and management and psychogeriatric care.

Terms	Definition
Triage category	The urgency of the patient's need for medical and nursing care: category 1 – resuscitation (immediate within seconds) category 2 – emergency (within 10 minutes) category 3 – urgent (within 30 minutes) category 4 – semi-urgent (within 60 minutes) category 5 – non-urgent (within 120 minutes).
Urgency category for elective surgery	Category 1 patients – admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it can become an emergency. Category 2 patients – admission within 90 days is desirable for a condition that is causing some pain, dysfunction or disability, but that is not likely to deteriorate quickly or become an emergency. Category 3 patients – admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, that is unlikely to deteriorate quickly and that does not have the potential to become an emergency.

References

Australian Commission on Safety and Quality in Health Care (ACSQHC) 2020, *Annual Report 2019-20,* ACSQHC, Sydney, https://www.safetyandquality.gov.au/publications-and-resources/resource-library/acsqhc-annual-report-2019-20 (accessed 12 October 2023).

—— 2014 *Using hospital mortality indicators to improve patient care: A guide for Boards and Chief Executives,* ACSQHC, Sydney, https://www.safetyandquality.gov.au/sites/default/files/migrated/Using-hospital-mortality-indicators-to-improve-patient-care-A-guide-for-Boards-and-Chief-Executives.pdf (accessed 12 October 2023).

AIHW (Australian Institute of Health and Welfare) 2023, *Hospital resources 2021-22: Australian hospital statistics,* Health services series, AIHW, Canberra, https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients (Hospital resources 2021-22 data tables, accessed 3 October 2023).

—— 2023a, *Admitted patient care 2021-22: Australian hospital statistics,* AIHW, Canberra, https://www.aihw.gov.au/reports-data/myhospitals/intersection/access/apc (accessed 3 October 2023).

—— 2023b, *Non-admitted patient care 2021-22: Australian hospital statistics,* Health services series, AIHW, Canberra, https://www.aihw.gov.au/reports-data/myhospitals/sectors/non-admitted-patients (accessed 3 October 2023).

Report on Government Services 2024

PART E, SECTION 13: RELEASED ON 31 JANUARY 2024

13 Services for mental health

This section reports on the Australian, state and territory governments' management of mental health and mental illnesses. Performance reporting focuses on state and territory governments' specialised mental health services, and services for mental health subsidised under the Medicare Benefits Schedule (MBS) (provided by General Practitioners (GPs), psychiatrists, psychologists and other allied health professionals).

The **Indicator results** tab uses data from the data tables to provide information on the performance for each indicator in the **Indicator framework.** The same data is also available in CSV format.

Data downloads

13 Services for mental health data tables (XLSX 697.6 KB)

13 Services for mental health dataset (CSV 2.3 MB)

Refer to the corresponding table number in the data tables for detailed definitions, caveats, footnotes and data source(s).

Guide: How to find what you need in RoGS (PDF 288.5 KB)

Context

Objectives for services for mental health

Services for mental health aim to:

- promote mental health and wellbeing, and where possible prevent the development of mental health problems, mental illness and suicide, and
- when mental health problems and illness do occur, reduce the impact (including the effects of stigma and discrimination), promote recovery and physical health and encourage meaningful participation in society, by providing services that:
    - are high quality, safe and responsive to consumer and carer goals
    - facilitate early detection of mental health issues and mental illness, followed by appropriate intervention
    - are coordinated and provide continuity of care
    - are timely, affordable and readily available to those who need them
    - are sustainable.

Governments aim for services for mental health to meet these objectives in an equitable and efficient manner.

Service overview

Mental health relates to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC 1999). The World Health Organization describes positive mental health as:

… a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001).

Mental illness is a term that describes a diverse range of behavioural and psychological conditions. These conditions can affect an individual's mental health, functioning and quality of life. Each mental illness is unique in its incidence across the lifespan, causal factors and treatments.

There are a range of services provided or funded by Australian, state and territory governments that are specifically designed to meet the needs of people with mental health issues; the key services are:

- MBS subsidised mental health specific services that are partially or fully funded under Medicare on a fee-for-service basis and are provided by GPs, psychiatrists, psychologists or other allied health professionals under specific mental health items.
- State and territory government specialised mental health services (treating mostly low prevalence, but severe, mental illnesses), which include:
    - Admitted patient care in public hospitals – specialised services provided to inpatients in stand-alone psychiatric hospitals or psychiatric units in general acute hospitals. While not a state and territory government specialised mental health service, this section also reports on emergency department presentations for mental health related care needs (where data is available). (Data on emergency department presentations for mental health related care needs is reported where available in table 13A.18.)
    - Community-based public mental health services, comprising:
        - ambulatory care services and other services dedicated to assessment, treatment, rehabilitation and care, and
        - residential services that provide beds in the community, staffed onsite by mental health professionals.
- Not for profit, non-government organisation (NGO) services, funded by the Australian, state and territory governments focused on providing wellbeing, support and assistance to people who live with a mental illness. These include crisis, support and information services such as Beyond Blue, Lifeline, Kids Helpline, and ReachOut.
- The National Disability Insurance Scheme (NDIS), which began full roll out in July 2016. People with a psychiatric disability who have significant and permanent functional impairment are eligible to access funding through the NDIS. In addition, people with a disability other than a psychiatric disability, may also be eligible for funding for mental health-related services and support if required.

- The Australian, state and territory governments also share a focus on prevention and early intervention through suicide prevention programs and investment to reduce gaps in care (including emphasising a whole of system approach and the role of social determinants of health on people's mental health and wellbeing).

There are also other services (for example, specialist homelessness services) provided and/or funded by governments that make a significant contribution to the mental health treatment of people with mental illness but are not specialised or specific mental health services. Information on these services can be found on the *Mental Health* section of the AIHW website (2024).

Roles and responsibilities

State and territory governments are responsible for funding, delivering and/or managing specialised services for mental health including inpatient/admitted care in hospitals, community-based ambulatory care and community-based residential care.

The Australian Government is responsible for overseeing and funding of a range of services for mental health and programs that are primarily provided or delivered by private practitioners or NGOs. These services and programs include MBS subsidised services provided by GPs (under both general and specific mental health items), private psychiatrists and other allied mental health professionals, Pharmaceutical Benefits Scheme (PBS) funded mental health-related medications and other programs designed to prevent suicide or increase the level of social support and community-based care for people with a mental illness and their carers. The Australian Government also funds state and territory governments for health services, most recently through the approaches specified in the National Mental Health and Suicide Prevention Agreement and the National Health Reform Agreement (NHRA) which includes a mental health component.

A number of national initiatives and nationally agreed strategies and plans underpin the delivery and monitoring of services for mental health in Australia including:

- the *Mental Health Statement of Rights and Responsibilities* (Australian Health Ministers 1991)
- the *National Mental Health Policy* 2008 (DoH 2009)
- the *National Mental Health Strategy* (DoH 2014)
- National Mental Health Plans, the most recent being the *Fifth National Mental Health and Suicide Prevention Plan* 2017-2022 (COAG 2017).

Under the *National Mental Health and Suicide Prevention Agreement* [1], the Australian, state and territory governments are jointly responsible for a number of areas including:

- mental health workforce planning, training and accreditation
- mental health promotion, prevention, early intervention and social and emotional wellbeing programs, suicide prevention, stigma reduction
- help and crisis hotlines
- psychosocial support services for people who are not supported through the NDIS
- contributions to the National Agreement on Closing the Gap (reducing suicide of Aboriginal and Torres Strait Islander peoples towards zero, ensuring all services funded by Australian governments are culturally safe and responsive, and building a strong, sustainable community-controlled sector).

1. National Mental Health and Suicide Prevention Agreement, 2022 https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-03/nmh_suicide_prevention_agreement.pdf

Funding

Nationally in 2021-22, around $11.6 billion in real government recurrent expenditure was allocated to services for mental health, equivalent to $449.90 per person in the population (table 13A.1 and figure 13.1). State and territory governments made the largest contribution ($7.3 billion or 63.1%, which includes Australian Government funding under the NHRA), with Australian Government expenditure of $4.3 billion (table 13A.1).

Expenditure on MBS subsidised services was the largest component of Australian Government expenditure on services for mental health in 2021-22 ($1.6 billion or 36.5%) (table 13A.2). This comprised MBS payments for psychologists and other allied health professionals (19.2%), consultant psychiatrists (9.9%) and GP services (7.4%) (table 13A.2). The Australian Government also spent $622.5 million in 2021-22 on mental health related medications under the PBS (table 13A.2).

Nationally in 2021-22, expenditure on admitted patient services was the largest component of state and territory governments' expenditure on specialised mental health services ($3.1 billion or 41.5%), followed by expenditure on community-based ambulatory services ($2.8 billion or 38.6%) (table 13A.3). State and territory governments' expenditure on specialised mental health services, by source of funds and depreciation (which is excluded from reporting) are in tables 13A.4 and 13A.5 respectively.

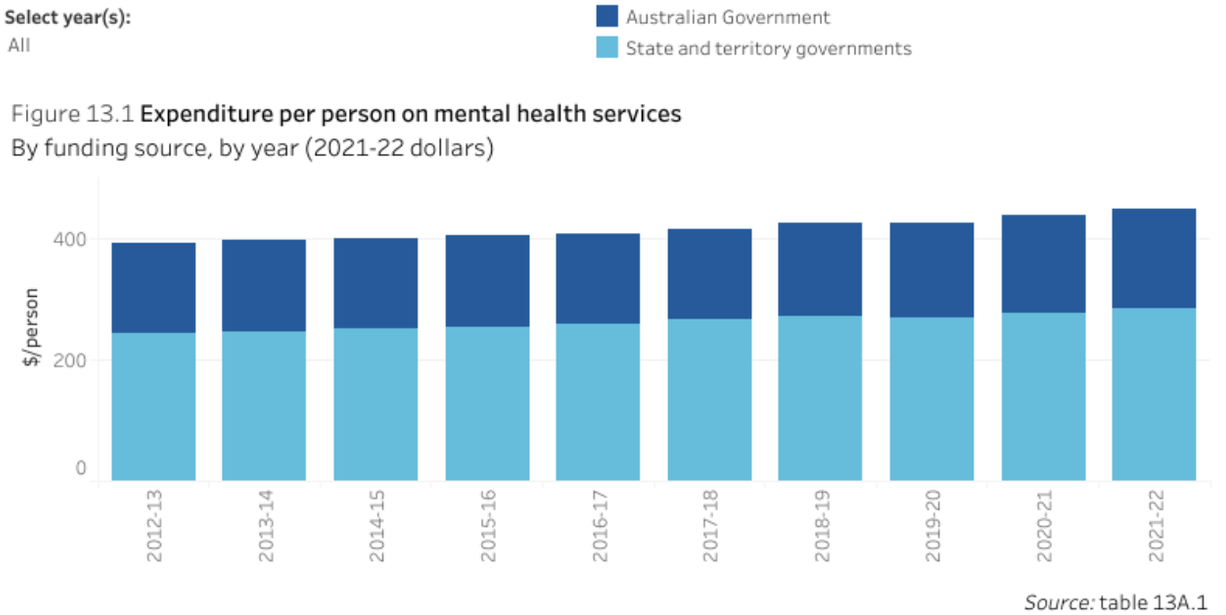


Figure 13.1 **Expenditure per person on mental health services**
By funding source, by year (2021-22 dollars)

Source: table 13A.1

(a) Data was not available for the ACT for 2021-22. Total does not include ACT jurisdictional funds.

Data tables are referenced above by a '13A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Size and scope

In 2022-23, 10.9% of the total population received MBS/DVA services, with 1.9% of the total population receiving state and territory government specialised mental health services in 2021-22 (the most recent data available) (figure 13.2). While the proportion of the population using state and territory government specialised mental health services has remained relatively constant, the proportion using MBS/DVA services has increased steadily over time from 8.4% in 2013-14 to 10.9% in 2022-23. Service use per person increased for all service types across the time series, however GPs remain the most commonly accessed service provider (table 13A.7).

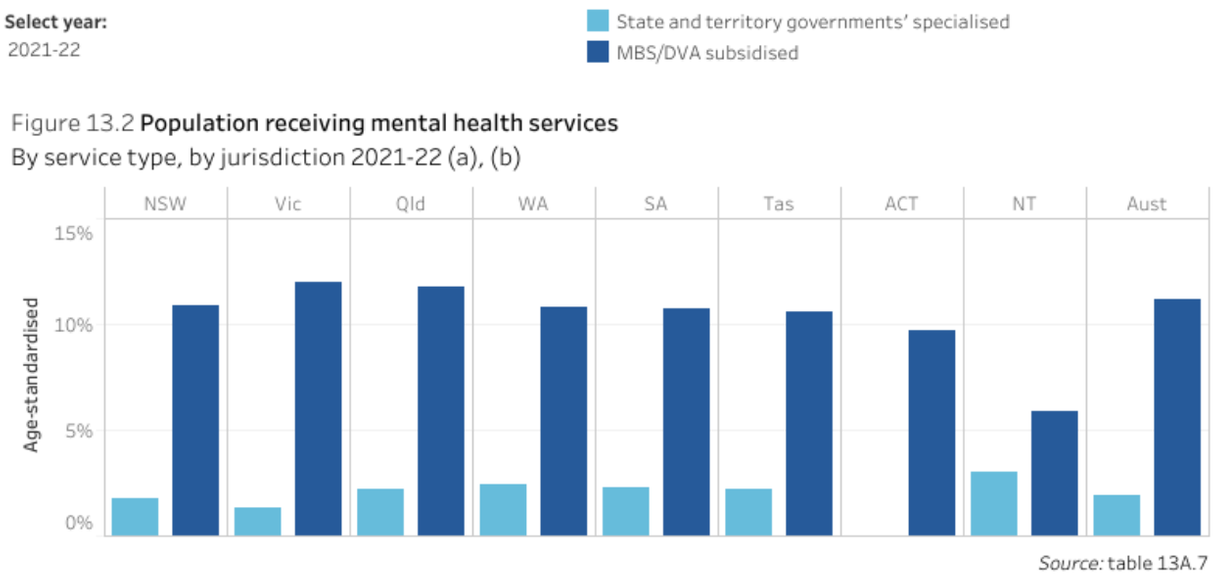


Figure 13.2 **Population receiving mental health services**
By service type, by jurisdiction 2021-22 (a), (b)

Source: table 13A.7

(a) The most recent year of data available for MBS/DVA subsidised mental health services is for 2022-23 and for state and territory governments specialised public mental health services is 2021-22. (b) Data for state and territory governments specialised public mental health services was not available for the ACT for 2021-22. The Australian total does not include ACT.

Data tables are referenced above by a '13A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Information on the proportion of new consumers who accessed state and territory governments' specialised and MBS subsidised services for mental health are available in tables 13A.8–9.

For the first time, the 2021 Census collected information on diagnosed long-term health conditions. Over two million people reported having a diagnosed long-term mental health condition (2,231,543) (ABS 2022).

MBS subsidised services for mental health

In 2022-23, 13.2 million MBS subsidised services for mental health were provided by; psychologists (clinical and other services) (6.4 million), psychiatrists (2.6 million) and other allied health professionals (0.6 million). GPs provided a further 3.5 million MBS subsidised specific services for mental health. Service usage rates varied across states and territories (table 13A.10).

GPs are often the first service accessed by people seeking help when suffering from a mental illness (AIHW 2022). They can diagnose, manage and treat mental illnesses and refer patients to more specialised service providers. According to a 2023 report by the Royal Australian College of General Practitioners, mental health issues were the single most common reason patients visited their GP for the seventh year in a row (RACGP 2023).

State and Territory governments' specialised mental health services

Across states and territories, the mix of admitted patient and community-based services and care types differ. As the unit of activity varies across these three service types, service mix differences can be partly understood by considering items which have comparable measurement such as expenditure (table 13A.3), numbers of full time equivalent (FTE) direct care staff (table 13A.11), accrued mental health patient days (table 13A.12) and mental health beds (table 13A.13).

Additional data is also available on the most common principal diagnosis for admitted patients, community-based ambulatory contacts by age group and specialised mental health care by Indigenous status on the *Mental Health* section of the AIHW website (2024).

Crisis and support organisations

Crisis, support and information services such as Beyond Blue, Lifeline and Kids Helpline are provided to support Australians experiencing mental health issues. In 2022-23:

- Lifeline received 1,095,899 calls and answered 870,710 calls.
- Kids Helpline received 317,681 answerable contact attempts (call, webchat and email) with 138,970 contacts answered.
- Beyond Blue received 333,503 contacts and responded to 205,905 contacts (unpublished AIHW).

National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) provides support to people with a significant and enduring primary psychosocial disability. At June 30, 2023, there were 62,011 active NDIS participants with a psychosocial disability (10.2% of all participants) (NDIA 2023), receiving approximately $4.3 billion in payments (table 13A.14).

Indicator framework

The performance indicator framework provides information on equity, effectiveness and efficiency, and distinguishes the outputs and outcomes of services for mental health.

The performance indicator framework shows which data is complete and comparable in this report. For data that is not considered directly comparable, text includes relevant caveats and supporting commentary. Section 1 discusses data comparability and completeness from a report-wide perspective. In addition to the contextual information for this service area (see Context tab), the report's statistical context (section 2) contains data that may assist in interpreting the performance indicators presented in this section.

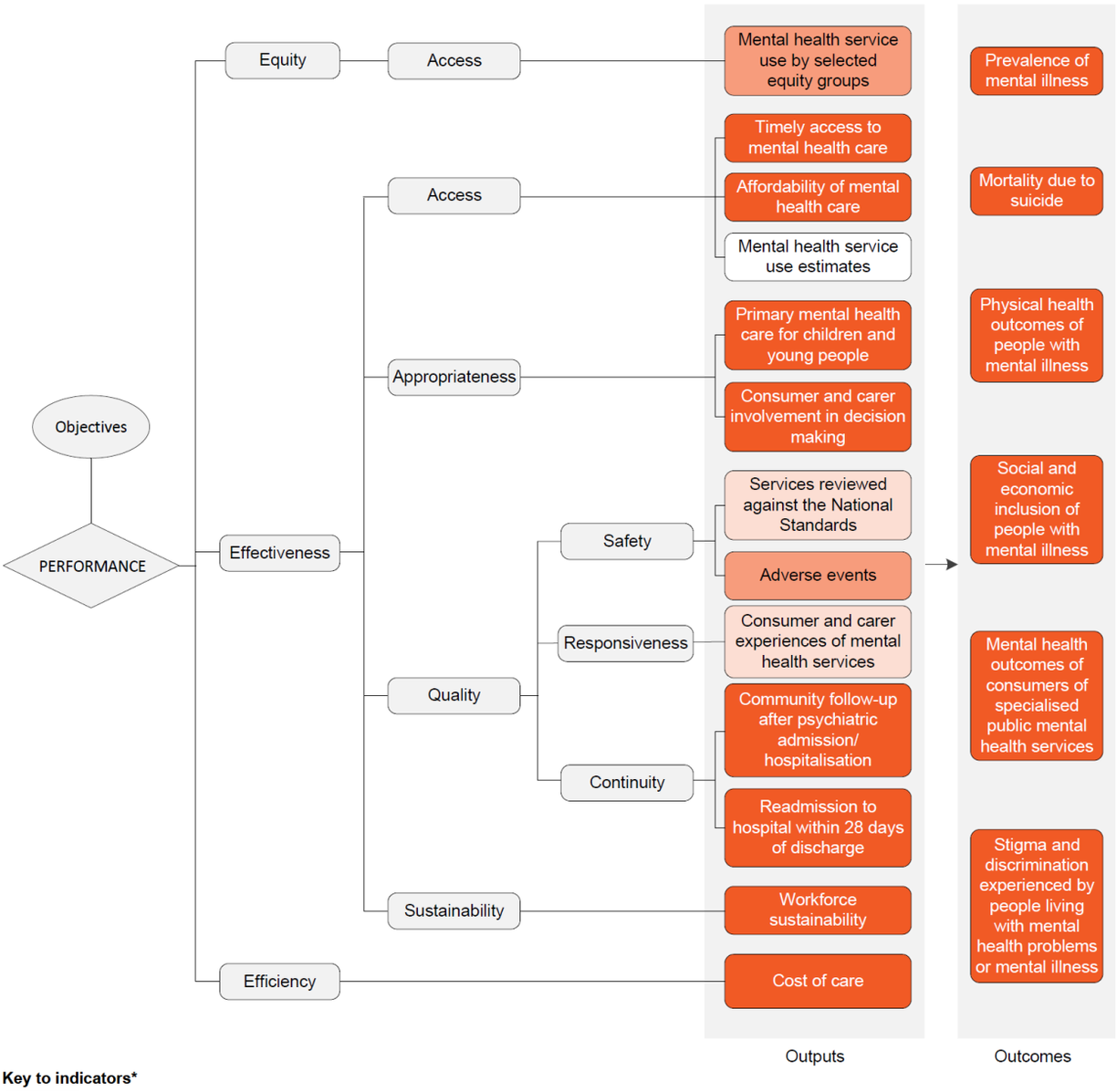
Improvements to performance reporting for services for mental health are ongoing and include identifying data sources to fill gaps in reporting for performance indicators and measures, and improving the comparability and completeness of data.

Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (see section 1). Output information is also critical for equitable, efficient and effective management of government services.

Outcomes

Outcomes are the impact of services on the status of an individual or group (see section 1).



Key to indicators*

Text	Most recent data for all measures is comparable and complete
Text	Most recent data for at least one measure is comparable and complete
Text	Most recent data for all measures is either not comparable and/or not complete
Text	No data reported and/or no measures yet developed

* A description of the comparability and completeness is provided under the Indicator results tab for each measure

Text version of indicator framework

Performance – linked to Objectives

Outputs

Equity – Access

- Mental health service use by selected equity groups – most recent data for at least one measure is comparable and complete

Effectiveness – Access

- Timely access to mental health care – most recent data for all measures is comparable and complete
- Affordability of mental health care – most recent data for at least one measure is comparable and complete
- Mental health service use estimates – no data reported and/or no measures yet developed

Effectiveness – Appropriateness

- Primary mental health care for children and young people – most recent data for all measures is comparable and complete
- Consumer and carer involvement in decision making – most recent data for all measures is comparable and complete

Effectiveness – Quality – Safety

- Services reviewed against the National Standards – most recent data for all measures is either not comparable and/or not complete
- Adverse events – most recent data for at least one measure is comparable and complete

Effectiveness – Quality – Responsiveness

- Consumer and carer experiences of mental health services – most recent data for all measures is either not comparable and/or not complete

Effectiveness – Quality – Continuity

- Community follow-up after psychiatric admission/hospitalisation – most recent data for all measures is comparable and complete
- Readmission to hospital within 28 days of discharge – most recent data for all measures is comparable and complete

Effectiveness – Sustainability

- Workforce sustainability – most recent data for all measures is comparable and complete

Efficiency

- Cost of care – most recent data for all measures is comparable and complete

Outcomes

- Prevalence of mental illness – most recent data for all measures is comparable and complete
- Mortality due to suicide – most recent data for all measures is comparable and complete
- Physical health outcomes of people with mental illness – most recent data for all measures is comparable and complete
- Social and economic inclusion of people with mental illness – most recent data for all measures is comparable and complete

- Mental health outcomes of consumers of specialised public mental health services – most recent data for all measures is comparable and complete
- Stigma and discrimination experienced by people living with mental health problems or mental illness – most recent data for all measures is comparable and complete

A description of the comparability and completeness is provided under the Indicator results tab for each measure.

Indicator results

This section provides an overview of 'Services for mental health' performance indicator results. Different delivery contexts, locations and types of consumers can affect the equity, effectiveness and efficiency of services for mental health.

Information to assist the interpretation of this data can be found with the indicators below and all data (footnotes and data sources) is available for download above as an excel spreadsheet and as a CSV dataset. Data tables are identified by a ‘13A’ prefix (for example, table 13A.1).

Specific data used in figures can be downloaded by clicking in the figure area, navigating to the bottom of the visualisation to the grey toolbar, clicking on the 'Download' icon and selecting 'Data' from the menu. Selecting 'PDF' or 'Powerpoint' from the 'Download' menu will download a static view of the performance indicator results.

1. Mental health service use by selected equity groups

‘Mental health service use by selected equity groups’ is an indicator of governments’ objective to provide services in an equitable manner.

‘Mental health service use by selected equity groups’ is defined by two measures:

- the proportion of the population in a selected equity group using the service, compared to the proportion of the population outside the selected equity group, for each of:
    - state and territory governments’ specialised public mental health services
    - MBS/DVA subsidised mental health services.

The selected equity groups reported are Aboriginal and Torres Strait Islander people, people from outer regional, remote and very remote locations and people residing in low socioeconomic areas (Socio Economic Indexes for Areas (SEIFA) quintiles 1 and 2).

Results for this indicator should be interpreted with caution. Variation in use could be due to variation in access but could also be a result of differences in the prevalence of mental illness. This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

> A higher proportion of the population access MBS/DVA subsidised mental health services than state and territory governments’ specialised public mental health services (table 13A.7). However, the pattern of service use differs across the selected equity groups.

> In 2021-22, for state and territory governments’ specialised public mental health services, a higher proportion of Aboriginal and Torres Strait Islander people accessed these services than non-Indigenous people (figure 13.3a). People residing in lower socioeconomic areas (SEIFA quintiles 1 and 2) had greater use of mental health services compared to people residing in higher socioeconomic areas (SEIFA quintiles 4 and 5), and people in outer regional, remote and very remote areas had greater use of mental health services compared to people in inner regional and major cities.

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2021-22.

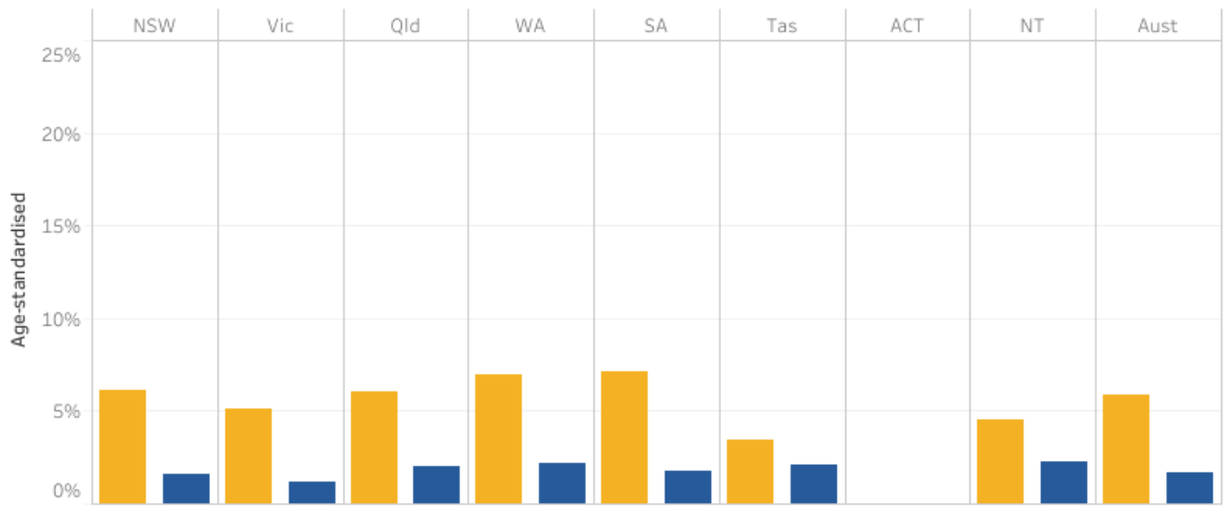
Select year:
2021-22

Select equity group:
- (●) Indigenous status
- ( ) Remoteness area
- ( ) SEIFA of residence

Aboriginal and Torres Strait Islander people

Non-Indigenous people

Figure 13.3a **State and territory governments' specialised Mental health service use**
By jurisdiction, by Indigenous status, 2021-22 (a), (b)



Source: table 13A.16

(a) Refer to data table 13A.15-17 for information on non-publication of data on Indigenous status, remoteness or SEIFA for individual jurisdictions. (b) Data was not available for the ACT for 2021-22. The Australian total does not include ACT.

Nationally in 2022-23, the proportion of people who accessed MBS/DVA services (figure 13.3b) was lower for people in lower socioeconomic areas compared to higher socioeconomic areas (table 13A.15) and lower for people in outer regional, remote and very remote areas compared to people in inner regional and major cities (table 13A.17), although results varied across jurisdictions. The latest year of data on MBS/DVA service use by Indigenous status is 2021-22. Nationally in 2021-22, the proportion of people who accessed MBS/DVA services was equivalent for Aboriginal and Torres Strait Islander people and non-Indigenous people, although results varied across jurisdictions (table 13A.16).

Data is comparable (subject to caveats) across jurisdictions and over time.

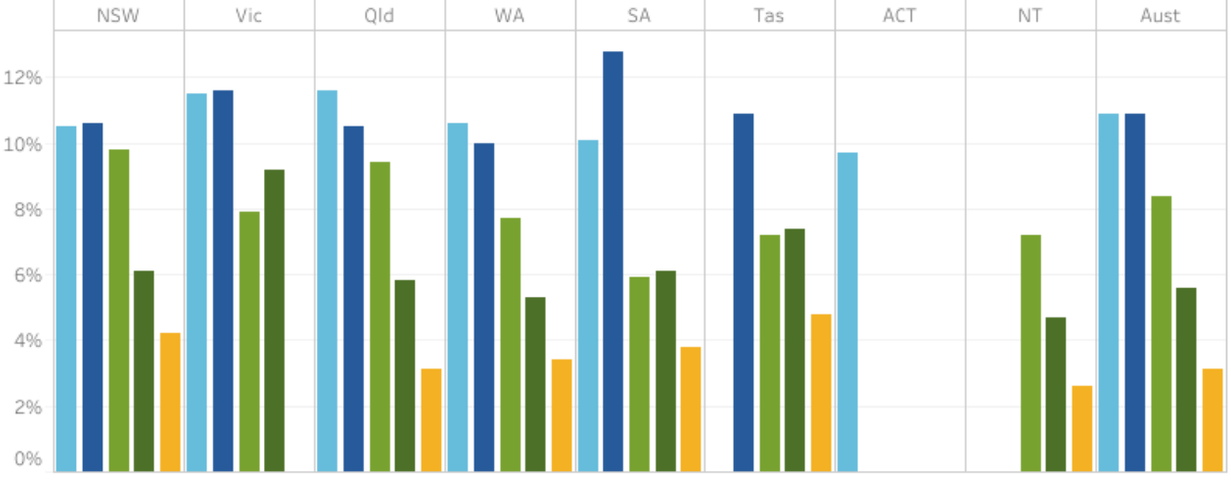
Data is complete (subject to caveats) for the current reporting period. The most recent year of data available by Indigenous status is for 2021-22.

Select year:
2022-23

Select equity group:
Indigenous status
Remoteness area
SEIFA of residence

Major cities
Inner regional
Outer regional
Remote
Very remote

Figure 13.3b **MBS/DVA subsidised mental health service use**
By jurisdiction, by Remoteness area, 2022-23 (a), (b)



Source: table 13A.17

(a) Refer to data table 13A.15-17 for information on non-publication of data on Indigenous status, remoteness or SEIFA for individual jurisdictions. (b) Data by Indigenous status are not available for MBS/DVA subsidised mental health services for the latest year.

Data on the use of private hospital mental health services are available in tables 13A.7 and 13A.15–17.

2. Timely access to mental health care

'Timely access to mental health care' is an indicator of governments' objective to provide services in a timely manner.

'Timely access to mental health care' is defined as the proportion of people who present to an emergency department with a mental health related care need (principal diagnosis of F00–F99) seen within clinically recommended waiting times.

The proportion of people seen within clinically recommended waiting times is defined as the proportion of patients seen within the benchmarks set by the Australasian Triage Scale. The Australasian Triage Scale is a scale for rating clinical urgency, designed for use in hospital-based emergency services in Australia and New Zealand. The benchmarks, set according to triage category, are as follows:

- triage category 1: need for resuscitation – patients seen immediately
- triage category 2: emergency – patients seen within 10 minutes
- triage category 3: urgent – patients seen within 30 minutes

- triage category 4: semi urgent – patients seen within 60 minutes
- triage category 5: non urgent – patients seen within 120 minutes.

High or increasing proportions of patients seen within the recommended waiting times is desirable. Contextual data for all presentations (not just those with a mental health related care need) is reported in section 12.

This is a partial measure for this indicator as emergency departments are only one of many services that provide access to mental health care. Future reporting will focus on timely access to state and territory governments' specialised public mental health services and MBS subsidised services for mental health.

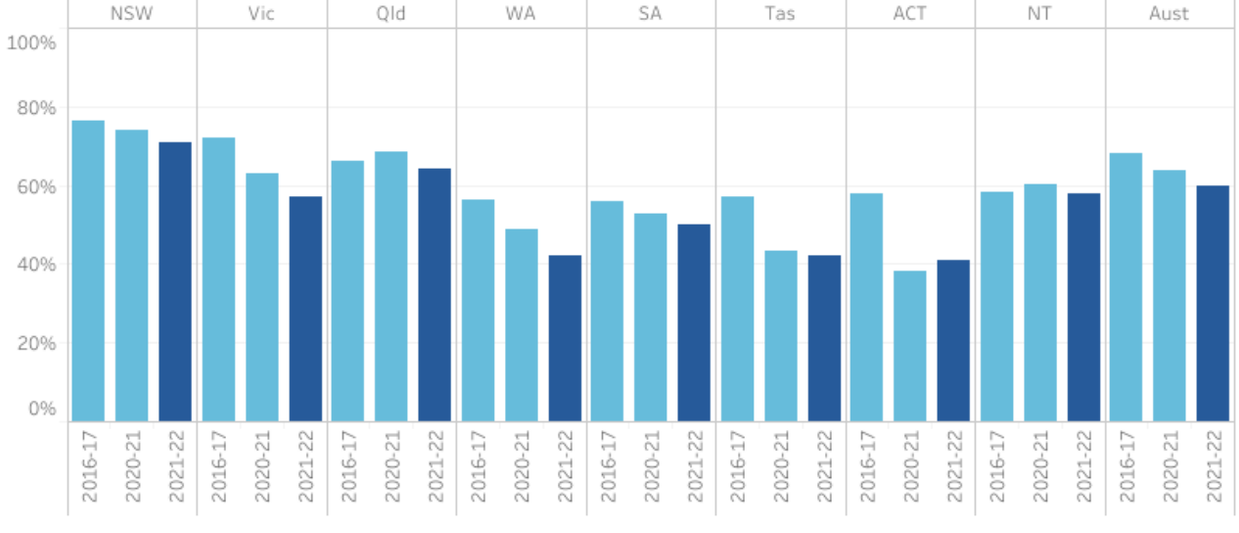
> Nationally in 2021-22, 60.0% of people who presented to an emergency department with a mental health related care need were seen within clinically recommended waiting times (figure 13.4).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 13.4 **Mental health related emergency department presentations seen within clinically recommended waiting times**
By jurisdiction, by year



Source: table 13A.18

3. Affordability of mental health care

'Affordability of mental health care' is an indicator of governments' objective to provide services that are affordable.

‘Affordability of mental health care’ is defined by three measures:

- The proportion of people who delayed seeing or did not see a GP for their mental health due to cost
- The proportion of people who delayed seeing or did not see a psychologist, psychiatrist or other mental health professional for their mental health due to cost
- The proportion of people who delayed filling or did not fill a prescription for their mental health due to cost.

A low or decreasing proportion for each measure is desirable.

Data is not available for measure 3.

> Nationally in 2022-23, 19.3% of all respondents delayed seeing any mental health professional in the last 12 months due to cost, continuing a year on year increase over the available time series (16.7% in 2021-22 and 12.0% in 2020-21). Respondents were more than twice as likely to report delaying mental health care due to cost for psychologists, psychiatrists and other mental health professionals (23.4%) than for GPs (10.4%) (figure 13.5). Survey respondents who self-reported as having a mental health condition were more likely to delay seeking mental health care from providers other than GPs (Psychologists, Psychiatrists and Other mental health professionals) (24.8%) than people who did not self-report having a mental health condition (but who still reported delaying mental health care due to cost) (20.5%).

(measures 1 and 2) Data is comparable (subject to caveats) across jurisdictions and over time.

(measures 1 and 2) Data is complete (subject to caveats) for the current reporting period.

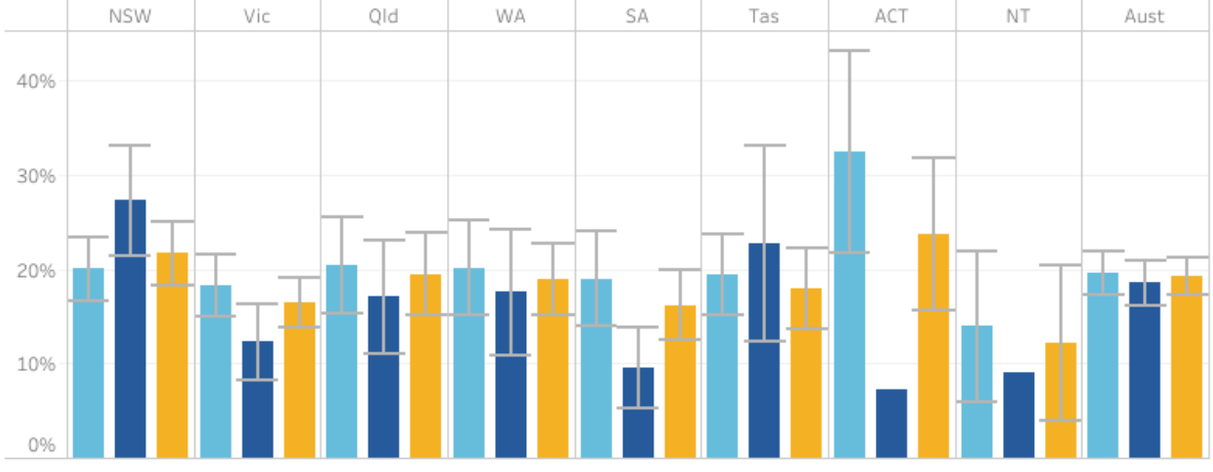
Data is not yet available for Measure 3.

Select year:
2022-23

Mental health status:
People with a mental health condition
People without a mental health condition
All people

Select health professional:
GP
Psychologist
Psychiatrist
Other mental health professional
Total psychologist, psychiatrist or other mental health professional
Total any mental health professional

Figure 13.5 Measures 1 and 2: **People who delayed seeing or did not see a mental health professional at least once in the last 12 months for their mental health due to cost**
By mental health status, by jurisdiction 2022-23 (a), (b)



Source: table 13A.19

(a) Confidence intervals are not available where the proportion has a relative standard error greater than 50%. (b) Refer to data tables for information on the non-publication of data for individual jurisdictions.

tableau

4. Mental health service use estimates

'Mental health service use estimates' is an indicator of governments' objective to provide services that are readily available to those who need them.

'Mental health service use estimates' is defined as the estimated proportion of the population with a mental health condition receiving a mental health service.

A high or increasing proportion of the population with a mental health condition receiving services for mental health suggests greater access to treatment. However, not all people with a mental health condition will want or need treatment. Furthermore, accessing a service does not guarantee that the service will be effective.

An agreed method for reporting against this indicator is not yet available.

5. Primary mental health care for children and young people

‘Primary mental health care for children and young people’ is an indicator of governments’ objective to facilitate early detection of mental health issues and mental illness, followed by appropriate intervention.

‘Primary mental health care for children and young people’ is defined as the proportion of young people aged under 25 years who received an MBS subsidised mental health care service from a GP, psychologist or other allied health professional.

High or increasing proportions of young people who had contact with MBS subsidised primary mental health care services are desirable.

Results for this indicator should be interpreted with caution. Variations in use could be due to variations in access but could also be a result of differences in the prevalence of mental illness. This indicator does not provide information on whether services are appropriate for the needs of young people receiving them, or correctly targeted to young people most in need. Further, some primary mental health services for children and young people are excluded from these data; for example, community health centres, school and university counsellors and nurses and some mental health care provided by state and territory governments’ specialised mental health services (NMHPSC 2011a).

> The proportion of all children and young people who received MBS subsidised primary mental health care services increased over the past 10 years, from 6.5% in 2013-14 to 9.6% in 2022-23. MBS mental health service use increases with age. Nationally, 16.4% of young people aged 18–24 years received MBS subsidised primary health care in 2022-23 (figure 13.6).

MBS telehealth services were introduced in 2019-20. The proportion of people under 25 accessing subsidised primary mental health care consultations via telehealth in 2022-23 was 2.4% compared to 7.2% in person, similar to the proportion in 2019-20 (2.1% of consultation via telehealth compared to 7.4% in person) (13A.20 and figure 13.6).

Proportions of young people accessing MBS subsidised mental health care are higher for females compared to males and higher for young people in major cities and inner regional areas compared to other areas (table 13A.21). Data by Aboriginal and Torres Strait Islander status and service type are available in tables 13A.21–22.

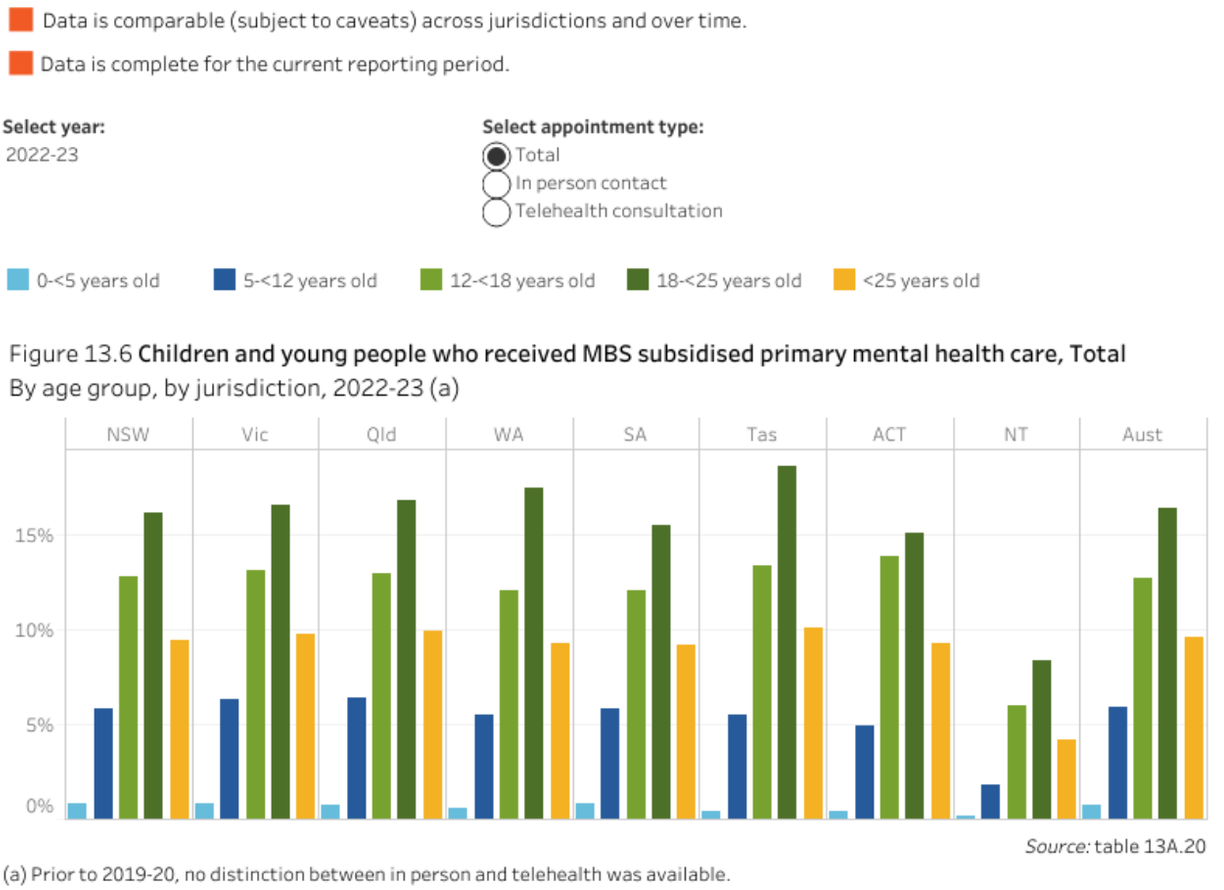


Figure 13.6 **Children and young people who received MBS subsidised primary mental health care, Total**
By age group, by jurisdiction, 2022-23 (a)

Source: table 13A.20

(a) Prior to 2019-20, no distinction between in person and telehealth was available.

6. Consumer and carer involvement in decision making

'Consumer and carer involvement in decision making' is an indicator of governments' objective to provide universal access to services that are responsive to consumer and carer goals.

'Consumer and carer involvement in decision making' is defined by two measures, the number of paid FTE:

- consumer workers per 1,000 FTE direct care staff
- carer workers per 1,000 FTE direct care staff.

High or increasing proportions of paid FTE direct care staff who are consumer or carer workers implies better opportunities for consumers and carers to influence the services received.

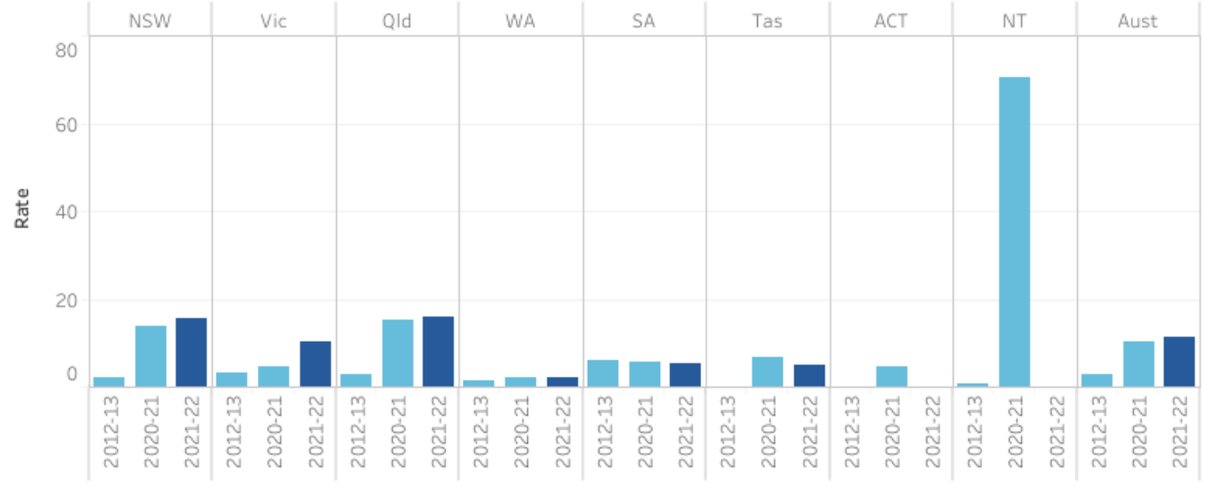
> Nationally in 2021-22 there were 11.3 paid FTE consumer workers per 1,000 paid FTE direct care staff (figure 13.7a)

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2021-22.

Select year(s):
Multiple values

Figure 13.7a Measure 1: **Consumer workers**
Per 1,000 paid FTE direct care staff, by jurisdiction, by year (a),(b)



Source: table 13A.23

(a) Consumer staff could not be separately identified in the ACT for 2013-14 to 2015-16. The Australian total excludes the ACT for these years. The ACT did not employ any consumer workers in 2018-19. The NT did not employ consumer workers prior to 2012-13. Tasmania did not employ consumer workers in 2012-13. (b) Data was not available for the ACT for 2021-22. The Australian total does not include ACT.

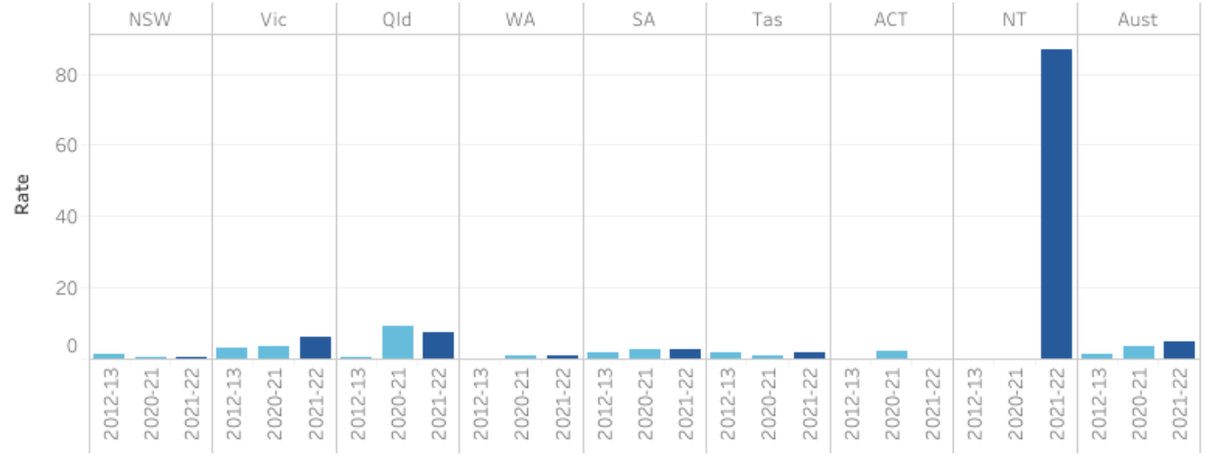
Nationally in 2021-22, there were 5.0 paid FTE carer workers per 1,000 paid FTE direct care staff (figure 13.7b).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2021-22.

Select year(s):
Multiple values

Figure 13.7b Measure 2: **Carer workers**
Per 1,000 paid FTE direct care staff, by jurisdiction, by year (a), (b)



Source: table 13A.23

(a) WA did not employ carer workers in 2013-14 or 2018-19. The NT did not employ carer workers prior to 2014-15 or from 2016-17. Carer workers could not be separately identified in the ACT for 2013-14 to 2015-16 (the Australian total excludes the ACT for these years). The ACT did not employ any carer workers in 2017-18 to 2018-19. (b) Data was not available for the ACT for 2021-22. The Australian total does not include ACT.

7. Services reviewed against the National Standards

'Services reviewed against the National Standards' is an indicator of governments' objective to provide universal access to services that are high quality.

'Services reviewed against the National Standards' is defined as the proportion of expenditure on state and territory governments' specialised public mental health services that had completed a review by an external accreditation agency against the National Standards for Mental Health Services (NSMHS) and met 'all standards' (level 1). The assessment levels are defined in the 'Key terms and references' tab.

A high or increasing proportion of expenditure on specialised mental health services that had completed a review by an external accreditation agency and had been assessed against the NSMHS as level 1 is desirable.

This is a process indicator of quality, reflecting progress made in meeting the NSMHS. It does not provide information on whether the standards or assessment process are appropriate. In addition, services that had not been assessed do not necessarily deliver services of lower quality. Some services that had not completed an external review included those that were undergoing a review and those that had booked for review and were engaged in self-assessment preparation.

> Nationally at 30 June 2022, 93.7% of expenditure on specialised public mental health services was on services that had completed an external review against the NSMHS and met 'all standards' (level 1) (figure 13.8).

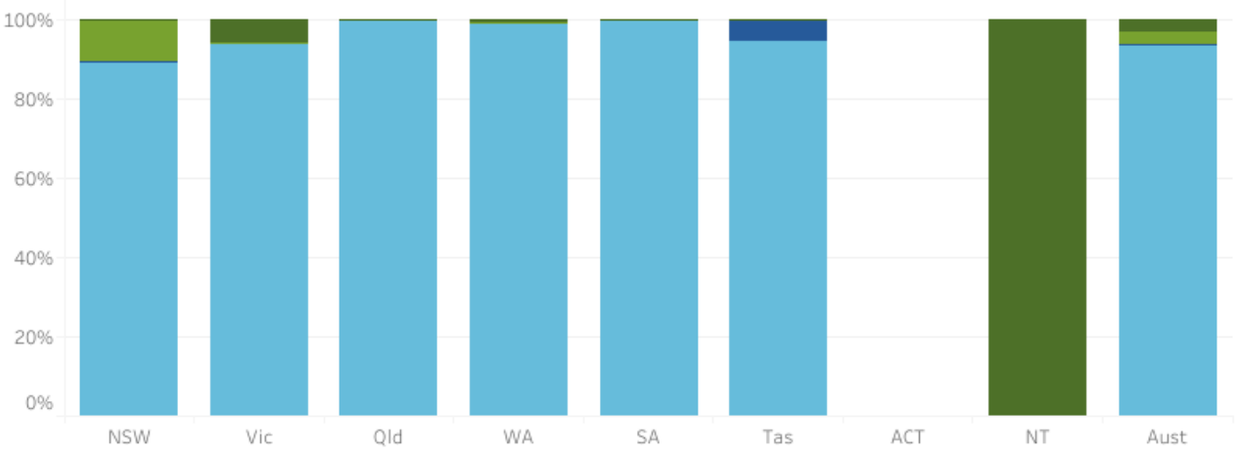
Data is not comparable across jurisdictions, but is comparable (subject to caveats) within jurisdictions over time.

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2022.

Select year:
2022

Level 4
Level 3
Level 2
Level 1

Figure 13.8 **Expenditure on state and territory government specialised public mental health services by level assessed against the National Standards for Mental Health Services (NSMHS)**
By NSMHS level, by jurisdiction, 2022 (a)



Source: table 13A.24

(a) Data was not available for the ACT for 2022. The Australian total does not include ACT.

8. Adverse events

'Adverse events' is an indicator of governments' objective to provide services that promote recovery, and are high quality, safe and responsive to consumer and carer goals.

'Adverse events' is defined by seven measures:

- Measure 1: Restrictive practices:
  - Seclusion, defined as the number of seclusion events per 1,000 bed days in state and territory governments' specialised mental health acute inpatient units
  - Restraint, defined as:
    - the number of mechanical restraint events per 1,000 bed days in state and territory governments' specialised mental health acute inpatient units
    - the number of physical restraint events per 1,000 bed days in state and territory governments' specialised mental health acute inpatient units
    - the number of chemical restraint events. (Measurement of this concept is under development.)

- Measure 2: Suicide in an inpatient facility
    - Suicide in an inpatient facility, defined as suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward, reported as a number, by jurisdiction.

- Measure 3: Self-harm in an in-patient facility
    - Self-harm is defined as deliberately injuring or hurting oneself, with or without the intention of dying. (Measurement of this concept is under development.)

- Measure 4: Assault in an inpatient facility
    - Assault is defined as physical or sexual assault of a patient in an inpatient facility. (Measurement of this concept is under development.)

- Measure 5: Medical errors in an inpatient facility
    - Medical errors are defined as the administration of an incorrect diagnosis, intervention, or medication, or delay in administration resulting in harm or deterioration. (Measurement of this concept is under development.)

- Measure 6: Absent without leave from an inpatient facility
    - Absent without leave is defined as leaving or not returning to an admitted healthcare facility without prior agreement. (Measurement of this concept is under development.)

- Measure 7: Falls in an inpatient facility
    - Falls is defined as a loss of balance resulting in serious harm. (Measurement of this concept is under development.)

Restrictive practices

Seclusion involves confining a person at any time of the day or night alone in a room or area from which he or she cannot leave (the ‘Explanatory material’ tab provides further details on seclusion and ‘seclusion events’). Legislation or mandatory policy governs the use of seclusion in each state and territory and may result in exceptions to the definition of a seclusion event and variations in the data collected across jurisdictions (NMHPSC 2011b).

Supporting data on the duration of seclusion events are provided in table 13A.26. These data, when considered with the rate of seclusion, provide information on the use and management of seclusion across jurisdictions.

A low or decreasing rate of seclusion events combined with shorter average durations is desirable.

Restraint involves restricting a person's freedom of movement by physical or mechanical means. The ‘Explanatory material’ tab provides further details on mechanical and physical restraint.

A low or decreasing rate of restraint events per 1,000 bed days in specialised public mental health inpatient units is desirable.

> Nationally in 2022-23 (excluding the Australian Capital Territory), the rate of seclusion was 5.9 events per 1,000 bed days (figure 13.9a).

For both seclusion and restraint, results varied across target populations. In 2022-23, the lowest seclusion, physical and mechanical restraint rates were in Older people units. Child and adolescent

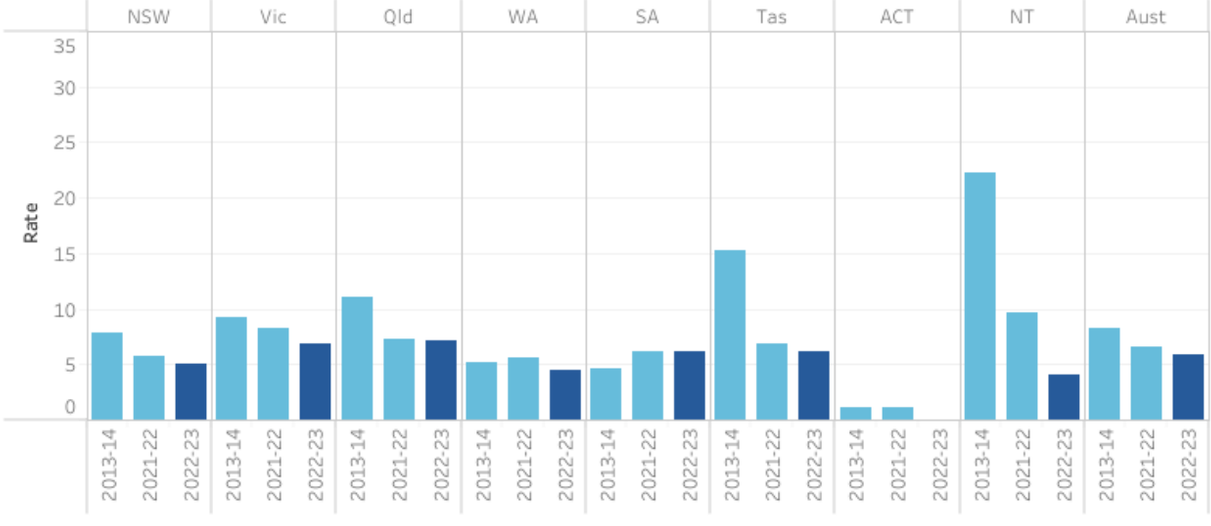
units had the highest rates of seclusion and physical restraint, while forensic units had the highest rate of mechanical restraint (tables 13A.26 and 13A.28).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2022-23.

Select year(s):
Multiple values

Figure 13.9a Measure 1a: **Restrictive practices - Seclusion**
Seclusion events per 1,000 bed days, by jurisdiction, by year (a)



Source: table 13A.25

(a) Data was not available for the ACT for 2022-23. The Australian total does not include ACT.

Nationally in 2022-23 (excluding the Australian Capital Territory), the rate of physical restraint was 9.7 events per 1,000 bed days, and for mechanical restraint was 0.7 events per 1,000 bed days (figure 13.9b and table 13A.27).

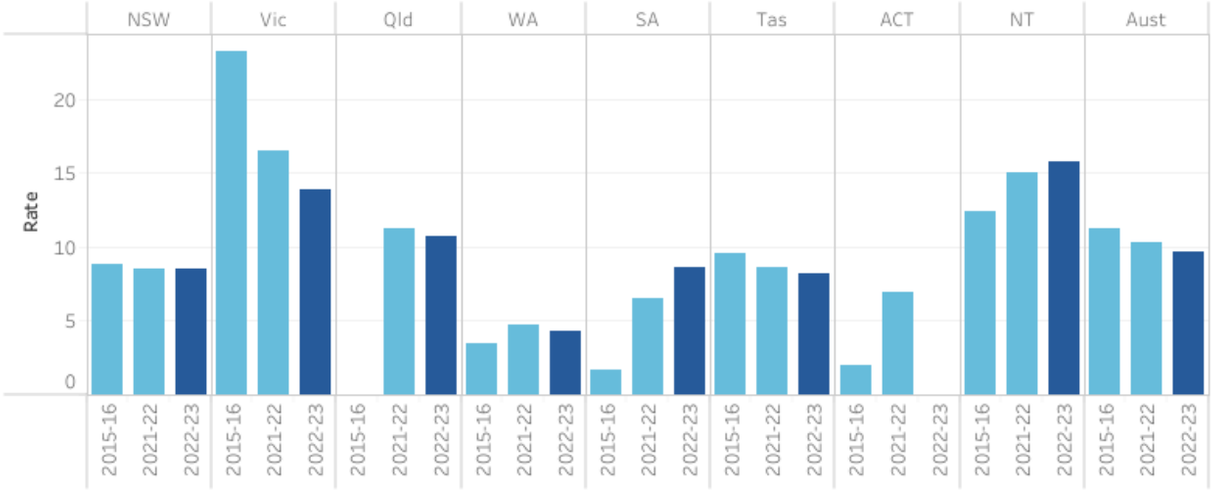
Data is not comparable across jurisdictions or over time.

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2022-23.

Select year(s):
Multiple values

Select restraint type:
(●) Physical restraint
( ) Mechanical restraint

Figure 13.9b Measure 1b: **Restrictive practices - Physical restraint**
Restraint events per 1,000 bed days, by jurisdiction, by year (a), (b)



Source: table 13A.27

(a) Refer to data table 13A.27 for information on non-publication of data on mechanical and physical restraint for individual jurisdictions.
(b) Data was not available for the ACT for 2022-23. The Australian total does not include ACT.

Suicide in an inpatient facility

A suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward is known as a 'sentinel event'. Sentinel events are adverse events that occur because of hospital system and process deficiencies, and which result in the death of, or serious harm to, a patient.

Australian health ministers agreed version 2 of the Australian sentinel events list in December 2018. All jurisdictions implemented these categories on 1 July 2019. 'Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward' is one of ten sentinel events in the Australian sentinel events list. Further details are available in section 12.

A low or decreasing number of suspected suicides of patients in acute psychiatric units or acute psychiatric wards is desirable.

> Nationally in 2021-22, there were 16 suspected suicides in psychiatric inpatient facilities, a decrease on the number of inpatient suicides in 2020-21 (table 13.1 and table 13A.29).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Table 13.1 Measure 2: **Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward**
By jurisdiction, by year

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2021-22	no.	7	4	2	–	2	–	–	1	16
2020-21	no.	4	9	2	3	–	–	–	–	18
2019-20	no.	2	8	3	2	–	–	–	–	15

Source: table 13A.29
– Nil or rounded to zero.

9. Consumer and carer experiences of mental health services

'Consumer and carer experiences of mental health services' is an indicator of governments' objective to provide access to services that are responsive to consumer and carer goals.

'Consumer and carer experiences of mental health services' is defined by two measures:

- the proportion of mental health service consumers reporting positive experiences of mental health services
- the proportion of carers of mental health service consumers reporting positive experiences of mental health services.

A high or increasing proportion of mental health consumers and carers with positive experiences of service is desirable. Data is reported by service delivery setting (residential care, admitted care and ambulatory care – see 'Explanatory material' tab for definitions).

> In 2021-22, for jurisdictions where data is available, a higher proportion of consumers reported positive experiences of service in residential and ambulatory care (non-admitted care) than in admitted care (table 13.2).

(measure 1) Data is not comparable across jurisdictions, but is comparable within jurisdictions over time.

(measure 1) Data is not complete for the current reporting period.

Data is not available for the measure of carers experience (measure 2).

Select year(s):
Multiple values

Table 13.2 **Mental health service consumers reporting positive experiences of mental health services**
By type of service, by jurisdiction, by year (per cent) (a)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Admitted Care	2021-22	69.0	51.0	47.0	na	na	na	na	na	na
	2020-21	71.3	52.5	50.7	na	na	na	na	na	na
	2015-16	67.0	52.6	46.4	na	na	na	na	na	na
Ambulatory Care	2021-22	78.0	70.0	80.0	na	na	na	na	na	na
	2020-21	81.4	74.6	81.8	na	na	na	na	na	na
	2015-16	78.9	69.0	79.5	na	na	na	na	na	na
Residential Care	2021-22	na	80.0	77.0	na	na	na	na	na	na
	2020-21	na	77.5	78.1	na	na	na	na	na	na
	2015-16	..	77.9	..	na	na	na	na	na	na

Source: table 13A.30
na Not available. .. Not applicable.

(a) Victoria did not conduct the survey during 2019–20 due to the COVID-19 pandemic.

10. Community follow-up after psychiatric admission/hospitalisation

'Community follow-up after psychiatric admission/hospitalisation' is an indicator of governments' objective to provide services that are coordinated and provide continuity of care.

'Community follow-up after psychiatric admission/hospitalisation' is defined as the proportion of state and territory governments' specialised public admitted patient overnight acute separations from psychiatric units for which a community-based ambulatory contact was recorded in the seven days following separation.

A high or increasing rate of community follow-up within the first seven days of discharge from hospital is desirable.

This indicator does not measure the frequency of contacts recorded in the seven days following separation. Neither does it distinguish between the mode of contact. Only follow-up contacts made by state and territory governments' specialised public mental health services are included.

> Nationally, the rate of community follow-up for people within the first seven days of discharge from an acute inpatient psychiatric unit was 75.2% in 2021-22, an increase over the 10 years from 2012-13 (60.6%) (figure 13.10).

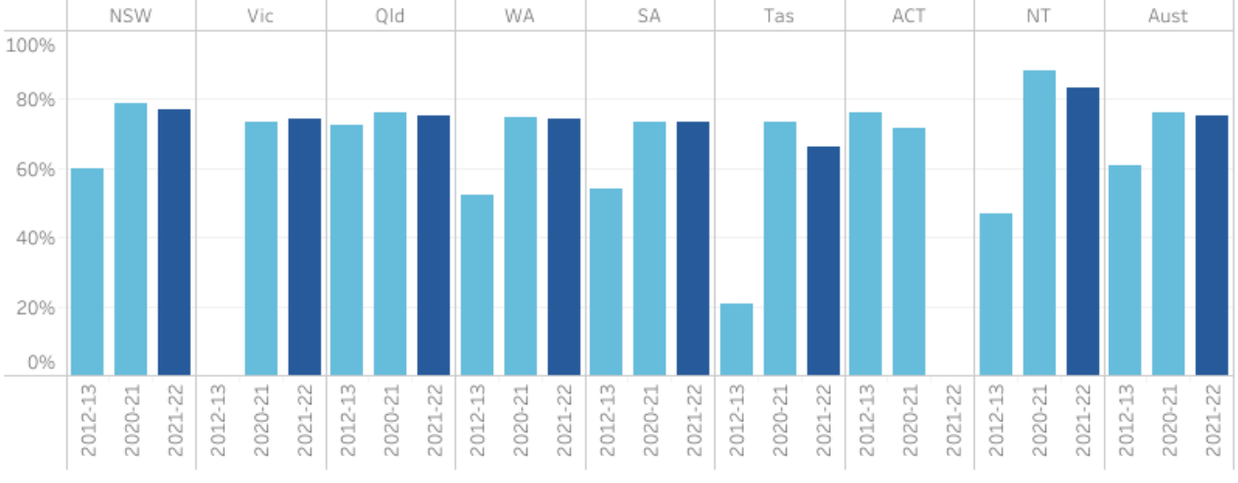
Community follow-up rates by Indigenous status, remoteness areas, SEIFA, age groups and sex are in tables 13A.31-32.

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2021-22.

Select year(s):
Multiple values

Figure 13.10 **Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation**
By jurisdiction, by year (a), (b)



Source: table 13A.33

(a) Data is not available for Victoria prior to 2013-14. (b) Data was not available for the ACT for 2021-22. The Australian total does not include ACT.

11. Readmissions to hospital within 28 days of discharge

'Readmissions to hospital within 28 days of discharge' is an indicator of governments' objective to provide services that are coordinated and provide continuity of care.

'Readmissions to hospital within 28 days of discharge' is defined as the proportion of state and territory governments' admitted patient overnight separations from psychiatric acute inpatient units that were followed by readmission to the same type of unit within 28 days of discharge.

A low or decreasing rate of readmissions to hospital within 28 days of discharge is desirable.

While readmissions can indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate, they can also reflect the cyclic and episodic nature of some illnesses.

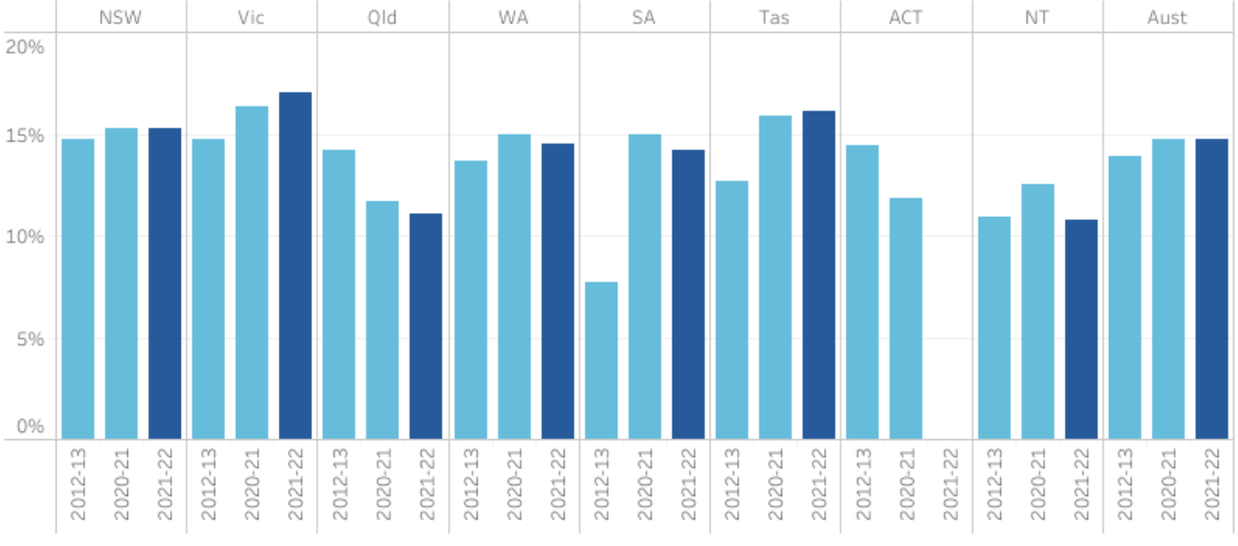
> Nationally in 2021-22, the rate of readmission to hospital acute psychiatric units within 28 days of discharge was 14.7%. The proportion has remained steady since 2018-19 (figure 13.11).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2021-22.

Select year(s):
Multiple values

Figure 13.11 **Readmissions to hospital within 28 days of discharge**
By jurisdiction, by year (a)



Source: table 13A.35

(a) Data was not available for the ACT for 2021-22. The Australian total does not include ACT.

Data by Indigenous status, remoteness areas, SEIFA, age group and sex is in table 13A.34.

12. Workforce sustainability

'Workforce sustainability' is an indicator of governments' objective to provide sustainable services.

'Workforce sustainability' reports age profiles for the mental health workforce. It shows the proportion of full time equivalent (FTE) medical practitioners (including psychiatrists), mental health nurses, registered psychologists and other allied mental health practitioners in ten year age brackets, by jurisdiction.

High or increasing proportions of the workforce that are new entrants and/or low or decreasing proportions of the workforce that are close to retirement are desirable.

Health workforce sustainability relates to the capacity of the health workforce to meet current and projected service demand. These measures are not a substitute for a full workforce analysis that allows for migration, trends in full-time work and expected demand increases. They can, however, indicate that further attention should be given to workforce sustainability for mental health services.

> Nationally in 2022, allied mental health practitioners had the highest proportion of FTEs who were aged less than 30 years, followed by nurses, psychologists and medical practitioners (including psychiatrists). The medical practitioner (including psychiatrist) workforce had the highest proportion of FTEs aged 60 years or over (figure 13.12).

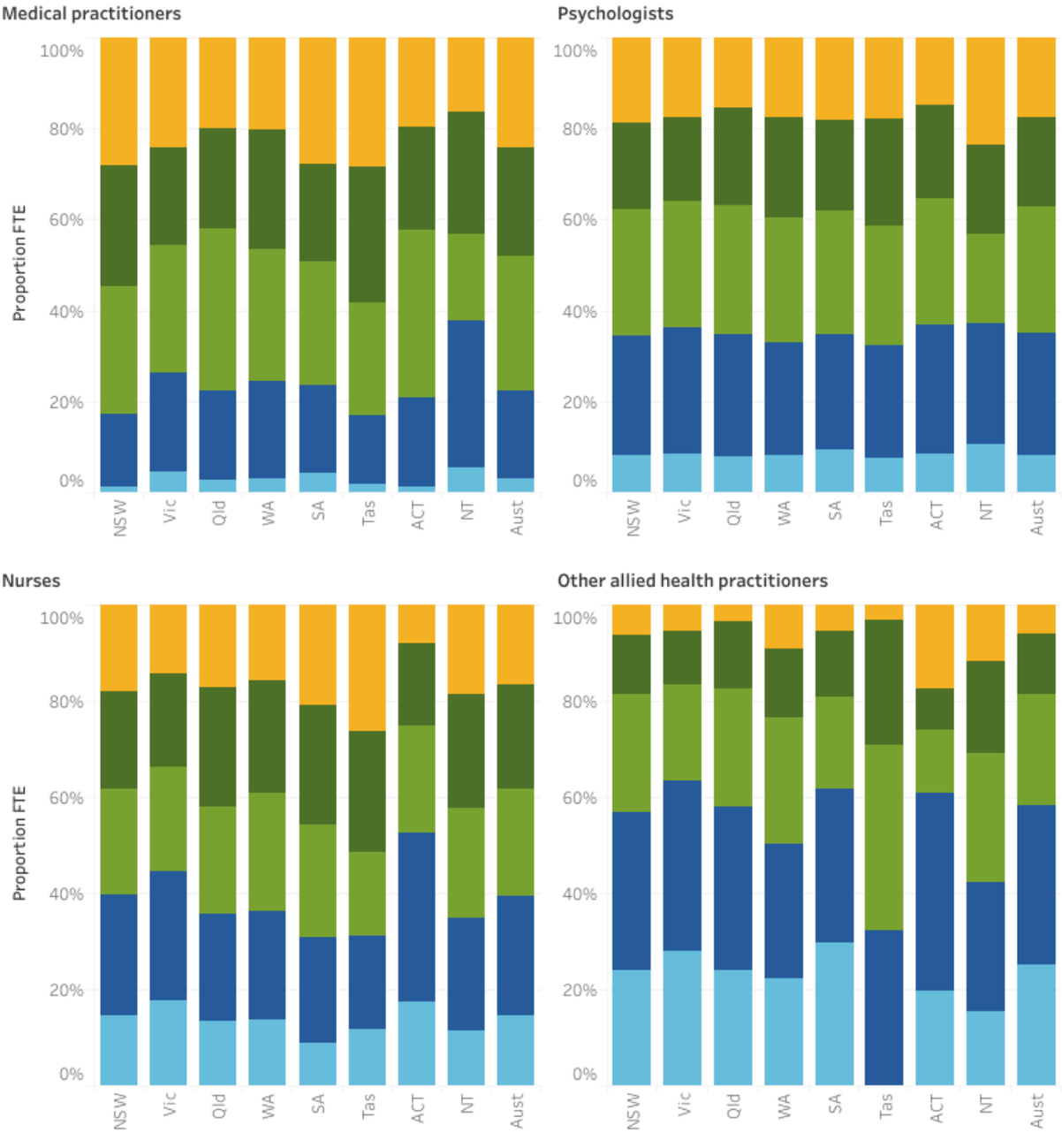
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year:
2022

60+ years old
50-59 years old
40-49 years old
30-39 years old
<30 years old

Figure 13.12 **Mental health workforce**
By age group, by jurisdiction, 2022



Source: table 13A.36

13. Cost of care

‘Cost of care’ is an indicator of governments’ objective to provide services in an efficient manner.

‘Cost of care’ has three measures.

- Measure 1: ‘Cost of inpatient care’, defined by two sub measures:
    - ‘Cost per inpatient bed day’, defined as expenditure on inpatient services divided by the number of inpatient bed days – data is disaggregated by hospital type (psychiatric and general hospitals) and care type (acute and non-acute units) and by inpatient target population (acute units only)
    - ‘Average length of stay’, defined as the number of inpatient patient days divided by the number of separations in the reference period – data is disaggregated by inpatient target population (acute units only). Patient days for consumers who separated in the reference period (2020-21) that were admitted during the previous period (2019-20) are excluded. Patient days for consumers who remain in hospital (and therefore are not included in the separations data) are included. Data for this sub measure are not yet reported.

  These sub measures are considered together for the inpatient acute units by target population to provide a ‘proxy’ measure to improve understanding of service efficiency. Average inpatient bed day costs can be reduced with longer lengths of stay because the costs of admission, discharge and more intensive treatment early in a stay are spread over more days of care. Data for forensic services are included for costs per inpatient bed day only, as the length of stay is dependent on factors outside the control of these services.
- Measure 2: ‘Cost of community-based residential care’ is defined as the average cost per patient day. Data is reported for both the care of general adult and older people services.
- Measure 3: ‘Cost of ambulatory care’ is defined by two sub measures:
    - average cost per treatment day
    - average number of treatment days per episode – this measure is provided, along with average costs, as frequency of servicing is the main driver of variation in care costs.

For each measure, a low or decreasing cost per input is desirable as this might indicate more efficient service delivery. However, efficiency data need to be interpreted with care as they do not provide information on service quality or patient outcomes.

Mainstreaming (that is, providing mental health care in general health care settings rather than psychiatric settings) has occurred at different rates across states and territories, with some jurisdictions treating a greater proportion of consumers with severe mental illnesses in community-based services than other jurisdictions (see ‘Explanatory material’ tab for a definition of mainstreaming). This can create differences across states and territories in the mix of consumers, and therefore the costs, within service types.

Nationally in 2021-22, the average cost per inpatient bed day was higher in acute than non-acute units (figure 13.13a). Older people units have lower costs per inpatient day (table 13A.38) but have considerably longer lengths of stay than general adult or child and adolescent units (table 13A.40). Data on the average cost per inpatient bed day by target population for all care types are reported in tables 13A.38–40.

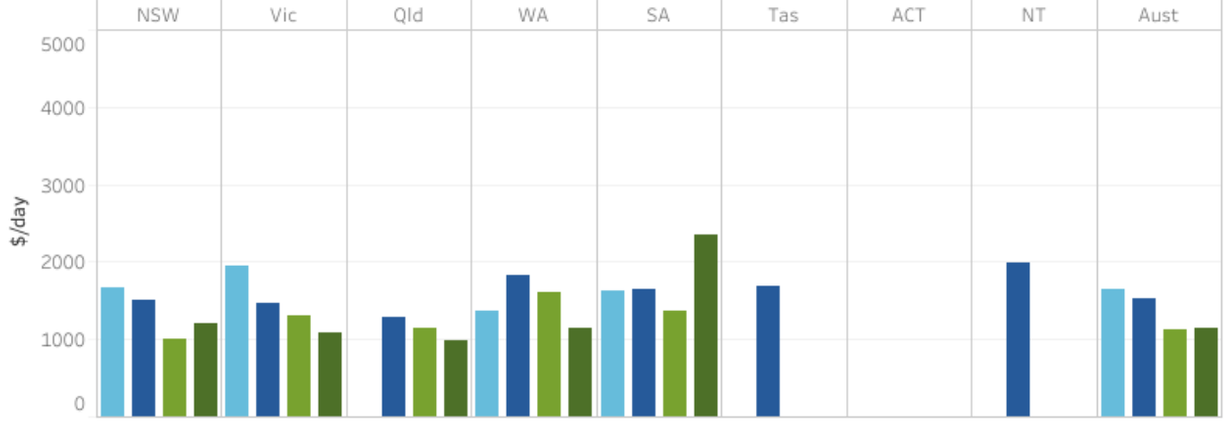
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is not complete for the current reporting period. General acute hospital data for the Australian Capital Territory is not available for 2021-22.

Select year:
2021-22

Psychiatric hospitals (acute units)
General acute hospitals (acute units)
Psychiatric hospitals (non-acute units)
General acute hospitals (non-acute units)

Figure 13.13a Measure 1a: **Average recurrent cost**
Per inpatient bed day, by hospital and care type, by jurisdiction, 2021-22 (2021-22 dollars) (a), (b)



Source: table 13A.37

(a) Queensland does not provide acute services in psychiatric hospitals. Tasmania, the ACT and the NT do not have psychiatric hospitals. SA, Tasmania and the NT do not have non-acute units in general hospitals. The ACT did not have non-acute units in general hospitals prior to 2018-19. (b) General acute hospital data was not available for the ACT for 2021-22. Australian totals do not include ACT.

Nationally in 2021-22, the average cost for 24-hour staffed residential care is higher for general adult units ($760.40 per patient day) compared to older people care units ($693.67 per patient day) (figure 13.13b). Nationally, the average recurrent cost per patient day for general adult units staffed 24 hours a day was over two and a half times the cost of those that were not staffed 24 hours a day (table 13A.41).

Data is comparable (subject to caveats) across jurisdictions and over time.

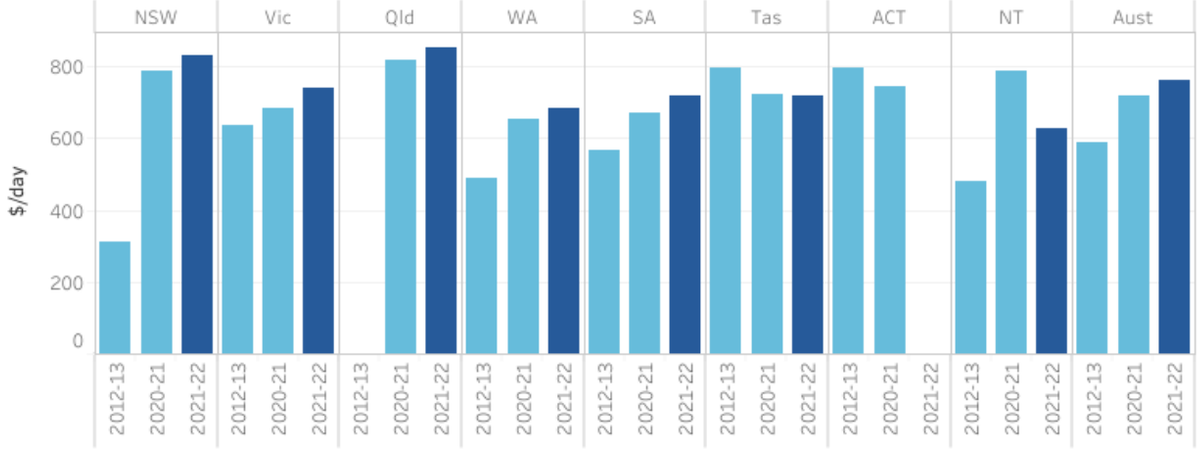
Data is not complete for the current reporting period. General adult unit data for the Australian Capital Territory is not available for 2021-22.

Select year:
Multiple values

Select target population:
(●) General adult units
( ) Older people care units

Select staffing level:
(●) 24-hour staffed units
( ) Non-24-hour staffed units

Figure 13.13b Measure 2: **Cost of community-based residential care** per inpatient bed day, General adult units, 24-hour staffed units, by jurisdiction, by year (a), (b)



Source: table 13A.41

(a) Refer to data table 13A.41 for information on non-publication of data for individual jurisdictions. (b) General adult unit data was not available for the ACT for 2021-22. Australian totals do not include ACT.

Nationally in 2021-22, the average recurrent cost per treatment day of ambulatory care was $408.31 (figure 13.13c), and the average number of treatment days per episode of ambulatory care was 6.6 days (figure 13.13d).

(all measures) Data is comparable (subject to caveats) across jurisdictions and over time.

(measure 3a) Data is not complete for the current reporting period. Average cost per treatment day data for the Australian Capital Territory is not available for 2021-22.

(measure 3b) Data is complete (subject to caveats) for the current reporting period.

Select year(s) (applies to figures 13.13c and 13.13d):
Multiple values

Figure 13.13c **Measure 3a: Average cost per treatment day of ambulatory care**
By jurisdiction, by year (2021-22 dollars) (a), (b)

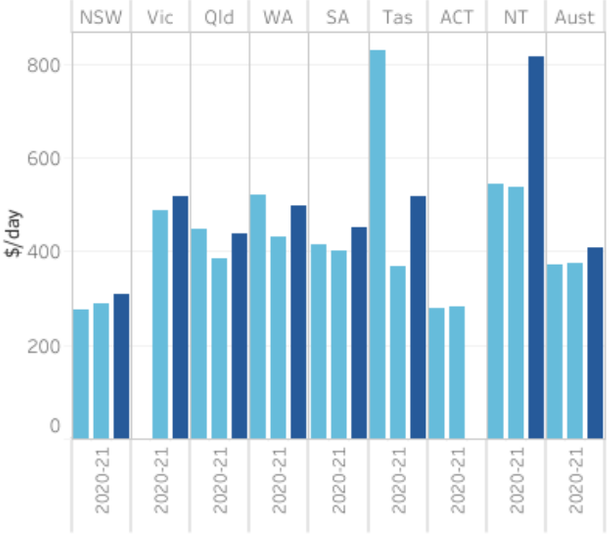
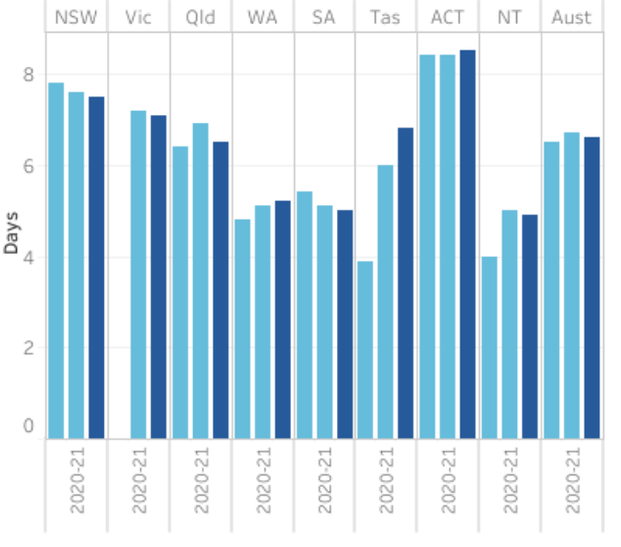


Figure 13.13d **Measure 3b: Average treatment days**
Per episode of ambulatory care, by jurisdiction, by year (a)



Source: table 13A.42

(a) Data is not available for Victoria prior to 2013-14. (b) Average cost per treatment day data was not available for the ACT for 2021-22. The Australian total does not include ACT.

14. Prevalence of mental illness

‘Prevalence of mental illness’ is an indicator of governments’ objective to, where possible, prevent the development of mental health problems, mental illness and suicide.

‘Prevalence of mental illness’ is defined as the proportion of the total population who have a mental illness.

A low or decreasing prevalence of mental illness can indicate that measures to prevent mental illness have been effective.

Many of the risk and protective factors that can affect the development of mental health problems and mental illness are outside the scope of the mental health system. These include environmental, sociocultural and economic factors, some of which can increase the risk of mental illness while others can support good mental health.

Not all mental illnesses are preventable and a reduction in the effect of symptoms and an improved quality of life will be a positive outcome for many people with a mental illness.

Nationally in 2020-2022, more than one in five Australians (21.5%) aged 16 to 85 years reported a mental health disorder with symptoms in the previous 12 months (table 13.3). National data by disorder, age and sex are reported in tables 13A.43–45.

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Table 13.3 **People with 12-month mental disorders among adults aged 16-85 years**
By jurisdiction, by year (a)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2020-2022	%	19.5 ± 1.6	21.4 ± 1.6	23.7 ± 2.0	23.1 ± 2.5	21.6 ± 3.0	19.8 ± 5.7	25.5 ± 7.0	28.8 ± 13.6	21.5 ± 0.8
2007	%	19.7 ± 2.1	19.9 ± 2.3	19.0 ± 2.6	20.8 ± 4.3	18.9 ± 3.4	13.5 ± 4.8	np	np	19.5 ± 1.1

Source: table 13A.43

np Not published.

(a) Percentages reported in these tables include 95% confidence intervals (for example, 80% ± 2.7 percentage points).

The prevalence of mental illness among children and young people aged 4–17 years was an estimated 13.9% in 2013-14 (Lawrence et al. 2015). Attention deficit/hyperactivity disorder (ADHD) was the most common mental illness for this age group (7.4%) followed by anxiety disorders (6.9%) (Lawrence et al 2015).

A proxy measure of the overall mental health and wellbeing of the population is the Kessler 10 (K10) psychological distress scale. Very high levels of psychological distress may signify a need for professional help and provide an estimate of the need for mental health services (ABS 2012).

Nationally in 2017-18, the age standardised proportion of adults with high/very high levels of psychological distress was 13.0% (table 13A.47), and of those 4.0% had very high levels (table 13A.46). Proportions were higher for:

- females compared to males (table 13A.46)
- people with disability compared to people without (tables 13A.47–48)
- people in lower compared to higher socioeconomic areas (tables 13A.47–48)
- Aboriginal and Torres Strait Islander people (2018-19) compared to non-Indigenous people (2017-18) (table 13A.49).

High rates of substance use and abuse can contribute to the onset of, and poor recovery from, mental illness. Information on rates of licit and illicit drug use can be found in tables 13A.50–52 and the National Drug Strategy Household Survey (AIHW 2020).

15. Mortality due to suicide

‘Mortality due to suicide’ is an indicator of governments’ objective to, where possible, prevent the development of mental health problems, mental illness and suicide.

‘Mortality due to suicide’ is defined as the suicide rate per 100,000 people. Deaths from suicide are defined as causes of death with the International Classification of Diseases (ICD) 10 codes X60–X84 and Y87.0.

A low or decreasing suicide rate per 100,000 people is desirable.

While services for mental health contribute to reducing suicides, other services also have a significant role including public mental health programs and suicide prevention programs (addressed through the initiatives of other government agencies, NGOs and other special interest groups).

Many factors outside the control of services for mental health can affect suicide risk. These include environmental, sociocultural and economic risk factors. Often a combination of these factors can increase the risk of suicidal behaviour.

> People with a mental illness are at a higher risk of suicide compared to the general population. For the period 2018–2022, there were 16,193 suicides recorded in Australia – equivalent to 12.4 deaths per 100,000 people (table 13A.53). There were 2.4 deaths per 100,000 people aged 5–17 years in the population, and 27.6 deaths per 100,000 Aboriginal and Torres Strait Islander people in the population (figure 13.14).

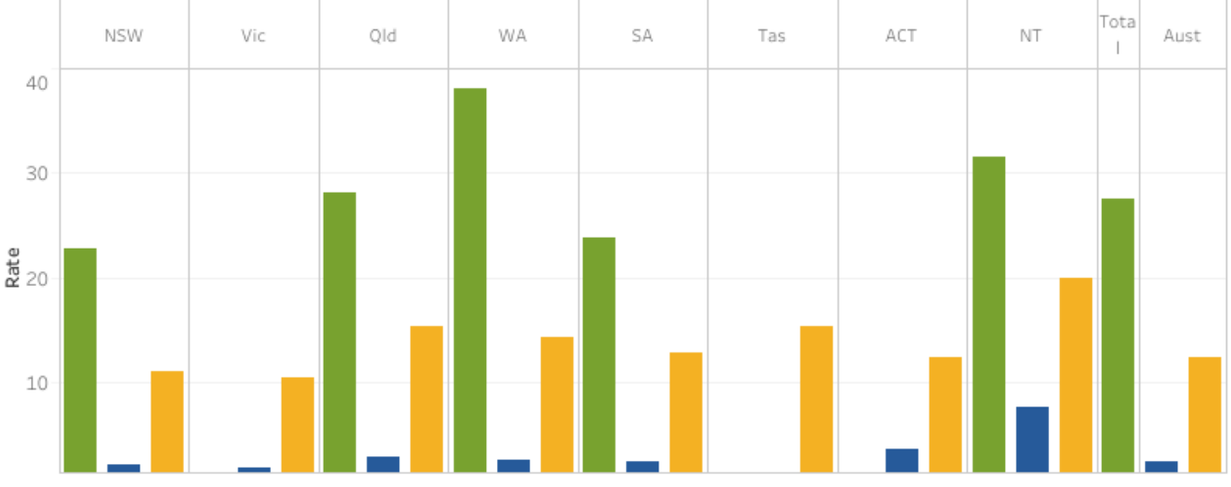
Nationally, suicide rates per 100,000 population for 2022 show that rates are lower for females compared to males (5.9 deaths compared to 18.8 deaths) (ABS 2022), lower in capital cities compared to other areas (10.4 deaths compared to 16.0 deaths) (table 13A.55) and (for 2018–2022) lower for non-Indigenous compared to Aboriginal and Torres Strait Islander people (12.2 deaths compared to 27.6 deaths) (table 13A.56).

Data is comparable (subject to caveats) across jurisdictions and over time for some years and disaggregations, but is not comparable for other years and disaggregations.

Data is complete (subject to caveats) for the current reporting period.

Aboriginal and Torres Strait Islander people
5-17 years old
All people

Figure 13.14 **Mortality due to suicide**
Suicide rate per 100,000 people, by selected equity group, by jurisdiction, 2018-2022 (a)



Source: tables 13A.53, 13A.54, 13A.56

(a) Total includes data for NSW, Queensland, SA, WA and the NT only. Data for Victoria, Tasmania and the ACT has been excluded in line with national reporting guidelines.

16. Physical health outcomes for people with a mental illness

'Physical health outcomes for people with a mental illness' is an indicator of governments' objective to promote recovery and physical health and encourage meaningful participation in society.

'Physical health outcomes for people with a mental illness' is defined as the proportion of adults with a mental illness (compared to those without a mental illness) who experienced a long-term physical health condition: cancer, diabetes, arthritis, cardiovascular disease and asthma.

Low or decreasing proportions of people with a mental illness who experience a long-term physical health condition are desirable.

People with a mental illness have poorer physical health outcomes than people without mental illness (Happell et al. 2015; Lawrence, Hancock and Kisely 2013), but the relationship between the two is complex. Poor physical health can exacerbate mental health problems and poor mental health can lead to poor physical health. In addition, some psychiatric medications prescribed to treat mental health conditions may lead to poorer physical health.

Greater exposure to particular health risk factors can also contribute to poorer physical health. Information on selected risk factors by mental illness status can be found in table 13A.57.

A higher proportion of adults with a mental illness reported having long-term health conditions compared to adults without a mental illness. Nationally in 2022, the age-standardised proportion of people who reported having a long-term health condition was higher for people with a mental illness than people without a mental illness for all reported conditions. For example, almost a quarter of people with a mental illness reported having arthritis (24.7%), compared to 13.4% of people without a mental illness (figure 13.15 and table 13A.58).

Data is comparable (subject to caveats) across jurisdictions and over time.

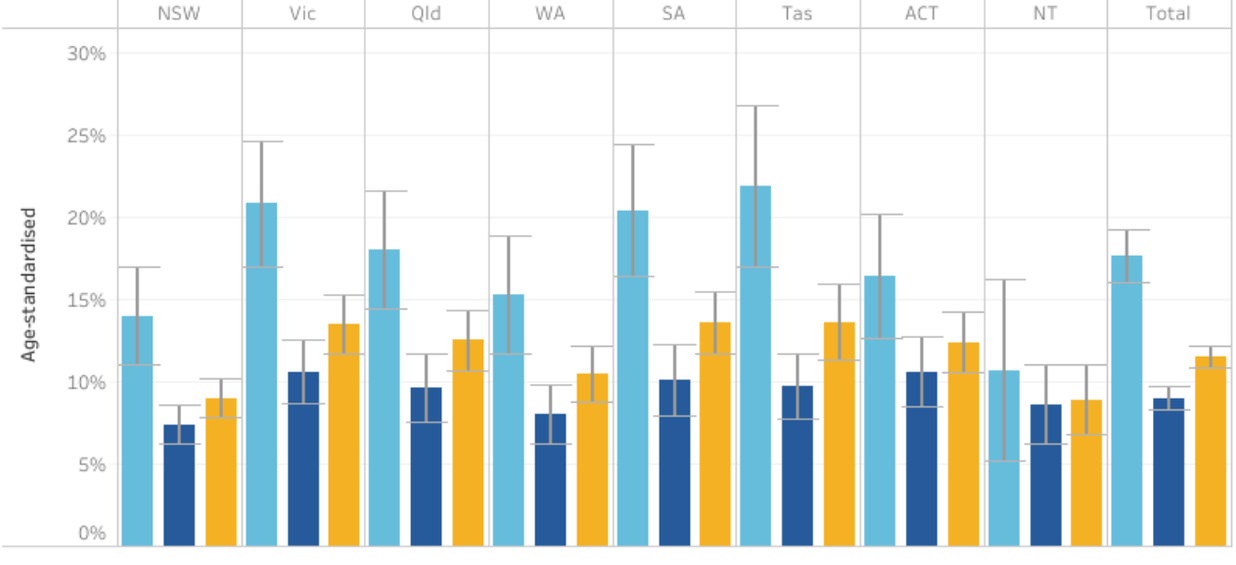
Data is complete (subject to caveats) for the current reporting period.

Select year:
2022

Mental illness status:
People with a mental illness
People without a mental illness
All people

Select condition:
Asthma
Arthritis
At risk of long-term harm from alcohol
Cancer
Cardiovascular disease
Daily smoker
Diabetes
Overweight/obese

Figure 13.15 **Adults with long-term health conditions, Asthma**
By mental illness status, by jurisdiction, 2022 (a)



Source: 13A.58

(a) Data was not published for people with a mental illness with cancer in the ACT (2017-18) and NT (2017-18 and 2014-15).

17. Social and economic inclusion of people with a mental illness

'Social and economic inclusion of people with a mental illness' is an indicator of governments' objective to promote recovery and physical health and encourage meaningful participation in society.

'Social and economic inclusion of people with a mental illness' is defined by two measures:

- the proportion of people aged 16–64 years with a mental illness who are employed

- the proportion of people aged 15 years or over with a mental illness who had face-to-face contact with family or friends living outside the household in the past week.

High or increasing proportions of people with a mental illness who are employed, or who had face-to-face contact with family or friends, are desirable.

This indicator does not provide information on whether the employment, education or social activities were appropriate or meaningful. It also does not provide information on why people who were not employed were not looking for work (for example, those outside the labour force).

Nationally in 2022, the age-standardised proportion of 16–64 year olds with a mental illness who were employed was 72.3% (figure 13.16), a large increase since 2017-18 (63.9%).

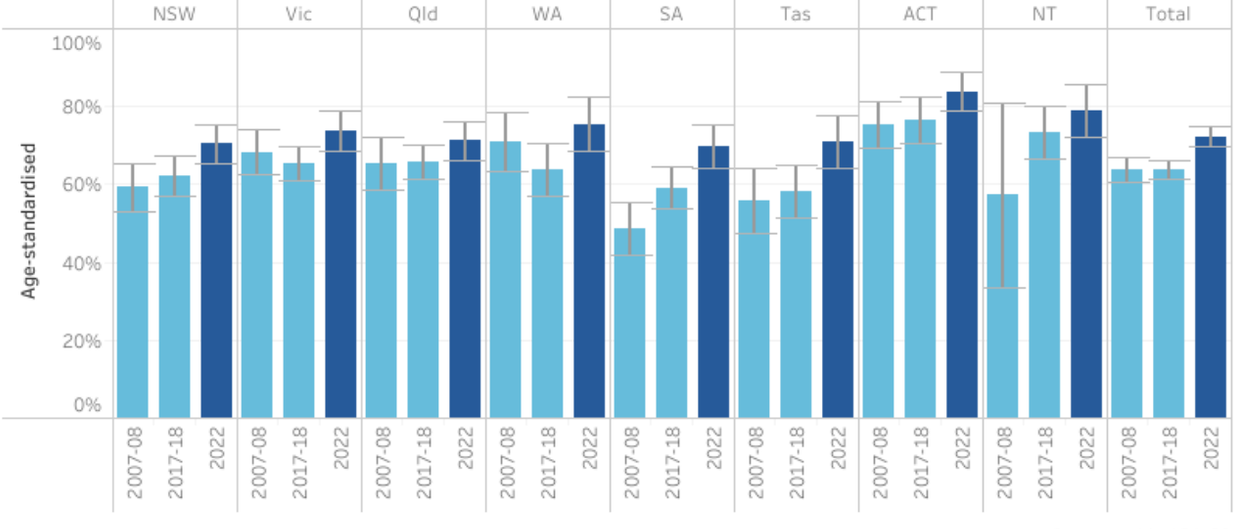
Information on the proportion of people aged 16–30 years with a mental illness who were employed and/or are enrolled for study in a formal secondary or tertiary qualification can be found in table 13A.59.

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Figure 13.16 Measure 1: **People 16-64 years old, with a mental illness who are employed**
By jurisdiction, by year



Source: table 13A.60

Nationally in 2020, the proportion of people aged 15 years or over with a mental illness who had face-to-face contact with family or friends living outside the household in the last week was 40.6% (Table 13.4).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

Table 13.4 Measure 2: **People who had face-to-face contact with family or friends living outside the household in the last week**
By jurisdiction, by year (a)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2020	%	41.9 ± 8.5	33.7 ± 10.3	34.0 ± 11.2	58.1 ± 13.6	39.7 ± 10.8	52.5 ± 8.8	49.4 ± 13.9	64.4 ± 18.4	40.6 ± 4.1
2019	%	np	np	np	np	np	np	np	np	64.0 ± 7.0
2014	%	75.4 ± 7.3	79.0 ± 5.3	72.5 ± 5.2	77.0 ± 6.6	81.7 ± 8.1	78.1 ± 5.2	76.3 ± 5.9	54.8 ± 11.5	76.5 ± 3.1

Source: table 13A.61
np Not published.

(a) Percentages reported in these tables include 95% confidence intervals (for example, 80% ± 2.7 percentage points).

18. Mental health outcomes of consumers of specialised public mental health services

‘Mental health outcomes of consumers of specialised public mental health services’ is an indicator of governments’ objective to promote recovery and physical health and encourage meaningful participation in society.

‘Mental health outcomes of consumers of specialised public mental health services’ is defined as the proportion of people receiving care who had a significant improvement in their clinical mental health outcomes, by service type. The ‘Explanatory material’ tab provides information on how the consumer outcomes average score is derived.

Outcomes are calculated for the following consumer groups:

- Group A: Consumers separated from hospital. People who received a discrete episode of inpatient care within a state/territory designated psychiatric inpatient unit during the reference year. The defining characteristic of the group is that the episode of care commenced, and was completed, within the year.
- Group B: Consumers discharged from community-based ambulatory care. People who received relatively short-term community care from a state or territory mental health service during the reference year. The defining characteristic of the group is that the episode of care commenced, and was completed, within the year.

- Group C: Consumers in ongoing community-based ambulatory care. People receiving relatively long-term community care from a state or territory mental health service. It includes people who were receiving care for the whole of the reference year, and those who commenced community care sometime after 1 July who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June).

A high or increasing proportion of people receiving care in state and territory governments' specialised public mental health services who had a significant improvement in their clinical mental health outcomes is desirable.

Supplementary data is reported on the proportion of people receiving care who experienced no significant change or a significant deterioration in their mental health outcomes. Information on the proportion of episodes for which completed outcomes data is available is in table 13A.64.

This indicator has a number of issues:

- The outcome measurement tool is imprecise as a single 'average score' does not reflect the complex service system in which services are delivered across multiple settings and provided as both discrete, short-term episodes of care and prolonged care over indefinite periods (AHMC 2012).
- The approach separates a consumer's care into segments (hospital versus the community) rather than tracking his or her overall outcome across treatment settings.
- A consumer's outcomes are measured from a clinician's perspective rather than the consumer's.

> Nationally in 2021-22, 71.0% of people discharged from a hospital psychiatric inpatient unit, 49.7% of people discharged from community-based ambulatory care and 27.1% of people in ongoing community-based ambulatory care showed a significant improvement in their clinical mental health outcomes (figure 13.17).

Since 2019-20, young people aged 0–17 who had been discharged from community-based ambulatory care or were in ongoing community-based ambulatory care had higher rates of significant improvement than other age groups, while people aged 65 years and older had the highest rate of significant improvement when discharged from hospital (table 13A.63).

Data is comparable (subject to caveats) across jurisdictions and over time.

Data is complete (subject to caveats) for the current reporting period.

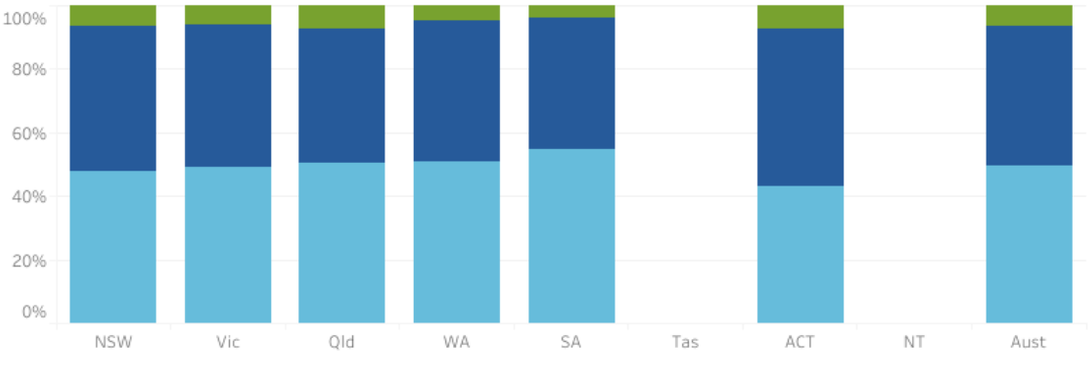
Figure 13.17 **Mental health outcomes of consumers of specialised public mental health services**
By type of mental health care service, by jurisdiction, 2021-22 (a)

Select year:
2021-22

Significant deterioration
No significant change
Significant improvement

Group A: People discharged from hospital

Group B: People discharged from community-based ambulatory care



Group C: People in ongoing community-based ambulatory care

Source: table 13A.64

(a) Data is not published for jurisdictions with small numbers but is included in Australian totals. Refer to data table 13A.65 for information on non-publication of data for individual jurisdictions.

19. Stigma and discrimination experienced by people living with mental health problems or mental illness

'Stigma and discrimination experienced by people living with mental health problems or mental illness' is an indicator of governments' objective to reduce the impact of mental illness (including the effects of stigma and discrimination).

'Stigma and discrimination experienced by people with a mental health condition' is defined by two measures:

- the proportion of people with a mental health condition who have experienced discrimination or been treated unfairly
- the proportion of people with a mental health condition who have experienced discrimination or been treated unfairly because of their mental health condition.

A low or decreasing proportion of people experiencing discrimination or being treated unfairly is desirable.

> In 2020, 20.8% of people with a mental illness reported experiencing discrimination or being treated unfairly (table 13.5). Data is not available on whether the discrimination was perceived to be due to a person's mental illness.

(measure 1) Data is comparable (subject to caveats) across jurisdictions and over time.

(measure 1) Data is complete for the current reporting period. 2019 and 2020 data is only available at the national level.

Data is not yet available for Measure 2.

Table 13.5 Measure 1: **People with a mental health condition who have experienced discrimination or been treated unfairly**
By jurisdiction (a)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2020	%	np	np	np	np	np	np	np	np	20.8 ± 3.9
2019	%	np	np	np	np	np	np	np	np	31.7 ± 7.0
2014	%	29.6 ± 6.5	24.9 ± 6.6	31.7 ± 6.5	36.2 ± 8.3	25.0 ± 5.7	23.7 ± 5.2	29.3 ± 6.8	31.0 ± 9.6	29.1 ± 3.2

Source: table 13A.65
np Not published.
(a) Percentages reported in these tables include 95% confidence intervals (for example, 80% ± 2.7 percentage points).

Indigenous data

Performance indicator data for Aboriginal and Torres Strait Islander people in this section are available in the data tables listed below. Further supporting information can be found in the Indicator results tab and data tables.

Mental health data disaggregated for Aboriginal and Torres Strait Islander people

Table number	Table title
Table 13A.16	Age standardised proportion of people receiving clinical mental health services by service type and Indigenous status
Table 13A.21	Proportion of young people (aged < 25 years) who had contact with MBS subsidised primary mental health care services, by selected characteristics and telehealth status (%)
Table 13A.31	Rates of community follow up within first seven days of discharge from a psychiatric admission, by state and territory, by Indigenous status and remoteness
Table 13A.34	Readmissions to hospital within 28 days of discharge, by selected characteristics
Table 13A.49	Age-standardised rate of adults with high/ very high levels of psychological distress, by state and territory, by Indigenous status
Table 13A.56	Suicide deaths, by Indigenous status

Explanatory material

Key terms

Terms	Definition
Accrued mental health patient days	Mental health patient days are days of admitted patient care provided to admitted patients in psychiatric hospitals, designated psychiatric units and days of residential care provided to residents in residential mental health services. Accrued mental health patient days can also be referred to as occupied bed days in specialised mental health services. The days to be counted are only those days occurring within the reference period, which is from 1 July to the following 30 June for the relevant period, even if the patient/resident was admitted prior to the reference period or discharged after the reference period. The number of accrued mental health patient days are calculated as follows: • for a patient admitted and discharged on different days, all days are counted as mental health care days except the day of discharge and any leave days • admission and discharge on the same day are equal to one patient day • leave days involving an overnight absence are not counted • a patient day is recorded on the day of return from leave.
Admitted care	A specialised mental health service that provides overnight care in a psychiatric hospital or a specialised mental health unit in an acute hospital. Psychiatric hospitals and specialised mental health units in acute hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. These services are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder/illness.
Acute services	Services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short-term treatment. Acute services can: • focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric illness for whom there has been an acute exacerbation of symptoms • target the general population or be specialised in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, youth and forensic mental health services.

Terms	Definition
Affective disorders	Disorders characterised by prolonged and extreme changes in affect or mood, often referred to as mood disorders. Includes depressive episodes, dysthymia and bipolar disorders.
Allied health practitioners	Qualified staff (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, occupational therapists, physiotherapists, Aboriginal and Torres Strait Islander health practitioners, and other diagnostic and health professionals.
Ambulatory care	A specialised mental health service that provides services to people who are not currently admitted to a mental health admitted or residential service. Services are delivered by health professionals with specialist mental health qualifications or training. Ambulatory mental health services include: • community-based crisis assessment and treatment teams; • day programs; • mental health outpatient clinics provided by either hospital or community-based services; • child and adolescent outpatient and community teams; • social and living skills programs; • psychogeriatric assessment services; • hospital-based consultation-liaison and in-reach services to admitted patients in non-psychiatric and hospital emergency settings; • ambulatory-equivalent same day separations; • home based treatment services; and • hospital based outreach services.
Anxiety disorders	Disorders associated with feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder.
Carer staff	A person specifically employed for the expertise developed from their experience as a mental health carer.

Terms	Definition
Child and adolescent services	These services principally target children and young people under the age of 18 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.
Comparability	Data is considered comparable if (subject to caveats) it can be used to inform an assessment of comparative performance. Typically, data is considered comparable when it is collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data.
Completeness	Data is considered complete if all required data is available for all jurisdictions that provide the service.
Consumer staff	A person specifically employed for the expertise developed from their lived experience of mental illness.
Forensic mental health services	Services principally providing assessment, treatment and care of mentally ill people whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained. This includes prison-based services but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.
General mental health services	Services that principally target the general adult population (18–65 years old) but that can provide services to children, adolescents or older people. Includes, therefore, services that cannot be described as specialised child and adolescent services, youth services, services for older people or forensic services. General mental health services include hospital units with a principal function to provide some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on specific clinical disorders within the adult population (for example, postnatal depression, anxiety disorders).
General practice	The organisational structure with one or more general practitioners (GPs) and other staff such as practice nurses. A general practice provides and supervises healthcare for a ‘population’ of patients and may include services for specific populations, such as women’s health or Aboriginal and Torres Strait Islander health.

Terms	Definition
General Practitioners (GPs)	From June 2021, to be recognised as a specialist general practitioner for the purposes of Medicare, medical practitioners must either: hold specialist registration as a general practitioner with the Australian Health Practitioner Regulation Agency (AHPRA); or participate in an approved workforce or training program (commonly known as 3GA programs). To be registered as a specialist general practitioner by AHPRA, general practitioners must hold fellowship of the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM). Medical practitioners who were on the vocational register on 16 June 2021 will maintain their access to general practice items in the Medicare Benefits Schedule.
Health management	The ongoing process beginning with initial consumer contact and including all actions relating to the consumer. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.
Mainstreaming	The First National Mental Health Plan emphasised decreasing the number of psychiatric beds in favour of community-based options, reducing the reliance on stand-alone psychiatric hospitals, and ‘mainstreaming’ the delivery of acute inpatient care into general hospitals.
Medical practitioner	Registered medical practitioners who are employed in medicine in Australia excluding those on extended leave. Medical practitioners must be registered with the Medical Board of Australia (MBA) and meet the MBA’s registration standards.
Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental illness.
Mental illness	A diagnosable illness that significantly interferes with an individual’s cognitive, emotional and/or social abilities.

Terms	Definition
National Standards for Mental Health Services (NSMHS)	Services at level 1 – services reviewed by an external accreditation agency and judged to have met all National Standards. Services at level 2 – services reviewed by an external accreditation agency and judged to have met some but not all National Standards. Services at level 3 – services (i) in the process of being reviewed by an external accreditation agency but the outcomes are not known, or (ii) booked for review by an external accreditation agency. Services at level 4 – services that do not meet criteria detailed under levels 1 to 3 (AHMC 2010).
Non-acute services	Non-acute services are defined by two categories: • Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to midterm. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. • Extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which can include high levels of severe unremitting symptoms of mental illness. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.
Non-government organisations (NGOs)	Private not-for-profit community managed organisations that receive government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the NGO sector can include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.

Terms	Definition
Nurses	Registered and enrolled nurses who are employed in nursing in Australia, excluding those on extended leave. Registered nurses: people with at least a three-year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. Enrolled nurses: refers to people who are second level nurses who are enrolled in all states except Victoria where they are registered by the State registration board to practise in this capacity. Mental health nurses have specified that their principal area of work is mental health.
Older people mental health services	Services principally targeting people in the age group 65 years or over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged people. These services can include a forensic component. Excludes general mental health services that may treat older people as part of a more general service.
Outcomes measurement – calculating the consumers 'score'.	The assessment of a consumer's clinical mental health outcomes is based on the changes reported in a consumer's 'score' on a rating scale known as the Health of the Nation Outcomes Scale (HoNOS), or for children and adolescents, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Outcome scores are classified based on effect size – a statistic used to assess the magnitude of a treatment effect (AHMC 2012). The effect size is based on the ratio of the difference between the pre and post scores to the standard deviation of the pre score. Individual episodes are classified as 'significant improvement' if the effect size index is greater than or equal to positive 0.5; 'no change' if the index is between 0.5 and -0.5; and 'significant deterioration' if the effect size index is less than or equal to -0.5 (AHMC 2012).
Outpatient services – community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. They can include outreach or domiciliary care as an adjunct to services provided from the centre base.
Outpatient services – hospital based	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. They can include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

Terms	Definition
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of illnesses.
Psychiatric hospitals	Health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand-alone' category regardless of whether they are under the management control of a general hospital. A health establishment that operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus can also be a stand-alone hospitals if the following criteria are not met: • a single organisational or management structure covers the acute care hospital and the psychiatric hospital • a single employer covers the staff of the acute care hospital and the psychiatric hospital • the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus • the patients of the psychiatric hospital are regarded as patients of the single integrated health service.
Psychiatrist	A qualified medical practitioner with 5 years of specialist training in psychiatry. Psychiatrists and consultant psychiatrists are medical officers registered to practice psychiatry under the relevant State or Territory medical registration board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with the Health Insurance Commission as a specialist in Psychiatry. Psychiatry registrars and trainees are medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.
Psychologists	People who are registered as psychologists with the relevant State or Territory registration board after completing a 4-year accredited sequence of study followed by an approved 2-year supervised practice program.

Terms	Definition
Public health	The organised, social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.
Public (non-psychiatric) hospital	A hospital that provides free treatment, around the clock care and accommodation to eligible admitted persons who elect to be treated as public patients. It also provides free services to eligible non-admitted patients and can provide (and charge for) treatment and accommodation services to private patients.
Residential care	Settings that provide specialised treatment, rehabilitation or care on an overnight basis in a domestic-like environment for people affected by a mental illness or psychiatric disability. Services can be community based or specialised. To be defined as community-based residences, services must employ onsite staff for at least some part of the day. Specialised services are staffed by mental health professionals on a 24-hour or non-24-hour basis.

Terms	Definition
Restraint	**Mechanical restraint** The application of devices (including belts, harnesses, manacles, sheets and straps) on a person's body to restrict his or her movement. This is to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment. It does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's capacity to get off the furniture except where the devices are used solely for the purpose of restraining a person's freedom of movement. The use of a medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint. **Physical restraint** The application by health care staff of hands-on immobilisation or the physical restriction of a person to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment. **Chemical restraint** Medication given primarily to control a person's movements or behaviour, rather than to treat a mental illness or physical condition. Chemical restraint may involve the administration of higher than usual doses of a person's regular medication; or the administration of psychotropic medication (alone or in combination) to a person who does not have a diagnosed mental illness. Appropriate use of medications to reduce or manage symptoms of diagnosed anxiety, depression or psychosis is not chemical restraint. Some medications that are used to reduce symptoms of physical conditions or medically identified major mental illnesses have side effects. This may include sedating the person to whom they are given.
Seclusion	Seclusion is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. The intended purpose of the confinement is not relevant in determining what is or is not seclusion. Seclusion applies even if the consumer agrees or requests the confinement (NMHPSC 2011b). The awareness of the consumer that they are confined alone and denied exit is not relevant in determining what is or is not seclusion. The structure and dimensions of the area to which the consumer is confined is not relevant in determining what is or is not seclusion. The area may be an open area, for example, a courtyard. Seclusion does not include confinement of consumers to High Dependency sections of gazetted mental health units, unless it meets the definition (AIHW 2015).
Seclusion event	An event is when a consumer enters seclusion and when there is a clinical decision to cease seclusion. Following the clinical decision to cease seclusion, if a consumer re-enters seclusion within a short period of time this would be considered a new seclusion event. The term 'seclusion event' is utilised to differentiate it from the different definitions of 'seclusion episode' used across jurisdictions (NMHPSC 2011b).

Terms	Definition
Separation	A total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change in the type of care for an admitted patient (for example, acute to rehabilitation). Includes admitted patients who receive same day procedures.
Specialised mental health inpatient services	Services provided to admitted patients in stand-alone psychiatric hospitals or specialised psychiatric units located within general hospitals.
Specialised mental health services	Services whose primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental illness or psychiatric disability. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function. This criterion applies regardless of the source of funds.
Substance use disorders	Disorders that involve harmful use and/or dependence on alcohol and/or drugs to such an extent that social and occupational functioning is impaired and control becomes impossible. Reliance can be psychological (as in substance misuse) or physiological (as in substance dependence).
Youth mental health services	Services principally targeting children and young people generally aged 16-24 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

References

ABS (Australian Bureau of Statistics) 2022, *Health: 2021 Census, Information on long-term health conditions,* https://www.abs.gov.au/statistics/health/health-conditions-and-risks/health-census/2021 (accessed 16 October 2022).

—— 2023, *Causes of Death, Australia, 2022,* https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2022 (accessed 29 September 2023).

—— 2012, *Information Paper: Use of the Kessler Psychological Distress Scale in ABS Health Surveys, Australia, 2007-08,* Cat. no. 4817.0.55.001, Canberra.

Australian Health Ministers 1991, *Mental Health Statement of Rights and Responsibilities,* Australian Government Publishing Service, Canberra.

AHMC (Australian Health Ministers' Conference) 2010, *National Standards for Mental Health Services 2010,* Canberra.

—— 2012, *Council of Australian Governments National Action Plan for Mental Health 2006–2011: Progress Report 2009-10,* Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council.

AIHW (Australian Institute of Health and Welfare) 2023, *Mental Health,* https://www.aihw.gov.au/mental-health/topic-areas/summary (accessed 12 October 2023).

—— 2020, *National Drug Strategy Household Survey detailed report 2019,* Drug statistics series no. 32, Cat. no. PHE 270, Canberra.

—— 2015, *Seclusion,* Meteor Metadata Online Registry, http://meteor.aihw.gov.au/content/index.phtml/itemId/557975 (accessed 18 December 2017).

COAG (Council of Australian Governments) 2017, *The Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan),* https://apo.org.au/system/files/114356/apo-nid114356-451131.pdf (accessed 18 October 2018).

DoH (Department of Health) 2014, *National mental health strategy,* https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-strat (accessed 17 December 2019).

—— 2009, *National mental health policy 2008,* https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-pol08 (accessed 16 October 2019).

DHAC (Australian Government Department of Health and Community Services) and AIHW 1999, *National Health Priority Areas Report: Mental Health 1998,* AIHW Cat. no. PHE 13, Canberra.

Happell, B., Platania Phung, C., Webster, S., McKenna, B., Millar, F., Stanton, R., Galletly, C., Castle, D., Furness, T., Liu, D. and Scott, D 2015, *'Applying the World Health Organization Mental Health Action Plan to evaluate policy on addressing co-occurrence of physical and mental illnesses in Australia',* Australian Health Review, Vol. 39, pp. 370–378, CSIRO Publishing (available at http://dx.doi.org/10.1071/AH14098).

Lawrence, D., Hancock, K. and Kisely S. 2013, *'The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers',* British Medical Journal, Vol. 346.

Lawrence, D., Johnson, S., Hafekost, J., Boterhoven, K., Sawyer, M., Ainley, J., Zubrick, S. 2015, *The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing,* Department of Health, Canberra.

NDIA (National Disability Insurance Agency) 2023, *Public Data Sharing platform (NDIS Public Data),* https://data.ndis.gov.au/explore-data (accessed 3 October 2023).

NMHPSC (National Mental Health Performance Subcommittee) 2011a, *The Fourth National Mental Health Plan Measurement Strategy 2011,* Report produced for the Australian Health Ministers Advisory Council Mental Health Standing Committee, https://www.aihw.gov.au/getmedia/d8e52c84-a53f-4eef-a7e6-f81a5af94764/Fourth-national-mental-health-plan-measurement-strategy-2011.pdf.aspx (accessed 17 December 2019).

—— 2011b, *Key performance indicators for Australian public mental health services: second edition 2011,* Report produced for the Australian Health Ministers Advisory Council Mental Health Standing Committee, https://www.aihw.gov.au/getmedia/3c6614bb-87fd-4328-b276-f69542082a7c/Key-performance-indicators-for-Australian-public-mental-health-services-second-edition-2011.pdf.aspx (accessed 17 December 2019).

RACGP (Royal Australian College of General Practitioners) 2023, *General Practice: Health of the Nation 2023,* East Melbourne, Victoria, https://www.racgp.org.au/getmedia/80c8bdc9-8886-4055-8a8d-ea793b088e5a/Health-of-the-Nation.pdf.aspx (accessed 15 November 2023).

WHO (World Health Organization) 2001, *Strengthening mental health promotion,* Fact sheet no. 220, Geneva.