About

Use of non-hospital Medicare-subsidised services, such as GP, allied health, specialist, diagnostic imaging, and nursing and Aboriginal health workers, continues to vary considerably depending on where a person lives in Australia. In 2018–19, 88% of Australians saw a GP, an increase from 86% in 2013–14. People living in metropolitan Primary Health Network (PHN) areas were more likely to visit their GP after-hours than people from regional areas, whilst the converse was true for the use of GP services targeting chronic disease and complex care coordination and management.

Cat. no: PHC 4

Findings from this report:

- After-hours GP service use was higher in metropolitan PHN areas (28% of people) than regional areas (15%) in 2018–19
- Allied health use ranged from 25% of people (Northern Territory PHN area) to 43% (North Coast NSW) in 2018–19
- 30% of Australians had an optometry service in 2018–19, a small increase from 27% in 2013–14
- The number of specialist attendances per person increased by 6% between 2013–14 and 2018–19

Australian Government
Australian Institute of Health and Welfare

Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19

Web report | Last updated: **01 Oct 2020** | Topic: Primary health care

Introduction

Medicare-subsidised services provided in non-hospital settings enable eligible Australians to use a wide range of general practice, diagnostic, allied health, specialist, and nursing and Aboriginal health worker services at no or partial cost. This report provides the latest 2018–19 non-hospital Medicare-subsidised service use data, exploring trends in the use of these services.

There was growth in Medicare-subsidised service use between 2013–14 and 2018–19, for people who had a:

- GP attendance, from 86% (20 million Australians) to 88% (21.9 million)
- Diagnostic imaging service, such as an X-ray, from 37% (8.5 million people) to 39% (9.6 million)
- Allied health service, from 32% (7.4 million people) to 37% (9.4 million)
- Specialist attendance, from 30% (6.8 million people) to 31% (7.8 million)
- Service provided by a nurse or Aboriginal health worker, from 3.1% (725,000 people) to 7.1% (1.8 million).

Interestingly, while there was an increase in the proportion of people using after-hours GP services from 20% in 2013–14 to 24% in 2017–18, there was a slight decrease between 2017–18 and 2018–19 (23%).

These time series local area data between 2013–14 and 2018–19 confirm that use of non-hospital Medicare-subsidised services varies considerably depending on where people live.

The Technical Information and Technical Note sections of this report provide details about the data source, scope, limitations and measures included. Refer to Using non-hospital Medicare services for the potential use of this report to support decision-making.

In this report, GP attendances, allied health attendances and specialist attendances are also referred to as GP services, allied health services and specialist services, respectively.

The key findings in this report are not age standardised. See Data for age standardised services per 100 people for GP attendances, Specialist attendances, Diagnostic Imaging, Allied Health and GP After-hours.

In response to the COVID-19 pandemic, the Australian Government introduced a range of Medicare-subsidised telehealth services from March 2020. The findings in this report precede the introduction of these new telehealth services.

GP attendances

GP attendances

A growing number of Australians saw a GP

In 2018–19, 88% of Australians, or 21.9 million people, visited a GP. Between 2013–14 and 2018–19, there was a relative increase in the percentage of the population using GP services (1.6%), in the number of services per 100 people (9.2%), and in the Medicare benefits paid for GP services (18%) (Table 1).

Table 1: Change in use of Medicare-subsidised GP attendances, 2013–14 and 2018–19

Measure	2013-14	2018-19	Relative % change in rate since 2013-14[(a)]
Percentage of people[(b)] who had a GP attendance	86%	88%	1.6 ▲
Number of GP attendances per 100 people[(b)]	578 per 100 people	632 per 100 people	9.2 ▲
Total Medicare benefits paid for GP attendances per 100 people[(b)(c)(d)]	$27,300 per 100 people	$32,158 per 100 people	17.8 ▲

Notes:

(a) Discrepancies may be due to rounding of numbers.

(b) The numerator is the number of people who had a GP attendance and the denominator is the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP).

(c) Does not include government expenditure on bulk-billing incentives for non-referred attendances. In 2018–19, this amounted to $653 million, or $2,613 per 100 people (Services Australia, 2020). See Technical Note for further details.

(d) Expenditure results are not adjusted for inflation.

Sources: AIHW analysis of Department of Health, Medicare Benefits Schedule (MBS) claims data; ABS ERP.

GP visits continue to vary depending on where people live

The percentage of people who visited a GP in 2018–19 ranged from 76% of people living in the Northern Territory PHN area to 94% in the South Western Sydney PHN area. This pattern remains unchanged since 2013–14, with the Northern Territory PHN area having the lowest percentage of people visiting a GP (72%) and the South Western Sydney PHN area having the highest percentage (94%) (Figure 1). This variation may be due to a range of factors, see Interpreting the data for more details.

Figure 1: Percentage of people who had a Medicare-subsidised GP attendance, by Primary Health Network (PHN) area, 2013-14 and 2018-19

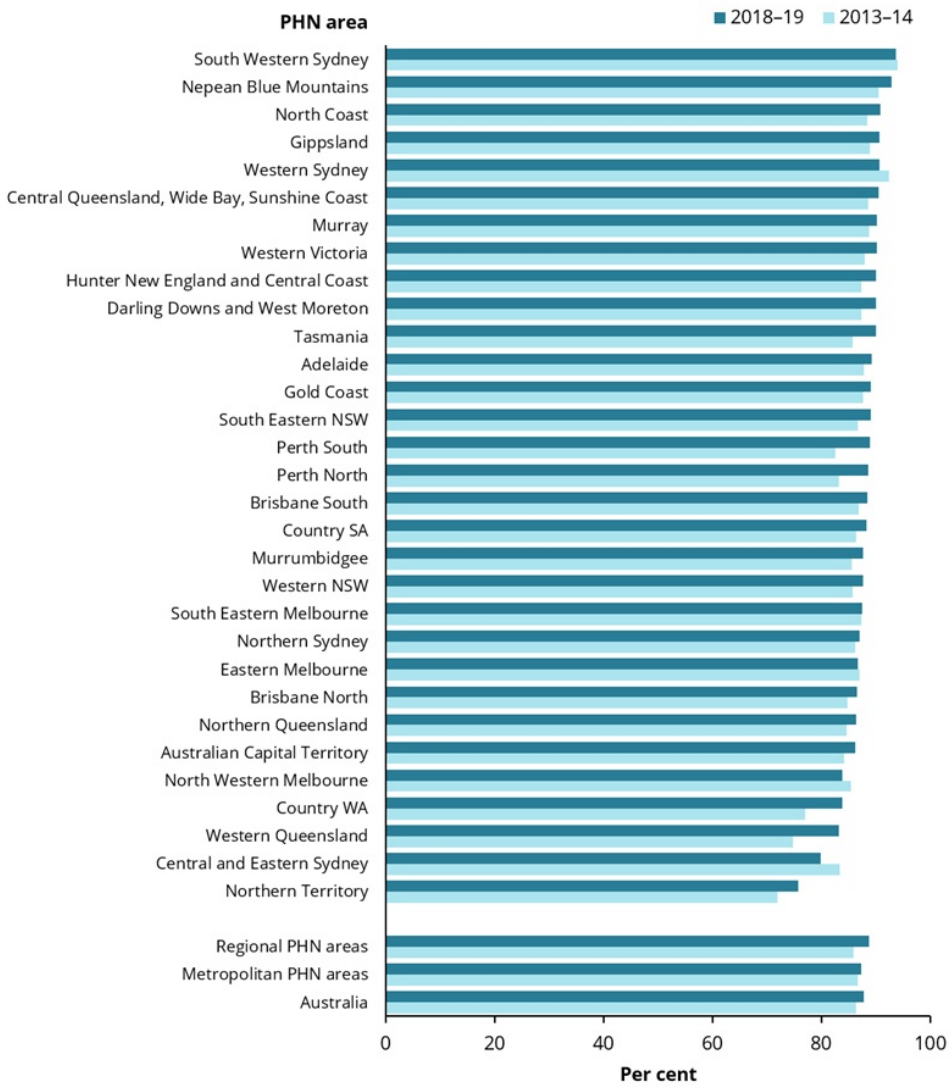

Chart: AIHW. *Sources:* AIHW analysis of Department of Health, MBS claims data; ABS ERP.

Growth in the proportion of people using GP services in remote areas

In some of the more remote PHN areas, there was a noticeable increase in the proportion of people using GP services between 2013–14 and 2018–19. The largest percentage points increase was in the Western Queensland PHN area which grew from 75% in 2013–14 to 83% in 2018–19, followed by the Country WA PHN area from 77% to 84%.

Other PHN areas in Western Australia including Perth South and Perth North also experienced noticeable percentage point increases in the proportion of people using GP services, from 83% in 2013–14 to 89% in 2018–19.

The largest decrease was in the Central and Eastern Sydney PHN area where 83% of people had a GP visit in 2013–14 compared to 80% in 2018–19. This was followed by the Western Sydney PHN area where 92% of people had a GP visit in 2013–14 which decreased to 91% in 2018–19.

References

Services Australia 2020. Medicare Australia statistics. Canberra: DHS. Viewed 14 July 2020.

GP attendances

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

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

An increasing percentage of people had a GP Enhanced Primary Care service in 2018–19, 24% (5.9 million people), up from 18% (4.2 million people) in 2013–14. This change may be attributed to the steady growth in the percentage of people who had Chronic Disease Management Plans and mental health services between 2013–14 and 2018–19 (Table 2).

Box 1: GP Enhanced Primary Care

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

Table 2: Change in percentage of people who had a GP Enhanced Primary Care service[(a)], 2013–14 and 2018–19

Enhanced Primary Care services[(b)(c)]	2013–14 (%)	2018–19 (%)	Percentage point change[(d)]
Chronic Disease Management Plan	10	15	4.6 ▲
Mental Health	6.6	8.8	2.2 ▲
Health Assessments	4.0	4.2	0.2 ▲
Multidisciplinary Case Conference	0.1	0.2	0.1 ▲
Medication Management Review (domiciliary)	0.40	0.29	−0.11 ▼
Medication Management Review (residential)	0.30	0.29	−0.01 ▼
Total Enhanced Primary Care[(c)]	18	24	5.5 ▲

Notes:

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

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

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

The percentage of people receiving Enhanced Primary Care services rose steadily in almost every PHN area since 2013–14. A higher percentage of people living in regional PHN areas (26%) had a GP Enhanced Primary Care service than people living in metropolitan PHN areas (22%) in 2018–19. This pattern remains unchanged since 2013–14—20% of people living in regional PHN areas had a GP Enhanced Primary Care service compared with 17% of people living in metropolitan PHN areas (Figure 2). The most noticeable change was in the Western Queensland regional PHN area where GP Enhanced Primary Care service use grew from 14% of people in 2013–14 to 24% in 2018–19.

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

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

Figure 2: Percentage of people who had a Medicare-subsidised GP Enhanced Primary Care service, by PHN groups, 2013–14 to 2018–19

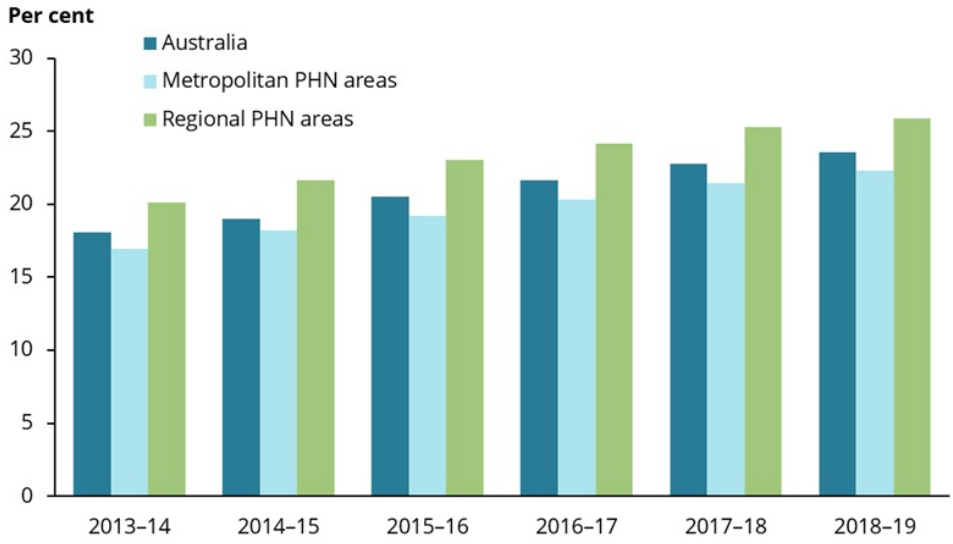

Chart: AIHW. *Sources:* AIHW analysis of Department of Health, MBS claims data; ABS ERP.

Use of Residential and Home Medication Management Reviews remains low

In 2018–19, people aged 80 and over were the most common recipients of Residential and Home Medication Management Reviews, accounting for more than half (54%) of the services claimed.

The proportion of people aged 80 and over receiving these Medication Management Reviews declined slightly between 2013–14 and 2018–19:

- Residential Medication Management Reviews decreased from 5.9% to 5.4%
- Home Medication Management Reviews decreased from 3.3% to 2.5%.

Box 3: Residential and Home Medication Management Reviews

Residential and Home Medication Management Reviews are provided by GPs and are designed to enhance the quality use of medicines by helping people and their carers to better manage their medicines. Residential Medication Management Reviews are only available to people living in residential aged care facilities (also known as nursing homes). Quality use of medicines refers to the appropriateness to use a medicine, identifying which is the most appropriate medicine and monitoring safety and effectiveness of the medicine to ensure that the best possible results are achieved for the patient (Department of Health 2016a). For more details on Residential and Home Medication Management Reviews, see Technical Information.

References

Department of Health 2016a. Quality Use of Medicines. Canberra: Department of Health. Viewed 14 July 2020.

GP attendances

Changes over time in the use of after-hours GP visits

In 2018–19, 23% of Australians had an after-hours GP visit. While there was a steady increase in the proportion of people using after-hours GP services from 20% in 2013–14 to 24% in 2017–18, there was a slight decrease between 2017–18 (24%) and 2018–19 (23%).

Visits to after-hours GP services were higher in metropolitan areas and varied considerably across PHNs

People in regional PHN areas were less likely to visit a GP after-hours (15%) than people in metropolitan PHN areas (28%) in 2018–19 (Figure 3). This pattern remains unchanged since 2013–14, with 13% of people in regional PHN areas visiting a GP after-hours, compared with 24% of people in metropolitan PHN areas.

Across PHN areas, after-hours GP visits ranged from 9.5% of people living in North Coast (NSW) to 37% of people in Western Sydney in 2018–19. However, the Perth South PHN area had the highest percentage point change in the proportion of people who had an after-hours GP visit, with an increase from 15% in 2013–14 to 25% in 2018–19.

Figure 3: Percentage of people who had a Medicare-subsidised after-hours GP attendance, by PHN area, 2013-14 and 2018-19

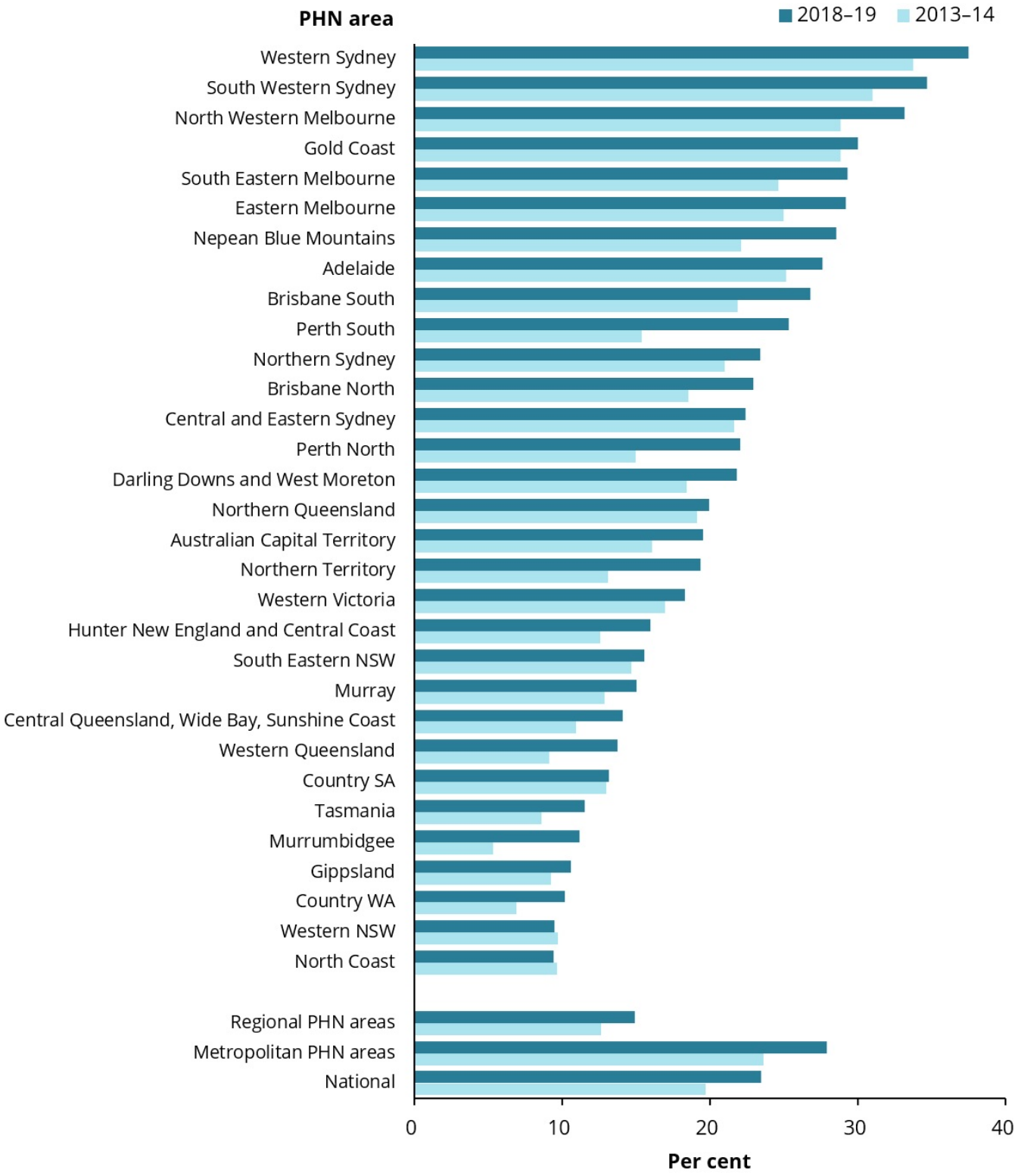

Chart: AIHW. *Sources:* AIHW analysis of Department of Health, MBS claims data; ABS ERP.

Box 4: After-hours GP visits

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

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

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

The percentage of people who had an after-hours GP visit in *Major cities* was consistently higher in lower socioeconomic SA3 areas, than in medium and higher socioeconomic areas across all 6 years. In 2018–19, 33% of people in lower socioeconomic SA3 areas had an after-hours GP visit compared with 27% in medium and 21% in higher socioeconomic SA3 areas.

Only 1 in 10 after-hours GP visits was urgent in 2018–19

GP after-hours visits billed as urgent accounted for 13% of all GP after-hours visits in 2013–14, rising to 16% in 2015–16 but decreasing to 10% in 2018–19 (Figure 4).

Figure 4: Proportion of Medicare-subsidised urgent and non-urgent after-hours GP visits, 2013–14 to 2018–19

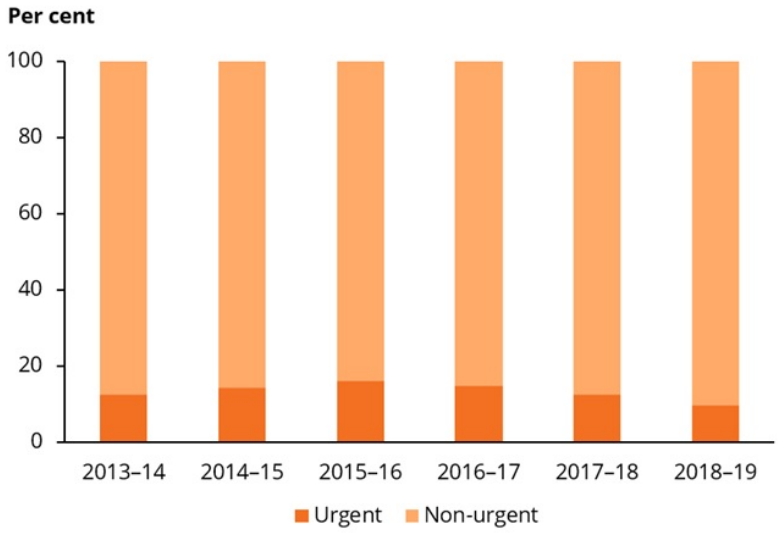

Chart: AIHW. *Sources:* AIHW analysis of Department of Health, MBS claims data; ABS ERP.

Use of urgent after-hours GP services varied across the country. In 2018–19, the rate of urgent after-hours GP services ranged from 0.5 visits per 100 people in the Northern Territory PHN area to 12 visits per 100 people in the Gold Coast PHN area. People living in the Gold Coast PHN area consistently had the highest rate of urgent after-hours GP service use across all 6 years—from 19 visits per 100 people in 2013–14, increasing to 22 per 100 people in 2015–16, and decreasing to 12 per 100 people in 2018–19.

Box 5: GP telehealth services

In 2018–19, the Australian Government introduced a range of Medicare-subsidised GP telehealth services, providing general consultation services by video conference to people living in flood-affected areas in Queensland, and mental health and well-being support to people living in drought-affected communities. These Medicare-subsidised services are not reported separately in this publication due to small numbers at local areas. These telehealth items are included in this publication in the following GP service groups: Short, Long, Standard, Prolonged, Mental Health and Focussed Psychological Strategies and Family Group Therapy. Note, in response to the COVID-19 pandemic, the Australian Government further expanded these Medicare-subsidised GP telehealth services from March 2020. The findings in this report precede the introduction of these new GP telehealth services. For further detail, see Technical Information.

For more information on Medicare-subsidised services, see the following AIHW reports on:

- Mental health services: *Mental health services in Australia*
- Indigenous services: *Indigenous health checks and follow-ups*
- Residential aged care services: *Interfaces between the aged care and health systems in Australia—GP use by people living in permanent residential aged care 2012-13 to 2016-17* and GEN Aged Care Data

For local area data on after-hours emergency department presentations for lower urgency care, see AIHW's *Use of emergency departments for lower urgency care: 2015-16 to 2018-19*.

Diagnostic imaging services

Steady growth in use of diagnostic imaging services over the last 6 years

Almost 2 in 5 Australians (39%, or 9.6 million people) had a diagnostic imaging service in 2018–19. Between 2013–14 and 2018–19, there was a relative increase in the percentage of the population who had a diagnostic imaging service (4.3%), in the number of attendances per 100 people (12.8%), and in the Medicare benefits paid (21.1%) (Table 3).

Table 3: Change in use of Medicare-subsidised diagnostic imaging service, 2013–14 and 2018–19

Measure	2013-14	2018-19	Relative change in rate since 2013-14[(a)]
Percentage of people[(b)] who had a diagnostic imaging service	37%	39%	4.3% ▲
Number of diagnostic imaging services per 100 people[(b)]	91 per 100 people	103 per 100 people	12.8% ▲
Total Medicare benefits paid for diagnostic imaging services per 100 people[(b)(c)]	$11,795 per 100 people	$14,285 per 100 people	21.1% ▲

Notes:

(a) Discrepancies may be due to rounding of numbers.

(b) The numerator is the number of people who had a diagnostic imaging service and the denominator is the ABS ERP.

(c) Expenditure results are not adjusted for inflation.

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

Use of diagnostic imaging services varies across PHN areas

Across PHN areas, the Nepean Blue Mountains PHN area consistently had the highest percentage of people who had a diagnostic imaging service, while the Northern Territory PHN area had the lowest percentage between 2013–14 and 2018–19 (Figure 5). In 2018–19, 45% of people in the Nepean Blue Mountains PHN area had a diagnostic imaging service compared with 26% of people in the Northern Territory PHN area (see Interpreting the data for more details).

Between 2013–14 and 2018–19, the Perth South PHN area had the highest percentage point increase in the proportion of people who had a diagnostic imaging service, from 30% to 36%. This was followed by the Western Queensland PHN (from 28% to 32%), the Perth North PHN (from 31% to 35%) and the Country WA PHN areas (from 29% to 32%). The Central and Eastern Sydney PHN area had a slight decrease in the percentage of people who had a diagnostic imaging service, from 37% in 2013–14 to 36% in 2018–19.

Figure 5: Percentage of people who had a Medicare-subsidised diagnostic imaging service, by PHN area, 2013-14 and 2018-19

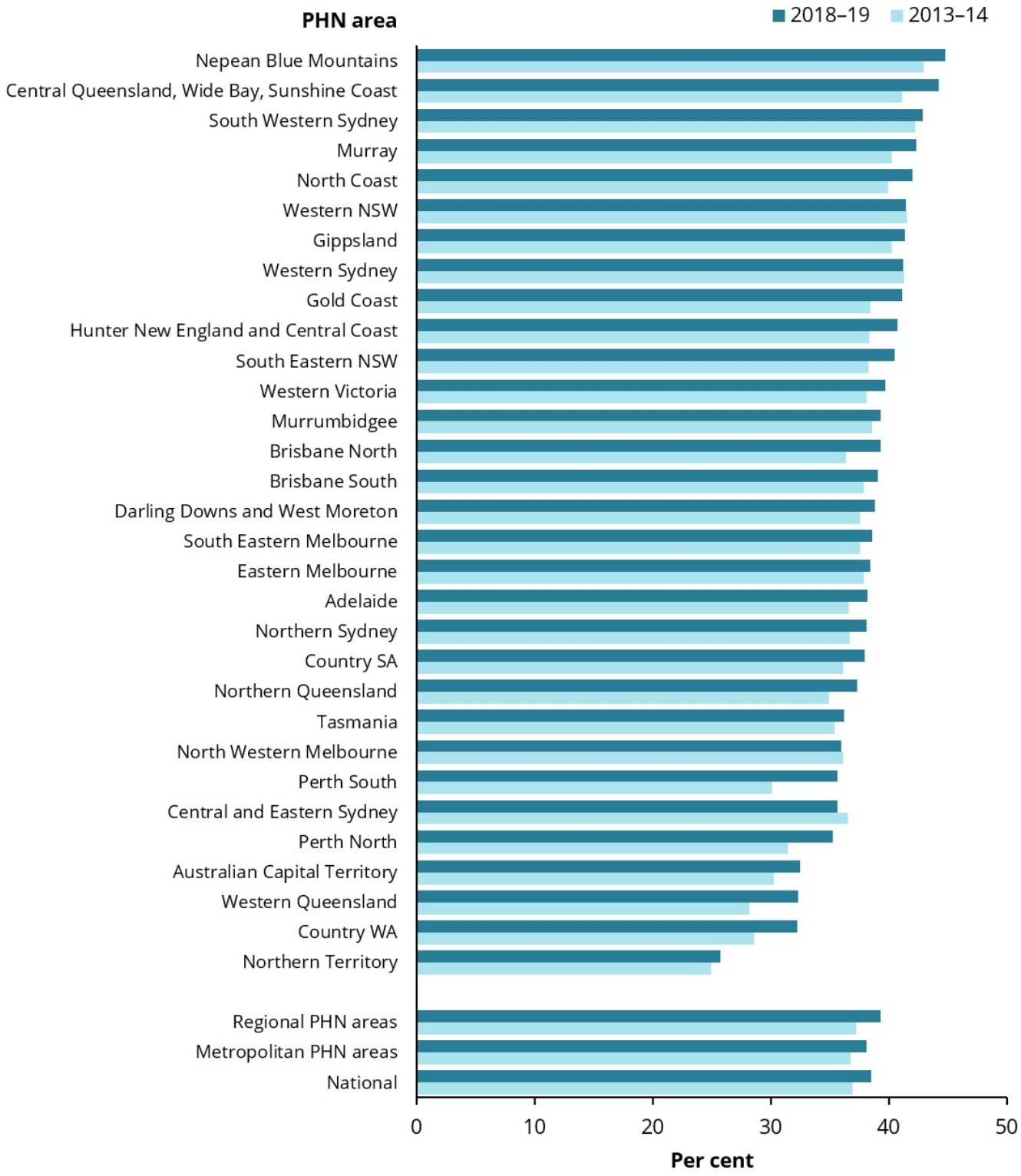

Chart: AIHW. *Sources:* AIHW analysis of Department of Health, Medicare Benefits claims data; ABS ERP.

Allied health services

 

Allied health services

Steady rise in the use of allied health services since 2013-14

In 2018–19, 37% of the population, or 9.4 million people, had at least one Medicare-subsidised allied health service, a steady growth from 32% in 2013–14. In the same period, the number of services rose from 73 to 96 per 100 people.

This change was driven predominantly by an increasing percentage of people who had Medicare-subsidised optometry services, physiotherapy, podiatry services, or allied mental health services (provided by a psychologist) (Table 4).

Table 4: Change in percentage of people who had a Medicare-subsidised allied health service[(a)], 2013–14 and 2018–19

Service groups[(b)]	2013-14 (%)	2018-19 (%)	Percentage point change[(c)]
Allied health services[(d)(e)]	32	37	5.2
Optometry[(d)]	27	30	3.3
Mental health care[(d)(f)]	3.9	5.3	1.3
Clinical Psychologist	1.6	2.2	0.5
Other Psychologist	2.2	2.9	0.7
Other Allied Mental Health	0.3	0.4	0.2
Physical health care[(d)(g)]	2.6	4.7	2.1
Physiotherapy	1.9	3.4	1.6
Exercise Physiology	0.4	0.7	0.3
Chiropractic Services	0.3	0.6	0.3
Osteopathy	0.2	0.3	0.1
Allied health - Other[(d)(h)]	4.1	5.8	1.7
Podiatry	3.1	4.4	1.3
Dietetics	0.8	1.1	0.3
Occupational Therapy	0.08	0.14	0.06
Speech Pathology	0.17	0.21	0.04
Diabetes Education	0.22	0.25	0.03
Audiology	0.03	0.06	0.03
Other Allied Health	0.02	0.05	0.02

Notes:

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

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

Box 6: What are Medicare-subsidised allied health services?

Allied health includes a broad range of services delivered by health practitioners who are not doctors, nurses or dentists. This includes audiologists, chiropractors, occupational therapists, optometrists, osteopaths, physiotherapists, podiatrists, psychologists and speech pathologists (AHPA 2017a). Australians eligible for Medicare-subsidised allied health services can use allied health services through many channels, including Medicare, general private health insurance ('ancillary' or 'extras' cover), or by paying for the service entirely out-of-pocket. At present, there is no national data on allied health service use outside of Medicare or private health insurance (AIHW 2018).

Who is eligible for Medicare-subsidised allied health services?

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

Allied health services subsidised by private health insurance

In 2018–19, private health insurers subsidised 52 million allied health-related services (APRA 2019). This compares with 24 million allied health services subsidised by Medicare in the same year. To

assist with interpretation of Medicare-subsidised allied health services, general private health insurance data by state and territory are included in the accompanying Data tables (APRA 2019).

People aged 65 and over use allied health services more than younger age groups

Overall, older people use allied health services more than younger people. In 2018–19, 65% of people aged 65 to 79 and 72% of people aged 80 and over had an allied health service, compared with 32% of people aged under 65. However, the types of services people use changes with age.

More than one in five people aged 65 and over had a podiatry service

Allied health services including optometry, physiotherapy and podiatry were commonly used by older people. For example, 4.4% of the Australian population had a Medicare-subsidised podiatry service in 2018–19, but more than one in five people aged 65 and over (21%) used this service (Figure 6). This is likely due to chronic conditions-related complications (healthdirect 2018a). This pattern remains unchanged since 2013–14.

Figure 6: Percentage of people who had a Medicare-subsidised podiatry service, by age groups, 2013-14 and 2018-19

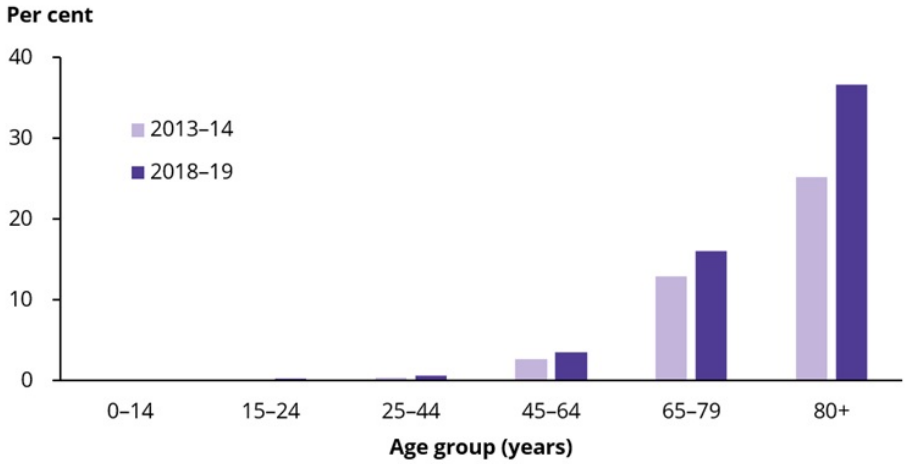

Chart: AIHW. *Sources:* AIHW analysis of Department of Health, MBS claims data; ABS ERP.

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

Between 2013–14 and 2018–19, younger Australians were more likely to see a Medicare-subsidised psychologist or allied mental health care worker than older Australians (Figure 7). For example, in 2018–19, around 1 in 14 people (7.3%) aged 15–24 had a Medicare-subsidised allied mental health service, followed by people aged 25–44 years (7.0%).

Figure 7: Percentage of people who had a Medicare-subsidised allied mental health service, by age groups, 2013-14 and 2018-19

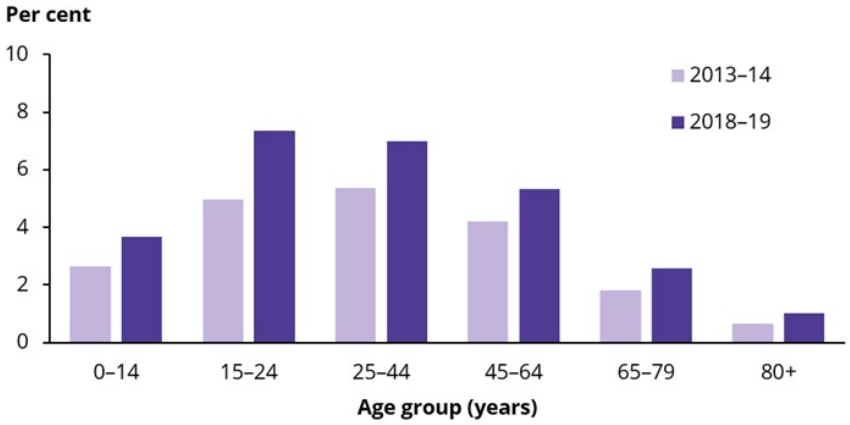

Chart: AIHW. *Sources:* AIHW analysis of Department of Health, MBS claims data; ABS ERP.

Box 7: Allied mental health telehealth services

In 2017–18, the Australian Government introduced a range of Medicare-subsidised allied mental health telehealth services. These provide psychological therapy services through video conferencing to people located in a telehealth eligible area and are provided by psychologists or allied health mental health workers such as occupational therapists or social workers. These Medicare-subsidised services are not reported separately in this publication due to small numbers at local areas. These telehealth items are included in Clinical Psychologists, Other Psychologists and Other Allied Mental Health service groups. Note, in response to the COVID-19 pandemic, the Australian Government further expanded these telehealth services from March 2020. The findings in this report precede the introduction of these new telehealth services. For further detail, see Technical Information.

Allied health service use varied across PHN areas and age groups

Across all 6 years, people living in the North Coast PHN area (NSW) were most likely to use a Medicare-subsidised allied health service (from 38% in 2013–14 to 43% in 2018–19) compared with the Northern Territory PHN area where people were least likely to use these services (from 22% in 2013–14 to 25% in 2018–19).

The variation in allied health service use across PHN areas was also evident when looking at specific age groups. For example, between 2013–14 and 2017–18, young people aged 15–24 living in the North Coast PHN area (NSW) had the highest rates of Medicare-subsidised psychologist or allied mental health service visits (ranging from 7.9% in 2013–14 to 10% in 2017–18) compared with young people from the Northern Territory PHN area who had the lowest rates (1.2% in 2013–14 to 2.0% in 2017–18).

References

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AIHW (Australian Institute of Health and Welfare) 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW. Viewed 14 July 2020.

APRA (Australian Prudential Regulation Authority) 2019. Private Health Insurance Benefit Trends - December 2019: Ancillary Benefits [Microsoft Excel spreadsheet]. Private health insurance statistical trends. Viewed 14 July 2020.

healthdirect 2018a. What is a podiatrist?. Canberra: healthdirect. Viewed 14 July 2020.

Allied health services

Almost 1 in 3 Australians had an optometry service

In 2018–19, 30% of Australians had a Medicare-subsidised optometry service, accounting for 41% of all Medicare-subsidised allied health services. Between 2013–14 and 2018–19, people who had a Medicare-subsidised optometry service increased slightly from 27% to 30% (Table 4).

Northern Territory PHN had the lowest rate of optometry use over all 6 years

Across PHN areas, in 2018–19, use of optometry services ranged from 22% of people living in the Northern Territory PHN area to 34% in the Central Queensland, Wide Bay and Sunshine Coast PHN area. The Northern Territory PHN area consistently had the lowest percentage of people who had an optometry service compared with other PHN areas—only 20% to 22% of people in the Northern Territory PHN area used these services between 2013–14 and 2018–19. This may be due to a range of factors, see Interpreting the data for more details.

Optometry service use generally increases with age

In 2018–19, 17% of people aged under 15 had an optometry service compared with 54% of people aged 65 and over (Figure 8), likely due to age-related vision loss or impairment (healthdirect 2018b). This trend is evident over the 6 years.

Box 8: Optometry services

Optometrists provide a wide range of services including vision-testing, prescription of glasses and contact lenses, assessment and reporting on fitness to drive, and diagnosis and treatment of other eye conditions (AHPA 2017b). Since January 2015, Australians aged under 65 are eligible to receive a Medicare-subsidised comprehensive eye examination every three years and annually for those aged 65 and over. See Interpreting the data section and Technical Information for more details.

Figure 8: Percentage of people who had a Medicare-subsidised optometry service, by age groups, 2013-14 and 2018-19

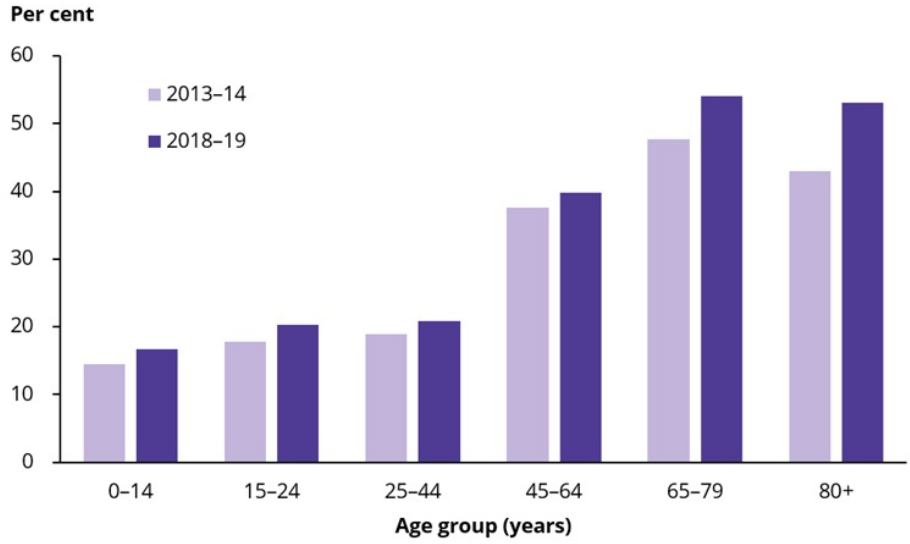

Chart: AIHW. *Sources:* AIHW analysis of Department of Health, MBS claims data; ABS ERP.

References

AHPA (Allied Health Professions Australia) 2017b. Optometry. Melbourne: AHPA. Viewed 14 July 2020.

healthdirect 2018b. Eye health tips for over-60s. Canberra: healthdirect. Viewed 14 July 2020.

Specialist attendances

1 in 3 people had a non-hospital specialist attendance

Around 1 in 3 Australians (31%, or 7.8 million people) had a non-hospital specialist attendance in 2018–19. Between 2013–14 and 2018–19, there was a relative increase in the percentage of the population who had a specialist attendance (5.1%), in the number of attendances per 100 people (6.2%), and in the Medicare benefits paid (12%) (Table 5).

Table 5: Change in use of Medicare-subsidised specialist attendances, 2013–14 to 2018–19

Measure	2013-14	2018-19	Relative change in rate since 2013-14[(a)]
Percentage of people[(b)] who had a specialist attendance	30%	31%	5.1% ▲
Number of specialist attendances per 100 people[(b)]	90 per 100 people	95 per 100 people	6.2% ▲
Total Medicare benefits paid for specialist attendances per 100 people[(b)(c)]	$7,382 per 100 people	$8,284 per 100 people	12.2% ▲

Notes:

(a) Discrepancies may be due to rounding of numbers.

(b) The numerator is the number of people who had a specialist attendance and the denominator is the ABS ERP.

(c) Expenditure results are not adjusted for inflation.

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

Specialist attendances outside of hospital continue to vary depending on where people live

There was considerable variation across the country each year—between 2013–14 and 2018–19, the Northern Sydney PHN area consistently had the highest rate of specialist attendances (36% in 2013–14 and 38% in 2018–19), while the Northern Territory PHN area had the lowest rate (14% in 2013–14 and in 2018–19) (Figure 9). This variation may be due to a range of factors, see Interpreting the data for more details.

Figure 9: Percentage of people who had a Medicare-subsidised specialist attendance, by PHN area, 2013-14 and 2018-19

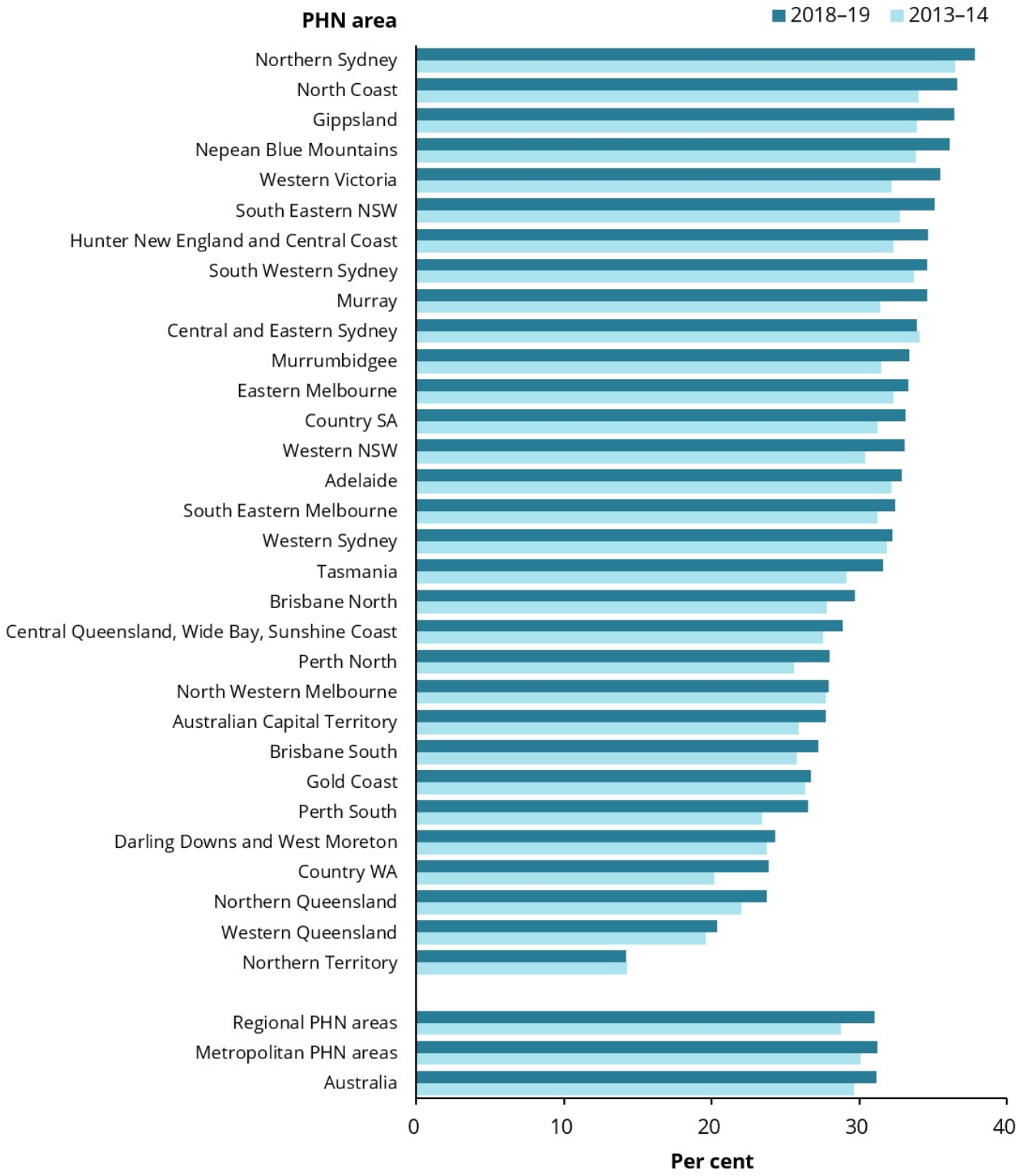

Chart: AIHW. *Sources:* AIHW analysis of Department of Health, MBS claims data; ABS ERP.

Higher growth in use of specialist attendances in regional PHN areas than metropolitan PHN areas

Across the 6 years, almost all PHN areas experienced an increase in the percentage of people who had a specialist attendance. During this time, regional PHN areas experienced a slightly higher increase in the percentage of people who had a specialist attendance (from 29% in 2013–14 to 31% in 2018–19) compared with metropolitan PHN areas (from 30% in 2013–14 to 31% in 2018–19). The largest increase in percentage points was seen in the Country WA PHN area (from 20% in 2013–14 to 24% in 2018–19), followed by the Western Victoria PHN area (from 32% to 35%).

Nursing and Aboriginal health worker services

Growth in services provided by nursing and Aboriginal health workers across all 6 years

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

In the last 6 years, there has been a steady increase in the percentage of people who received a Medicare-subsidised service provided by a nurse practitioner, practice nurse, midwife or Aboriginal health worker—from 3.1% of Australians (725,000 people) in 2013–14 to 7.1% (1.8 million people) in 2018–19.

This increase was observed across all PHN areas, with the Northern Territory PHN area consistently having the highest percentage of people receiving these services, growing from 6.7% in 2013–14 to 15% in 2018–19 (Figure 10).

Figure 10: Percentage of people who had a Medicare-subsidised service provided by a nurse practitioner, practice nurse, midwife or Aboriginal health worker, by PHN area, 2013–14 and 2018–19

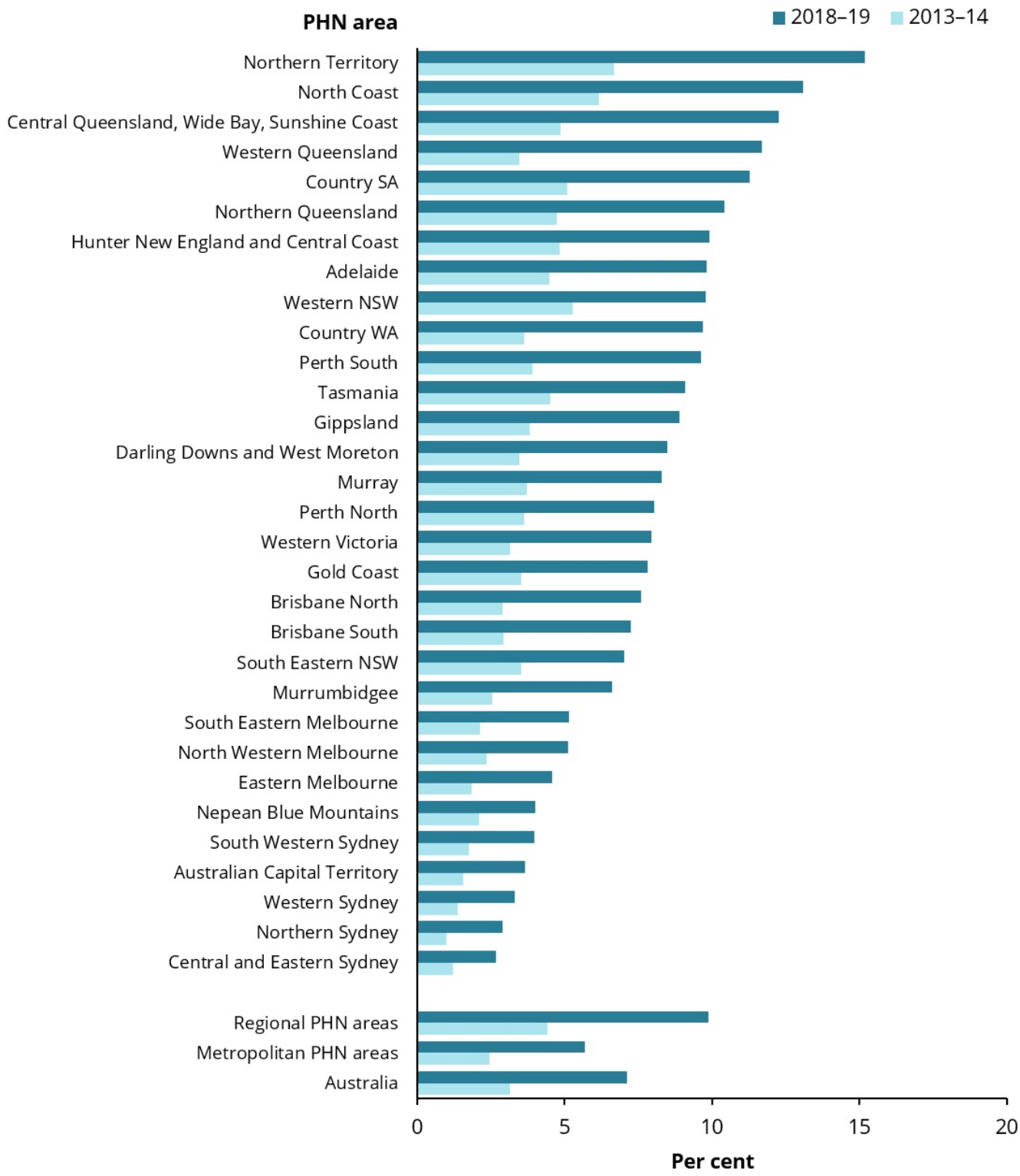

Chart: AIHW. *Sources:* AIHW analysis of Department of Health, MBS claims data; ABS ERP.

Using non-hospital Medicare service data

How can information in this report be used?

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

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

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

Interpreting the data

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

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

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

- prevalence of health conditions—areas with higher rates of health service use may have more people with complex health conditions
- availability and quality of other community-based programs, services and support outside of MBS arrangements (e.g. Visiting Optometrists Scheme, Rural Health Outreach Fund or Medical Outreach - Indigenous Chronic Disease Program) (Department of Health 2016b; 2016c; 2020), or equivalent services provided by jurisdictions or other providers
- changes to MBS arrangements where certain services may be ceased or amended, and new services are introduced (see Technical Information and Technical Note for details)
- incentives arrangement (e.g. bulk-billing)
- access to and availability of health care providers
- age and sex distribution of the population in regions across Australia.

References

Department of Health 2016b. Visiting Optometrists Scheme. Canberra: Department of Health. Viewed 14 July 2020.

Department of Health 2016c. Rural Health Outreach Fund. Canberra: Department of Health. Viewed 14 July 2020.

Department of Health 2020. Medical Outreach - Indigenous Chronic Disease Program.Canberra: Department of Health. Viewed 14 July 2020.

Technical information

Description of non-hospital Medicare-subsidised services

This release provides information on non-hospital Medicare Benefits Schedule (MBS) service items up to 30 June 2019, which precedes the introduction of new MBS items in response to the COVID-19 pandemic.

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

For detailed information on the reported services and MBS items, see the Australian Government Department of Health website: MBS Online.

GP attendances

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

See Notes section below for more information.

GP – Enhanced Primary Care

Reported service groups	Description	BTOS/Group/subgroup/item included[a][b]
GP subtotal – Enhanced Primary Care	In this report, GP Enhanced Primary Care refers to a range of services such as health assessments, medication management reviews, the creation and review of treatment plans, and coordination of care for people living with complex health conditions who require multidisciplinary, team-based care from a GP and at least two other providers. GP subtotal – Enhanced Primary Care includes Health Assessments, Chronic Disease Management Plans, Multidisciplinary Case Conferences, Domiciliary and Residential Medication Management Reviews, and Mental Health services (including preparation or review of mental health treatment plans, extended consultations related to a mental health issue but excluding focussed psychological strategies and family group therapy). These services are designed to provide a structured approach for GPs and non-specialist medical practitioners to care for people with chronic conditions and complex care needs, and to improve coordination of care for people who require multidisciplinary, team-based care.	BTOS 102[c][d]

GP Health Assessment	Health assessment of a patient's physical and psychological health and function and recommendation of preventive health care or education to improve that patient's health and physical, psychological and social function. Eligible patients include: people of Aboriginal and Torres Strait Islander descent, people who have an intellectual disability, refugees and humanitarian entrants, residents of residential aged care facilities, people aged 75 years or older, and people aged 40-49 years with a high risk of developing type 2 diabetes or at risk of developing another chronic disease. From 1 April 2019, Heart Health Assessments were added for people who have or are at risk of developing cardiovascular disease.	Group A14; Subgroup A7.5
GP Chronic Disease Management Plan	Services relating to the preparation, coordination and review of a GP Management Plan or Team Care Arrangements, or the contribution to a Multidisciplinary Care Plan for patients with a chronic or terminal medical condition. A chronic medical condition is one that has been, or is likely to be, present for six months or longer.	Subgroup A15.1; Items 229, 230, 231, 232, 233
GP Multidisciplinary Case Conference	Service where a medical practitioner (not including a specialist or consultant physician) organises and coordinates, or participates in, multidisciplinary case conferences for patients who have a chronic condition that has been (or is likely to be) present for 6 months or longer, or is terminal, and who has complex multidisciplinary care needs. Case conferences generally involve the patient's usual GP, or non-specialist medical practitioner, and at least two other providers, such as allied health professionals, other medical practitioners, home and community service providers, and care organisers (e.g. "meals on wheels" providers).	Items 235, 236, 237, 238, 239, 240, 243, 244, 735, 739, 743, 747, 750, 758
Medication Management Review (domiciliary)	Also known as Home Medicines Review. Available for people living in the community who are at risk of medication misadventure. Intended to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP, or non-specialist medical practitioner, and preferred community pharmacy or accredited pharmacist. These items are claimed by GPs or non-specialist medical practitioners.	Items 245, 900
Medication Management Review (residential)	A collaborative medication management service available to permanent residents of a residential aged care facility for whom quality use of medicines may be an issue or who are at risk of medication misadventure because of a significant change in their condition or medication regimen. These items are claimed by GPs or non-specialist medical practitioners.	Items 249, 903
GP Mental Health	Early intervention, assessment and management of patients with mental disorders by GPs or other medical practitioners (who are not specialists or consultant physicians). These services include assessments, planning patient care and treatments, referring to other mental health professionals, ongoing management and review of the patient's progress. This group comprises MBS items for the preparation and review of GP Mental Health Treatment Plans as well as extended consultations related to mental health issues, excluding GP Focussed Psychological Strategies and Family Group Therapy. Items 894, 896, 898, 2121, 2150 and 2196 are attendances by video conferencing to provide mental health and well-being support to people living in drought-affected communities.	Subgroup A20.1; Items 272, 276, 277, 279, 281, 282, 894, 896, 898, 2121, 2150 and 2196

See Notes section below for more information.

GP – After-hours GP attendances

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

GP subtotal – After-hours GP attendances	GP subtotal – After-hours GP attendances include urgent and non-urgent after-hours GP care. GP and non-specialist medical practitioner attendances provided on a public holiday, a Sunday, and during specified periods between Monday and Saturday. Note times vary depending on type of after-hours care, whether urgent or non-urgent, and for services provided at a place other than a consulting room. See After-hours GP (urgent) and After-hours GP (non-urgent) for more information.	Group A11, A22, A23; Subgroup A7.10 (all items/groups below)

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

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

See Notes section below for more information.

GP – Practice Incentive Program (PIP) services

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

GP subtotal – PIP	GP subtotal PIP includes services provided as part of the Practice Incentive Program. This program aims to support general practice activities including continuous improvements, quality care, enhance capacity and improve access and health outcomes for patients. A practice must be accredited, or registered for accreditation to participate in PIP services. Includes cervical smear, diabetes mellitus annual cycle of care and asthma cycle of care PIP services.	Group A18, A19; Subgroup A7.8 (all items/groups below)
Cervical smear PIP	A service claimed by a GP, or by non-specialist medical practitioners in eligible areas, where a cervical smear is taken from a person between the age of 24 years and 9 months and 74 years inclusive who has not had a cervical smear in the last four years. Eligibility requirements changed on 1 December 2017, which may affect comparability over time. Prior to this date, people aged between 20 and 69 years inclusive who have not had a cervical smear in the last four years could receive the service.	Subgroups A18.1, A19.1; Items 251, 252, 253, 254, 255, 256, 257
Diabetes Mellitus Annual Cycle of Care PIP	This service aims to encourage GPs and non-specialist medical practitioners to provide earlier diagnosis and effective management of people with established diabetes mellitus. The Annual Diabetes Cycle of Care must be completed over a period of 11 to 13 months, and includes (but is not limited to) measuring patients' blood pressure, cholesterol and HbA1c, examining eyes and feet and reviewing diet, physical activity and medications. Services counted represent a completed cycle of care claimed by a GP, or non-specialist medical practitioners in *eligible areas*. The completion of the Diabetes Mellitus Annual Cycle of Care can be used as an indication of GP and non-specialist medical practitioner care for patients with diabetes, but do not reflect the quality of care, prevalence of diabetes, or all diabetes-related care provided in the GP setting. Patients may also use other forms of health care to manage their diabetes, such as standard and long GP consultations, Chronic Disease Management plans, and paediatric and specialist services.	Subgroups A18.2, A19.2; Items 259, 260, 261, 262, 263, 264
Asthma Cycle of Care PIP	At a minimum the Asthma Cycle of Care includes at least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma. This includes diagnosis and assessment of level of asthma control and severity of asthma, review of the patient's use of and access to asthma related medication and devices, provision of an asthma action plan and asthma self-management education. Services counted represent a completed cycle of care claimed by a GP, or by non-specialist medical practitioners in *eligible areas*. The completion of the Asthma Cycle of Care can be used as an indication of GP and non-specialist medical practitioner care for patients with asthma, but do not reflect the quality of care, prevalence of asthma, or all asthma-related care provided in the GP setting. Patients may also use other forms of health care to manage their asthma, such as standard and long GP consultations, Chronic Disease Management plans, and paediatric and specialist services.	Subgroups A18.3, A19.3; Items 265, 266, 268, 269, 270, 271

See Notes section below for more information.

GP – Other

Reported service groups	Description	BTOS/Group/subgroup/ item included[(a)(b)]
GP subtotal – Other[(d)]	GP subtotal – Other includes: GP Short (Level A), GP Standard (Level B), GP Long (Level C), GP Prolonged (Level D), Other non-referred medical practitioner, GP Focussed Psychological Strategies and Family Group Therapy, GP Prolonged - Imminent danger of death, GP Acupuncture, GP Pregnancy support counselling and GP Telehealth (patient-end support) services. These are non-referred attendances by a GP or other medical practitioner. Does not include after-hours, Enhanced Primary Care and PIP GP attendances.	Groups A1, A2, A5, A6, A16[(f)], A27, A30, A35; Subgroups A7.1, A7.2, A7.3, A7.4, A7.11, A7.12, A20.2; Items 283, 285, 286, 287, 371 and 372.

GP Short (Level A)	Professional attendance by a GP for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management. From 1 March 2019, includes telehealth consultations by GPs for patients in selected flood affected areas (item 2095). This item is different to items in GP Telehealth (patient-end support) where the medical practitioner provides clinical support to a patient who is participating in a video conferencing consultation with a specialist or consultant physician. Medicare benefits paid, and the resulting provider fees may be underestimated in 2018–19, as some expenditure relating to residential aged care item 90020 cannot be allocated. This expenditure is claimed under the new item 90001, introduced 1 March 2019 (included in 'GP attendances (total)' and 'GP subtotal – Other' only).	Items 3, 4, 2095, 90020
GP Standard (Level B)	Professional attendance by a GP lasting less than 20 minutes, involving (where clinically relevant) taking patient history, performing a clinical examination, arranging any necessary investigation, implementing a management plan, and/or providing appropriate preventive health care. From 1 March 2019, includes telehealth consultations by GPs for patients in selected flood affected areas (item 2144). This item is different to items in GP Telehealth (patient-end support) where the medical practitioner provides clinical support to a patient who is participating in a video conferencing consultation with a specialist or consultant physician. Medicare benefits paid, and the resulting provider fees may be underestimated in 2018–19, as some expenditure relating to residential aged care item 90035 cannot be allocated. This expenditure is claimed under the new item 90001, introduced 1 March 2019 (included in 'GP attendances (total)' and 'GP subtotal – Other' only).	Items 23, 24, 2144, 90035
GP Long (Level C)	Professional attendance by a GP lasting at least 20 minutes, involving (where clinically relevant) taking detailed patient history, performing a clinical examination, arranging any necessary investigation, implementing a management plan, and/or providing appropriate preventive health care. From 1 March 2019, includes telehealth consultations by GPs for patients in selected flood affected areas (item 2180). This item is different to items in GP Telehealth (patient-end support) where the medical practitioner provides clinical support to a patient who is participating in a video conferencing consultation with a specialist or consultant physician. Medicare benefits paid, and the resulting provider fees may be underestimated in 2018–19, as some expenditure relating to residential aged care item 90043 cannot be allocated. This expenditure is claimed under the new item 90001, introduced 1 March 2019 (included in 'GP attendances (total)' and 'GP subtotal – Other' only).	Items 36, 37, 2180, 90043
GP Prolonged (Level D)	Professional attendance by a GP lasting at least 40 minutes, involving (where clinically relevant) taking extensive patient history, performing a clinical examination, arranging any necessary investigations, implementing a management plan, and/or providing appropriate preventive health care. From 1 March 2019, includes telehealth consultations by GPs for patients in selected flood affected areas (item 2193). This item is different to items in GP Telehealth (patient-end support) where the medical practitioner provides clinical support to a patient who is participating in a video conferencing consultation with a specialist or consultant physician. Medicare benefits paid, and the resulting provider fees may be underestimated in 2018–19, as some expenditure relating to residential aged care item 90051 cannot be allocated. This expenditure is claimed under the new item 90001, introduced 1 March 2019 (included in 'GP attendances (total)' and 'GP subtotal – Other' only).	Items 44, 47, 2193, 90051

Other Non-referred Medical Practitioner attendances	Non-referred professional attendance by a medical practitioner who is not a vocationally registered GP. These services are broadly similar to the other GP services included in this report. Includes services provided to patients in the community and residential aged care facilities. From 1 March 2019, includes telehealth consultations by medical practitioners for patients in selected flood affected areas (items 899, 901, 905 and 906). These items are different to items in GP Telehealth (patient-end support) where the medical practitioner provides clinical support to a patient who is participating in a video conferencing consultation with a specialist of consultant physician. From 1 July 2018, for Group A2 and Subgroups A7.2, A35.3 and A35.4, changes in provider eligibility in selected geographic areas may impact comparability over time.	Groups A2, A16[(f)]; Subgroups A7.2, A35.3, A35.4; Items 899, 901, 905, 906, 90002
GP Focussed Psychological Strategies and Family Group Therapy	Includes Focussed Psychological Strategies for patients with assessed mental disorders, and family group therapy. The provision of Focussed Psychological Strategies to a patient must be made either in the context of a GP Mental Health Treatment Plan, shared care plan or a psychiatrist assessment and management plan. Family group therapy services can be provided by medical practitioners, including specialists and consultant physicians other than consultant psychiatrists. Prior to 1 July 2018, Focussed Psychological Strategy services could be provided by eligible medical practitioners who practiced in a general practice (other than a specialist or a consultant physician). From 1 July 2018, these items were not restricted to being provided in a general practice.	Group A6; Subgroups A20.2, A7.4; Items[(d)] 283, 285, 286, 287, 371, 372
GP Prolonged - Imminent danger of death	Prolonged attendance for a patient in imminent danger of death. Services range from at least 1 hour to 5 hours or more. From 1 July 2018, new items were introduced to enable non-specialist medical practitioners to provide general attendance services.	Group A5; Subgroup A7.3
GP Acupuncture	Professional attendance at which acupuncture is performed by a medical practitioner who is a qualified medical acupuncturist by application of stimuli on or through the surface of the skin by any means. For the purpose of payment of Medicare benefits "acupuncture" is interpreted as including treatment by means other than the use of acupuncture needles where the same effect is achieved without puncture, e.g. by application of ultrasound, laser beams, pressure or moxibustion, etc.	Items 173, 193, 195, 197, 199
GP Pregnancy Support Counselling	Non-directive pregnancy support counselling services provided to a person who is pregnant or who has been pregnant in the 12 months preceding the first service, by a medical practitioner (including a GP, but not including a specialist or consultant physician). From 1 July 2018, new items were introduced to enable non-specialist medical practitioners to provide general attendance services.	Group A27; Subgroup A7.11
GP Telehealth (patient-end support)	Provision of clinical support by a medical practitioner to a patient (in a telehealth eligible area) who is participating in a video conferencing consultation with a specialist or consultant physician. Does not include telephone or email consultations. From 1 July 2018, new items were introduced to enable non-specialist medical practitioners to provide general attendance services.	Subgroups A30.1, A30.2; Items 812, 827, 829, 867, 868, 869, 873, 876, 881, 885, 891, 892

See Notes section below for more information.

GP attendances relating to residential aged care facilities

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

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

See Notes section below for more information.

Diagnostic Imaging

Reported service groups	Description	BTOS/Group/subgroup/item included[(a)]
Diagnostic Imaging services (total)	Medicare-subsidised diagnostic imaging procedures such as X-rays, computerised tomography scans, ultrasound scans, magnetic resonance imaging scans and nuclear medicine scans.	BTOS 600

See Notes section below for more information.

Allied Health attendances

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

See Notes section below for more information.

Allied Health - Optometry

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

See Notes section below for more information.

Allied Health - Mental Health Care

Reported service groups	Description	BTOS/Group/subgroup/item included[a]
Allied Health subtotal – Mental Health Care	Allied Health subtotal – Mental Health Care includes assessment, treatment and management of patients with mental disorders by clinical psychologists, other psychologists and other allied mental health workers. Does not include psychiatry services. Note: From 1 November 2017, patients living in telehealth eligible areas (regional, rural and remote Australia) were able to claim telehealth psychological services.	Groups M6, M7; Items 10956, 10968, 81325, 81355, 82000, 82015
Clinical Psychologist[i]	Psychological therapy services provided by eligible clinical psychologists. Includes individual attendances, group therapy, and telehealth video consultations. Note: Clinical psychologists may also claim services included in the 'Other Psychologists' and 'Other Allied Mental Health' categories. Items 80001, 80011 and 80021 refer to psychological therapy services via videoconferencing to people located in telehealth eligible areas.	Group M6
Other Psychologist[i]	Focussed Psychological Strategies and enhanced primary care services provided by any eligible psychologist, including clinical and other psychologists (i.e. fully registered psychologists in the relevant jurisdiction regardless of any specialist clinical training). Includes individual attendances, group therapy, and telehealth video consultations. Items 80101, 80111 and 80121 refer to telehealth services provided to people located in eligible areas.	Items 10968, 80100, 80101, 80105, 80110, 80111, 80115, 80120, 80121, 81355, 82000, 82015
Other Allied Mental Health[i]	Mental health services provided by other allied health professionals such as occupational therapists, mental health nurses, Aboriginal health workers and some social workers. Psychologists (clinical or other) may also provide some of these services, however they cannot be readily separated from the other mental health workers included in the group. These services cover Focussed Psychological Strategies – allied mental health (occupational therapist and social worker items) and enhanced primary care – allied health (mental health worker item). Includes individual attendances, group therapy, and telehealth video consultations. Items 80126, 80136, 80146, 80151, 80161 and 80171 refer to telehealth services provided to people located in eligible areas.	Items 10956, 80125, 80126, 80130, 80135, 80136, 80140, 80145, 80146, 80150, 80151, 80155, 80160, 80161, 80165, 80170, 80171, 81325

See Notes section below for more information.

Allied Health – Physical Health Care

Reported service groups	Description	BTOS/Group/subgroup/item included[a]
Allied Health subtotal – Physical Health Care	Allied Health subtotal – Physical Health Care includes physiotherapy, exercise physiology, chiropractic and osteopathy services provided to a person who has a chronic condition and complex care needs, and/or is of Aboriginal or Torres Strait Islander descent who has had a health check and identified as needing a follow-up allied health service.	Items 10953, 10960, 10964, 10966, 81110, 81115, 81315, 81335, 81345, 81350
Physiotherapy[j]	Physiotherapy service involving the non-surgical treatment of musculoskeletal and related pain and movement issues. Provided by an eligible physiotherapist to a person who has a chronic condition and complex care needs, and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service.	Items 10960, 81335
Exercise Physiology	Exercise physiology service involving exercise-based interventions for a broad range of health conditions. Provided by an eligible exercise physiologist to a person who has a chronic condition and complex care needs, and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service. Includes individual and group services.	Items 10953, 81110, 81115, 81315

Chiropractic Services	Chiropractic service involving the non-surgical treatment of musculoskeletal and related pain and movement issues. Provided by an eligible chiropractor to a person who has a chronic condition and complex care needs, and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service.	Items 10964, 81345
Osteopathy	Osteopathy service involving the non-surgical treatment of musculoskeletal and related pain and movement issues. Provided by an eligible osteopath to a person who has a chronic condition and complex care needs, and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service.	Items 10966, 81350

See Notes section below for information on footnotes.

Allied Health - Other

Reported service groups	Description	BTOS/Group/subgroup/ item included[(a)]
Allied Health subtotal - Other	Allied Health subtotal - Other includes podiatry, dietetics, occupational therapy, speech pathology, diabetes education, audiology and other allied health services provided to a person who has a chronic, developmental, and/or complex health condition and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service.	Items 10950, 10951, 10952, 10954, 10958, 10962, 10970, 81000, 81005, 81010, 81100, 81105, 81120, 81125, 81300, 81305, 81310, 81320, 81330, 81340, 81360, 82005, 82010, 82020, 82025, 82030, 82035, 82300, 82306, 82309, 82312, 82315, 82318, 82324, 82327, 82332
Podiatry	Podiatry service involving diagnosis and treatment of disorders of the foot, ankle and lower extremity. Provided by an eligible podiatrist to a person who has a chronic condition and complex care needs, and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service.	Items 10962, 81340
Dietetics	Dietetics service provided by an eligible dietitian to help patients appropriately manage their diet and nutrition. Eligible patients include people who have a chronic condition and complex care needs, and/or are of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service. Includes individual and group services.	Items 10954, 81120, 81125, 81320
Occupational Therapy[(k)]	Occupational therapy service involving the assessment and intervention to develop, recover, or maintain meaningful activities, or occupations. Provided by an eligible occupational therapist to a person who has a chronic condition and complex care needs; and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service; or is a child aged under 15 years for the diagnosis or treatment of a pervasive developmental disorder (PDD) or an eligible disability.	Items 10958, 81330, 82010, 82025
Speech Pathology	Speech pathology service involving the diagnosis and treatment of communication disorders of eligible patients with a referral, including people with chronic and complex conditions; people of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service; children aged under 13 years; or for the treatment of a PDD for children aged under 15 years.	Items 10970, 81360, 82005, 82020
Diabetes Education	Diabetes education service to assist in managing diabetes by enhancing patient's knowledge about diabetes and self-management. Provided by an eligible diabetes educator to a person who has a chronic condition and complex care needs, and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service. Includes individual and group services.	Items 10951, 81100, 81105, 81305

Audiology[j]	Audiology service involving the diagnosis, treatment, and monitoring of disorders of the auditory and vestibular systems. Provided by an eligible audiologist to a person who has a chronic condition and complex care needs; and/or is of Aboriginal or Torres Strait Islander descent who have had a health check and identified as needing a follow-up allied health service; or for the diagnosis and/or treatment and/or management of ear disease or a related disorder; or for the detection of permanent congenital hearing impairment of an infant or child.	Items 10952, 81310, 82300, 82306, 82309, 82312, 82315, 82318, 82324, 82327, 82332
Other Allied Health	Medicare-subsidised allied health services not included in the above six sub-groups. Includes Aboriginal or Torres Strait Islander health services by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner; non-directive pregnancy support counselling services provided by an eligible psychologist, social worker or mental health nurse; and audiology, optometry, orthoptic or physiotherapy health services provided to a child aged under 13 years with a PDD or eligible disability. To protect confidentiality, these items were combined.	Items 10950, 81000, 81005, 81010, 81300, 82030, 82035

See Notes section below for more information.

Specialist attendances

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

See Notes section below for more information.

Nursing and Aboriginal Health Workers

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

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

See Notes section below for more information.

Notes

Sources: AHPA 2017a; Department of Health 2019a

Notes:

(a) Medicare codes are based on the 1 May 2019 Medical Benefits Schedule book (Department of Health 2019a). Broad Type of Service (BTOS) groups similar Medicare services. For information on BTOS groups, see Department of Health's Annual Medicare Statistics. MBS items can also be grouped into a hierarchy of Group – Subgroup – Item. MBS Groups start with a letter followed by two numbers, e.g. Group A15. All items within a nominated group are included, unless stated. An MBS Subgroup is represented by a Group code followed by a full stop and a number, e.g. Subgroup A15.1. This indicates all items within the subgroup have been included, unless stated. Where a Group or Subgroup is followed by numbers in brackets (e.g. A15.2 (735–779)), only the MBS items in the brackets are included.

(b) From 1 July 2018, new MBS items were introduced to enable non-specialist practitioners to provide general attendance services. The new MBS item group established differential (tiered) rebates on GP items for non-vocationally recognised general practitioners (non-VR GPs) that integrated an incentive for doctors to become fully qualified and to work in regional, rural and remote areas. New MBS items have been created under Group A7 – Acupuncture and non-specialist practitioner items. These items replicate the General Practice items under Schedule A of the MBS, and set the relevant item fee at 80% of the equivalent VR item. For GP subtotal PIP and subgroups (Cervical smear PIP, Diabetes Cycle of Care PIP or Asthma Cycle of Care PIP), new items were introduced to enable non-specialist practitioners to provide services in eligible areas. Note, the terms non-specialist practitioner and other medical practitioner are used interchangeably in this report. For more information see 1 May 2019 Medicare Benefits Schedule book (Department of Health 2019a).

(c) In 2017–18, item 6087 (Health Care Home MBS item) was excluded to protect confidentiality. In 2018–19, item 6087 is included but not reported separately.

(d) Items 283, 285, 286, 287, 371 and 372 (GP Focussed Psychological Strategies MBS items) are included in both GP subtotal – Other and GP subtotal – Enhanced Primary Care for 2018–19 results. These new items contribute to GP Focussed Psychological Strategies and Family Group Therapy which is a service group of GP subtotal – Other. These new items are also categorised as GP subtotal – Enhanced Primary Care items under BTOS groups.

(e) Completion of cervical screening, Diabetes Cycle of Care or Asthma Cycle of Care through the use of relevant MBS items initiated the relevant Service Incentive Payment (SIP) through the PIP until 31 July 2019. From 1 August 2019, claims made against these items by GPs or non-specialist medical practitioners will no longer receive an incentive payment. This change does not affect data presented in this report, but will be reflected in future reporting for the period 2019–20 onwards.

(f) Items discontinued, however, some services were processed during 2013–14 to 2017–18.

(g) These items refer to GP attendances within residential aged care facilities. People who live in residential aged care facilities may access other GP services, including visiting a GP at their practice outside of the facility. In particular this group does not include MBS items 244, 225, 226, 227, 701, 703, 705 or 707 (health assessments) or items 235, 236, 237, 238, 239, 240, 243, 244, 735, 739, 743, 747, 750 or 758 (case conferences), which can also be provided to permanent residents of residential aged care facilities. In MBS claims data, it is not possible to distinguish between patients who are permanent residents and those who are receiving respite care in residential aged care facilities.

(h) Excludes items in groups N1, N2, N3 (Medicare Chronic Disease Dental Scheme), which ceased 1 December 2012.

(i) Clinical psychologist refers to Clinical psychologist psychological therapy services. Other psychologist includes other psychology services that can be provided by clinical psychologists or other psychologists. Psychologists (clinical or other) also provide some Other Allied Mental Health services.

(j) Does not include Other Allied Health MBS items 82030 and 82035.

(k) Does not include the Other Allied Mental Health MBS items 80140, 80145 and 80146 (Mental health services provided by occupational therapists).

(l) Does not include items 297, 320, 322, 324, 326 and 328 as these items refer to attendances in hospitals. However, a small number of services for these items were processed as non-hospital in 2014–15 and 2015–16, which may be due to administrative error (see Technical Note for more information). These small number of services have been included in the report for 2014–15 and 2015–16.

References

AHPA 2017a. What is allied health?. Melbourne: AHPA. Viewed 14 July 2020.

Department of Health 2019a. Medicare Benefits Schedule book, operating from 01 May 2019. Canberra: Department of Health. Viewed 14 July 2020.

Technical notes

Technical notes

Summary

The release uses two data sources:

- Medicare Benefits Schedule
- Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) at 30 June 2001 (see Age standardised rates) and 2013 to 2018.

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

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

About the data and measures

About the data source

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

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

Scope of the MBS claims data

Under MBS arrangements, Medicare claims can be made by eligible persons: this includes Australian and New Zealand citizens and holders of permanent residence visas. Applicants for permanent residence may also be eligible depending on circumstances. In addition, persons from countries with which Australia has reciprocal health care agreements might also be entitled to benefits under MBS arrangements.

It is important to note that some Australian residents may obtain similar medical services through other arrangements. MBS claims data do not include:

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

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

Scope and measures of the report

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

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

The report includes information about use of the following non-hospital Medicare-subsidised services from 2013–14 to 2018–19:

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

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

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

Data are reported by the financial year in which they are processed (see '*Reporting year'*).

These analyses exclude services delivered to patients admitted to hospital at the time of receiving the service or where the care was provided as part of an episode of hospital-substitute treatment where the patient received a benefit from a private health insurer. Further information about out-of-hospital Medicare-subsidised services, by broad type of service, are available in the Department of Health's Annual Medicare Statistics (Department of Health 2019b).

The following information is reported for each Medicare service group:

- Percentage of the population who claimed the service
- Services per 100 people
- Medicare benefits per 100 people
- Number of patients
- Number of services
- Total Medicare benefits paid
- Total provider fees
- Estimated population of the area.

See Table A for how each measure is defined.

All Medicare service groups listed in the Technical Information are reported by Primary Health Network (PHN) areas and by smaller geographic areas known as Statistical Areas Level 3 (SA3s, or 'local areas') (ABS 2016). Note, GP aged care attendances are only reported by PHN area.

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

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

What are the limitations of the data?

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

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

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

- This release uses the ERP at the beginning of the financial year (for example, 30 June 2018 for 2018–19 data). As the population changes, some people may be included in the numerator (MBS data), but not the denominator (ERP), for instance a person who migrated to Australia after 30 June 2018 but who claimed a service in 2018–19.
- The ERP includes people who usually live in Australia, that is, people who have been residing in Australia for a period of 12 months or more over the last 16 months. Some temporary visitors who are not included in the ERP are able to claim Medicare services, for instance through reciprocal health care agreements. However, some residents who usually live in Australia (e.g. international students or those on working visas) are not eligible for Medicare.

- The ERP, the official estimate of the Australian population, is produced by the ABS using a range of data sources, including the Census of Population and Housing, and births, deaths, and migration administrative data. ERP data sources are subject to non-sampling error, which may arise from inaccuracies in collecting, recording and processing data (ABS 2019).

Table A: List of measures included in the report and their calculation

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

Estimated Population	ABS Estimated Resident Population (ERP) as at 30 June at the end of the previous financial year (e.g. 30 June 2018 for 2018–19 results).
GP attendances per residential aged care patient	**Numerator:** Sum of services from eligible claims for the specified service type. This does not include any bulk billed incentive items or other top-up items. **Denominator:** Number of patients who had at least one GP attendance in a residential aged care facility processed in the reporting year. **Calculation:** (Numerator ÷ denominator) x 100

About the method

Reporting year

Data are reported by the financial year in which the service is processed, not the date the service occurred. Most non-hospital Medicare services (approximately 98%) occurred within the same year as the year of processing. Approximately 2% occurred in the previous year, and less than 0.1% occurred more than 2 years before the processing date. The gap between date of processing and date of service varies across Australia and across provider groups.

Number of patients

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

Percentage of people or proportion of population

The terms 'people' or 'population' refer to the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) at 30 June at the end of the previous financial year (e.g. 30 June 2013 for 2013–14 results). This release used the final ERPs at 30 June 2013, 2014, 2015 and 2016, and the preliminary ERP at 30 June 2017 and 2018.

Expenditure

Expenditure results are not adjusted for inflation. In the analysis, if a service was flagged as bulk billed, the fee charged was equal to the benefit paid.

Australian Government expenditure associated with bulk billing incentives for non-hospital non-referred services (items 10990, 10991 and 10992) are not included in the analysis, as it is not possible to allocate the expenditure with specific services. In 2018–19, this amounted to $653 million nationally (Table B; Services Australia 2020). Most of this expenditure will relate to GP attendances, but may also relate to Practice Nurse/Aboriginal Health Worker items, pre-operative anaesthesia attendances, obstetrics, operations and assistance at operations. As such the Medicare benefits paid, and the resulting provider fees reported in this release, are underestimated for GP attendances and Practice Nurse/Aboriginal Health Worker services.

Table B: Medicare benefits for bulk billing incentives for non-referred services

Year	Total Medicare benefits paid ($)[(a)]
2013–14	$542,594,565
2014–15	$578,766,777
2015–16	$603,188,422
2016–17	$615,391,699
2017–18	$639,659,829
2018–19	$653,219,021

Notes:
(a) Expenditure results are not adjusted for inflation.

Source: Services Australia 2020.

Disaggregation by age and sex

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

- PHN area level analysis by six age groups (0–14, 15–24, 25–44, 45–64, 65–79, 80+).

- SA3 analysis by four age groups (0–24, 25–44, 45–64, 65+). Due to smaller populations, SA3 results by age and sex are reported for the 'total' Medicare service groups only.

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

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

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

Age standardised rates

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

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

Suppression

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

- there were fewer than six patients or fewer than six health service providers in the area (SA3/PHN)—note a patient/provider was only included if they provided or received at least one service in the area
- one provider provided more than 85% of services or two providers provided more than 90% of services
- one patient received more than 85% of services or two patients received more than 90% of services
- the number of attendances/services was fewer than 20 for an area
- the total population of an area was fewer than 1,000
- the population of the reported age group or sex group in an area was fewer than 300.

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

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

Technical notes

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

The report presents information nationally and at the geography of:

- **Primary Health Network (PHN) areas** – 31 geographic areas covering Australia, with boundaries defined by the Australian Government Department of Health (2018).
- **Metropolitan and regional PHN groups** – PHN areas have been assigned into 2 groups: metropolitan and regional
- **Statistical Areas Level 3 (SA3s)** – 340 geographic areas covering Australia, with boundaries defined by the ABS (2016).
- **SA3 groups -** SA3s have been assigned into 6 groups: *Major cities* (Higher socioeconomic), *Major cities* (Medium socioeconomic), *Major cities* (Lower socioeconomic), *Inner regional*, *Outer regional* and *Remote* (ABS 2018a; 2018b).

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

Where a postcode boundary overlapped more than one PHN area or SA3, the percentage of records attributed to each area was the same as the percentage of the postcode population that fell within each area.

Postcodes are updated (introduced, retired or changed) over time, which can affect the comparability of how patients are allocated to regions over time. A key postcode change that affects how patients are allocated to SA3s is postcode 4306 in Queensland, which prior to 1 February 2018 encompassed two distinct areas approximately 100 km apart. From 1 February 2018 the postcode was split into two postcodes (4306 and 4314). As patients living in postcode 4314 were registered to postcode 4306 prior to 1 February 2018, a concordance file which used the former postcode 4306 boundaries was used for 2013–14 to 2016–17 reporting years. An updated concordance file that reflects the new 4306 and 4314 boundaries was used for 2017–18 and 2018–19 data.

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

Metropolitan and regional PHN groups

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

Local area (SA3) groups

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

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

SA3s in major cities

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

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

- Lower: IRSD quintiles 1 and 2

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

SA3s in *Major cities* were allocated to a socioeconomic group based on the largest number of SA1s in each group. In this report, across all SA3s, the percentage of the population that lived in the socioeconomic group allocated to that area ranged from 26% to 100%. This indicates that some SA3s have a broad diversity in socioeconomic status.

SA3s by remoteness

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

SA3s were allocated to one remoteness category based on the largest percentage of the population in each of the categories, using the population distribution as of 30 June 2016. This ranged from 48% to 100%. However, if 95% of the geographic area in an SA3 was *Remote* or *Very remote*, it was categorised on the basis of geographic area rather than population. This affected four SA3s – Broken Hill and Far West (NSW), Outback-North and East (SA), Goldfields (WA) and Mid West (WA).

Table C: Metropolitan and regional Primary Health Network areas

Primary Health Network (PHN) area	**Proportion of population[(a)] in *Major cities*[(b)]**
Metropolitan PHN areas	
Central and Eastern Sydney	100%
Australian Capital Territory	100%
Western Sydney	99%
Northern Sydney	99%
Adelaide	99%
South Eastern Melbourne	98%
Gold Coast (Qld)	98%
Perth South	98%
Perth North	98%
North Western Melbourne	98%
Eastern Melbourne	96%
Brisbane South	96%
Brisbane North	95%
South Western Sydney	90%
Nepean Blue Mountains (NSW)	86%
Regional PHN areas	
Hunter New England and Central Coast (NSW)	64%
South Eastern NSW	52%
Darling Downs and West Moreton (Qld)	35%
Central Queensland, Wide Bay, Sunshine Coast	34%
Western Victoria	30%
North Coast (NSW)	16%
Country SA	10%
Western NSW	0%
Murrumbidgee (NSW)	0%

Gippsland (Vic)	0%
Murray (Vic & part NSW)	0%
Western Queensland	0%
Northern Queensland	0%
Country WA	0%
Tasmania	0%
Northern Territory	0%

Notes:
(a) Population = ABS ERP at 30 June 2016.
(b) Major cities – as defined by the Australian Statistical Geography Standard 2016 Remoteness Areas (ABS 2018a).
Source: ABS Estimated Resident Population at 30 June 2016.

Technical notes

ABS (Australian Bureau of Statistics) 2016. Australian Statistical Geography Standard (ASGS): Volume 1—Main structure and greater capital city statistical areas, July 2016. ABS cat. no. 1270.0.55.001. Canberra: ABS. Viewed 14 July 2020.

ABS 2018a. Australian Statistical Geography Standard: Volume 5 – Remoteness Structure, July 2016, ABS cat. no. 1270.0.55.005. Canberra: ABS. Viewed 14 July 2020.

ABS 2018b. Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016. ABS cat. no. 2033.0.55.001. Canberra: ABS. Viewed 14 July 2020.

ABS 2019. Regional Population Growth, Australia, 2017-18. ABS cat. no. 3218.0. Canberra: ABS. Viewed 14 July 2020.

AIHW (Australian Institute of Health and Welfare) 2005. Age-standardised rate. Canberra: AIHW. Viewed 14 July 2020.

Department of Health 2018. Primary Health Networks (PHNs). Canberra: Department of Health. Viewed 14 July 2020.

Department of Health 2019a. Medicare Benefits Schedule book, operating from 01 May 2019. Canberra: Department of Health. Viewed 14 July 2020.

Department of Health 2019b. Annual Medicare Statistics – Financial Year 1984–85 to 2018–19 [Excel spreadsheet]. Annual Medicare Statistics. Viewed 14 July 2020.

Services Australia 2020. Medicare Australia statistics. Canberra: DHS. Viewed 14 July 2020.

Notes

Previous versions of files that have been updated are presented below.

- Since October 2019, the following updates were made to the Medicare-subsidised GP, allied health and specialist health care across small geographic areas, 2013–14 to 2017–18 release: the .CSV file contains six years of data, with the additional year of 2018–19 data.
- The service group label 'Other Non-referred Medical Practitioner' was revised to 'Other Non-referred Medical Practitioner attendances'. This change was reflected across all relevant content, including Excel download, .CSV file and Technical Information.

Data

Report editions

Newer releases

- Medicare-subsidised GP, allied health and specialist health care across local areas: 2021–22 |
  Web report | 01 Dec 2022
- Medicare-subsidised GP, allied health and specialist health care across local areas: 2019–20 to 2020–21 |
  Web report | 27 Oct 2021

This release

Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19 | 01 Oct 2020

Previous releases

- Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2017–18 |
  Web report | 26 Sep 2019

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