

3.16 Care planning for clients with chronic diseases

The use of care planning for the management of chronic disease among the Aboriginal and Torres Strait Islander population

Data sources

Data on care planning come from the 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), the OATSIH Services Reporting (OSR) data collection and the Healthy for Life (HfL) data collection.

Note that these data sources only provide part of the picture of the use of care planning for the management of chronic disease among the Indigenous population. Data on care-planning Medicare items will provide a more complete picture of care planning once the voluntary Indigenous identifier is more complete.

National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)

The 2004–05 NATSIHS collected information from 10,439 Indigenous Australians of all ages. This sample was considerably larger than the supplementary Indigenous samples in the 1995 and 2001 National Health Surveys. The survey was conducted in remote and non-remote areas of Australia and collected a range of information from Indigenous Australians. This included issues of health-related actions, health risk factors, health status, socioeconomic circumstances and women's health. The survey provides comparisons over time in the health of Indigenous Australians. It is planned to repeat the NATSIHS at 6-yearly intervals, with the next NATSIHS to be conducted in 2010–11. Selected non-Indigenous comparisons are available through the 2004–05 National Health Survey (NHS).

Healthy for Life program

The Healthy for Life (HfL) program is an ongoing program funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) of the Australian Government Department of Health and Ageing (DoHA). The program aims to improve the capacity and performance of primary health-care services to deliver high-quality maternal, children's and chronic disease care to Aboriginal and Torres Strait Islander peoples. This is carried out through population health approaches using best-practice and quality improvement principles.

Services participating in the HfL program are required to submit de-identified, aggregate service data for 11 essential indicators. These indicators cover maternal health, child health and chronic disease care on a regular basis (6 and 12 months), as well as information about the characteristics of their service and organisational infrastructure. For the reporting period ending June 2009, 72 HfL services submitted data to the AIHW.

OATSIH Services Reporting (OSR)

In 2008–09, the Australian Institute of Health and Welfare (AIHW) collected the data from the Aboriginal and Torres Strait Islander primary health-care, substance use, and Bringing Them Home and Link Up counselling services funded by the Australian Government through the Office for Aboriginal and Torres Strait Islander Health (OATSIH). OATSIH funded services include both Indigenous Community Controlled Health Organisations and non-community controlled health organisations. Note that the OSR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some Australian Government funding to facilitate access to primary health care.

This collection, referred to as the OSR data collection replaces the Service Activity Reporting (SAR), Drug and Alcohol Services Reporting (DASR), and Bringing Them Home and Link Up counselling data collections previously collected by the OATSIH. The OSR data collection which was established in 2008–09 uses a new set of counting rules which treat all auspice services as individual services which yields a larger numerator and denominator on which the rates are based. While this change only marginally affects the aggregate rates, caution should be exercised when comparing rates based on earlier data collection periods.

The OSR data collection included 211 Australian Government-funded Aboriginal and Torres Strait Islander primary health-care services. Service-level data on health care and health-related activities were collected by survey questionnaire for the 2008–09 financial year reporting period and provided data on episodes of care, service population, clients and staffing. Response rates to the OSR questionnaire by Aboriginal and Torres Strait Islander primary health-care services in 2008–09 were around 97%.

Of the 86 Bringing Them Home and Link Up counselling services 81 (94%) responded to the OSR questionnaire, as well as 5 auspiced services. Many services providing Bringing Them Home and Link Up counselling are part of existing primary health-care or substance use service.

Forty five (90%) out of 50 stand-alone substance use services as well as 3 auspiced services responded to the OSR questionnaire.

Analyses

OATSIH Services Reporting (OSR) data

The 2008–09 OSR collected all data items relevant to care planning. The 2004–05 and 2005–06 SAR reports did not collect information on four relevant data items (services where the hospital regularly provides or facilitates information on the condition of the patient who has been admitted; services where the hospital regularly provides or facilitates information to a patient’s family on the condition of the patient who has been admitted; discharge planning for Indigenous patients is well coordinated between the hospital and the service; and services that provide or facilitate antenatal shared care arrangements). These data were re-instated in the 2006–07 SAR.

Data presented below are from the 2008–09 OSR collection.

- In 2008–09, 91% of Indigenous primary health-care services provided care planning, 78% provided or facilitated shared care arrangements for the management of people with chronic conditions, 74% used clinical practice guidelines, 73% provided antenatal shared-care arrangements and a further 73% maintained a health register (Table 3.16.1; Figure 3.16.1).

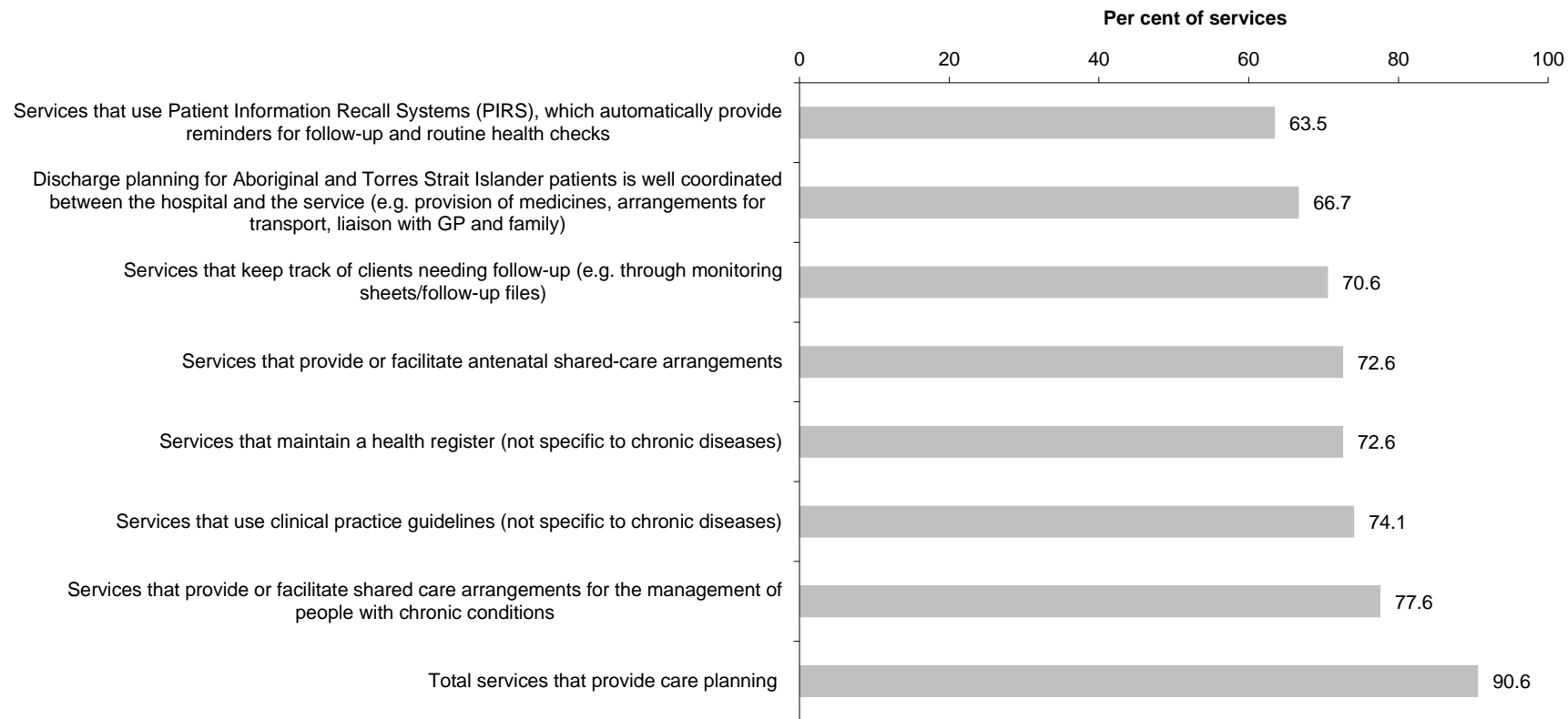
Table 3.16.1: Number and proportion of respondent Aboriginal and Torres Strait Islander primary health-care services that provide care planning, 2008–09

	No.	Per cent
Services that provide or facilitate shared care arrangements for the management of people with chronic conditions	156	77.6 ^(a)
Discharge planning for Aboriginal and Torres Strait Islander patients is well coordinated between the hospital and the service (e.g. provision of medicines, arrangements for transport, liaison with GP and family)	134	66.7
Services that provide or facilitate antenatal shared-care arrangements	146	72.6
Services that keep track of clients needing follow-up (e.g. through monitoring sheets/follow-up files)	142	70.6
Services that maintain a health register (not specific to chronic diseases)	146	72.6
Services that use clinical practice guidelines (not specific to chronic diseases)	149	74.1
Services that use Patient Information Recall Systems (PIRS), which automatically provide reminders for follow-up and routine health checks	129	63.5
Total services that provide care planning^(b)	184	90.6
Total services	203	

(a) 201 of the 205 respondent Aboriginal and Torres Strait Islander primary health care services provided valid data about health-related activities provided by the service. The percentages for first six categories in the table above are calculated as a proportion of these 201 services. However, more services (203) provided valid data about computer use. Thus the last two percentages are calculated as a proportion of 203 services. Because those categories are from two different questions, the denominator is not consistent.

(b) Total services that provide at least one of the activities listed.

Source: AIHW OSR data collection.



Notes

1. Total includes services that provide at least one of the activities listed
2. Two hundred and one of the 205 respondent Aboriginal and Torres Strait Islander primary health care services provided valid data about health related activities provided by the service. The percentages for first six categories in the table above are calculated as a proportion of these 201 services. However, more services (203) provided valid data about computer use. Thus the last two percentages are calculated as a proportion of 203 services. Because those categories are from two different questions, the denominator is not consistent.

Source: AIHW OSR data collection.

Figure 3.16.1: Proportion of respondent Aboriginal and Torres Strait Islander primary health-care services that provide care planning, 2008-09

Asthma action plans

The 2004–05 NATSIHS collected self-reported data on the number of Indigenous and non-Indigenous Australians in non-remote areas with long-term health conditions, such as asthma, and whether the person has a written action plan. Data on asthma action plans by Indigenous status, age and state/territory are presented below.

- In 2004–05, approximately 17% of Indigenous Australians living in non-remote areas reported asthma as a long-term condition. Indigenous Australians were almost twice as likely as non-Indigenous Australians to report asthma as a long-term condition (Table 3.16.2).
- In 2004–05, similar proportions of Indigenous and non-Indigenous Australians with asthma living in non-remote areas reported having written asthma action plans (25% and 22%, respectively) (Table 3.16.2).
- Indigenous Australians aged 0–4 and those aged 55 years and over were the most likely to have a written asthma action plan (44% and 35%, respectively).
- New South Wales had the highest (31%), and Western Australia the lowest (17%), proportion of Indigenous Australians reporting having a written asthma action plan (Table 3.16.3).
- In 2004–05, the majority of Indigenous and non-Indigenous Australians with written asthma action plans reported the source of their plan to be a doctor (91% and 95%, respectively) (Table 3.16.4).

Table 3.16.2: Whether persons in non-remote areas have a written asthma action plan, by Indigenous status and age group, 2004–05

Age group (years)	Does have a written asthma action plan	Does not have a written asthma action plan	Never heard of a written asthma action plan	Total ^(a)	Total with asthma	Total persons with asthma
	Per cent					No.
0–4						
Indigenous	44.1	51.6	2.8	100.0	12.3	5,621
Non-Indigenous	33.4	61.4	3.6	100.0	7.2	85,612
5–14						
Indigenous	33.7	63.0	2.9	100.0	17.7	15,801
Non-Indigenous	37.1	57.9	3.3	100.0	13.4	339,310
<i>Total aged 0–14</i>						
<i>Indigenous</i>	<i>36.5</i>	<i>60.0</i>	<i>2.9</i>	<i>100.0</i>	<i>15.9</i>	<i>21,422</i>
<i>Non-Indigenous</i>	<i>36.4</i>	<i>58.6</i>	<i>3.4</i>	<i>100.0</i>	<i>11.4</i>	<i>424,922</i>
15–24						
Indigenous	12.8	75.9	8.6	100.0	17.6	12,396
Non-Indigenous	21.4	73.1	5.3	100.0	12.6	327,611
25–34						
Indigenous	17.8	75.8	5.8	100.0	19.5	9,705
Non-Indigenous	18.1	77.2	4.7	100.0	10.6	288,858
35–44						
Indigenous	20.3	71.0	5.5	100.0	13.6	5,519
Non-Indigenous	18.9	77.0	4.1	100.0	8.7	249,056
45–54						
Indigenous	14.4	74.9	8.1	100.0	21.8	6,294
Non-Indigenous	18.7	76.2	5.1	100.0	9.0	241,475
55 years and over						
Indigenous	34.7	54.7	10.4	100.0	18.7	4,441
Non-Indigenous	18.1	73.4	7.8	100.0	9.1	407,322
Total non-age-standardised						
Indigenous	24.6	68.0	5.9	100.0	17.2	59,777
Non-Indigenous	22.8	71.5	5.1	100.0	10.2	1,939,245
Total age-standardised^(b)						
Indigenous	24.7	66.9	6.9	100.0	17.7	..
Non-Indigenous	22.4	71.9	5.2	100.0	10.2	..
Rate ratio	1.1	0.9	1.3	..	1.7	..

(a) Total includes 'not known if has a written asthma action plan', which represents 1.5% of Indigenous Australians and 0.5% of non-Indigenous Australians with asthma in non-remote areas.

(b) Totals are directly age-standardised using the 2001 Australian standard population.

Source: AIHW analysis of 2004–05 NATSIHS and 2004–05 NHS.

Table 3.16.3: Whether persons in non-remote areas have a written asthma action plan by Indigenous status and state/territory, 2004/05

Jurisdiction	Does have a written asthma action plan	Does not have a written asthma action plan	Never heard of a written asthma action plan	Total ^(a)	Total with asthma	Total persons with asthma
	Per cent					No.
New South Wales						
Indigenous	31.0	61.6	7.0	100.0	18.0	22,331
Non-Indigenous	23.5	73.3	2.5	100.0	9.2	595,171
Rate ratio	1.3	0.8	2.8	..	2.0	..
Victoria						
Indigenous	22.9	70.1	6.3	100.0	4.7	5,904
Non-Indigenous	26.5	65.8	7.5	100.0	7.7	496,570
Rate ratio	0.9	1.1	0.8	..	0.6	..
Queensland						
Indigenous	22.3	69.6	5.1	100.0	11.5	16,150
Non-Indigenous	20.4	73.6	5.6	100.0	6.1	390,422
Rate ratio	1.1	0.9	0.9	..	1.9	..
Western Australia						
Indigenous	16.6	72.8	10.3	100.0	5.6	6,808
Non-Indigenous	15.1	80.2	4.1	100.0	3.1	198,044
Rate ratio	1.1	0.9	2.5	..	1.8	..
South Australia						
Indigenous	22.1	70.4	3.0	100.0	2.9	3,517
Non-Indigenous	22.2	73.1	4.6	100.0	2.5	164,221
Rate ratio	1.0	1.0	0.7	..	1.1	..
Tasmania and ACT^(b)						
Indigenous	28.5	64.1	7.0	100.0	3.0	4,084
Non-Indigenous	20.3	67.7	11.8	100.0	1.3	85,930
Rate ratio	1.4	0.9	0.6	..	2.3	..
Northern Territory^(c)						
Indigenous	24.8	72.1	3.1	100.0	0.7	983
Non-Indigenous	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Rate ratio	..	..	..	..	..	..
Australia						
Indigenous	24.7	66.9	6.9	100.0	17.7	59,777
Non-Indigenous	22.4	71.9	5.2	100.0	10.2	1,939,245
Rate ratio	1.1	0.9	1.3	..	1.7	..

(continued)

Table 3.16.3 (continued): Whether person(s) in non-remote areas have a written asthma action plan by Indigenous status and state/territory, 2004–05

- (a) Includes 'not known if has a written asthma action plan', which represents 1.5% of Indigenous Australians and 0.5% of non-Indigenous Australians with asthma in non-remote areas.
- (b) Due to confidentiality reasons Tasmania and ACT were combined into a single category.
- (c) Non-Indigenous data for Northern Territory not presented because of the small sample size.

Note: Data have been directly age-standardised using the 2001 Australian standard population.

Source: AIHW analysis of 2004–05 NATSIHS and 2004–05 NHS.

Table 3.16.4: Source of written asthma action plan by Indigenous status and age group, 2004–05

	Doctor	Other	Total with written asthma action plan	Total persons with written asthma action plans
	Per cent			No.
Non-age-standardised				
Indigenous	91.8	8.2	100.0	14,682
Non-Indigenous	94.2	5.8	100.0	442,896
Age-standardised^(a)				
Indigenous	90.8	9.2	100.0	..
Non-Indigenous	94.9	5.1	100.0	..
Rate ratio	1.0	1.8	..	..

(a) Totals are directly age-standardised using the 2001 Australian standard population.

Source: AIHW analysis of 2004–05 NATSIHS and 2004–05 NHS.

Healthy for Life data

Chronic disease management plans (MBS item 721) General Practitioner Management Plan (GPMP)

From 1 July 2005, the Australian Government introduced chronic disease management Medicare items, including MBS items 721 and 723.

MBS item 721 is for patients with a chronic or terminal medical condition who will benefit from a structured approach to management of their care needs. A rebate can be claimed once the patient's GP has prepared a General Practitioner Management Plan (GPMP). The recommended frequency of GPMPs is once every 2 years. The GP may be assisted by their practice nurse, Aboriginal health worker or other health professional in the GP's medical practice or health service. The service must include a personal attendance by the GP with the patient.

A number of services prepare GPMPs that do not meet the requirements of a complete MBS Item 721 GPMP, because these services do not have a GP. These GPMPs are referred to as 'Alternative GPMPs'. The purpose of this indicator is to allow those services that are preparing Alternative GPMPs to report the data.

The proportion of Indigenous regular clients aged 15 years and over with Type II diabetes and coronary heart disease who had a GPMP for the reporting period 1 July 2008 to 30 June 2009 is shown in Tables 3.16.5a and 3.16.5b by type of GPMP and region.

- Of the 8,535 Indigenous adults with Type II diabetes who are regular clients of the HfL services, 2,813 (33%) were managed under a GPMP (MBS item 721) (Table 3.16.5a).

- Remote services had the highest proportion of Indigenous regular clients with Type II diabetes who were managed under a GPMP (38%) while the proportion was lowest in urban areas (20%).
- Of the 2,395 Indigenous regular clients with coronary heart disease, 691 (29%) were managed under a GPMP (Table 3.16.5b).
- Remote services had the highest proportion of Indigenous regular clients with coronary heart disease who were managed under a GPMP (39%) while the proportion was lowest in urban areas (18%).

Table 3.16.5a: Number and proportion of Indigenous regular clients with Type II diabetes^(a) who had a current GPMP, by type of GPMP and region, at 30 June 2009

Type of GPMP	Urban		Regional		Remote		Total	
	%	N/D ^(b)	%	N/D ^(b)	%	N/D ^(b)	%	N/D ^(b)
MBS GPMP	19.0	247/1,302	27.0	654/2,422	38.1	1,833/4,811	32.0	2,734/8,535
Alternative GPMP with all mandatory items	0.7	9/1,302	0.3	7/2,422	0.3	14/4,811	0.4	30/8,535
<i>MBS and/or Alternative GPMP with all mandatory items^(c)</i>	19.7	256/1,302	27.3	661/2,422	38.4	1,847/4,811	32.4	2,764/8,535
Alternative GPMP without all mandatory items	0.4	5/1,302	1.8	44/2,422	0.0	0/4,811	0.6	49/8,535
Total GPMPs^(c)	20.0	261/1,302	29.1	705/2,422	38.4	1,847/4,811	33.0	2,813/8,535

(a) Indigenous regular clients aged 15 years and over.

(b) N (numerator) is the number of Indigenous regular clients with Type II diabetes who had a current GPMP. D (denominator) is the total number of Indigenous regular clients with Type II diabetes.

(c) In a small number of services there is likely to be double counting of clients, because clients are reported to have had both an MBS and Alternative GPMP.

Notes

1. Valid data for this indicator were provided by 59 services (11 urban services, 27 regional services and 21 remote services).
2. Services used their own definition of regular client

Source: AIHW Healthy for Life data collection

Table 3.16.5b: Number and proportion of Indigenous regular clients with coronary heart disease^(a) who had a current GPMP by type of GPMP and region, at 30 June 2009

Type of GPMP	Urban		Regional		Remote		Total	
	%	N/D ^(b)	%	N/D ^(b)	%	N/D ^(b)	%	N/D ^(b)
MBS and/or Alternative GPMP with all mandatory items ^(c)	17.8	108/606	24.8	209/844	38.6	365/945	28.5	682/2,395
Alternative GPMP without all mandatory items	0.0	0/606	1.1	9/844	0.0	0/945	0.4	9/2,395
Total GPMPs^(c)	17.8	108/606	25.8	218/844	38.6	365/945	28.9	691/2,395

(a) Indigenous regular clients aged 15 years and over.

(b) N (numerator) is the number of Indigenous regular clients with coronary heart disease who had a current GPMP. D (denominator) is the total number of Indigenous regular clients with coronary heart disease.

(c) In a small number of services there is likely to be double counting of clients, because clients are reported to have had both an MBS and Alternative GPMP.

Notes

- Valid data for this indicator were provided by 59 services (11 urban services, 27 regional services and 21 remote services).
- Services used their own definition of regular client.

Source: AIHW Healthy for Life data collection.

Chronic disease management plans Team Care Arrangement (MBS item 723)

Chronic disease management plans Team Care Arrangement (TCA) (MBS item 723) provide a rebate for a GP to coordinate the preparation of TCAs for a patient with a chronic or terminal medical condition who also requires ongoing care from a multidisciplinary team of at least three health or care providers. The recommended frequency is once every 2 years, supported by regular review services.

For Type II diabetes, valid data were provided by 49, 50 and 56 services funded through the HfL program, for the reporting periods ending in June 2007, June 2008 and June 2009, respectively. For coronary heart disease, valid data were provided by 49, 49 and 56 services, for these reporting periods. The number and proportion of Indigenous regular clients of these services with a chronic disease who have a current MBS item 723 TCA, by type of chronic disease, is shown in Table 3.16.6.

- There was a consistent increase in the proportion of Indigenous regular clients with Type II diabetes and coronary heart disease who had a current TCA (MBS item 723) from 3.8% and 2.9% in the reporting period ending in June 2007 to 19% and 18%, respectively, in the current reporting period ending 30 June 2009 (Table 3.16.6).

Table 3.16.6: Number and proportion of Indigenous regular clients^(a) with a chronic disease^(b) who had a current TCA (MBS item 723), by type of chronic disease, at 30 June 2007, 30 June 2008 and 30 June 2009

Type of chronic disease	Jun-07		Jun-08		Jun-09	
	%	N/D ^(c)	%	N/D ^(c)	%	N/D ^(c)
Type II diabetes	3.8	85/2,252	13.1	931/7,084	19.2	1,520/7,905
Coronary heart disease	2.9	28/956	n.a.	n.a.	18.1	415/2,294

(a) Indigenous regular clients aged 15 years and over.

(b) Chronic diseases include Type II diabetes and coronary heart disease.

(c) N (numerator) is the number of Indigenous regular clients who had a current TCA. D (denominator) is the total number of Indigenous regular clients with a chronic disease.

Note: For Type II diabetes, valid data were provided by 49, 50 and 56 services, for the reporting periods ending in June 2007, June 2008 and June 2009, respectively. For coronary heart disease, valid data were provided by 49, 49 and 56 services, for the reporting periods ending in June 2007, June 2008 and June 2009, respectively.

Source: AIHW Healthy for Life data collection.

Care planning and health service linkages

- For the reporting period ending in June 2007, 64% of services reported they had care planning for their clients with chronic disease. Comparable data are not available for later reporting periods (Table 3.16.7).
- From the reporting periods ending June 2007 to that ending June 2009 there was an increase from 66% to 70% of services reporting they had hospital admission communication for clients with chronic disease. Over the same period, the proportion of services reporting they had hospital discharge communication for their clients with chronic disease increased from 68% to 72%. However, those reporting care provided in residential aged care services for clients with chronic disease declined from 54% to 43%.

Table 3.16.7: Proportion of services funded through the Healthy for Life Program that had care planning and health service linkages for their clients with chronic disease, reporting periods ending 30 June 2007, 30 June 2008 and 30 June 2009

HfL services had strategies for chronic disease management ^(a) for their clients with chronic disease that included:	Jun-07			Jun-08			Jun-09		
	% Yes	% No	% No response	% Yes	% No	% No response	% Yes	% No	% No response
Care planning	64.4	16.9	18.6	n.a.	n.a.	n.a.	..	..	100.0
Health service linkages									
Hospital admission communication	66.1	15.3	18.6	62.7	25.4	11.9	70.3	14.9	14.9
Hospital discharge communication	67.8	13.6	18.6	71.6	16.4	11.9	71.6	13.5	14.9
Care provided in residential aged care services	54.2	27.1	18.6	40.3	49.3	10.4	43.2	41.9	14.9

(a) 'Management' includes health promotion, prevention of complications, clinical care and advocacy

Source: AIHW Healthy for Life data collection.

Data quality issues

National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)

The NATSIHS uses the standard Indigenous status question. The NATSIHS sample was specifically designed to select a representative sample of Aboriginal and Torres Strait Islander Australians. It has therefore overcome the problem inherent in most national surveys with small and unrepresentative Indigenous samples. As with other surveys, the NATSIHS is subject to sampling and non-sampling errors. Calculations of standard errors and significance testing help to identify the accuracy of the estimates and differences.

Information recorded in this survey is essentially 'as reported' by respondents. The ABS makes every effort to collect accurate information from respondents, particularly through careful questionnaire design, pre-testing of questionnaires, use of trained interviewers and assistance from Indigenous facilitators. Nevertheless, some responses may be affected by imperfect recall or individual interpretation of survey questions.

Non-Indigenous comparisons are available through the National Health Survey (NHS). The NHS was conducted in Major cities and Inner and outer regional and Remote areas, but Very remote areas were excluded from the sample. Time series comparisons are available through the 1995 and 2001 National Health Survey.

In remote communities there were some modifications to the NATSIHS content in order to accommodate language and cultural appropriateness in traditional communities and help respondents understand the concepts. Some questions were excluded and some reworded. Also, paper forms were used in communities in remote areas and computer-assisted interview (CAI) instruments were used in non-remote areas. The CAI process included built-in edit checks and sequencing.

Further information on NATSIHS data quality issues can be found in the NATSIHS 2004-05 publication (ABS 2006).

Healthy for Life data

For the July 2008 to June 2009 reporting period, 72 services submitted data as part of the Healthy for Life Program.

Services started submitting their data through an electronic interface (OSCAR) for the February 2008 reporting period. This has improved the quality of data submitted.

Not all of the services were able to provide data for all of the essential indicators and service profile questions. The number of services who were able to provide data varies across the qualitative and quantitative indicators.

OATSIH Services Reporting (OSR)

The data were collected using the OSR questionnaire, (surveying all auspice services) which combined previously separate questionnaires for primary health, substance use, and Bringing Them Home and Link up counselling services.

OATSIH sent a paper copy of the 2008-09 OSR questionnaire to each participating service and asked the service to complete the relevant sections. The participating services sent their completed OSR questionnaires directly to the AIHW.

The AIHW examined all completed questionnaires received to identify any missing data and data quality issues. Where needed, AIHW staff contacted the relevant services to follow up and obtain additional or corrected data. After manually entering the data on the data repository system, staff conducted further data quality checks.

The AIHW identified three major problems with the data quality: missing data, inappropriate data provided for the question, and divergence of data from two or more

questions. The majority of 2008–09 OSR questionnaires received had one or more of these data quality issues.

Further information can be found in the data quality statement in the Aboriginal and Torres Strait Islander Health Services Report, 2008–09 (AIHW 2010).

List of symbols used in tables

n.a.	not available
–	rounded to zero (including null cells)
0	zero
..	not applicable
n.e.c.	not elsewhere classified
n.f.d.	not further defined
n.p.	not available for publication but included in totals where applicable, unless otherwise indicated

References

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