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AIHW

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

Web report

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

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

This report is updated periodically to include the latest data from these collections. This release contains nKPI data up to the June 2022 collection and OSR data up to the 2021–22 collection. Data tables accompanying this release can be found on the AIHW website.

Contents

Key findings

1. Indigenous-specific primary health care organisations employed over 8,800 full-time equivalent staff in 2021–22
2. Indigenous-specific primary health care organisations cared for around 586,000 clients in 2021–22
3. Indigenous-specific primary health care organisations provided over 4.0 million episodes of care in 2021–22
4. At June 2022, 86% of Indigenous babies born in the last year had a healthy birthweight, an improvement over time

Summary

Aboriginal and Torres Strait Islander (Indigenous–) specific primary health care organisations (referred to as organisations in this report) play a critical role in improving the health of Indigenous Australians through prevention, early intervention, health education, and the timely identification and management of health issues.

The Online Services Collection (OSR) includes contextual information about these organisations. In 2021–22, around:

200 organisations provided Indigenous-specific primary health care	**8,800** full-time equivalent staff were employed	**586,000** clients were cared for	**4.0 million** episodes of care were provided
Read more on Organisations	*Read more on Workforce*	*Read more on Clients*	*Read more on Episodes of care*

Most of these organisations also provide a set of process-of-care and health-status indicators for Indigenous Australians to the national Key Performance Indicators (nKPI) collection. These indicators focus on maternal and child health, preventative health, and chronic disease management. At June 2022, for Indigenous regular clients (that is, an Indigenous client who has visited a particular organisation 3 or more times in the previous 2 years):

30% aged 0–14 had an Indigenous health assessment in the last year	**62%** of adults had their body mass index (BMI) calculated in the last 2 years	**45%** with type 2 diabetes had their HbA1c (blood sugar) result recorded in the last 6 months
Read more on Maternal and child health indicators	*Read more on Preventative health indicators*	*Read more on Chronic disease management indicators*

Impact of COVID-19 and interpreting results over time

Summary information on how the COVID-19 pandemic affected organisations, and their results, from the 2019–20 OSR and June 2020 nKPI collection periods onwards is provided in this box and in selected sections throughout this report. A comparison of the pre-COVID-19 period with periods during COVID-19 for selected nKPI process-of-care indicators and OSR items is planned for release in 2023.

Although there are no COVID-19 specific items in either the OSR or nKPI collections, organisations that provided comments about variations in selected data items for the relevant periods indicated that:

In 2019–20 and 2020–21

- the pandemic affected their capacity to provide their usual services, for example, because of workforce availability or the need to pivot the delivery of services towards responding to COVID-19 (such as providing COVID-19 testing and/or vaccinations)
- the pandemic affected how they provided services (that is, by telehealth or in-person) and there were issues with the recording of telehealth consultations in their data
- pandemic-related restrictions (for example, stay-at-home orders) and anxiety over contracting or spreading COVID-19 affected clients' use of services.

Nationally, these factors resulted in decreases in the number of clients, client contacts and episodes of care delivered overall and changes in some nKPI measures.

In 2021–22

- in addition to their usual clients, additional clients attended their sites specifically for COVID-19 vaccinations (that is, not for other primary health care services)
- their usual clients began returning to their sites for primary health care services after COVID-19 restrictions ceased.

Nationally, these factors led to an increase in client numbers, client contacts and episodes of care overall but a decrease in the average client contacts and episodes of care per client, and changes in some nKPI measures.

Interpreting results over time

A combination of other factors also affects results over time. For example, variation in results between periods may also reflect:

- changes in reporting requirements (for example, the voluntary nature of reporting for periods in 2019–20 and 2020–21 and the associated decrease in the number of reporting organisations)
- general changes in the characteristics of organisations that report each period (for example, the number and type of organisations reporting to the collection varies between periods, an organisation may close or open a site, or an organisation may change their internal data recording processes).

See Technical notes for more information about interpreting results over time.

Introduction

Information on organisations funded by the Australian Government under its Indigenous Australians' Health Programme (IAHP) to provide primary health care services to Aboriginal and Torres Strait Islander (Indigenous) clients is available through two data collections, the Online Services Report (OSR) and the national Key Performance Indicators (nKPI):

- **OSR** – conducted annually (covering the period 1 July–30 June) to collect contextual information about the organisations, such as client numbers, client contacts, episodes of care and staffing levels
- **nKPI** – conducted twice a year (with census dates at 30 June and 31 December) to collect a set of process-of-care and health-status indicators focused on maternal and child health, preventative health and chronic disease management.

This report presents the latest results from these collections.

Purpose of the OSR and nKPI collections

The main purpose of the OSR and nKPI collections is to support continuous quality improvement (CQI) activity among organisations funded under the IAHP. They can also be used to support policy and service planning at the national and state/territory levels, by monitoring progress and highlighting areas for improvement. In addition to this, information from the collections helps monitor progress against the Council of Australian Governments (COAG) Closing the Gap targets, and supports the priorities set out in the National Aboriginal and Torres Strait Islander Health Plan 2021–2031.

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

Maternal and child health funded organisations

A small number of organisations that received funding only for maternal and child health services (MCH organisations) report to the OSR collection. These organisations are significantly different from organisations funded for comprehensive primary health care (PHC). For example, MCH organisations are funded only for specific maternal and child health programs (such as those based within a hospital or health service) and only report on their funded program. As such, OSR data presented in this report exclude these organisations unless otherwise noted. Selected data from these organisations can be found in the MCH section of OSR – summary over time.

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

2021–22 (OSR)/June 2022 (nKPI)

IAHP funding type	Reporting to OSR	Reporting to nKPI	Reporting to both collections
Primary health care	211	209	194
Maternal and child health[c]	19	21	16
Total	**230**	**230**	**210**

2020–21 (OSR)/June 2021 (nKPI)[b]

IAHP funding type	Reporting to OSR	Reporting to nKPI	Reporting to both collections
Primary health care	191	192	175
Maternal and child health[c]	20	23	18
Total	**211**	**215**	**193**

2019–20 (OSR)/June 2020 (nKPI)[b]

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

2018–19 (OSR)/June 2019 (nKPI)

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

2017–18 (OSR)/June 2018 (nKPI)

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

2016–17 (OSR)/June 2017 (nKPI)

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

a. Refers to the June collection period for the nKPI (see nKPI - introduction) and the financial year collection period for the OSR (see OSR - introduction).

b. Reporting to the collections for these periods was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19.

c. Organisations that received funding only for maternal and child health (MCH) services. MCH organisations reporting to the OSR are significantly different from organisations funded for comprehensive primary health care (PHC), both in the purpose of the funding and in what they report in the OSR. As such, OSR data presented in this report exclude these organisations unless otherwise noted. See also OSR - summary over time for selected data from these organisations, and Interpreting OSR data.

Notes

1. Not all funded organisations report to the collections each period. Organisations may receive an exemption from providing data for a particular period, or may be in-scope to report but do not report for some reason (for example, because reporting was made voluntary for a period).

2. See also Summary and Technical notes for information on interpreting changes over time.

Source: AIHW analysis of OSR and nKPI collections.

All organisations receiving IAHP funding share a commitment to providing holistic, comprehensive and culturally appropriate health care, and can be split into two main types:

- Aboriginal Community Controlled Health Organisations (ACCHOs) – initiated and operated by their local Aboriginal communities through locally elected Boards of Management. ACCHOs generally deliver a set of services deemed to be 'comprehensive health care'.
- Non-Aboriginal Community Controlled Health Organisations (non-ACCHOs) – a mix of government-run organisations (such as local health districts) and non-government organisations (such as not-for-profit charitable health services). Non-ACCHOs may offer a limited or a full range of services.

The two types of organisations can have very different profiles (Table 2), varying in governance structure, size, workforce composition, additional sources of funding, the services they offer, and the needs of their clients. Caution should therefore be used when comparing data by organisation type. For more information on interpreting data, see Technical notes and Glossary.

Table 2: Selected measures from the OSR collection, by organisation type, 2021–22

Measure	ACCHO	Non-ACCHO	Total
Clients (mean)	3,585	1,184	2,804
Clients (median)	2,656	794	1,993
Indigenous clients (mean)	2,710	901	2,121
Indigenous clients (median)	2,007	615	1,326
Client contacts (mean)	40,918	8,734	30,344
Client contacts (median)	29,721	6,447	18,876
Episodes of care (mean)	25,554	6,882	19,420
Episodes of care (median)	18,810	5,198	12,724
Employed health full time equivalent (FTE) staff (mean)	31	7	24
Employed health full time equivalent (FTE) staff (median)	20	5	14
Total number of organisations	142	69	211

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

Source: AIHW analysis of OSR data collection.

OSR – introduction

Organisations funded under the Australian Government's Indigenous Australians' Health Programme (IAHP) provide contextual information about their organisation to the Online Services Report (OSR) collection once each financial year (covering the period 1 July–30 June).

Clients

Organisations reporting to the OSR collection may see a mix of Indigenous and non-Indigenous clients. Data for both Indigenous and non-Indigenous clients are included in the OSR collection. Not all clients included in the OSR collection are regular clients of the organisations. See Technical notes and Glossary for more information.

The following boxes show key results for 2021–22. Clicking on a box will go to more information on the selected topic.

Organisations	FTE staff	FTE vacancies
Over 200 Indigenous-specific primary health care organisations	**Over 8,800** full-time equivalent staff employed	**Around 780** vacant full-time equivalent positions

Client numbers	Client contacts	Episodes of care
Around 586,000 clients cared for	**10.9** average contacts per client	**7.1** average episodes of care per client

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

OSR – summary over time

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

See Summary and Technical notes for information on interpreting changes over time.

Table 1: Indigenous-specific primary health care organisations, selected results (number)

	2017–18	2018–19	2019–20 (a)	2020–21 (a)	2021–22
Organisations	198	210	196	191	211
Clients	483,073	498,206	468,500	454,047	586,076
Indigenous clients	391,860	393,101	382,607	367,409	443,338
Client contacts	6,082,738	6,096,729	5,440,291	5,499,564	6,372,135
Average client contacts per client	12.6	12.2	11.6	12.1	10.9
Episodes of care	3,602,913	3,738,317	3,509,143	3,528,732	4,019,992
Average episodes of care per client	7.5	7.6	7.5	7.8	7.1
Full-time equivalent (FTE) staff(b)	8,215	8,343	7,634	8,557	9,119
Health FTE staff(b)	4,938	4,824	4,509	5,021	5,219
Employed FTE staff	7,945	7,981	7,352	8,310	8,831
Employed Health FTE staff	4,695	4,495	4,258	4,811	4,960

	2017–18	2018–19	2019–20 (a)	2020–21 (a)	2021–22
Employed Indigenous FTE staff	4,254	4,130	3,817	4,315	4,499
Health FTE per 1,000 clients	10.2	9.9	9.6	11.1	8.9

(a) Reporting to the collection for these periods was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19.

(b) Includes visiting FTE staff.

Notes:

1. Excludes data from organisations that received funding only for maternal and child health services. See Maternal and child health organisations for selected data over time.

2. See also Summary and Technical notes for information on interpreting changes over time.

Source: AIHW analysis of OSR data collection.

Maternal and child health organisations

A small number of organisations reporting to the OSR receive funding to deliver maternal and child health services only (referred to as MCH organisations). These organisations are significantly different from organisations funded to deliver comprehensive primary health care (PHC). For example, MCH organisations are funded only for specific maternal and child health programs (such as those based within a hospital or health service) and only report on their funded program. For this reason, data from these organisations are excluded from the data presented in this report unless otherwise noted.

Selected data from MCH organisations are presented in Table 2.

Table 2: Maternal and child health organisations, selected results (number)

	2018–19	2019–20[(a)]	2020–21[(a)]	2021–22
Organisations	22	19	20	19
Clients	7,964	8,018	7,411	7,638
Indigenous clients	5,723	5,387	5,941	6,115
Client contacts	70,762	47,440	83,729	65,588
Average contacts per client	8.9	5.9	10.8	8.6
Episodes of care	33,054	36,413	37,291	41,565
Average episodes of care per client	4.2	4.5	4.7	5.4
Full-time equivalent (FTE) staff[(b)]	119.4	99.9	125.2	128.2
Health FTE staff[(b)]	86.6	76.6	89.2	88.4

	2018–19	2019–20[(a)]	2020–21[(a)]	2021–22
Employed FTE staff	116.4	95.7	120.0	117.7
Employed Health FTE staff	83.9	72.7	84.7	80.1
Employed Indigenous FTE staff	68.1	38.3	53.1	60.0
Health FTE per 1,000 clients	10.9	9.6	11.2	11.6

(a) Reporting to the OSR collection for these periods was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19.

(b) Includes visiting FTE staff.

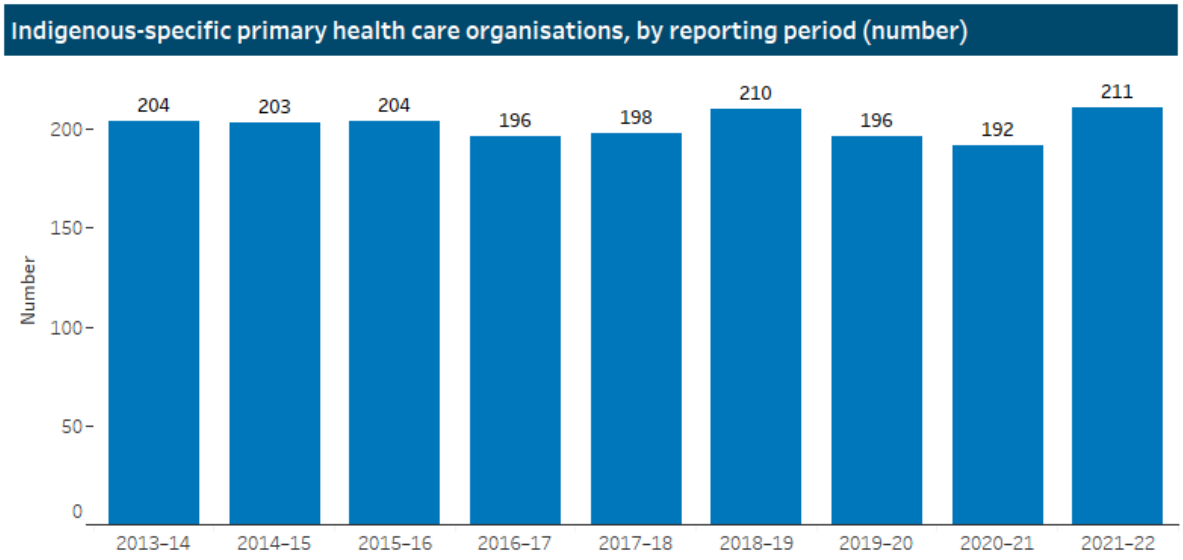
Note: See also Summary and Technical notes for information on interpreting changes over time.

Source: AIHW analysis of OSR data collection.

OSR – organisations

In 2021–22, 211 organisations reported to the Online Services Reporting (OSR) collection. Of these:

- 32% (or 68) were in the Northern Territory
- 35% (or 74) were in *Very remote* areas
- 67% (or 142) were Aboriginal Community Controlled Health Organisations (ACCHOs).

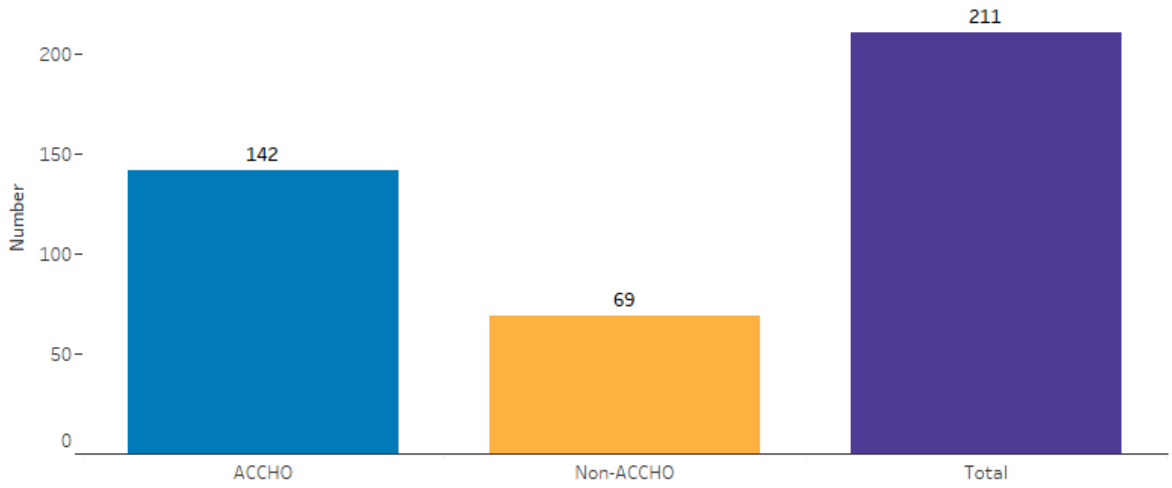


Note: See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

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

Select reporting period	Select service size	Select state/territory, remoteness or organisation type
2021–22	Total - all services	Organisation type

Indigenous-specific primary health care organisations, by service size (Total - all services) and Organisation type, 2021–22 (number)



Note: Includes organisations that provided valid client numbers in each year and total organisations. See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

OSR – workforce

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

Full-time equivalent

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

In the OSR this is the count of:

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

The following boxes show key results for 2021–22. Clicking on a box will go to more information on the selected topic.

FTE (employed staff)

Indigenous staff	Health staff	Remoteness
51% (or around 4,500) of employed full-time equivalent staff were Indigenous	**56%** (or around 5,000) of employed full-time equivalent staff were health staff	**35%** (or around 3,000) of employed full-time equivalent staff were in *Remote* or *Very remote* areas

Vacant FTE positions

Indigenous vacancies	Health vacancies	Remoteness
11% (or 86) of vacant full-time equivalent positions were for Aboriginal and Torres Strait Islander health workers and practitioners	**77%** (or around 600) of full-time equivalent vacancies were for health staff	**52%** (or around 400) of full-time equivalent vacancies were in *Remote* or *Very Remote* areas

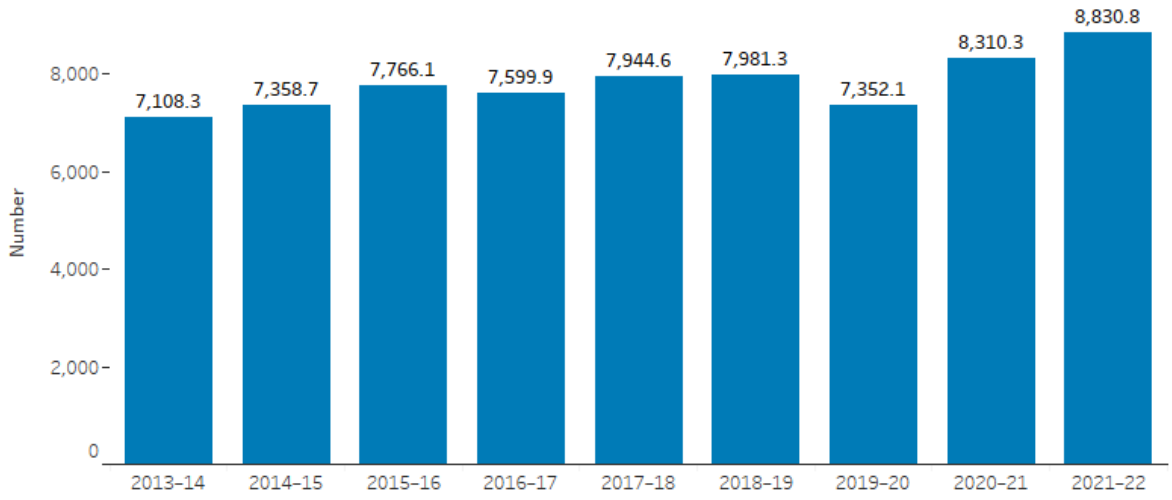
Staffing (FTE)

At 30 June 2022, organisations employed around 8,800 full-time equivalent (FTE) staff. During 2021–22, they also had around 288 visiting FTE staff not paid for by the organisations themselves.

Of the employed FTE staff around:

- 56% (or 5,000 FTE) were health staff
- 51% (or 4,500 FTE) were Indigenous
- 26% (or 2,300 FTE) were in Queensland
- 23% (or 2,000 FTE) were in both *Inner reginal* areas and *Major cities*
- 91% (or 8,100 FTE) were in Aboriginal Community Controlled Health Organisations (ACCHOs).

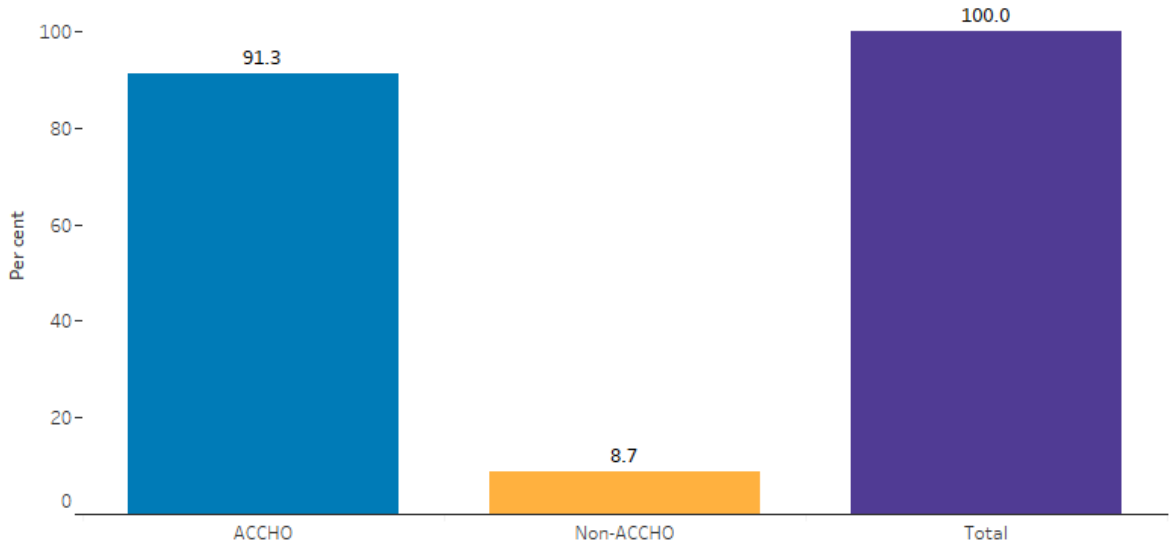
Employed FTE staff, by reporting period (number)



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

Select reporting period	Select position type	Select state/territory, remoteness, organisation type or Indigenous status
2021–22	Total	Organisation type

Employed FTE staff, by position type (Total) and Organisation type, 2021–22 (per cent)



Notes

1. **Other health** positions include sexual health workers, traditional healers, environmental health workers, trainee positions and 'other' health workers.
2. See Technical notes for more information.

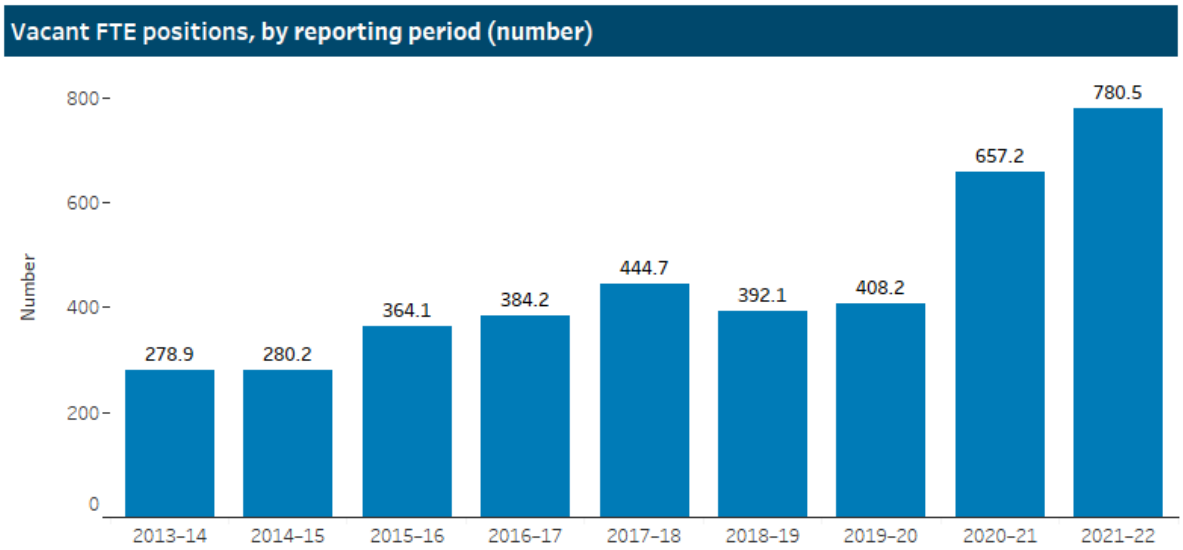
Source: AIHW OSR collection.

http://www.aihw.gov.au

Vacancies (FTE)

At 30 June 2022, organisations had around 780 vacant full-time equivalent (FTE) positions. Of these around:

- 77% (or 598) were for health positions
- 34% (or 265) were in the Northern Territory
- 29% (or 223) were in *Very remote* areas
- 87% (or 680) were at Aboriginal Community Controlled Health Organisations (ACCHOs).



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

There has been an increase in the number of vacant FTE positions reported in the most recent OSR collection periods (that is, in the number of vacant FTEs as at 30 June 2021 and as at 30 June 2022 compared with those reported for previous periods). While it is difficult to be definitive about the reasons for this, as many of the organisations with increased vacancies also had an increase in employed FTEs, it is likely that these vacancies relate to the delivery of new services rather than an increase in delivery of existing services. Some of this change may have been a result (direct or indirect) of the COVID-19 pandemic. However, not all comments organisations provided in 2020–21 and 2021–22 for variations in these numbers (reported for organisations with a 20% or more increase or decrease) clearly linked the increase in vacancies to COVID-19. These increases may also be the result of other unrelated factors, for example, general

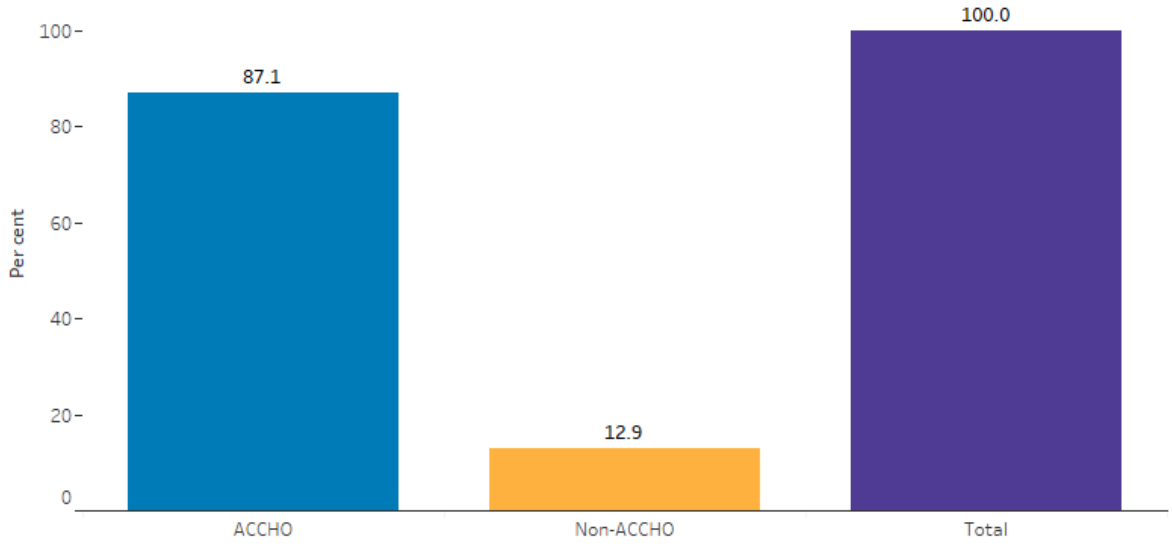
changes in funding, direction, structure or size resulting in more or different services being delivered.

Select reporting period
2021–22

Select position type
Total

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

Vacant FTE positions, by position type (Total) and Organisation type, 2021–22 (per cent)



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

OSR – clients

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

Client numbers

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

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

See also Technical notes.

Client contacts

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

See also Technical notes.

Episodes of care

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

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

undercounts for some services in 2016–17. This also affected counts of client contacts in that year.

See also Technical notes.

The following boxes show key results for 2021–22. Clicking on a box will go to more information on the selected topic.

Client numbers

Organisation type	Indigenous clients	Remoteness
86% (or around 506,000) of clients were seen by Aboriginal Community Controlled Health Services	**76%** (or around 443,000) of clients were Indigenous	**33%** (or around 193,000) of clients were seen in *Remote or Very remote* areas

Client contacts

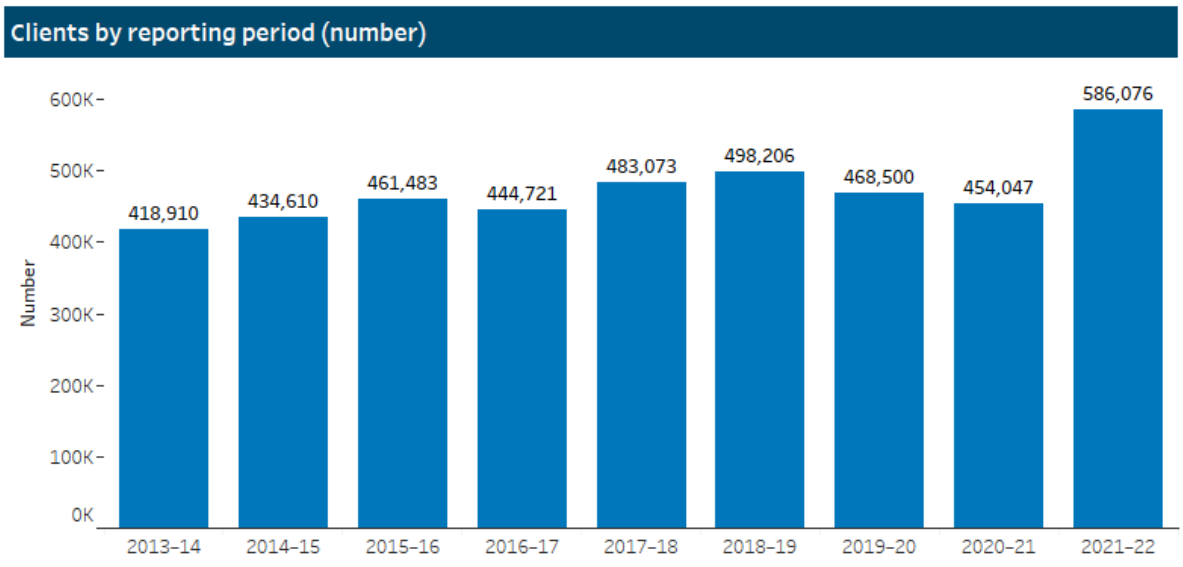
Organisation type	Indigenous clients	Remoteness
91% (or around 5.8 million) of client contacts were at Aboriginal Community Controlled Health Organisations	**34%** (or around 1.8 million) of Indigenous client contacts were with a nurse/midwife	**36%** (or around 2.3 million) of client contacts were in *Remote or Very remote* areas

Episodes of care

Organisation type	Indigenous clients	Remoteness
88% (or around 3.6 million) episodes of care were provided by Aboriginal Community Controlled Health Organisations	**84%** (or around 3.4 million) of episodes of care were with Indigenous clients	**35%** (or around 1.4 million) of episodes of care were provided in *Remote or Very remote* areas

Clients

In 2021–22, organisations saw around 586,000 clients.



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

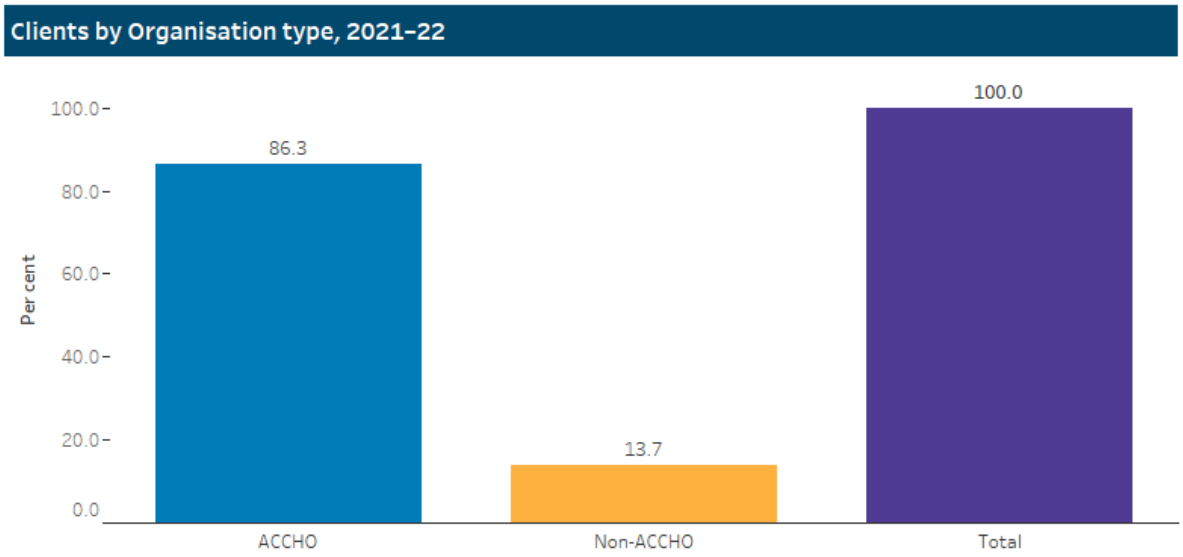
Of these around:

- 52% (308,000) were female
- 76% (443,000) were Indigenous
- 56% (328,000) were aged under 35
- 29% (169,000) were seen in Queensland
- 33% (193,000) were seen in *Remote* or *Very remote* areas
- 86% (506,000) were seen by Aboriginal Community Controlled Health Organisation (ACCHOs).

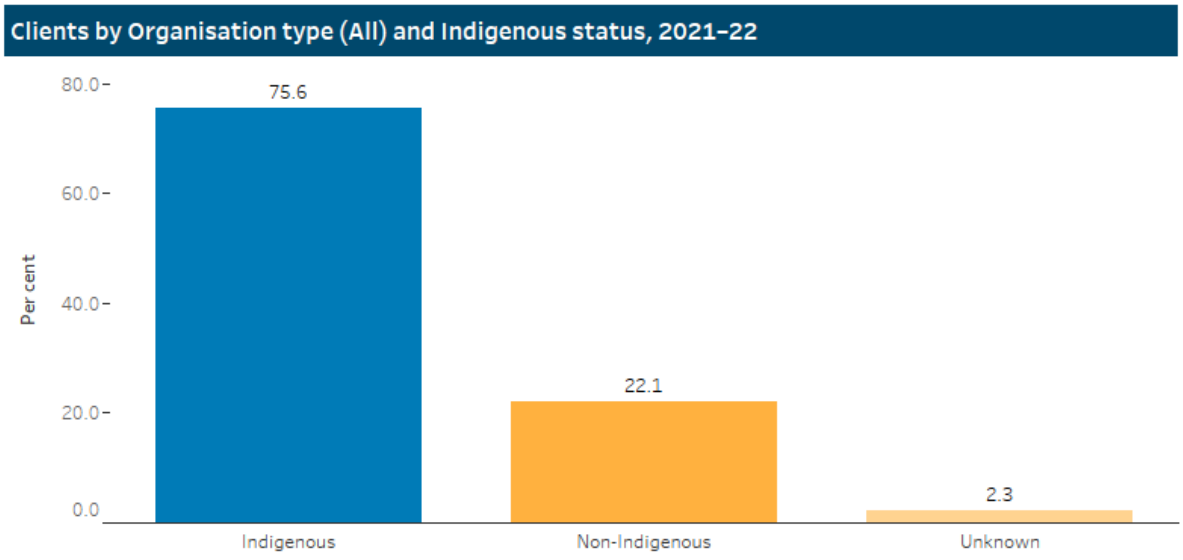
Select reporting period
2021–22

Select state/territory, remoteness or organisation type
Organisation type

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



Select sex or Indigenous status
Indigenous status



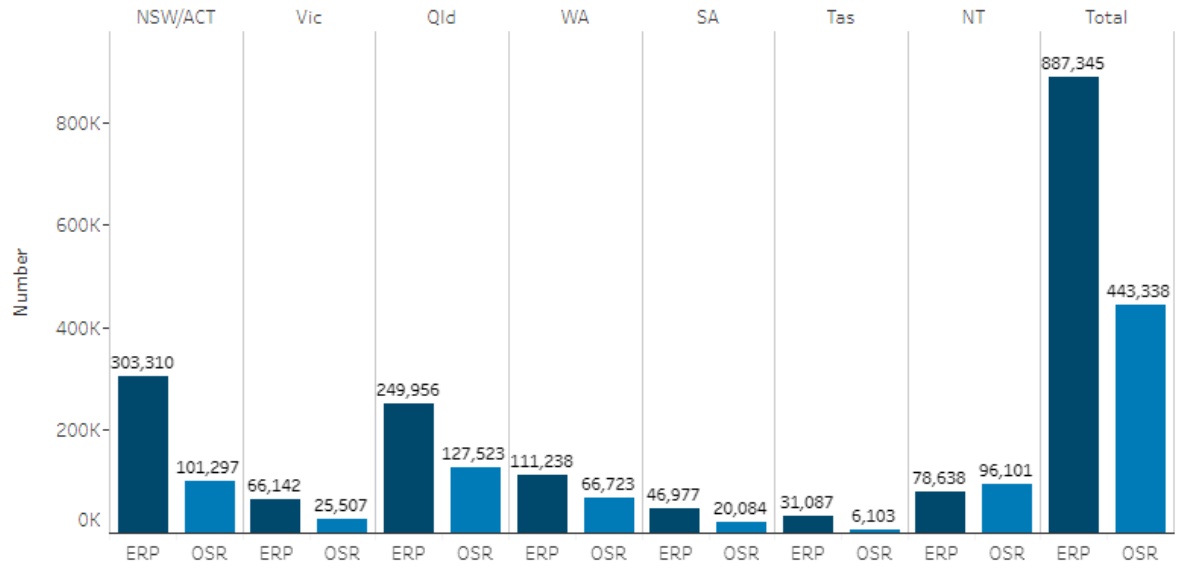
Note: See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

In 2021–22, around 50% (443,000) of the estimated resident Indigenous population (887,000) were Indigenous clients of organisations reporting to the OSR collection.

Select reporting period

2021–22

Indigenous clients compared to estimated resident Indigenous population, by state/territory, 2021–22



Notes

1.In some cases clients may be counted at more than one organisation. The number of clients being greater than the Indigenous ERP is most common in remote/very remote areas.

2. ERP is as at 31 December, the midpoint of the relevant reporting period. This is calculated by averaging the June population estimates before and after the relevant December. The ERP may vary from that used for the nKPI collection because of differences in reporting periods.

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

4. See Technical notes for more information.

Source: ABS 2019; AIHW OSR collection.

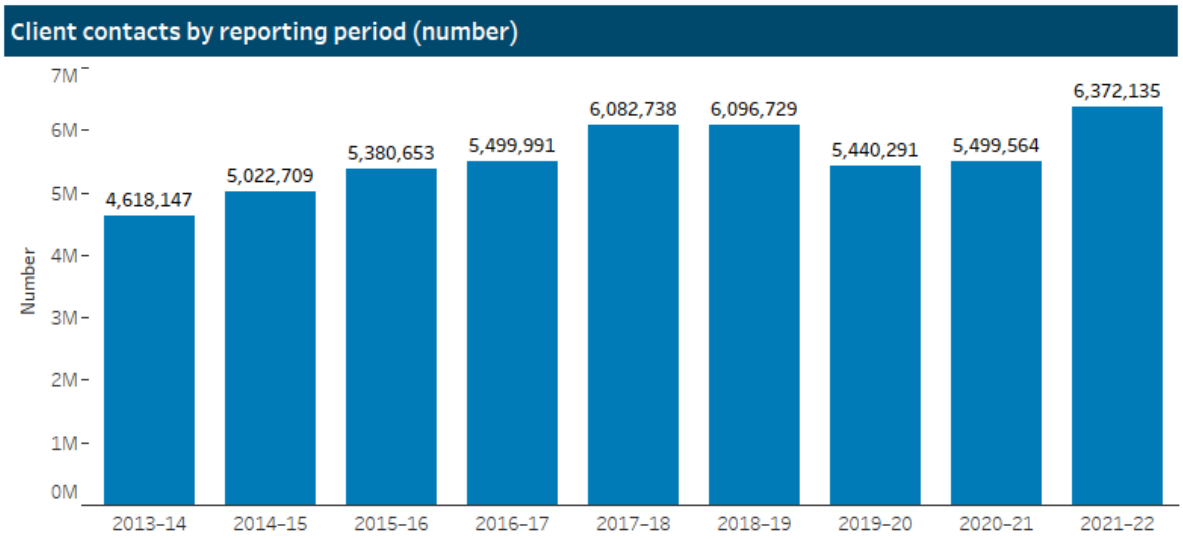
http://www.aihw.gov.au

Reference

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

Client contacts

In 2021–22, organisations had around 6.4 million client contacts.

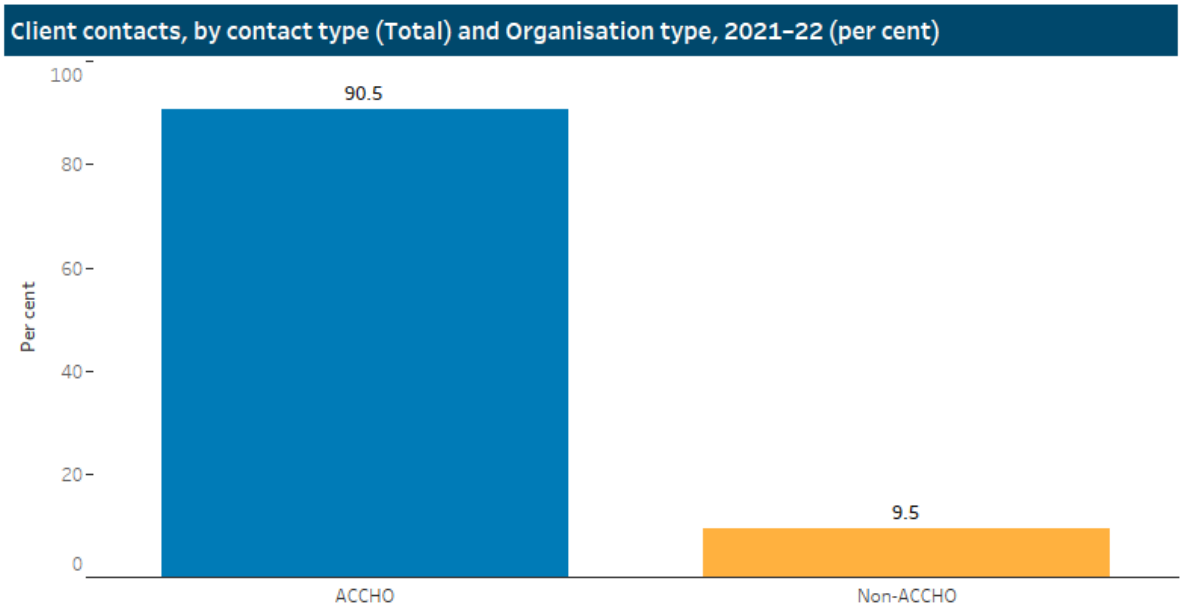


Note: See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

Of these around:

- 84% (5.3 million) were with Indigenous clients
- 25% (1.6 million) were provided in Queensland
- 22% (1.4 million) were provided in *Outer regional* areas
- 91% (5.8 million) were provided by Aboriginal Community Controlled Health Organisations (ACCHOs)
- 34% (2.2 million) were made by nurses and midwives
- 33% (2.1 million) were made by a general practitioner (GP)
- 11% (692,000) were made by Aboriginal and Torres Strait Islander health workers and practitioners.

Select reporting period: 2021–22
Select contact type: Total
Select state/territory, remoteness, organisation type or Indigenous status: Organisation type

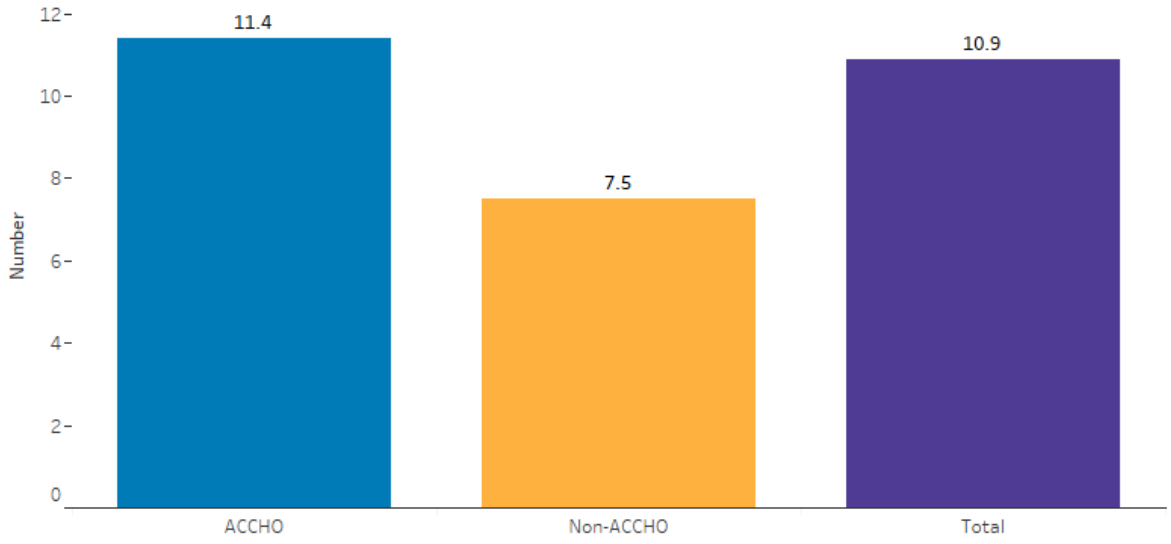


Notes
1. 'Other health' contacts include contacts made with dental care staff, substance misuse/drug and alcohol workers, tobacco workers, sexual health workers, traditional healers and 'other' health staff not recorded elsewhere.
2. See Technical notes for more information.
Source: AIHW OSR collection.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

There was an average of 10.9 contacts per client.

Select reporting period	Select contact type	Select state/territory, remoteness, organisation type or Indigenous status
2021–22	All	Organisation type

Average number of client contacts per client, by contact type (All contacts) and Organisation type, 2021–22



Notes

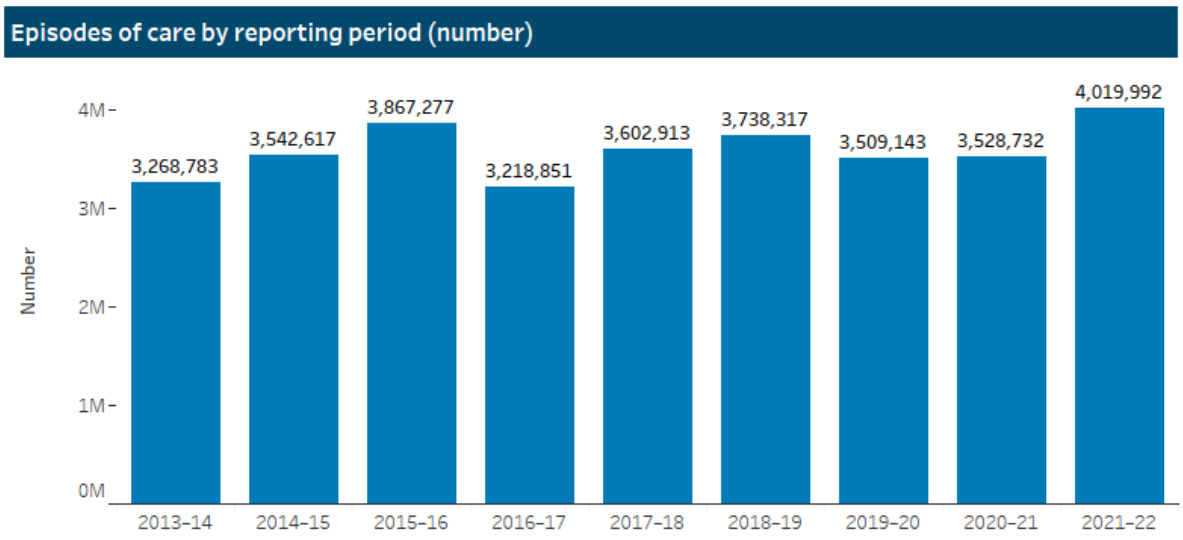
1. 'Other health' contacts include contacts made with dental care staff, substance misuse/drug and alcohol workers, tobacco workers, sexual health workers, traditional healers and 'other' health staff not recorded elsewhere.
2. See Technical notes for more information.

Source: AIHW OSR collection.

http://www.aihw.gov.au

Episodes of care

In 2021–22, organisations provided around 4.0 million episodes of care.



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

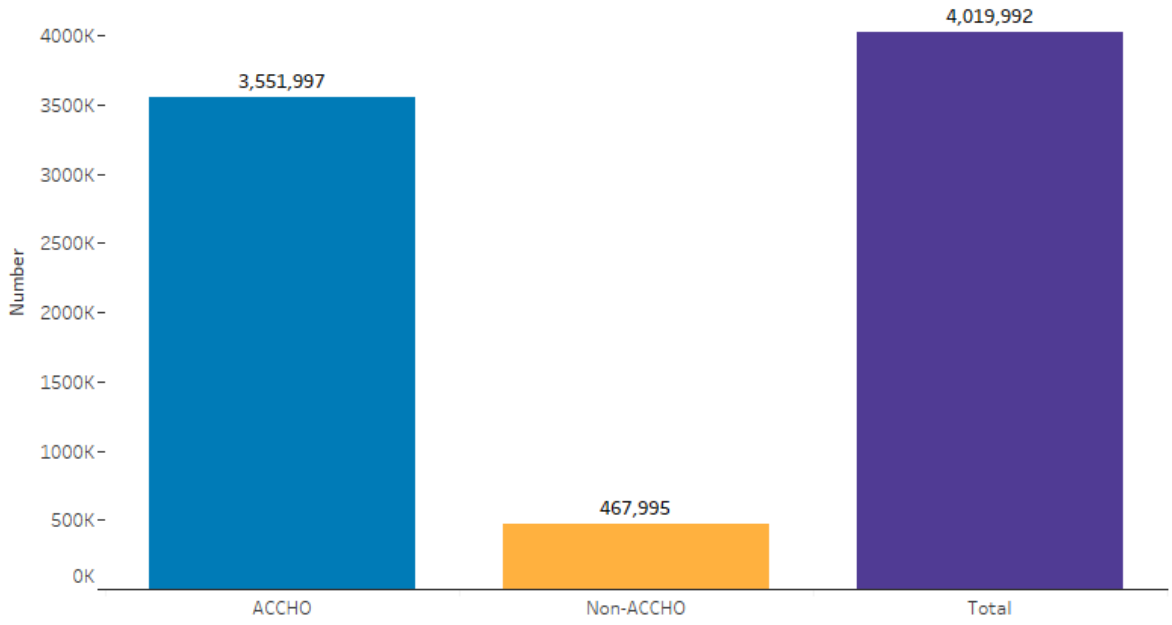
Of these around:

- 58% (2.3 million) were with female clients
- 84% (3.4 million) were with Indigenous clients
- 25% (988,000) were provided in Queensland
- 23% (905,000) were provided in *Major cities*
- 88% (3.6 million) were provided by Aboriginal Community Controlled Health Organisations (ACCHOs).

Select reporting period
2021–22

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

Episodes of care by Organisation type, 2021–22 (number)



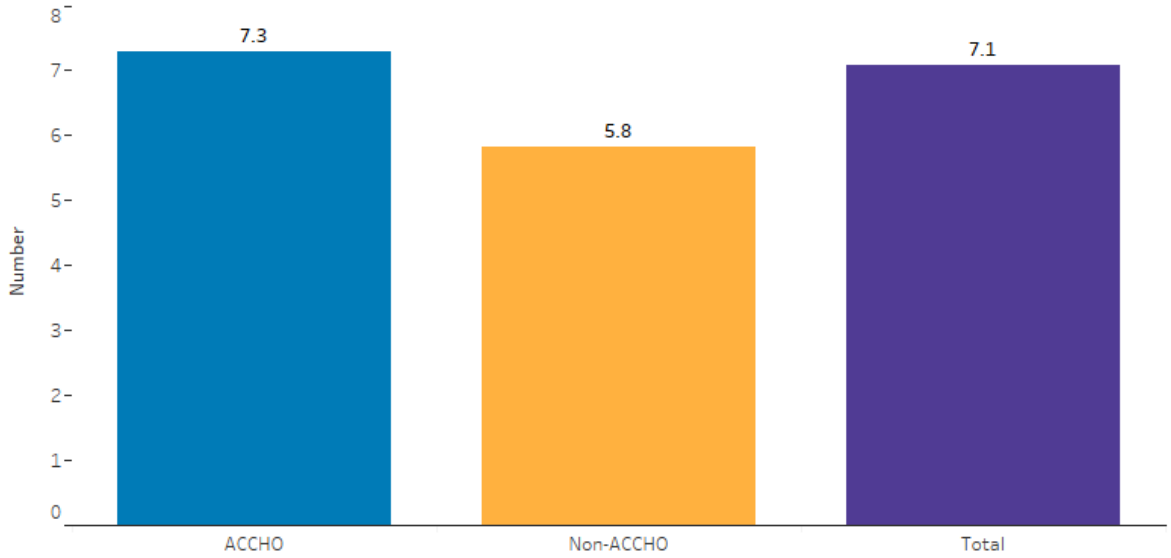
Note: See Technical notes for more information.
Source: AIHW OSR collection.
http://www.aihw.gov.au

There was an average of 7.1 episodes of care per client.

Select reporting period
2021–22

Select state/territory, remoteness, organisation type, Indigneous status or sex
Organisation type

Average number of episodes of care per client, by Organisation type, 2021–22



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

nKPI – introduction

The national Key Performance Indicator (nKPI) collection is a set of process-of-care and health-status indicators provided by organisations funded under the Australian Government's Indigenous Australians' Health Programme (IAHP).

These indicators are organised under 3 domains—maternal and child health; preventative health; and chronic disease management (see also Table 1 in Interpreting nKPI data for a list of indicators by domain and type). Some indicators consist of more than one measure (for example, an indicator might be collected by different types of chronic disease).

Data are collected twice a year, with census dates at 30 June and 31 December. The period of data covered varies by indicator. For example, for the 30 June 2022 census date, the data covers, depending on the indicator:

- 6 months up to the census date, that is, from, 1 January 2022 to 30 June 2022, or
- 12 months up to the census date, that is, from 1 July 2021 to 30 June 2022, or
- 24 months up to the census date, that is, from 1 July 2020 to 30 June 2022, or
- 5 years up to the census date, that is, from 1 July 2017 to 30 June 2022 (for cervical screening only).

Indigenous regular clients

Organisations reporting to the nKPI collection may see a mix of Indigenous and non-Indigenous clients. Some of these are considered regular clients of the organisation. The nKPI indicators include only data for Indigenous regular clients.

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

See Technical notes and Glossary for more information.

Process-of-care indicators are largely (but not completely) under the control of organisations and indicate good practice in primary health care. Health-status indicators, however, are influenced by a range of factors known as social determinants (such as education, employment, housing, access to resources, racism), some of which are beyond the immediate control of organisations. As such, the indicators need to be considered in context of the broader environment in which organisations operate and in which the data are collected. It is also important to acknowledge that the indicators capture only a subset of the important work that organisations do each day.

Reference

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

nKPI – summary over time

Trends for the national Key Performance Indicators in this report are calculated as a linear trend of comparable periods, including both the June and December collection periods. December data points are not shown in Table 1 but are available in the Data tables accompanying this report.

Of the 23 measures presented in Table 1, 3 have improved, 5 have had no (or limited) change, 10 have not improved, and trends for 5 cannot be calculated (for example because not enough comparable periods are available to calculate a trend).

Trends for collection periods from June 2020 onwards have been affected by the COVID-19 pandemic, especially the process-of-care indicators. See Summary for more information on the impact of COVID-19. See also Technical notes for more information on interpreting changes over time, and Interpreting nKPI data for more information on changes to indicator specifications.

Table 1: Trends for selected measures[a]

Maternal and child health indicators

Measure	June 2017	June 2018	June 2019	June 2020	June 2021	June 2022	Trend
PI13: First antenatal visit before 14 weeks[b]	*Data from June 2021 on cannot be compared with previous periods.*				62.9	61.6	×[a]
PI01: Birthweight recorded[c]	69.5	73.7	71.1	77.9	78.5	76.5	√
PI02: Healthy (normal) birthweight[c]	86.2	84.6	86.0	86.8	85.9	86.4	√
PI11: Smoking during pregnancy – ex-smoker/never smoked[b]	*Data from June 2021 on cannot be compared with previous periods for ages less than 20 or the total. Data for ages 20 and over can be compared with caution.*				54.8	56.2	√[a]
PI03: Indigenous health assessment – aged 0–14[b]	*Data from December 2021 on cannot be compared with previous period for ages 5–14 or the total. Ages 0–4 can be compared with caution.*				36.8	29.5	×[a]

Preventative health indicators

Measure	June 2017	June 2018	June 2019	June 2020	June 2021	June 2022	Trend
PI09: Smoking status recorded[b]	*Data from June 2021 on cannot be compared with previous periods for the total. Data for ages 15 and over can be compared.*				72.3	70.2	×[a]
PI10: ex-smoker/never smoked[b]	*Data from June 2021 on cannot be compared with previous periods for the total. Data for ages 15 and over can be compared.*				53.0	52.5	≈[a]
PI16: Alcohol consumption status recorded	59.4	61.7	62.0	61.5	62.0	55.0	×
PI03: Indigenous health assessment – aged 15 and over[b]	*Data from December 2021 on cannot be compared with previous period for ages 15–24 or the total. Data for ages 25 and over can be compared with caution.*				51.8	45.2	×[a]
PI20: Risk factors to enable CVD assessment	46.1	48.7	50.3	49.9	49.6	46.6	≈
PI21: low absolute cardiovascular risk	58.4	59.4	59.3	59.8	59.0	58.3	≈
PI22: Cervical screening[c]	43.9	46.7	42.5	42.4	39.7	39.6	×
PI14: Immunised against influenza[b]	*Data from December 2020 on cannot be compared with previous periods.*				18.6	21.1	×[a]

Measure	June 2017	June 2018	June 2019	June 2020	June 2021	June 2022	Trend
BMI – normal weight[b]	*Data from June 2022 on for the total cannot be compared with previous periods. Data for overweight and obese categories for ages 25 and over can be compared.*					24.4	n.a.

Chronic disease management indicators

Measure	June 2017	June 2018	June 2019	June 2020	June 2021	June 2022	Trend
PI07: Chronic Disease Management Plan – type 2 diabetes[c]	53.6	56.2	56.1	54.8	54.9	50.6	×
PI23: Blood pressure result recorded – type 2 diabetes	64.0	66.2	66.8	63.7	64.1	58.2	×
PI24: Blood pressure result of ≤140/90mmHg – type 2 diabetes[b]	*Data from June 2021 on cannot be compared with previous periods.*				65.2	65.4	≈[a]
PI05: HbA1c result recorded (previous 6 months) – type 2 diabetes	48.9	52.0	52.2	49.8	49.5	45.2	×
PI06: HbA1c result of ≤53 mmol/mol – type 2 diabetes	38.3	38.9	38.6	36.4	37.4	40.8	≈
PI18: Kidney function test recorded (both eGFR and ACR) – type 2 diabetes[b]	*Data from June 2022 on for the total cannot be compared with previous periods. Data for ages 25 and over can be compared.*					41.4	n.a.
PI19: Kidney function test result of 'normal risk' – type 2 diabetes[b]	*Data from June 2022 on cannot be compared with previous periods.*					38.2	n.a.
PI18: Kidney function test recorded (both eGFR and ACR) – CVD[b]	*Data from June 2022 on for the total cannot be compared with previous periods. Data for age groups 25 and over can be compared with caution.*					36.0	n.a.

Measure	June 2017	June 2018	June 2019	June 2020	June 2021	June 2022	Trend
PI19: Kidney function test result of 'normal risk' – CVD(b)	*Data from June 2022 on cannot be compared with previous periods.*					39.8	n.a.

(a) Trend is calculated as a linear trend of comparable periods between the June 2017 and June 2022 collection periods, including the December collection periods. December data points are not shown in this table but are available in the Data tables accompanying this report.

(b) There have been changes to the specification of this indicator over time. Data are not comparable over time for some components of this indicator. See Interpreting nKPI data for more information.

(c) There have been changes to the specification of this indicator over time, however, data can be compared between periods with caution. See Interpreting nKPI data for more information.

Notes:

1. Key: ✓ = improved; × = not improved; ≈ = little or no change; n.a. = not enough comparable periods available to calculate trend.
2. Some of the indicators in the national Key Performance Indicators (nKPI) collection have, or can be split into, more than one part.
3. Reporting to the nKPI collection for June 2020, December 2020 and June 2021 was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19.
4. See Technical notes for information on interpreting data over time.

Source: AIHW analysis of nKPI collection.

nKPI – organisations

At June 2022, 230 organisations reported to the national Key Performance Indicators (nKPI) collection. Of these:

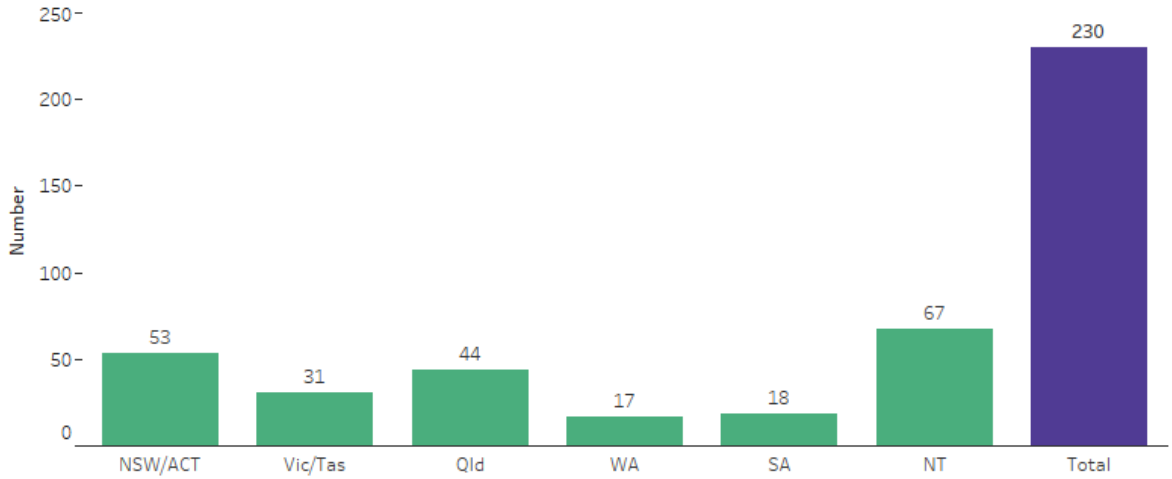
- 29% (or 67) were in the Northern Territory
- 33% (or 77) were in *Very remote* areas
- 64% (or 148) were Aboriginal Community Controlled Health Organisations (ACCHOs), of which:
  - 26% (38) were in Queensland, 26% (38) were in New South Wales/the Australian Capital Territory (combined), 18% (27) were in Victoria/Tasmania (combined), 12% (18) were in the Northern Territory, 11% (16) were in Western Australia and 7% (11) were in South Australia
  - 26% (39) were in *Inner regional* areas, 24% (36) were in *Outer regional* areas, 22% (32) were in *Very remote* areas, 16% (23) were in *Remote* areas and 12% (18) were in *Major cities*
- 36% (or 82) were organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs), of which:
  - 60% (49) were in the Northern Territory, 18% (15) were in New South Wales/the Australian Capital Territory (combined), 9% (7) were in South Australia, 7% (6) were in Queensland, 5% (4) were in Victoria/Tasmania (combined) and 1% (1) were in Western Australia
  - 55% (45) were in *Very remote* areas, 13% (11) were in *Inner regional* areas, 12% (10) were in *Major cities,* 10% (8) were in *Outer regional* areas and 10% (8) were in *Remote* areas.

Select reporting period
June 2022

Select state/territory or remoteness
State/territory

Select organisation type
All

Reporting organisations, by State/territory and organisation type (All), June 2022



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

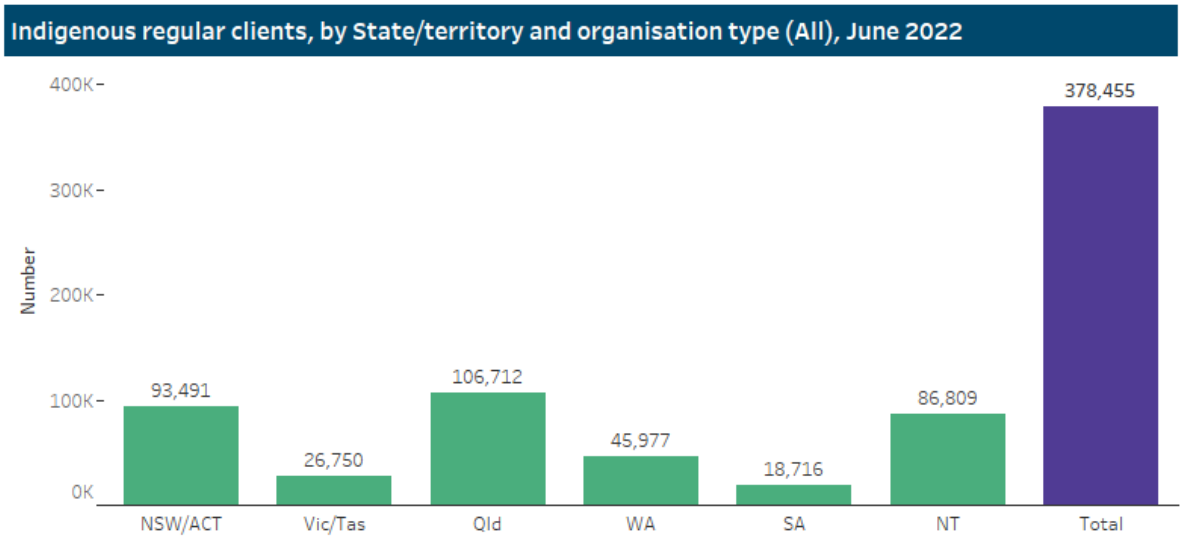
nKPI – clients

There were over 378,000 Indigenous regular clients at June 2022 (that is, Indigenous clients who had visited the organisation 3 or more times in the 2 years up to 30 June 2022). This is based on estimates provided by the organisations, and may differ from the number of Indigenous regular clients reported as indicator denominators (see Data for more information).

Select reporting period: June 2022

Select state/territory or remoteness: State/territory

Select organisation type: All



Notes:
1. Based on data provided on the number of Indigenous regular clients with age and sex recorded.
2. Includes Indigenous regular clients of all ages.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

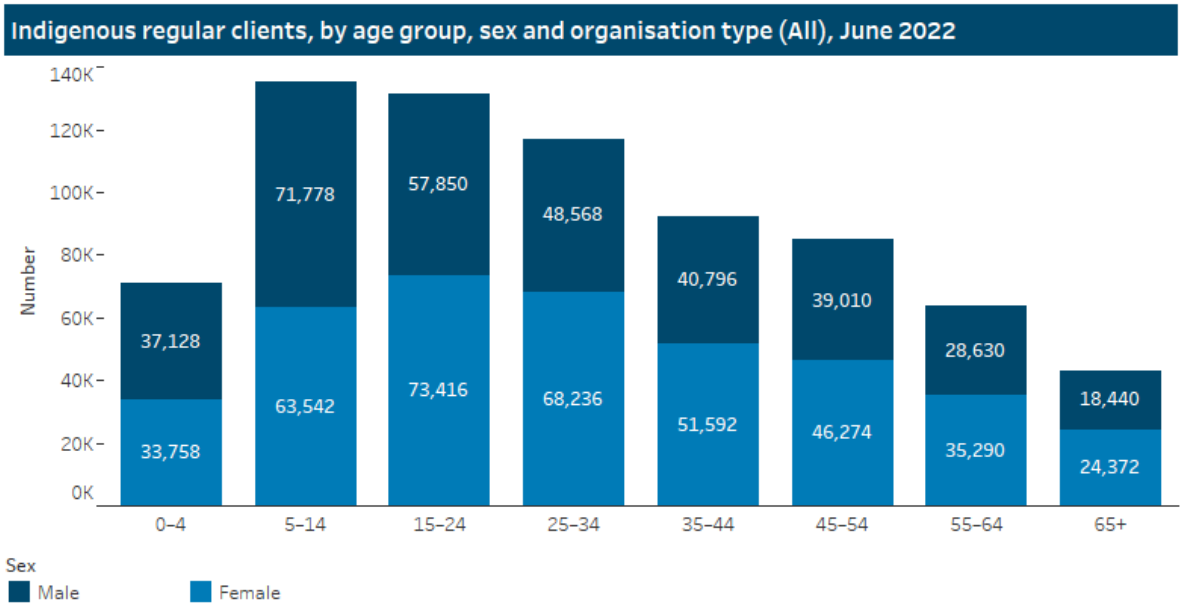
Of these:

- 28% (or around 107,000) were seen in Queensland
- 23% (or around 87,400) were seen in *Major cities*
- 84% (or around 317,000) were seen in Aboriginal Community Controlled Health Organisations (ACCHOs), of which:
  - 29% (91,700) were seen in Queensland, 27% (85,400) in New South Wales/the Australian Capital Territory (combined), 16% (52,000) in the Northern Territory, 14% (45,600) in Western Australia, 8% (25,100) in Victoria/Tasmania (combined) and 5% (16,900) in South Australia
  - 26% (81,300) were seen in *Major cities*, 22% (70,900) in *Inner regional* areas, 22% (69,200) in *Outer regional* areas, 17% (55,200) in *Remote* areas and 13% (40,200) in *Very remote* areas
- 16% (or around 61,600) were seen in organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs), of which:

- 56% (34,800) were seen in the Northern Territory, 24% (15,000) were seen in Queensland, 13% (8,000) in New South Wales/the Australian Capital Territory (combined), 3% (1,900) in South Australia, 3% (1,600) in Victoria/Tasmania (combined) and 1% (400) in Western Australia
- 59% (36,300) were seen in *Very remote* areas, 14% (8,500) in *Remote* areas, 12% (7,200) in *Inner regional* areas, 10% (6,100) in *Major cities* and 6% (3,600) in *Outer regional* areas.

Select reporting period
June 2022

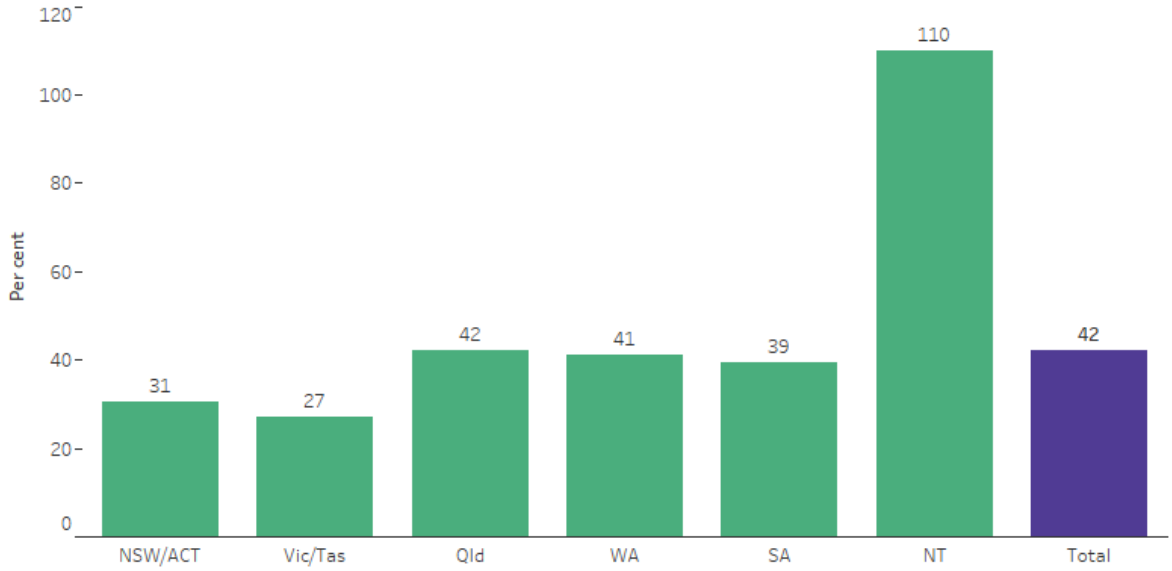
Select organisation type
All



Notes:
1. Prior to December 2020, results were calculated from the denominator of PI03 for Indigenous regular clients aged 0–4 and the denominator of PI09 for Indigenous regular clients aged 15 and over.
2. From December 2020 onward, results presented are from the denominator of PI03 only, as both sexes and all age groups are now collected for Indigenous regular clients.
3. From December 2020, ages 0–4 are disaggregated by sex and ages 5–14 are now collected.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

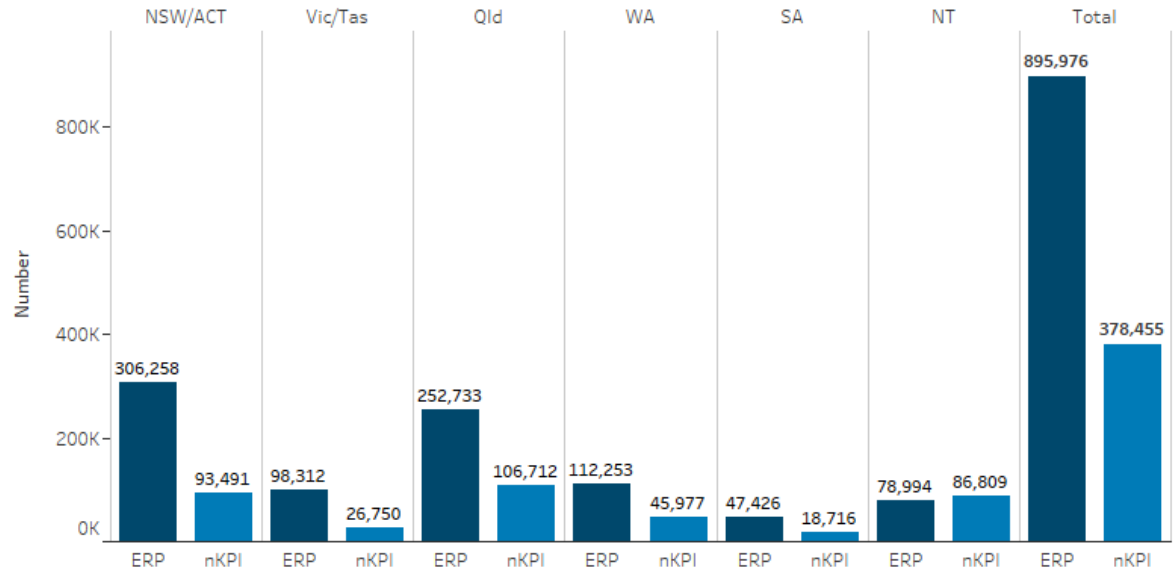
At June 2022, 42% of the estimated resident Indigenous population were Indigenous regular clients of organisations reporting to the nKPI collection.

Indigenous regular clients as a proportion of the estimated resident Indigenous population, by State/Territory, June 2022



Note:
1. In some cases clients may be counted at more than one organisation. The number of clients being greater than the Indigenous ERP is most common in remote/very remote areas.
2. ERP is as at 30 June of the relevant reporting period.
3. Total is the sum of the states and territories and does not include external territories.
Sources: ABS 2019; AIHW nKPI collection.
http://www.aihw.gov.au

Indigenous regular clients compared to estimated resident Indigenous population, by State/Territory, June 2022



Notes:
1. In some cases clients may be counted at more than one organisation. The number of clients being greater than the Indigenous ERP is most common in remote/very remote areas.
2. ERP is as at 30 June of the relevant reporting period. The ERP may vary from that used for the OSR collection because of differences in reporting periods.
3. Total is the sum of the states and territories and does not include external territories.
4. nKPI data are based on data provided on the number of Indigenous regular clients with age and sex recorded.
5. Includes all ages.

Sources: ABS 2019; AIHW nKPI collection.

http://www.aihw.gov.au

Reference

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

nKPI – maternal and child health indicators

The following boxes show selected maternal and child health indicator results for Indigenous regular clients at June 2022. Clicking on a box will go to more information on the associated indicator.

Antenatal visit

62%

(or around 2,800) who gave birth in the last year had their first antenatal visit before 14 weeks

Process-of-care indicator

Birthweight recorded

77%

(or around 5,800) born in the last year had their birthweight recorded

Process-of-care indicator

Birthweight result

86%

(or around 5,000) born in the last year had a healthy birthweight

Health-status indicator

Smoking during pregnancy

56%

(or around 2,900) who gave birth in the last year had never smoked or were an ex-smoker

Health-status indicator

Indigenous health assessment

30%

(or around 30,400) aged 0–14 had an Indigenous health assessment in the last year

Process-of-care indicator

First antenatal visit (PI13)

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

- before 11 weeks
- 11–13 weeks
- 14–19 weeks
- 20 or more weeks
- gestational age not recorded at first antenatal care visit or did not have an antenatal care visit.

It is reported here in two parts as the proportion of female Indigenous regular clients who gave birth within the previous 12 months who had:

- an antenatal care visit and gestational age recorded at their first antenatal care visit
- an antenatal care visit and gestational age recorded at their first antenatal care visit, with the timing of that visit recorded as either:
  - before 14 weeks
  - 14–19 weeks
  - 20 or more weeks.

It is collected for age groups:

- less than 20
- 20–34
- 35 and over.

There have been changes to the specification of this indicator over time. See Technical notes for more information.

Why antenatal care is important

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

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

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

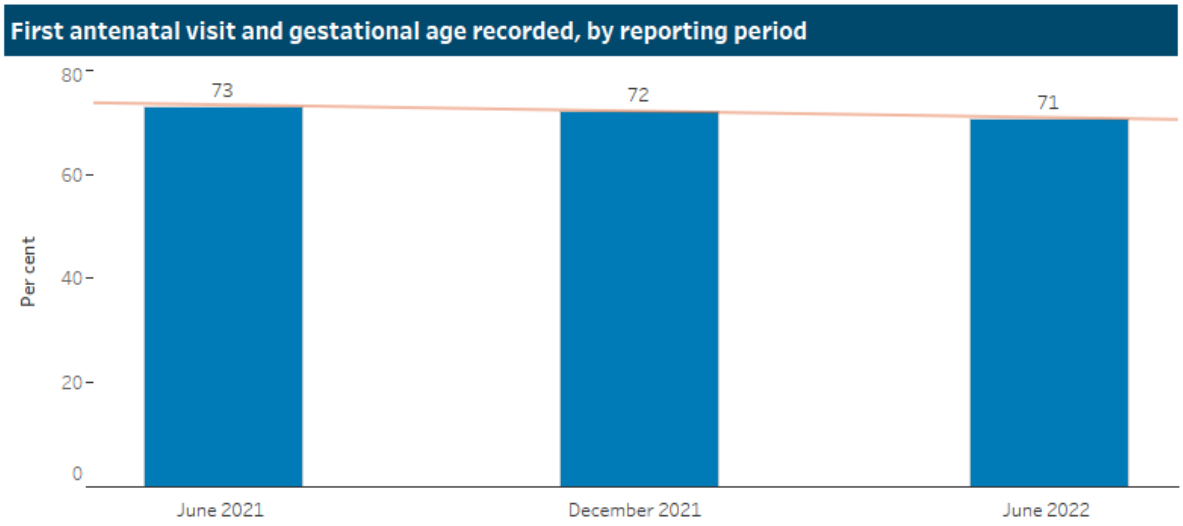
The proportion of Indigenous mothers attending an antenatal visit in the first trimester has increased over time. Indigenous mothers, however, are less likely than non-Indigenous mothers to have their first antenatal care visit in the first trimester (AIHW 2022).

At June 2022, 71% (or around 4,600) of female Indigenous regular clients had an antenatal care visit and gestational age recorded at their first antenatal care visit, 29% (1,900) did not.

Having an antenatal care visit and gestational age recorded at the first antenatal care visit was highest in:

- Western Australia (86%)
- *Inner regional* areas (82%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (74%).

Select antenatal care visit and gestational age recorded category
First antenatal visit and gestational age recorded



Note: In June 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Of those who had an antenatal care visit and gestational age recorded at their first antenatal care visit:

- 62% (or around 2,800) had their visit before 14 weeks (first trimester)
- 17% (or around 800) had their visit at 14–19 weeks
- 21% (or around 1,000) had their visit at 20 or more weeks.

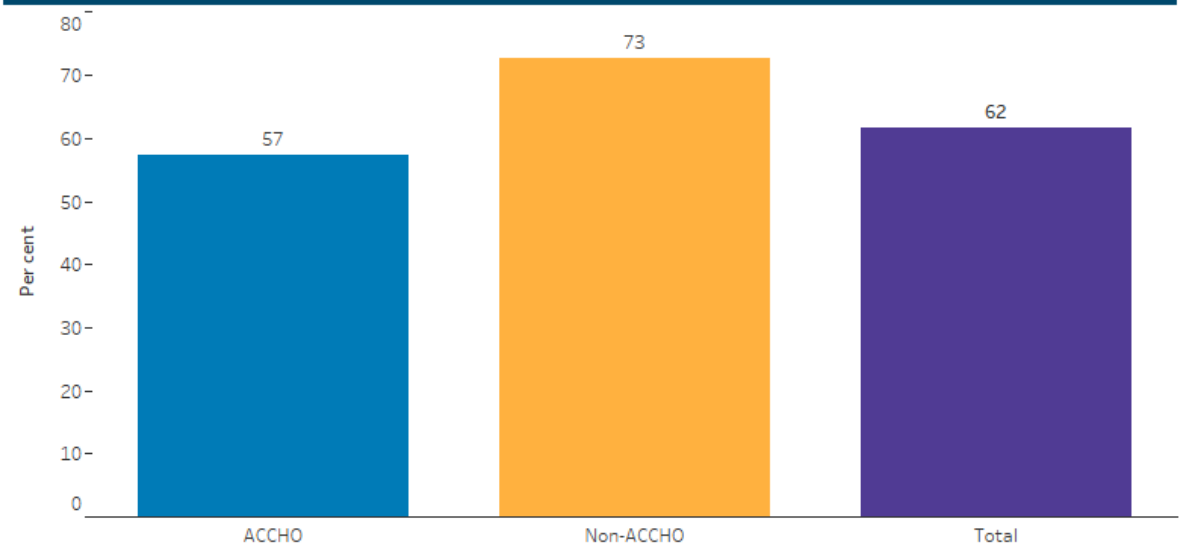
Of those who had an antenatal care visit and gestational age recorded at their first antenatal care visit, having the first antenatal visit in the first trimester was highest in:

- South Australia (67%)
- *Inner regional* areas (68%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (73%).

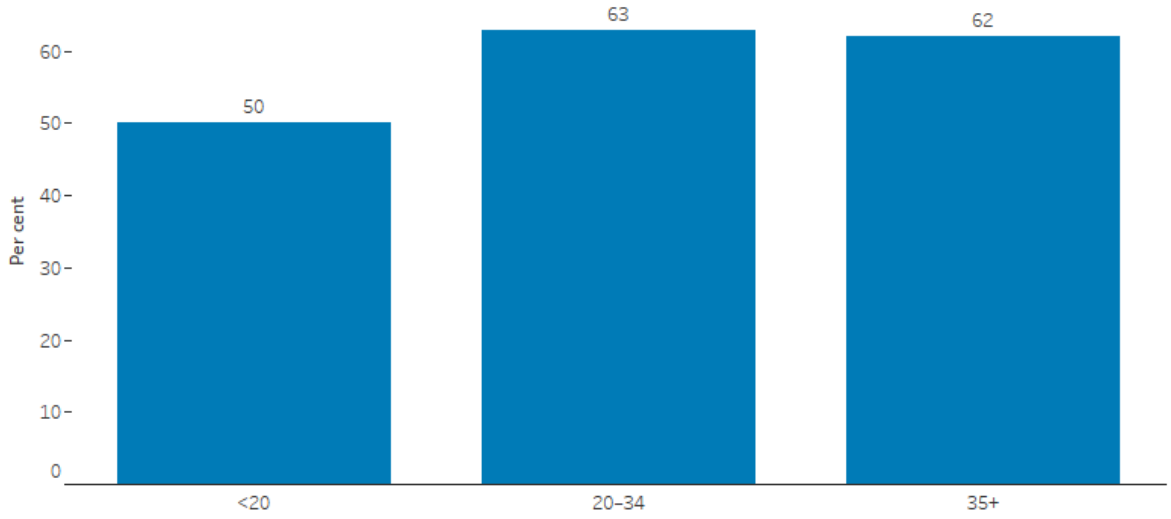
Select reporting period	Select state/territory, remoteness or organisation type	Select timing of first antenatal visit
June 2022	Organisation type	Before 14 weeks

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

First antenatal visit – Before 14 weeks, by Organisation type, June 2022



First antenatal visit – Before 14 weeks, by age group and Organisation type (All), June 2022



Notes:
1. In June 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
2. Proportions in this figure are calculated using the denominator of female Indigenous regular clients who had an antenatal care visit and gestational age recorded at their first antenatal care visit.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Reference

AIHW (Australian Institute of Health and Welfare) 2022. Aboriginal and Torres Strait Islander Health Performance Framework: antenatal care. Canberra: AIHW.

Birthweight (PI01 and PI02)

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

- birthweight recorded (PI01): the proportion of Indigenous babies born within the previous 12 months who attended the organisation more than once and whose birthweight was recorded
- birthweight result (PI02): the proportion of Indigenous babies born within the previous 12 months who attended the organisation more than once and whose birthweight result was low, normal or high.

There have been changes to the specifications of these indicators over time. See Technical notes for more information.

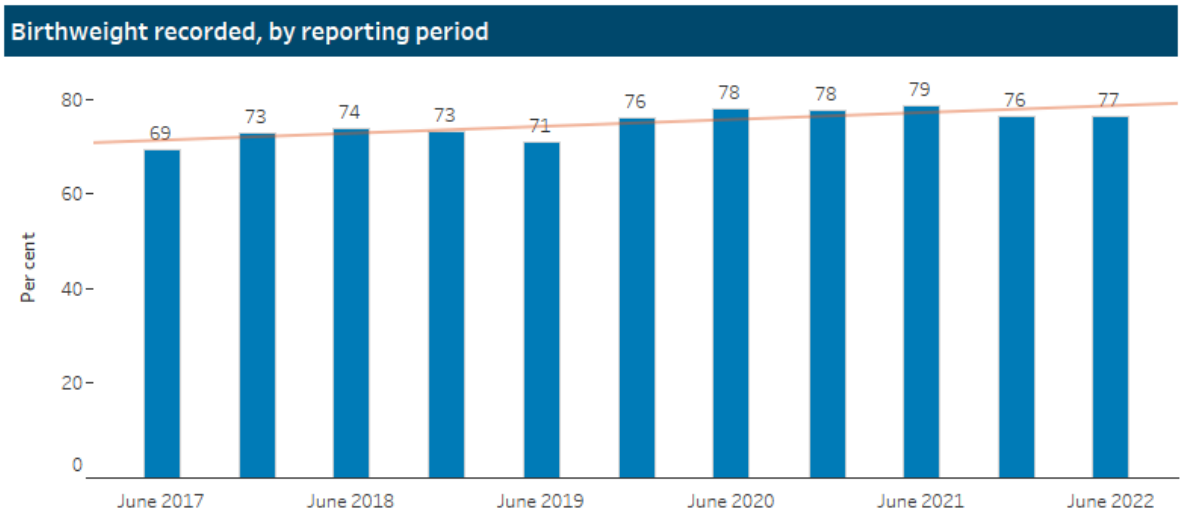
Why birthweight is important

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

The targets in the National Agreement on Closing the Gap include several aimed at children, including a target to increase the proportion of Indigenous babies with a healthy birthweight to 91% by 2031. The majority of babies born to Indigenous mothers have a normal birthweight, however, they are less likely to do so than babies born to non-Indigenous mothers (AIHW 2022). There has been little change in this in recent years.

Birthweight recorded (PI01)

At June 2022, 77% (or around 5,800) of Indigenous babies born in the previous 12 months had their birthweight recorded.



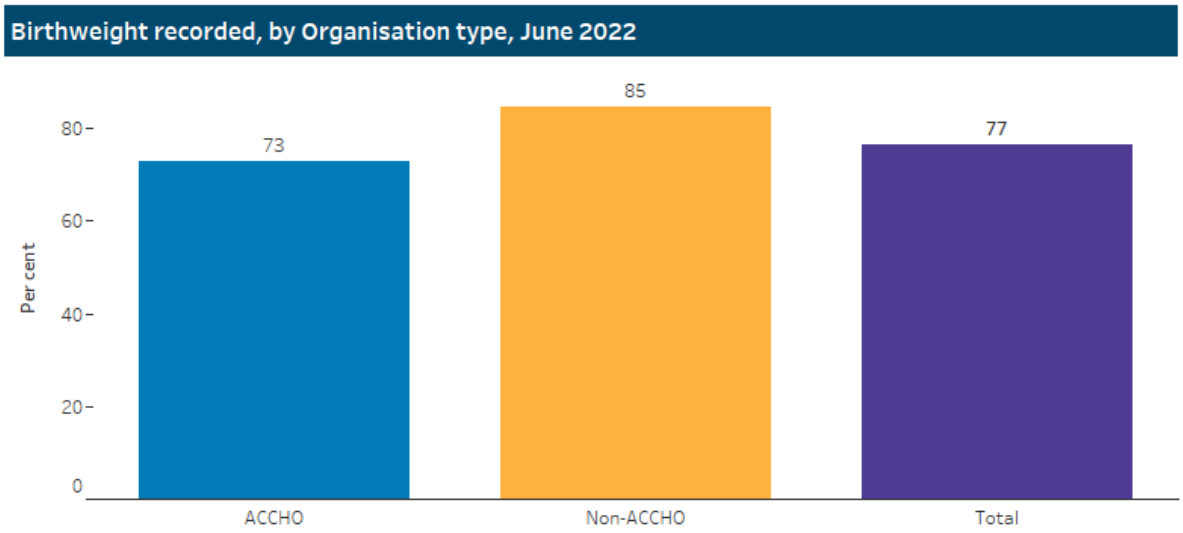
Note: In June 2021, specifications changed for this indicator. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Recording of birthweight was highest in:

- South Australia (90%)
- *Inner regional* areas (87%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (85%).

Select reporting period
June 2022

Select state/territory, remoteness or organisation type
Organisation type

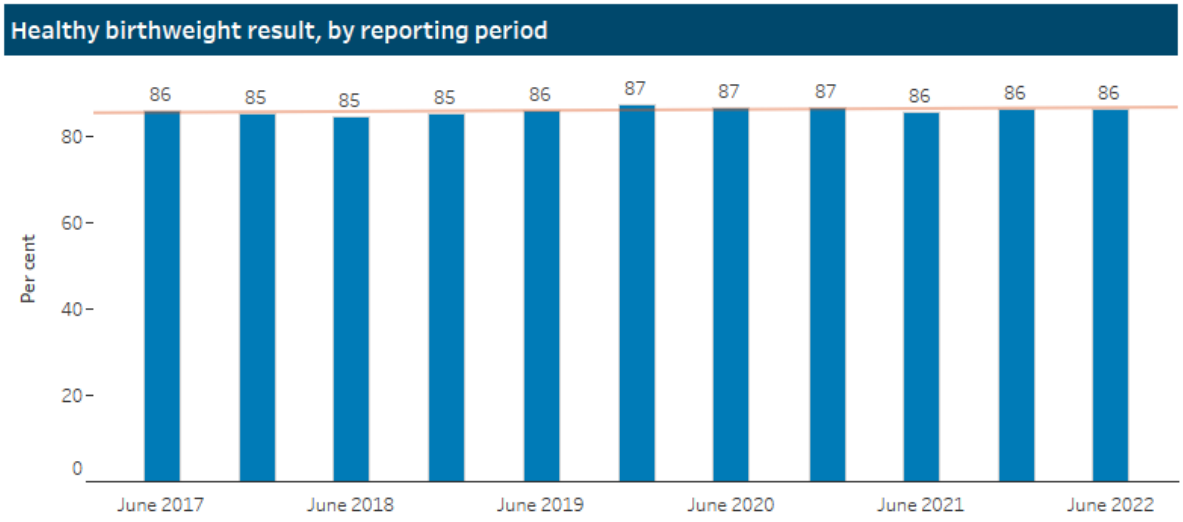


Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Birthweight result (PI02)

At June 2022, 86% (or around 5,000) of Indigenous babies born in the previous year had a healthy (normal) birthweight.

Select birthweight
Healthy

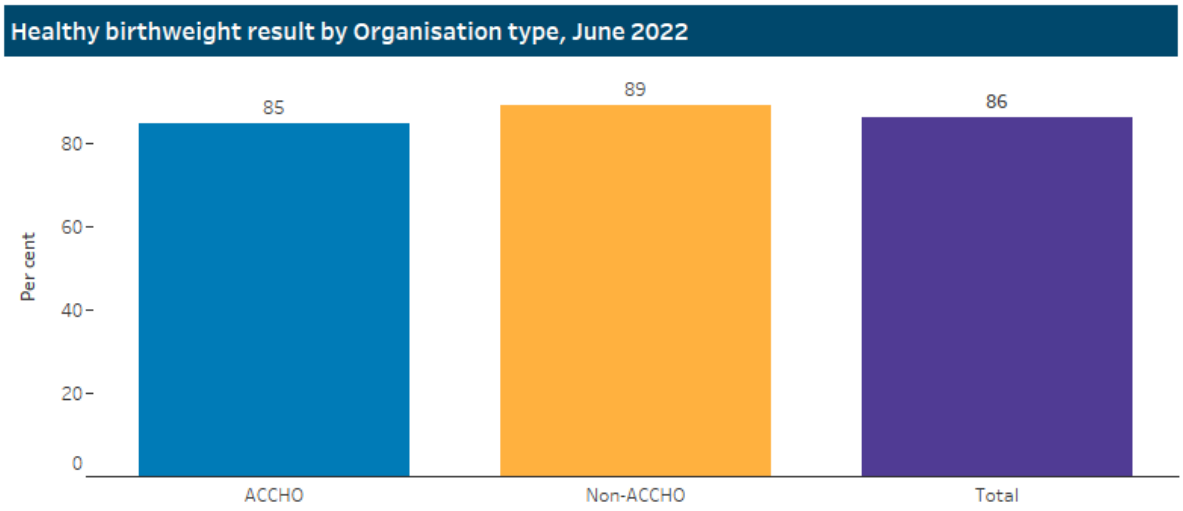


Note: In June 2021, specifications changed for this indicator. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Having a healthy birthweight was highest in:

- Victoria/Tasmania (combined) (91%)
- *Inner regional* areas and *Major cities* (both 88%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (89%).

Select reporting period: June 2022
Select state/territory, remoteness or organisation type: Organisation type
Select birthweight: Healthy



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

References

AIHW (Australian Institute of Health and Welfare) (2022) Aboriginal and Torres Strait Islander Health Performance Framework: birthweight, Canberra: AIHW.

Smoking during pregnancy (PI11)

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

- current smoker
- ex-smoker
- never smoked.

It is collected for age groups:

- less than 20
- 20–34
- 35 and over.

There have been changes to the specification of this indicator over time. See Technical notes for more information.

Indicators related to smoking for ages 11 and over are also collected, with data presented under the Preventative health domain.

Why not smoking during pregnancy is important

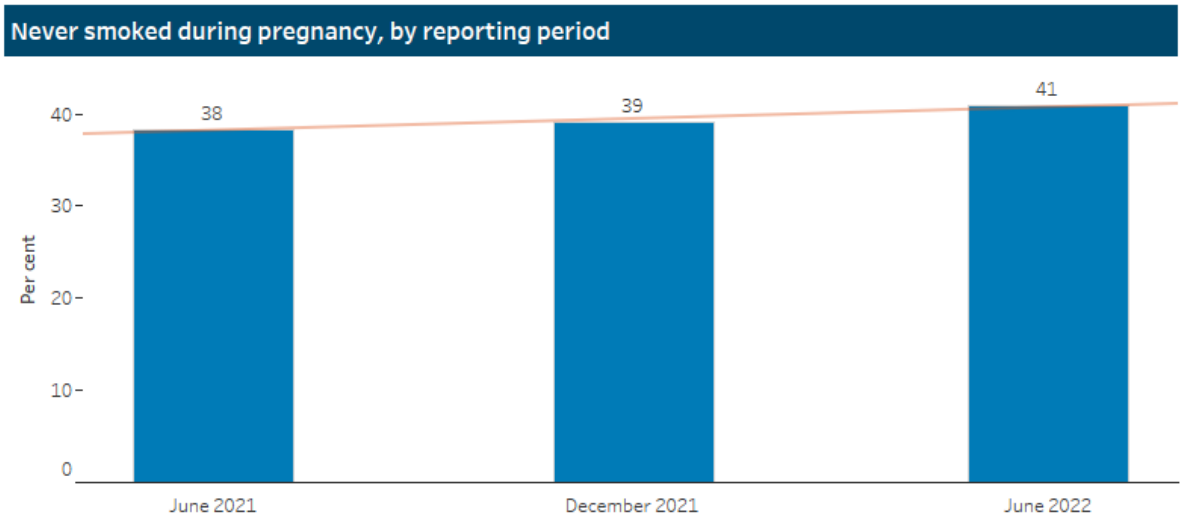
Tobacco smoking is the smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, cigars or pipes.

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

The proportion of Indigenous mothers who smoke during pregnancy has decreased over time. Indigenous mothers, however, are more likely to smoke during pregnancy than non-Indigenous mothers (AIHW 2022).

At June 2022, 44% (or around 2,300) of Indigenous regular clients who gave birth in the previous 12 months smoked at some point during pregnancy, 41% (2,100) had never smoked and 15% (800) were ex-smokers.

Select smoking status
Never smoked



Note: In June 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Having never smoked or being an ex-smoker during pregnancy (56%) was highest in:

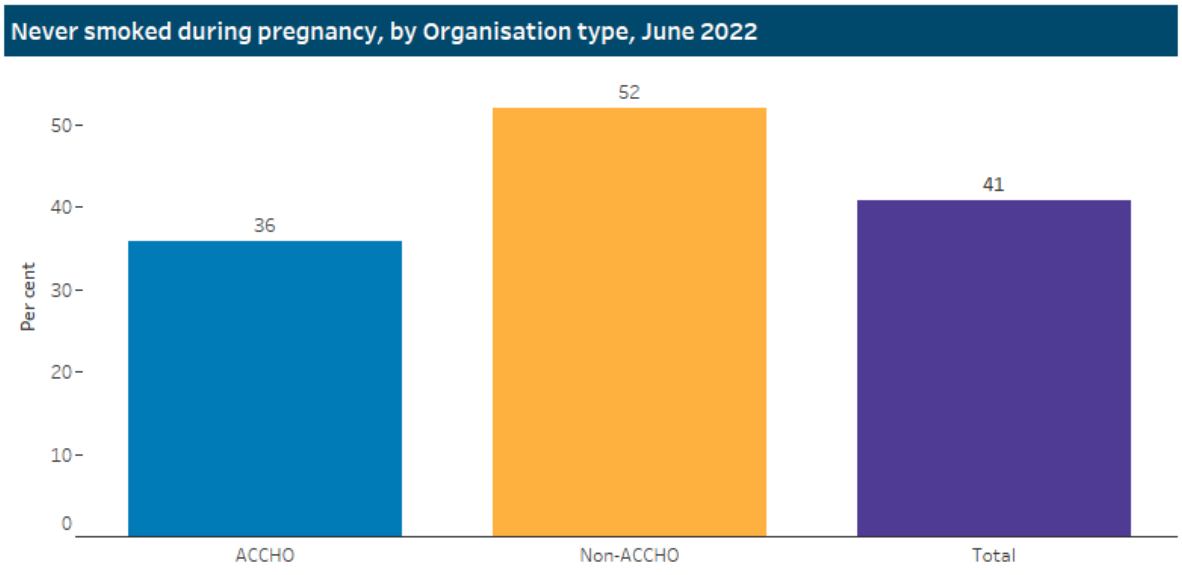
- Victoria/Tasmania (combined) (64%)
- *Major cities* (65%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (60%).

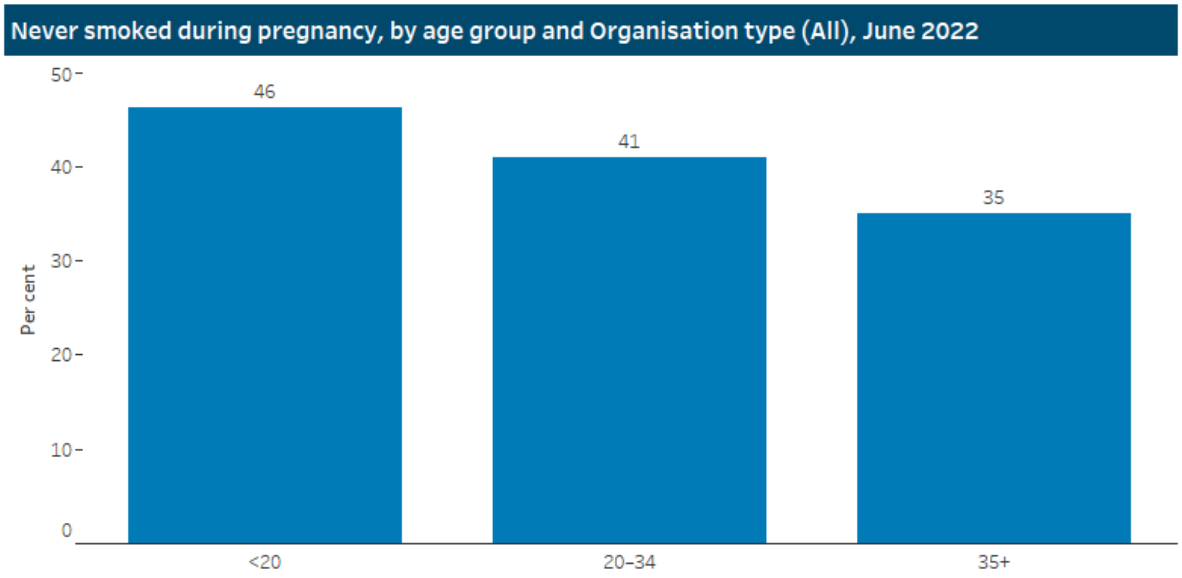
Select reporting period
June 2022

Select state/territory, remoteness or organi..
Organisation type

Select smoking status
Never smoked

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





Note: In June 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Reference

AIHW (Australian Institute of Health and Welfare) (2022) Aboriginal and Torres Strait Islander Health Performance Framework: health behaviours during pregnancy, Canberra: AIHW.

Indigenous health assessment – aged 0–14 (PI03)

This indicator is the proportion of Indigenous regular clients aged 0–14 who had an Indigenous health assessment within the previous 12 months.

It is collected for males and females in age groups:

- 0–4
- 5–14.

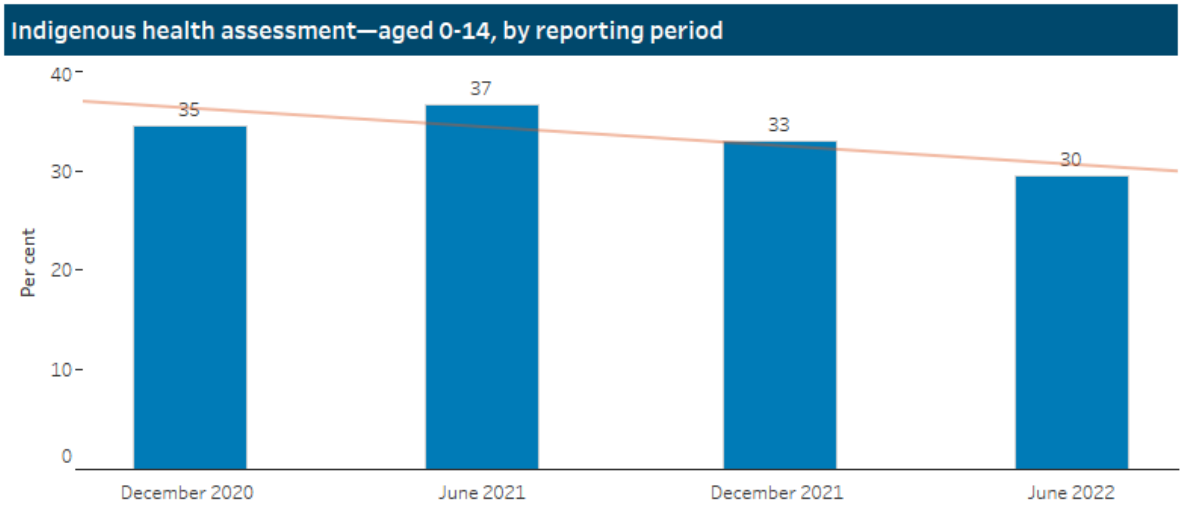
There have been changes to the specification of this indicator over time. See Technical notes for more information.

Ages 15 and over are also collected for PI03, with data presented under the Preventative health domain.

Why health checks are important

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

At June 2022, 30% (or around 30,400) of Indigenous regular clients aged 0–14 had an Indigenous health assessment in the previous 12 months.



Note: In December 2020, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was highest in:

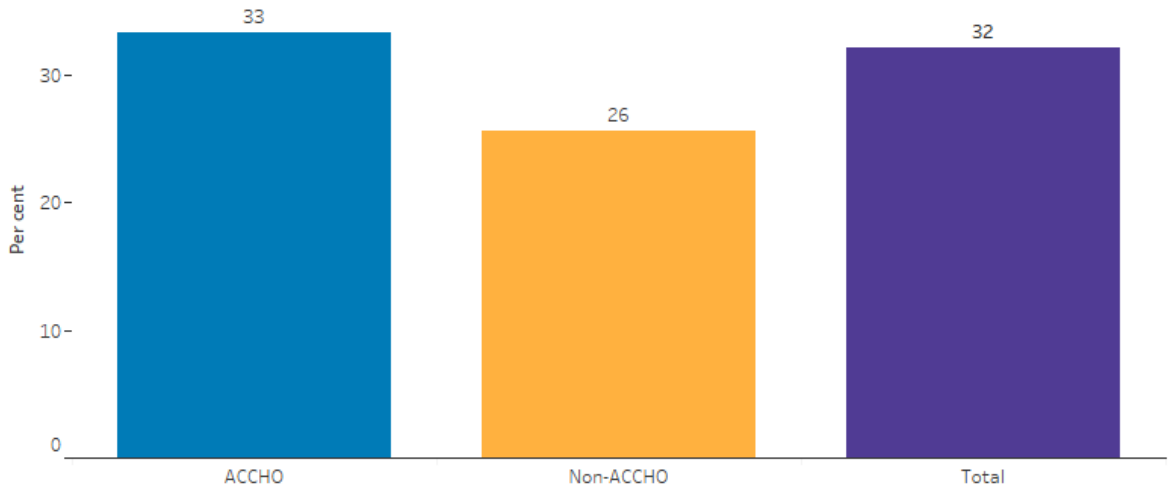
- Queensland (39%)
- *Major cities* (36%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (32%).

Select reporting period
June 2022

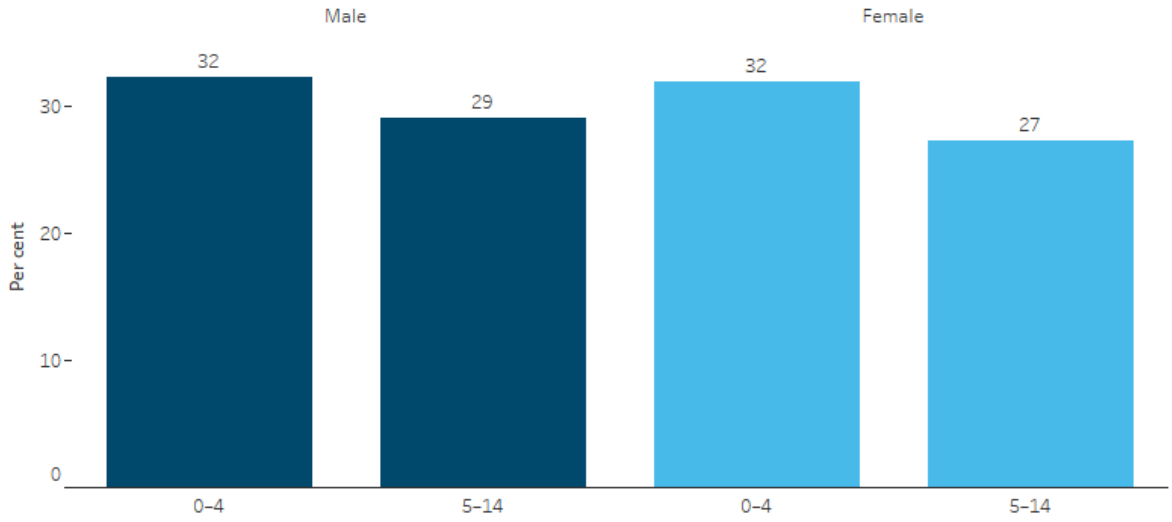
Select state/territory, remoteness or organisation type
Organisation type

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

Indigenous health assessment—aged 0–14, by Organisation type, June 2022



Indigenous health assessment—aged 0–14, by sex, age group and Organisation type (All), June 2022



Note: In December 2020, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

nKPI – preventative health indicators

The following boxes show selected preventative health indicator results for Indigenous regular clients at June 2022. Clicking on a box will go to more information on the associated indicator.

Smoking status recorded

70%

(or around 207,000) aged 11 and over had their smoking status recorded in the last year

Process-of-care indicator

Smoking status result

53%

(or around 109,000) aged 11 and over had never smoked or were an ex-smoker

Health-status indicator

Alcohol consumption recorded

55%

(or around 146,000) aged 15 and over had their alcohol consumption status recorded in the last 2 years

Process-of-care indicator

Indigenous health assessment

45%

(or around 120,000) aged 15 and over had an Indigenous health assessment in the last 2 years

Process-of-care indicator

CVD risk assessment

47%

(or around 56,400) aged 35–74 had risk factors recorded to enable CVD assessment

Process-of-care indicator

CVD risk assessment result

58%

(or around 7,900) aged 35–74 had a low absolute cardiovascular risk in the last 2 years

Health-status indicator

Cervical screening

40%

(or around 41,900) of females had a cervical screening test in the last 5 years

Process-of-care indicator

Immunised against influenza

21%

(or around 77,600) aged 6 months and over were immunised against influenza

Process-of-care indicator

BMI

24%

(or around 37,100) of adults were of 'normal' weight in the last 2 years

Health-status indicator

Smoking (PI09 and PI10)

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

- smoking status recorded (PI09): the proportion of Indigenous regular clients aged 11 and over whose smoking status was recorded within the previous 24 months
- smoking status result (PI10): the proportion of Indigenous regular clients aged 11 and over whose smoking status recorded within the previous 24 months was current smoker, ex-smoker or never smoked.

PI09 and PI10 are collected for males and females in age groups:

- 11–14
- 15–24
- 25–34
- 35–44
- 45–54
- 55–64
- 65 and over.

There have been changes to the specifications of these indicators over time. See Technical notes for more information.

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

Why not smoking is important

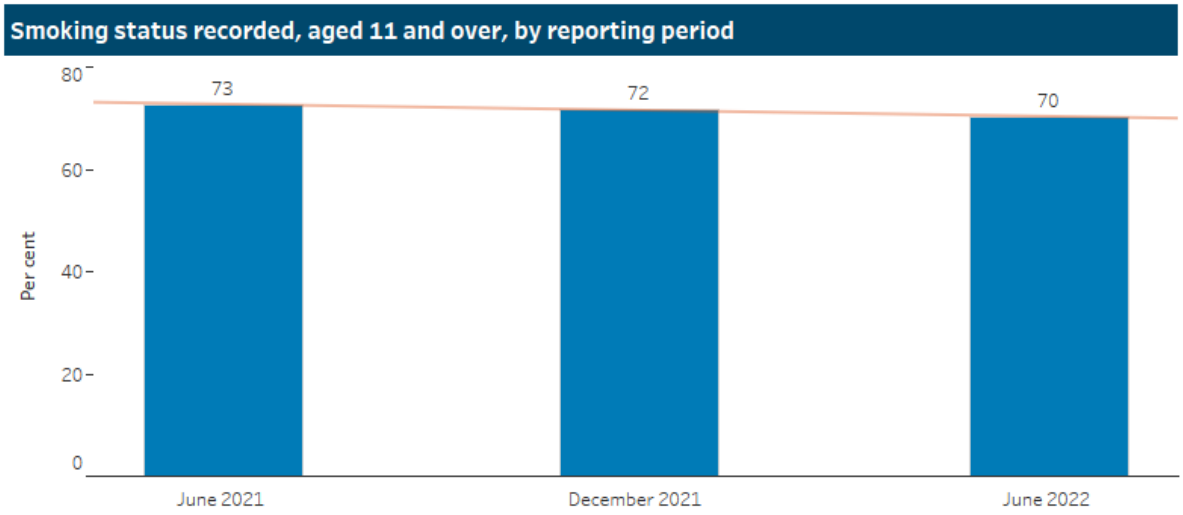
Tobacco smoking is the smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, cigars or pipes.

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

The proportion of Indigenous adults who smoke has decreased over time. Indigenous adults, however, are more likely to smoke than non-Indigenous adults (AIHW 2022).

Smoking status recorded (PI09)

At June 2022, 70% (or around 207,000) of Indigenous regular clients aged 11 and over had their smoking status recorded within the previous 24 months.



Note: In June 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Recording of smoking status was highest in:

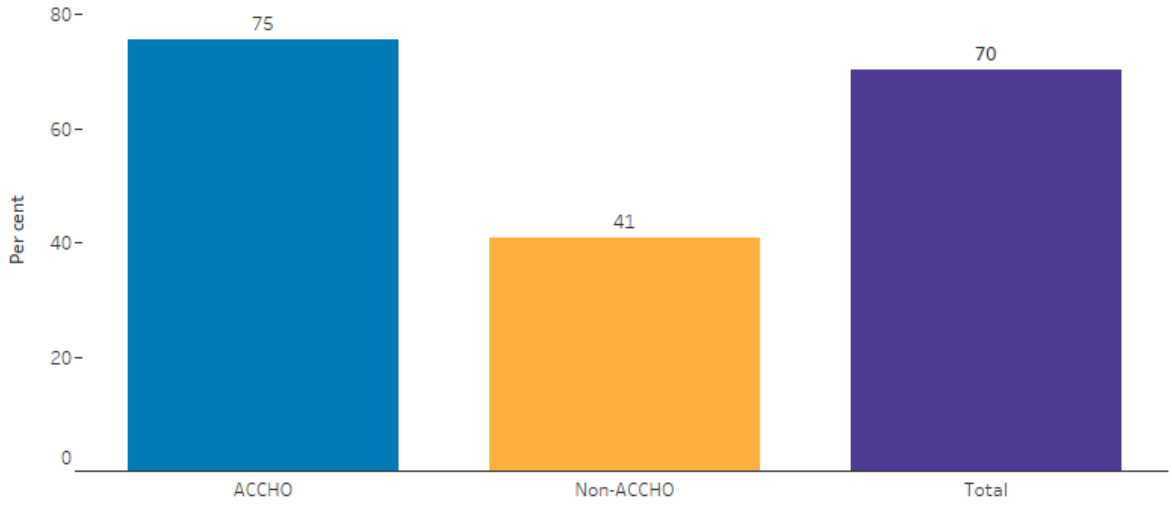
- New South Wales/the Australian Capital Territory (combined) (75%)
- *Outer regional* areas (78%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (75%).

Select reporting period
June 2022

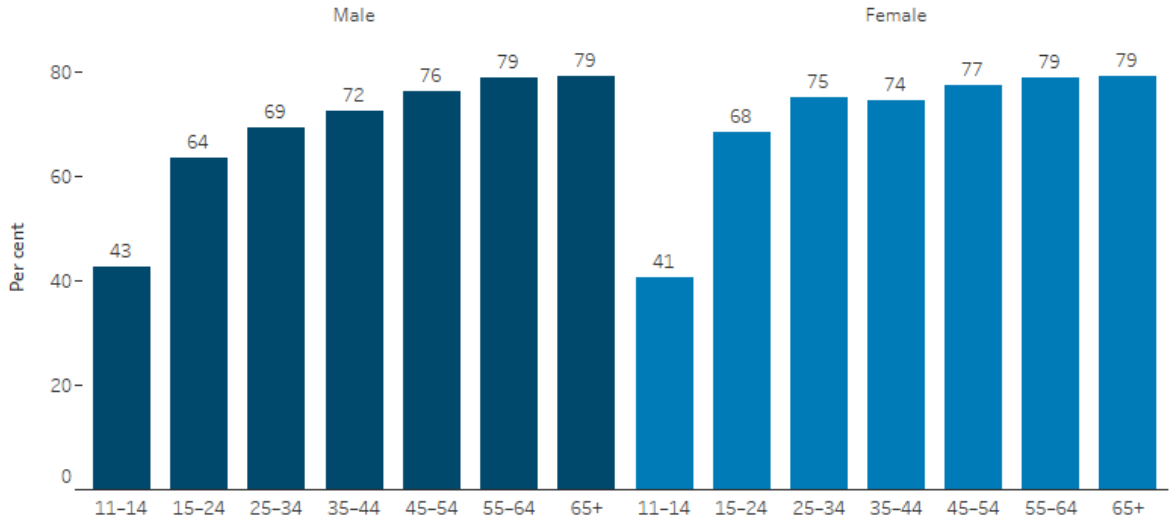
Select state/territory, remoteness or organisation type
Organisation type

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

Smoking status recorded, by Organisation type, June 2022



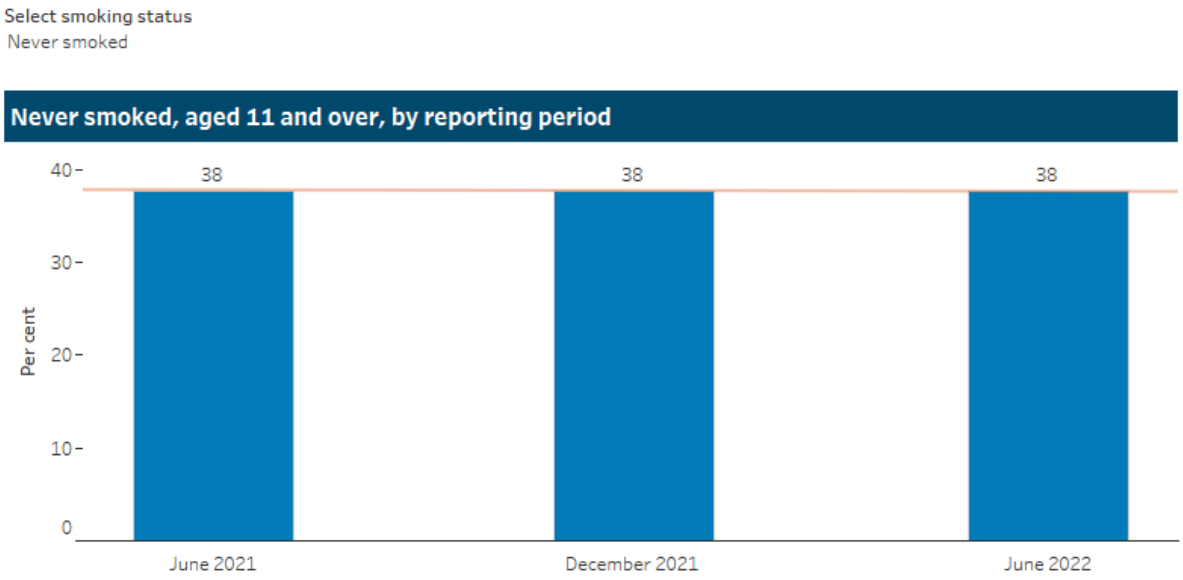
Smoking status recorded, by sex, age group and Organisation type (All), June 2022



Note: In June 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Smoking status result (PI10)

At June 2022, 47% (or around 99,000) of Indigenous regular clients aged 11 and over were current smokers, 38% (78,400) had never smoked and 15% (31,000) were ex-smokers.



Note: In June 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Having never smoked or being an ex-smoker (53%) was highest in:

- New South Wales/the Australian Capital Territory (combined) and Queensland (both 56%)
- *Major cities* (57%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (53%).

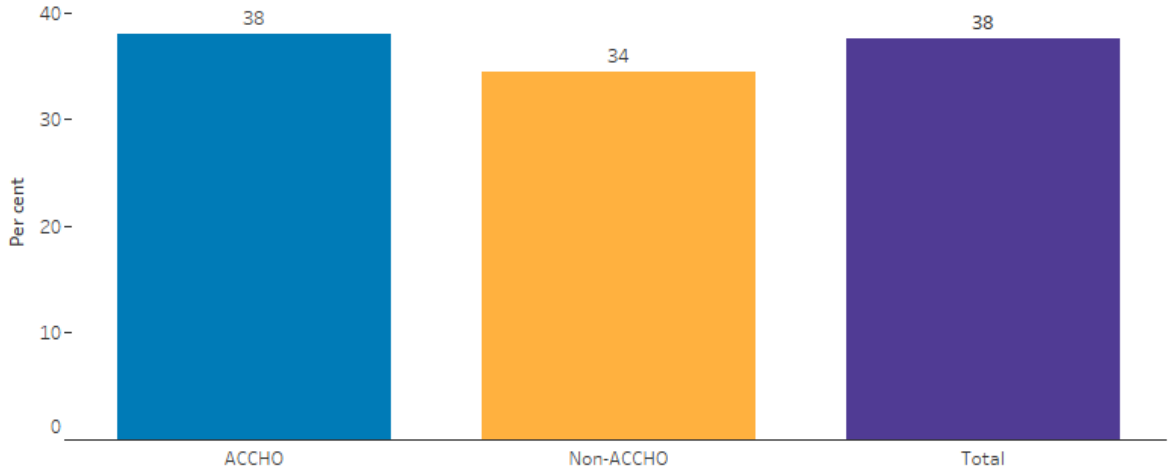
Select reporting period
June 2022

Select state/territory, remoteness or organisation type
Organisation type

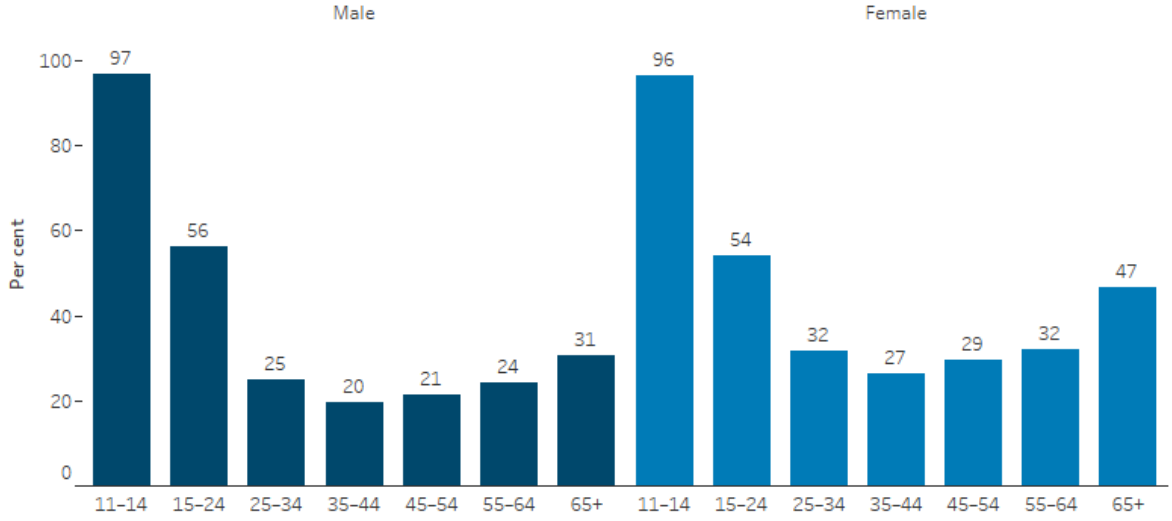
Select smoking status
Never smoked

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

Never smoked, by Organisation type, June 2022



Never smoked, by sex, age group, and Organisation type (All), June 2022



Note: In June 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Reference

AIHW (Australian Institute of Health and Welfare) (2022) Aboriginal and Torres Strait Islander Health Performance Framework: tobacco use, Canberra: AIHW.

Alcohol consumption (PI16 and PI17)

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

- alcohol consumption status recorded (PI16): the proportion of Indigenous regular clients aged 15 and over who had their alcohol consumption status recorded within the previous 24 months
- AUDIT-C result (PI17): the proportion of Indigenous regular clients aged 15 and over who had an AUDIT-C result recorded in the previous 24 months with a score of either high risk (greater than or equal to 4 in males and 3 in females) or low risk (less than 4 in males and 3 in females).

PI16 and PI17 are collected for males and females in age groups:

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

Data for AUDIT-C result (PI17) are not presented on this page but are available at Data (this indicator has been retired from the nKPI collection starting from the December 2022 period).

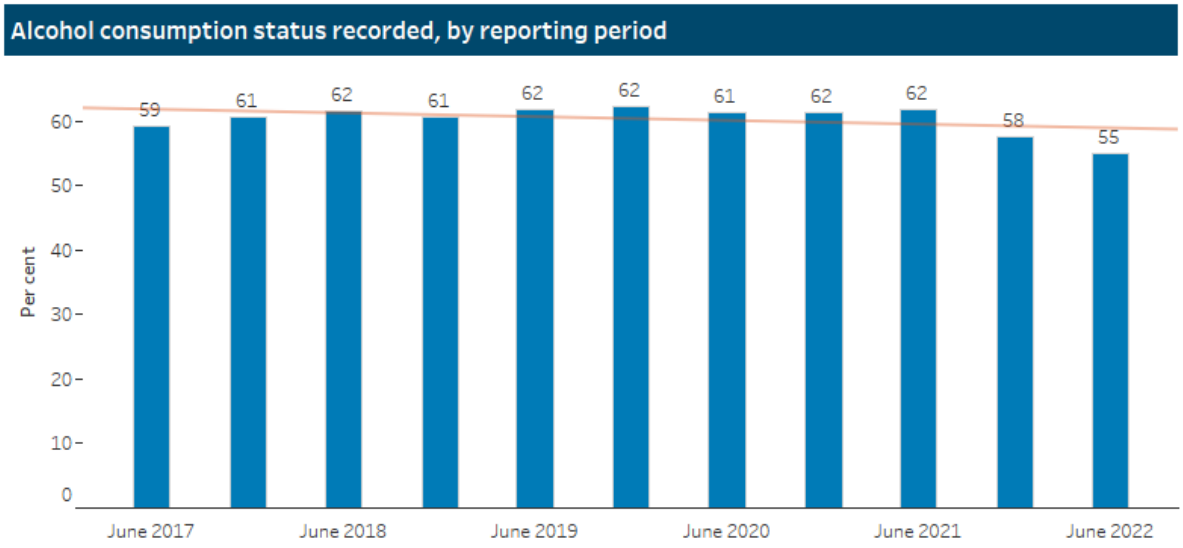
Why recording alcohol consumption is important

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

The harmful use of alcohol has both short-term and long-term health effects. Short-term effects are mainly related to potential injury suffered by the drinker and/or others who may be affected by the drinker's behaviour. Over the longer term, excessive alcohol consumption is associated with a variety of adverse health and social consequences. It is a major risk factor for conditions, including liver disease, pancreatitis, heart disease, stroke, diabetes, obesity and some types of cancer. It is also linked to social and emotional wellbeing, mental health and other drug issues. Alcohol use during pregnancy is associated with severe adverse perinatal outcomes, such as foetal alcohol syndrome and alcohol-related birth defects and developmental disorders.

The proportion of Indigenous Australians aged 15 and over who did not drink alcohol in the last 12 months has increased in recent years, and they were also more likely than non-Indigenous Australians to have not drunk alcohol in the previous 12 months (AIHW 2022).

At June 2022, 55% (or around 146,300) of Indigenous regular clients aged 15 and over had their alcohol consumption status recorded within the previous 24 months.



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

Recording of alcohol consumption status was highest in:

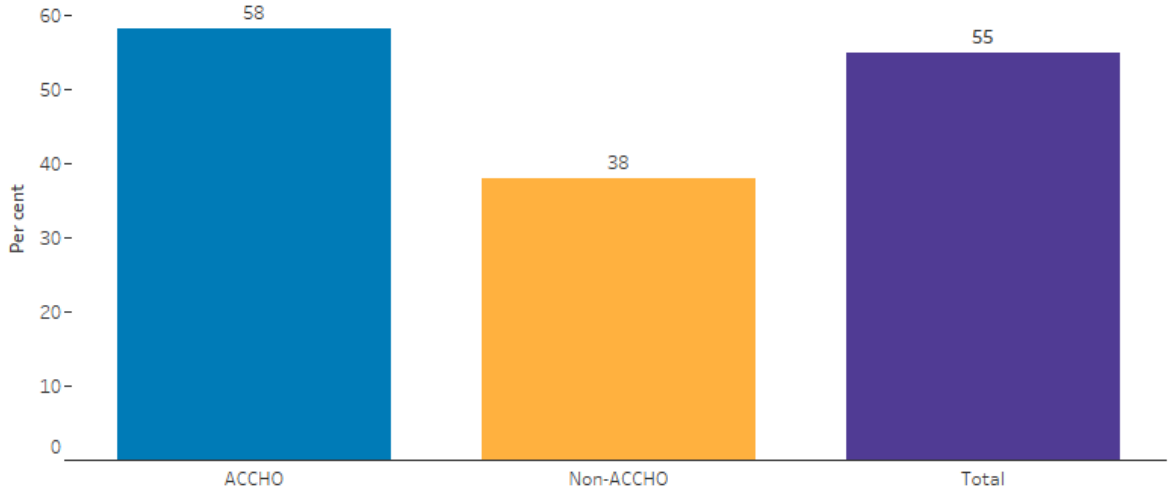
- Western Australia (66%)
- *Major cities* (64%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (58%).

Select reporting period
June 2022

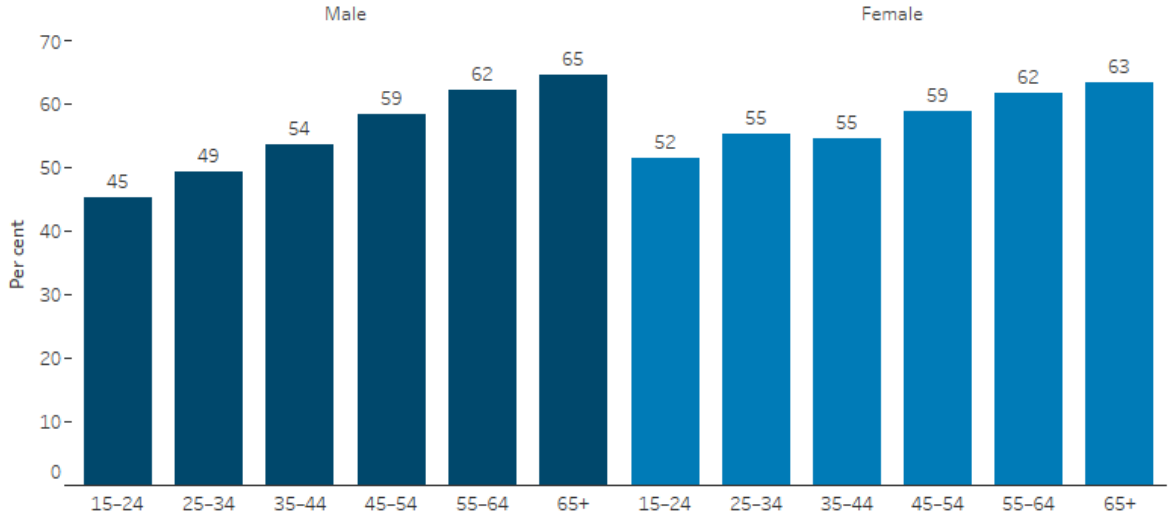
Select state/territory, remoteness or organisation type
Organisation type

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

Alcohol consumption status recorded, by Organisation type, June 2022



Alcohol consumption status recorded, by sex, age group and Organisation type (All), June 2022



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

References

AIHW (Australian Institute of Health and Welfare) (2022) Aboriginal and Torres Strait Islander Health Performance Framework: risky alcohol consumption, Canberra: AIHW.

Indigenous health assessment – aged 15 and over (PI03)

This indicator is the proportion of Indigenous regular clients aged 15 and over who had an Indigenous health assessment completed within the previous 24 months.

It is collected for males and females in age groups:

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

There have been changes to the specifications of this indicator over time. See Technical notes for more information.

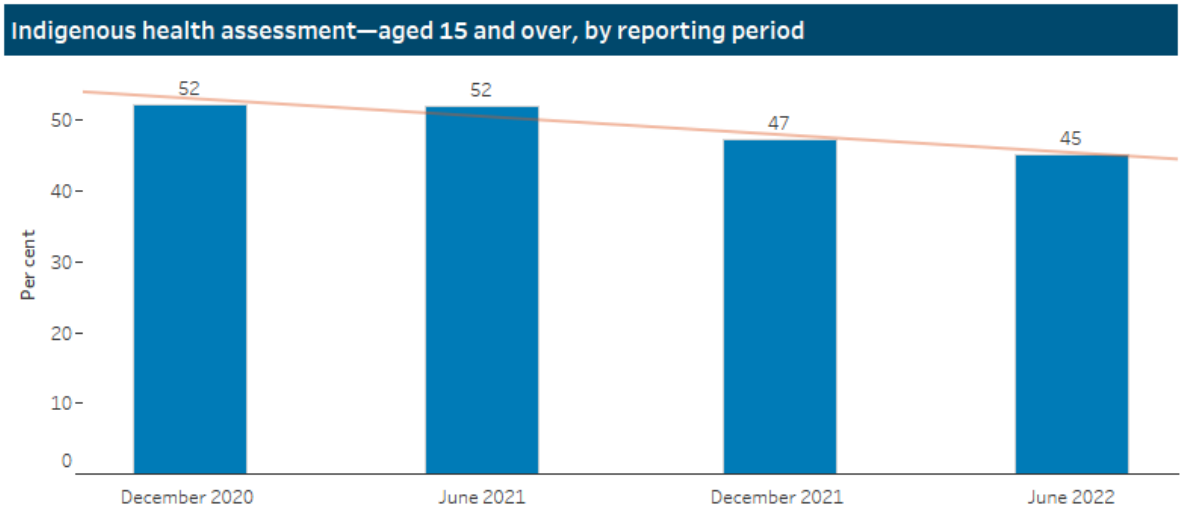
Ages 0–14 are also collected for PI03, with data presented under the Maternal and child health domain.

Why health checks are important

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

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

At June 2022, 45% (or around 120,400) of Indigenous regular clients aged 15 and over had an Indigenous health assessment completed within the previous 24 months.



Note: In December 2020, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was highest in:

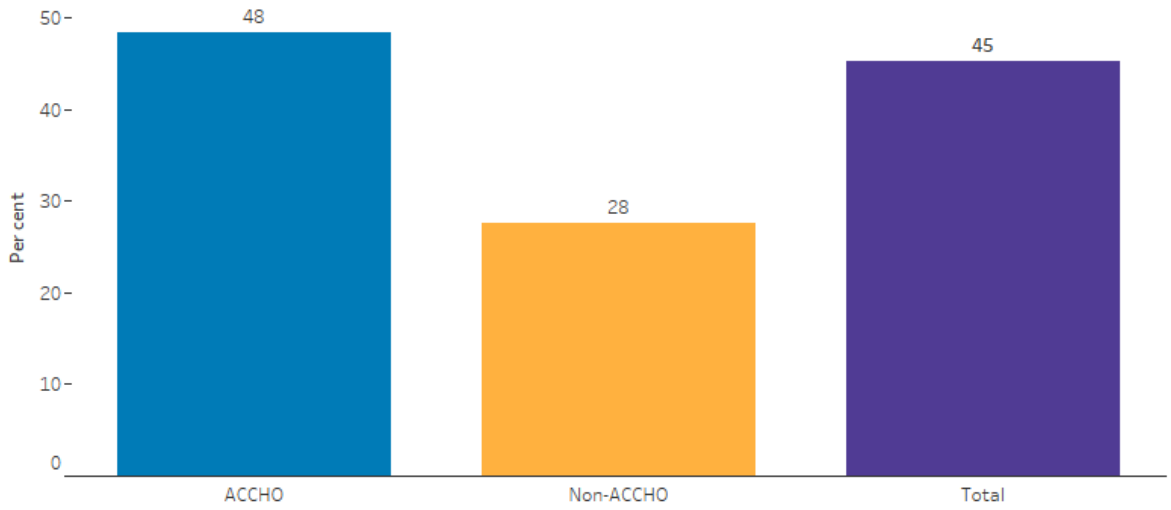
- Queensland (58%)
- *Major cities* (54%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (48%).

Select reporting period
June 2022

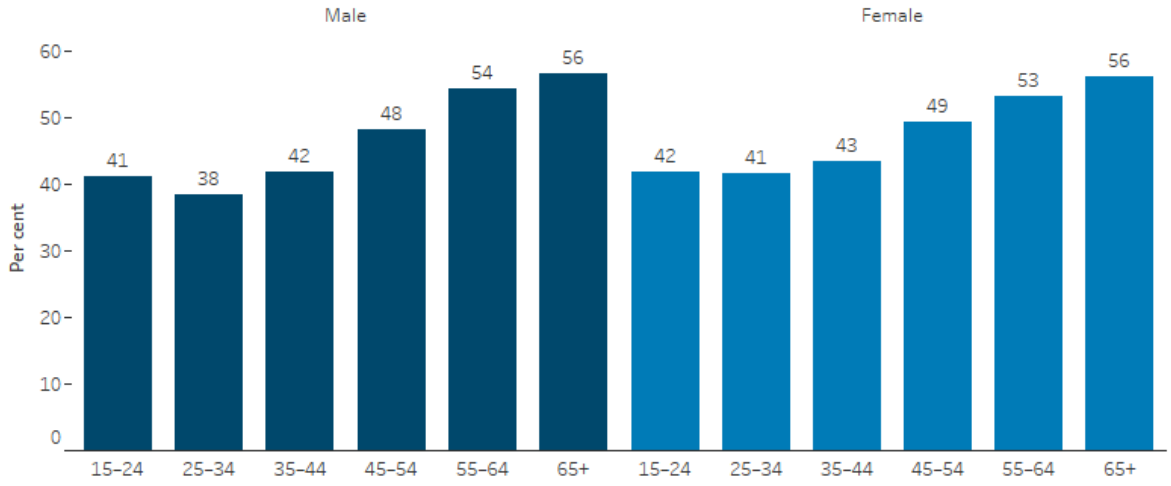
Select state/territory, remoteness or organisation type
Organisation type

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

Indigenous health assessment—aged 15 and over, by Organisation type, June 2022



Indigenous health assessment—aged 15 and over, by sex, age group and Organisation type (All), June 2022



Note: In December 2020, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

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

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

- CVD risk assessment (PI20): the proportion of Indigenous regular clients aged 35–74 with no known history of CVD who had the necessary risk factors recorded to assess their absolute CVD risk in the previous 24 months
- CVD risk assessment result (PI21): the proportion of Indigenous regular clients aged 35–74 with no known history of CVD who had an absolute CVD risk assessment result recorded in the previous 24 months as either:
  - low – less than 10% chance of a cardiovascular event in the next 5 years
  - medium – 10–15% chance of a cardiovascular event in the next 5 years
  - high – greater than 15% chance of a cardiovascular event in the next 5 years.

PI20 and PI21 are collected for males and females in age groups:

- 35–44
- 45–54
- 55–64
- 65–74.

Why CVD risk assessment is important

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

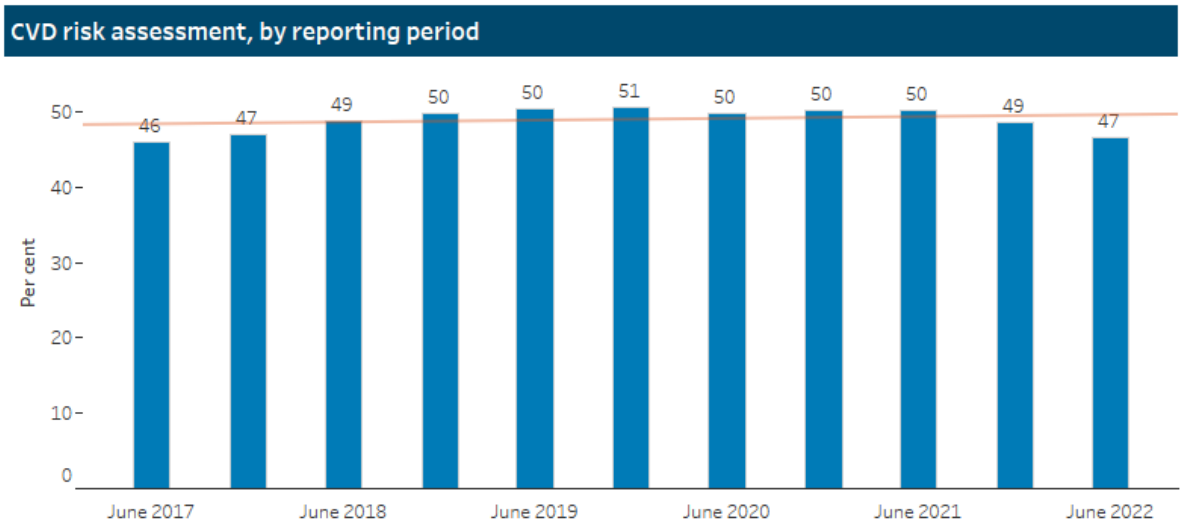
As a number of its risk factors are modifiable, CVD is preventable in many cases. Risk factors for CVD include overweight and obesity, tobacco smoking, high blood pressure, high blood cholesterol, insufficient physical activity, poor nutrition and diabetes.

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

Although age-standardised CVD mortality for Indigenous Australians has fallen over the past few decades, CVD remains the largest contributor to preventable morbidity and mortality in Indigenous Australians (Agostino et. al. 2020, AIHW 2021).

Cardiovascular disease (CVD) risk assessment (PI20)

At June 2022, 47% (or around 56,400) of Indigenous regular clients aged 35–74 with no known history of CVD had the necessary risk factors recorded to assess their absolute CVD risk in the previous 24 months.



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

This was highest in:

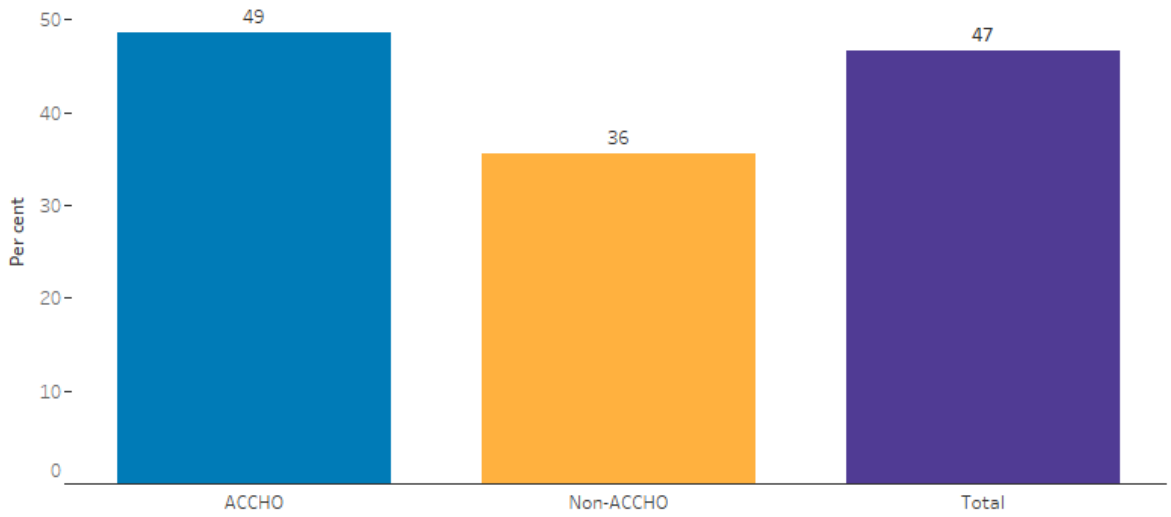
- Western Australia (54%)
- *Remote* areas (53%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (49%).

Select reporting period
June 2022

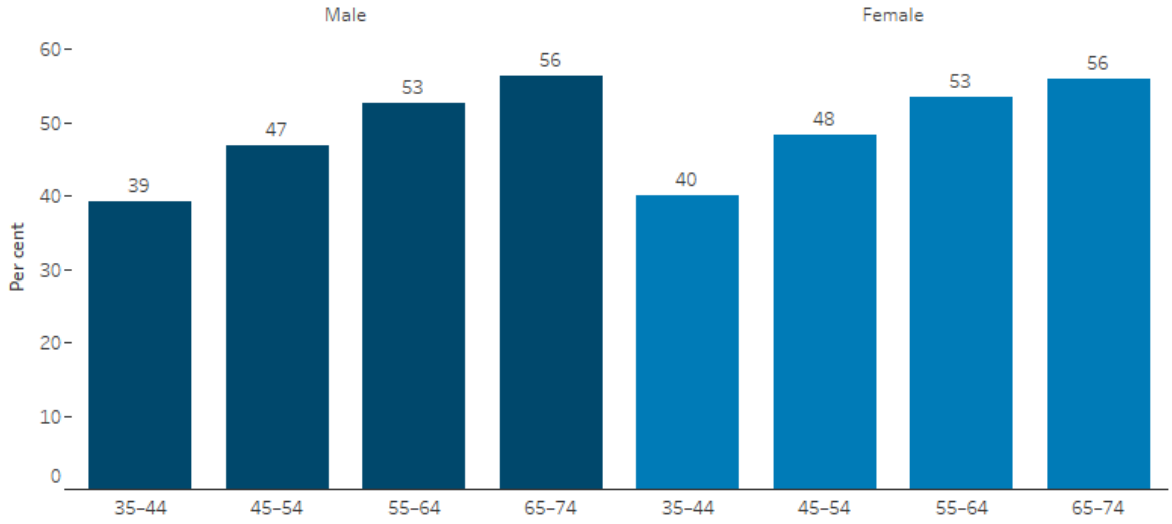
Select state/territory, remoteness or organisation type
Organisation type

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

CVD risk assessment, by Organisation type, June 2022



CVD risk assessment, by sex, age group and Organisation type (All), June 2022

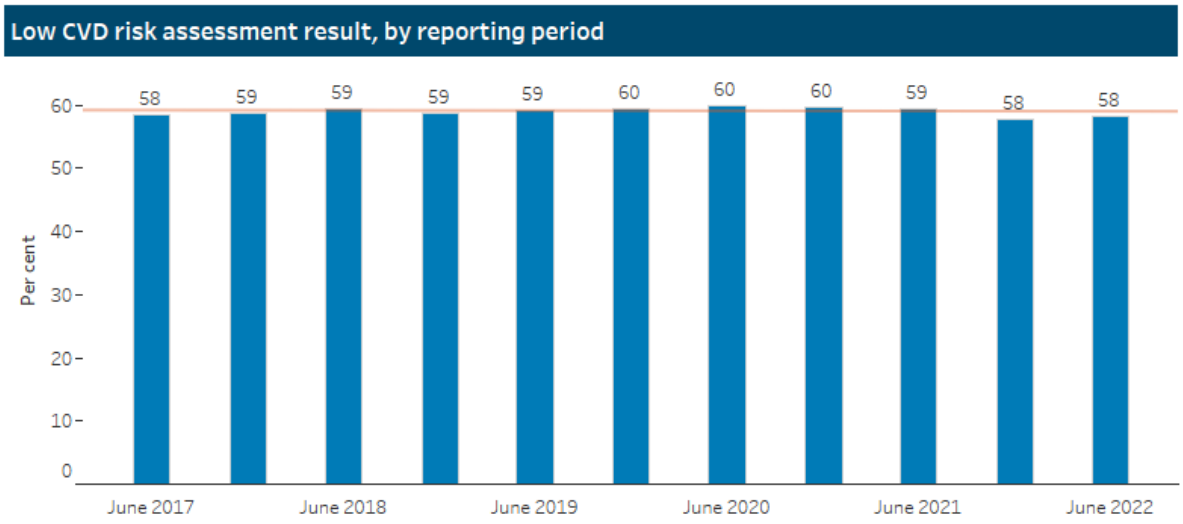


Note: See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Cardiovascular disease risk assessment result (PI21)

At June 2022, 58% (or around 7,900) of Indigenous regular clients aged 35–74 with no known history of CVD who had an absolute CVD risk recorded in the previous 24 months had a low absolute CVD risk, 7% (900) moderate and 35% (4,700) high.

Select result level
Low



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

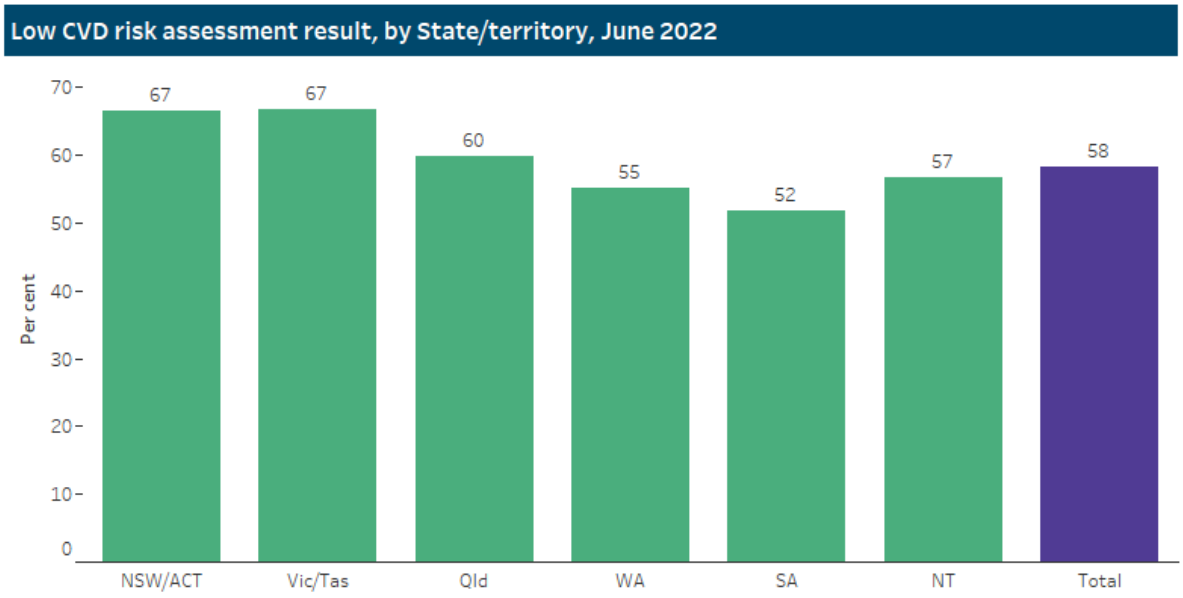
Having a low absolute CVD risk was highest in:

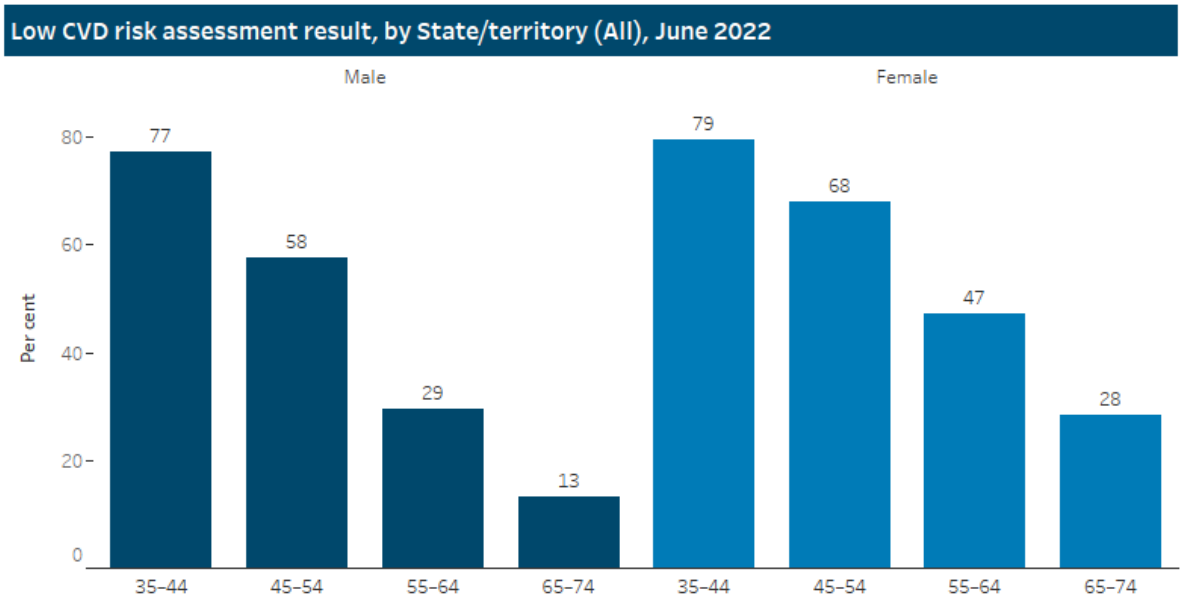
- Victoria/Tasmania (combined) and New South Wales/the Australian Capital Territory (combined) (both 67%)
- *Major cities* (66%).

Select reporting period
June 2022

Select state/territory, remoteness or organisation type
State/territory

Select result level
Low





Note: Organisation type filter not available for data later than June 2019 due to data confidentialisation. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

References

Agostino J, Wong D, Paige E, Wade V, Connell C, Davey ME, Peiris DP, Fitzsimmons D, Burgess CP, Mahoney R, Lonsdale E, Fernando P, Malamoo L, Eades S, Brown A, Jennings G, Lovett RW, Banks E (2020) Cardiovascular disease risk assessment for Aboriginal and Torres Strait Islander adults aged under 35 years: a consensus statement. *Medical Journal of Australia*, 212(9): 422–427, doi: 10.5694/mja2.50529

AIHW (Australian Institute of Health and Welfare) (2021) Cardiovascular disease, Cat. no. CVD 83, Canberra: AIHW.

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

Cervical screening (PI22)

This indicator is the proportion of female Indigenous regular clients aged 25–74 who have not had a hysterectomy and who had a cervical screening test within the previous 5 years.

It is collected for females in age groups:

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

There have been changes to the specification of this indicator over time. See *Why cervical screening is important* and Technical notes for more information.

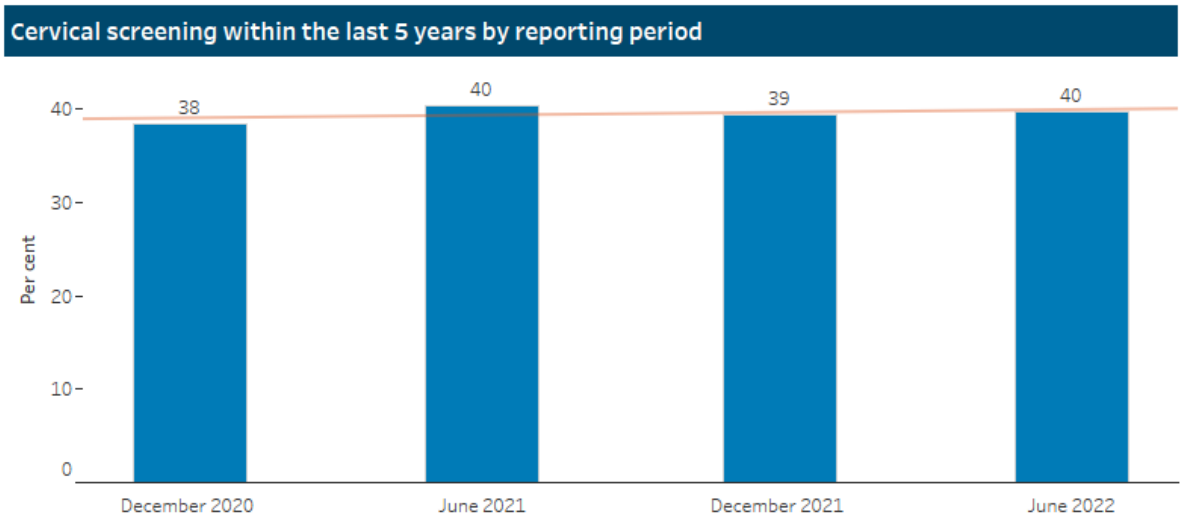
Why cervical screening is important

Cervical screening aims to detect and treat precancerous abnormalities that might otherwise progress to cervical cancer. Indigenous women generally experience a high burden from cervical cancer compared with non-Indigenous women (AIHW 2021).

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

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

At June 2022, 40% (or around 41,900) of female Indigenous regular clients aged 25–74 who have not had a hysterectomy had a cervical screening test within the previous 5 years.



Note: In December 2020, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

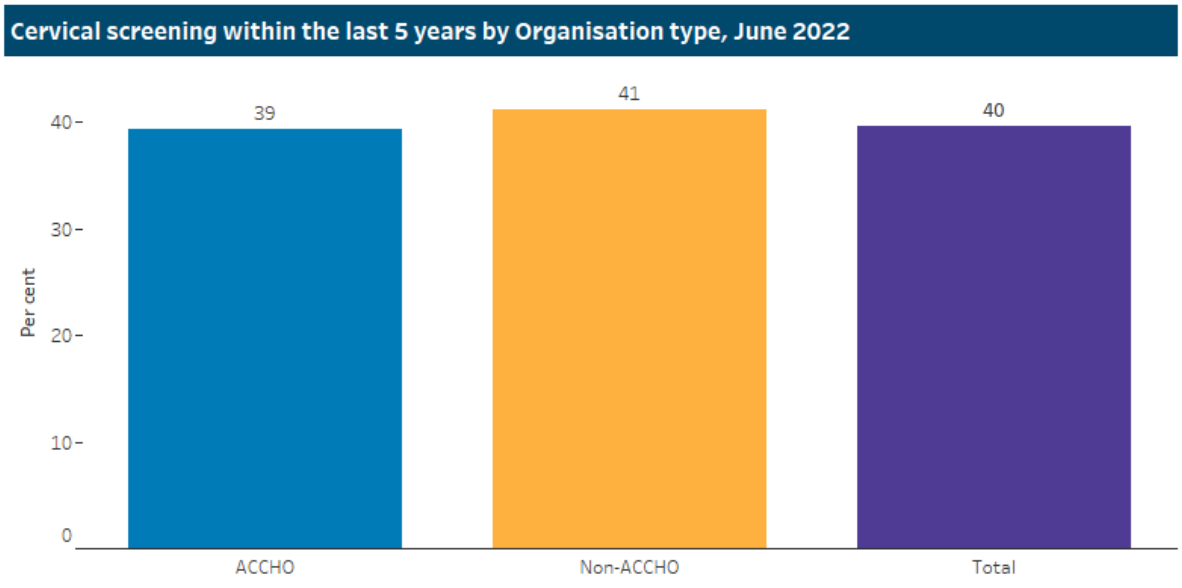
This was highest in:

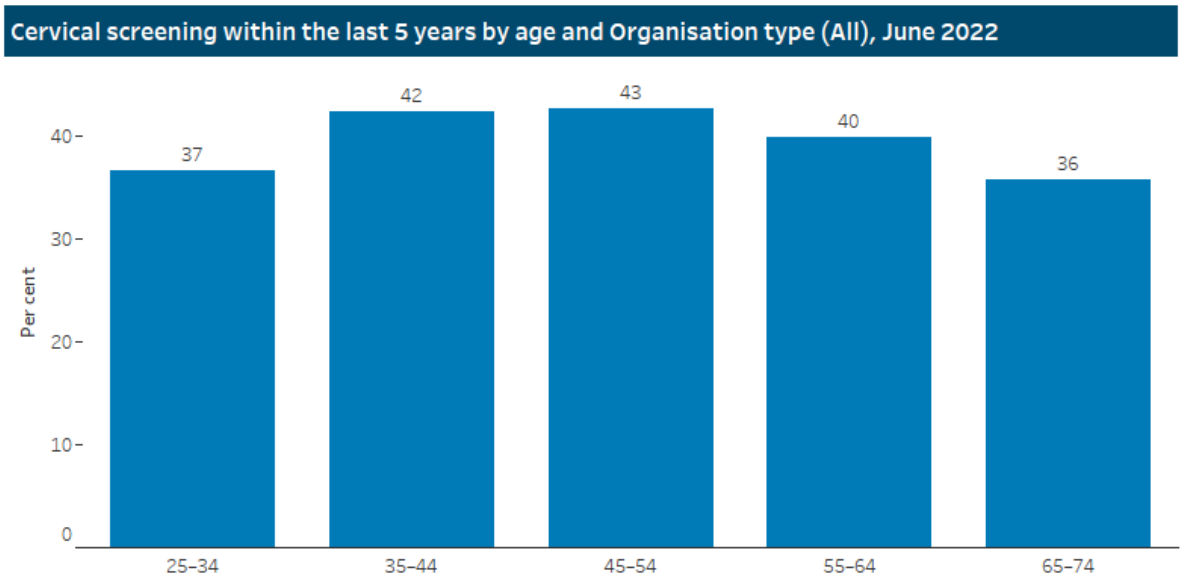
- the Northern Territory (48%)
- *Very remote* areas (47%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (41%).

Select reporting period
June 2022

Select state/territory, remoteness or organisation type
Organisation type

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





Note: In December 2020, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Reference

AIHW (Australian Institute of Health and Welfare) (2021). National Cervical Screening Program monitoring report 2021. Cancer series 134. Cat. no. CAN 141. Canberra: AIHW

Immunised against influenza – aged 6 months and over (PI14)

This indicator is the proportion of Indigenous regular clients aged 6 months and over who received an influenza immunisation within the previous 12 months.

It is collected for males and females in age groups:

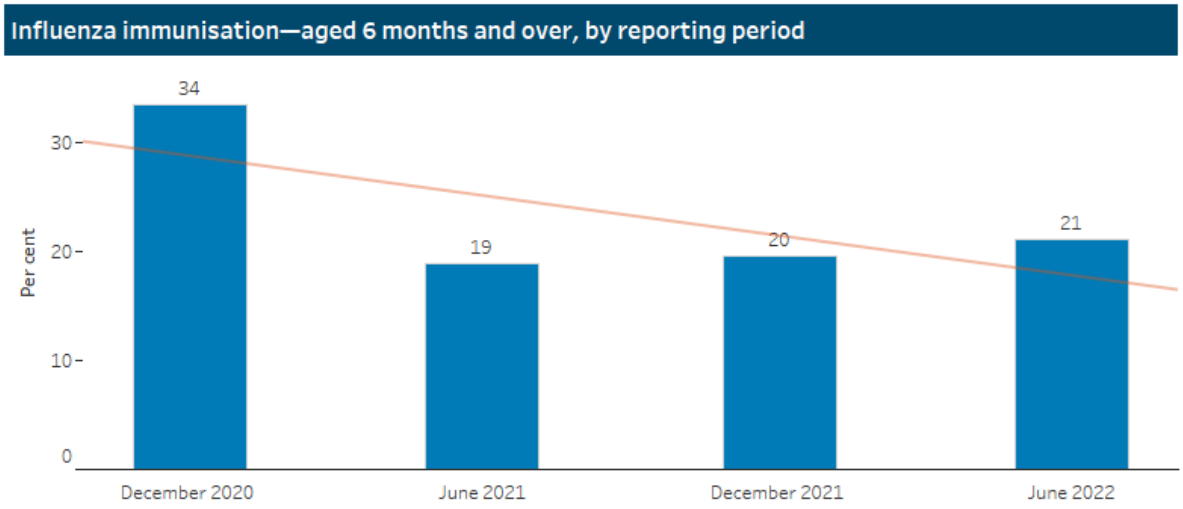
- 6 months–4 years
- 5–14 years
- 15–24 years
- 25–34 years
- 35–44 years
- 45–54 years
- 55–64 years
- 65 years and over.

There have been changes to the specification of this indicator over time. See Technical notes for more information.

Why immunisation against influenza is important

Influenza (the flu) is a contagious respiratory disease that causes seasonal epidemics in Australia. Anyone can be infected with influenza but some people, such as Indigenous Australians, have a higher chance of serious illness and complications, such as pneumonia. Some people with influenza die as a result of their infection. Annual influenza vaccination substantially reduces the risk of hospitalisation and death from influenza and pneumonia for Indigenous Australians (AIHW 2022).

At June 2022, 21% (or around 77,600) of Indigenous regular clients aged 6 months and over received an influenza immunisation within the previous 12 months.



Note: In December 2020, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

The proportion of clients receiving an influenza vaccination was affected by the COVID-19 pandemic, especially during the earlier periods. Comments received by organisations who had a 20% or more decrease in the number of clients receiving an influenza vaccination provide some insight into the reasons for this. For example, organisations noted:

- pandemic-related restrictions reduced the number of clients attending the organisations overall, not only for influenza vaccination
- the delivery of influenza vaccines to the organisations, and then the provision of those vaccines to clients, was initially delayed because of the rollout and prioritisation of the COVID-19 vaccination and testing program
- the time interval required between COVID-19 and influenza vaccination
- clients being confused and hesitant about receiving vaccines in-general, including for influenza.

Being immunised against influenza was highest in:

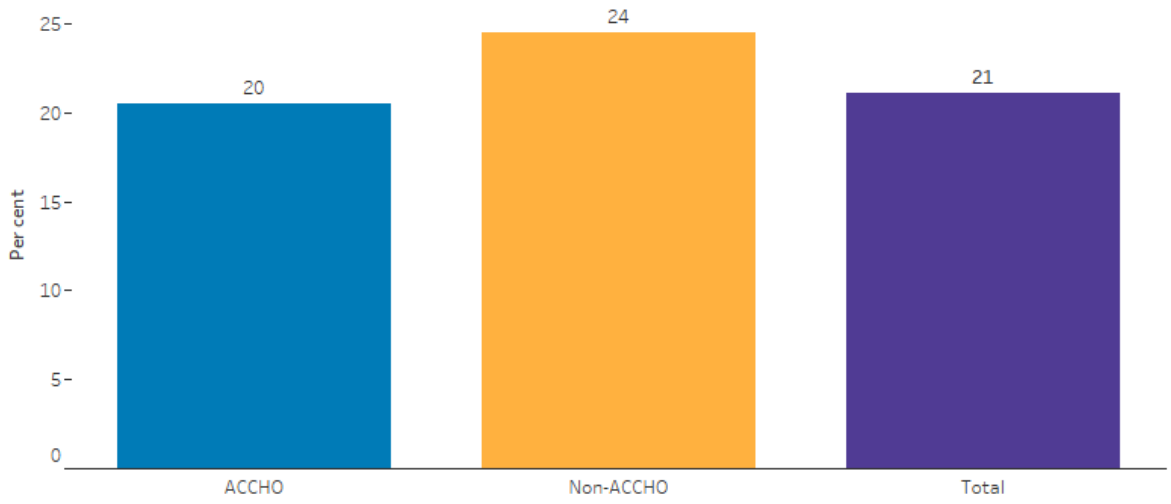
- the Northern Territory (30%)
- *Very remote* areas (26%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (24%).

Select reporting period
June 2022

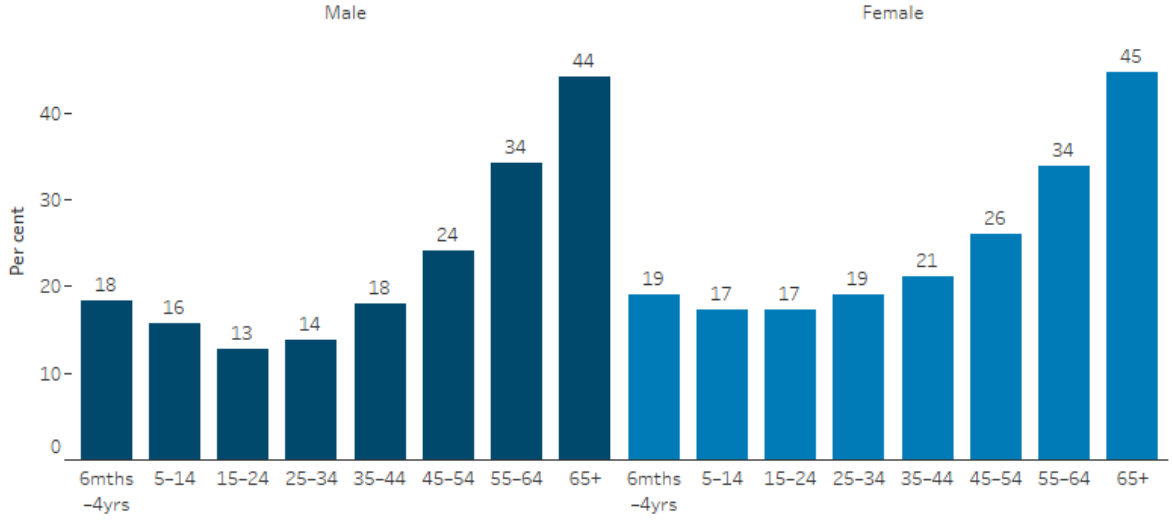
Select state/territory, remoteness or organisation type
Organisation type

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

Influenza immunisation—aged 6 months and over, by Organisation type, June 2022



Influenza immunisation—aged 6 months and over, by sex, Organisation type (All), June 2022



Note: In December 2020, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Reference

AIHW (Australian Institute of Health and Welfare) 2022. Aboriginal and Torres Strait Islander Health Performance Framework: immunisation. Canberra: AIHW.

Body Mass Index (BMI) (PI12)

This indicator is the proportion of Indigenous regular clients aged 18 and over who had their body mass index (BMI) classified within specified categories or not calculated within the previous 24 months.

It is reported here in two parts as the proportion of Indigenous regular clients aged 18 and over who, within the previous 24 months, had:

- their BMI calculated
- their BMI calculated with a result of either:
  - underweight
  - normal
  - overweight
  - obese.

It is collected for males and females in age groups:

- 18–24
- 25–34
- 35–44
- 45–54
- 55–64
- 65 and over.

There have been changes to the specification of this indicator over time. See Technical notes for more information.

Why weight is important

Being either underweight (for example, because of under-nutrition) or overweight or obese (where an abnormal or excessive amount of fat accumulates in the body) increases a person's risk of poor physical health. Both are risk factors for future illness.

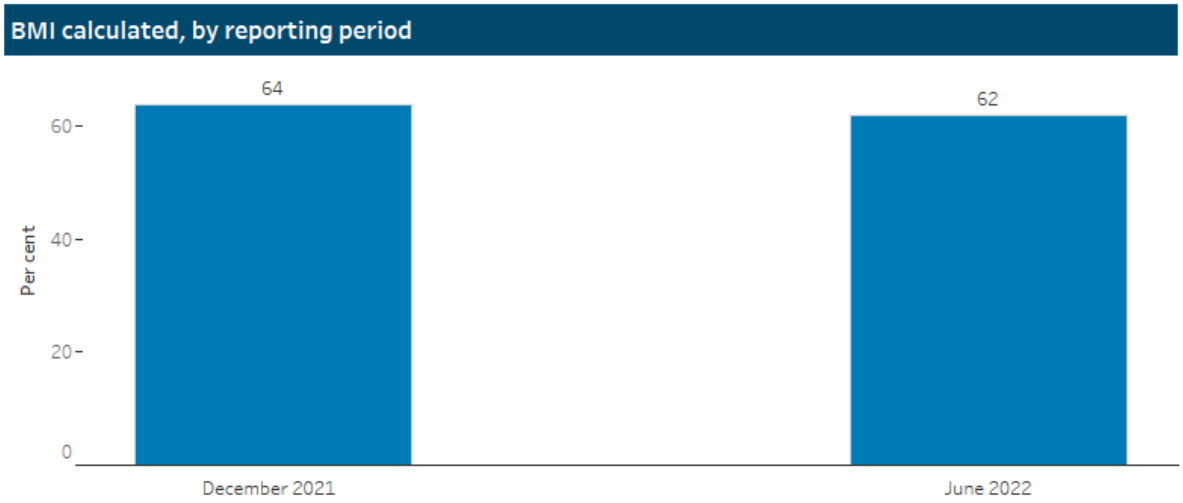
Indigenous Australians aged 15 and over are less likely to be of normal weight than non-Indigenous Australians (AIHW 2022). The proportion of Indigenous Australians who are of normal weight has decreased over time.

At June 2022, 62% (or around 152,000) of Indigenous regular clients had their BMI calculated, 38% (93,700) had not.

Having a BMI calculated was highest in:

- Western Australia and Queensland (both 73%)
- *Major cities* and *Outer regional* areas (both 67%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (66%).

Select BMI calculated category
Calculated



Note: In December 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Of those with their BMI recorded:

- 24% (or around 37,100) were of normal weight
- 26% (or around 39,200) were overweight
- 45% (or around 68,100) were obese
- 5% (or around 7,400) were underweight.

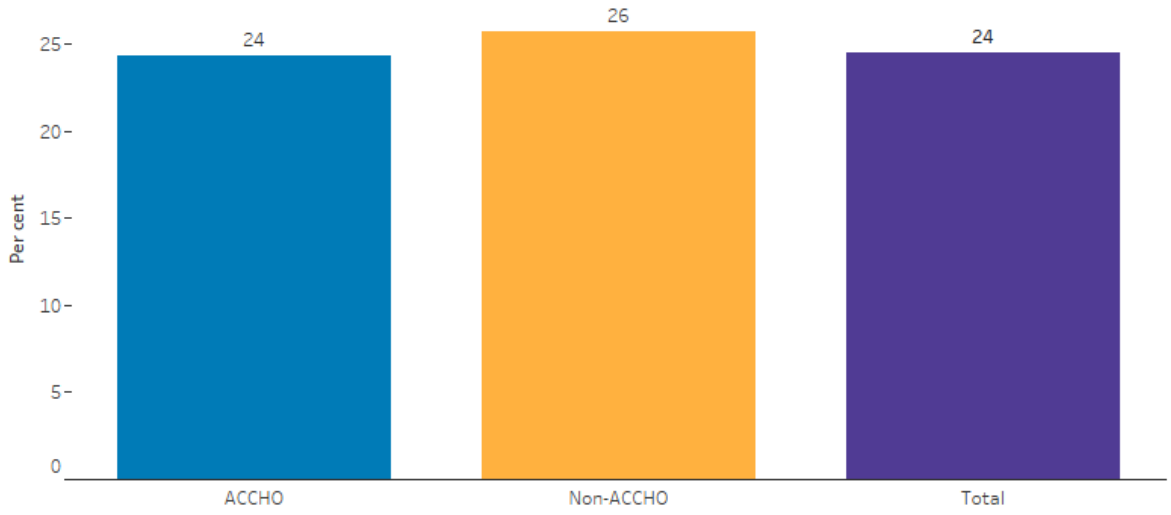
Of those with their BMI calculated, being of normal weight was highest in:

- the Northern Territory (30%)
- *Very remote* areas (27%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (26%).

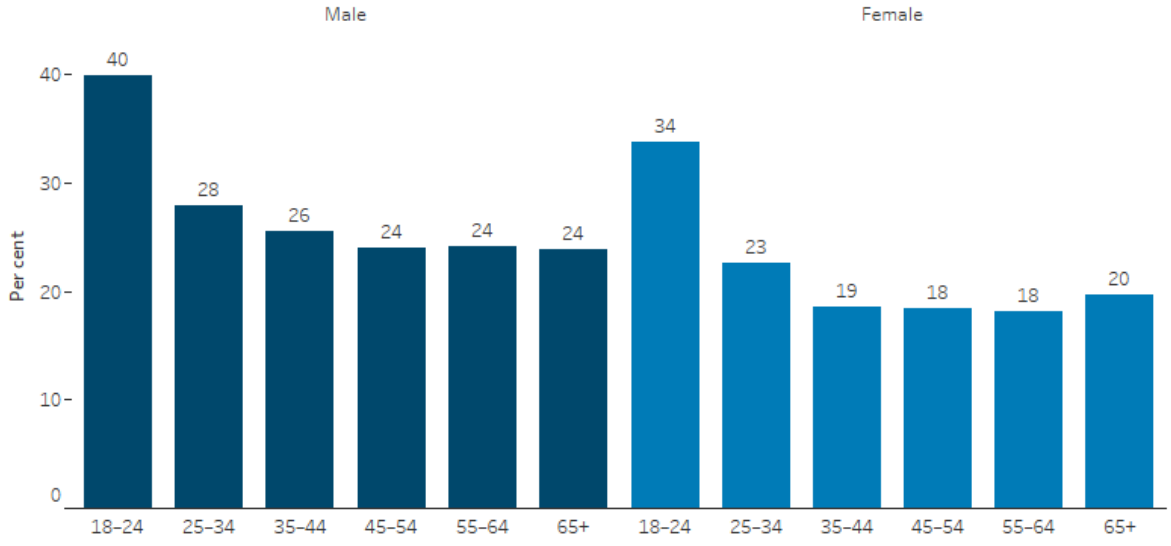
Select reporting period	Select state/territory, remoteness or organisation type	Select BMI
June 2022	Organisation type	Normal

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

BMI classified as Normal, by Organisation type, June 2022



BMI classified as Normal, by sex, age and Organisation type (All), June 2022



Notes:
1. In December 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
2. Proportions in this figure are calculated using the denominator of Indigenous regular clients with a BMI recorded.

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

Reference

AIHW (Australian Institute of Health and Welfare) 2022. Aboriginal and Torres Strait Islander Health Performance Framework: overweight and obesity. Canberra: AIHW.

nKPI – chronic disease management indicators

The following boxes show selected chronic disease management indicator results for Indigenous regular clients at June 2022. Clicking on a box will go to more information on the associated indicator.

Chronic Disease Management Plan	Blood pressure result recorded	Blood pressure result
51% (or around 24,800) with type 2 diabetes had a Chronic Disease Management Plan in the last 2 years Process-of-care indicator	**58%** (or around 28,600) with type 2 diabetes had their blood pressure result recorded in the last 6 months Process-of-care indicator	**65%** (or around 18,700) with type 2 diabetes had a blood pressure result within recommended guidelines in the last 6 months Health-status indicator

HbA1c result recorded	HbA1c result	Kidney function test type
45% (or around 22,200) with type 2 diabetes had their HbA1c result recorded in the last 6 months Process-of-care indicator	**41%** (or around 9,100) with type 2 diabetes had a HbA1c result within recommended guidelines in the last 6 months Health-status indicator	**41%** (or around 20,100) of adults with type 2 diabetes had both an eGFR and an ACR test recorded in the last year Process-of-care indicator

Kidney function test type	Kidney function test result	Kidney function test result
36% (or around 6,700) of adults with CVD had both an eGFR and an ACR test recorded in the last year Process-of-care indicator	**38%** (or around 7,600) of adults with type 2 diabetes had had a risk category of 'normal' recorded in the last year Health-status indicator	**40%** (or around 2,600) of adults with CVD had a risk category of 'normal' recorded in the last year Health-status indicator

Chronic Disease Management Plan – type 2 diabetes (PI07)

This indicator is the proportion of Indigenous regular clients with type 2 diabetes for whom a Chronic Disease Management Plan was prepared within the previous 24 months.

PI07 is collected for males and females in age groups from 0–4 to 65 and over and presented here for males and females in age groups:

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

There have been changes to the specification of this indicator over time. See Technical notes for more information.

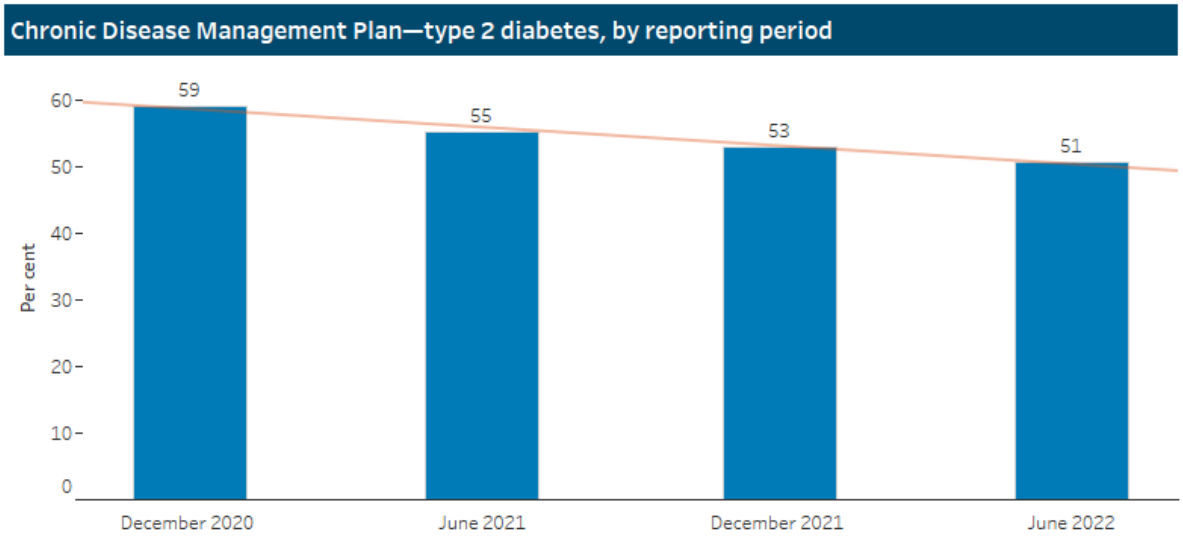
Why a Chronic Disease Management Plan is important

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

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

The Chronic Disease Management items on the Medicare Benefits Schedule (MBS) enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions.

At June 2022, 51% (or around 24,800) of Indigenous regular clients with type 2 diabetes had a Chronic Disease Management Plan prepared within the previous 24 months.



Note: In December 2020, specifications changed for this indicator. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was highest in:

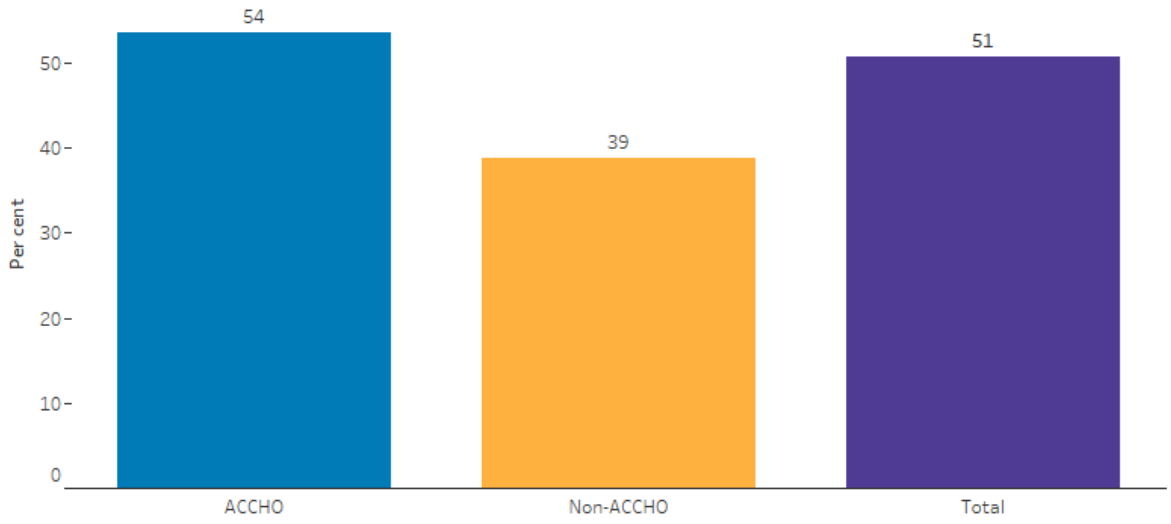
- Queensland (60%)
- *Major cities* (58%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (54%).

Select reporting period
June 2022

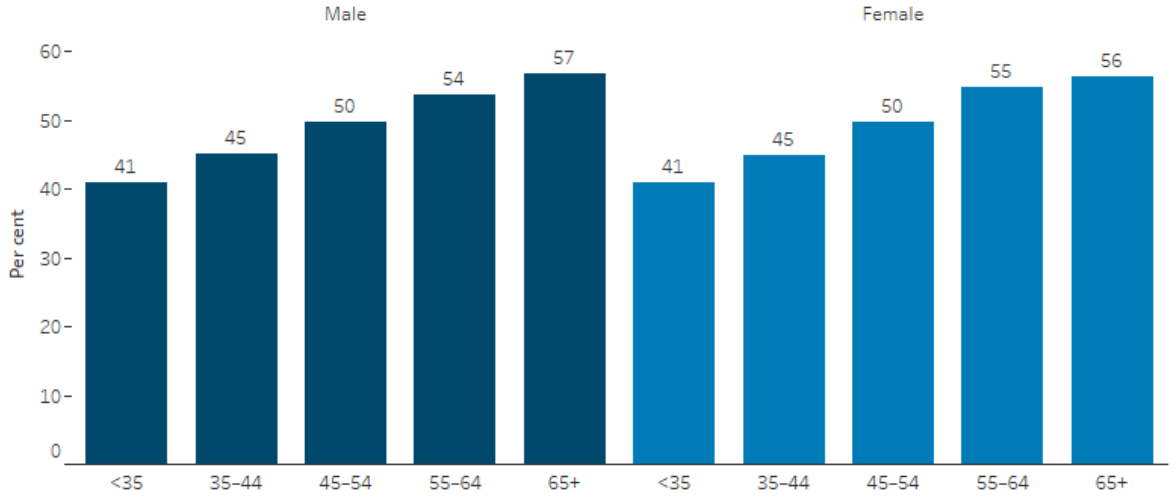
Select state/territory, remoteness or organisation type
Organisation type

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

Chronic Disease Management Plan—type 2 diabetes, by Organisation type, June 2022



Chronic Disease Management Plan—type 2 diabetes, by sex, age group and Organisation type (All), June 2022



Note: In December 2020, specifications changed for this indicator. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

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

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

- Blood pressure result recorded – type 2 diabetes (PI23): the proportion of Indigenous regular clients with type 2 diabetes whose blood pressure result was recorded in the last 6 months.
- Blood pressure result – type 2 diabetes (PI24): the proportion of Indigenous regular clients with type 2 diabetes whose blood pressure result recorded in the last 6 months was less than or equal to 140/90mmHg. There have been changes to the specification of this indicator over time. See Technical notes for more information.

PI23 and PI24 are collected for males and females in age groups from 0–4 to 65 and over, and presented here for males and females in age groups:

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

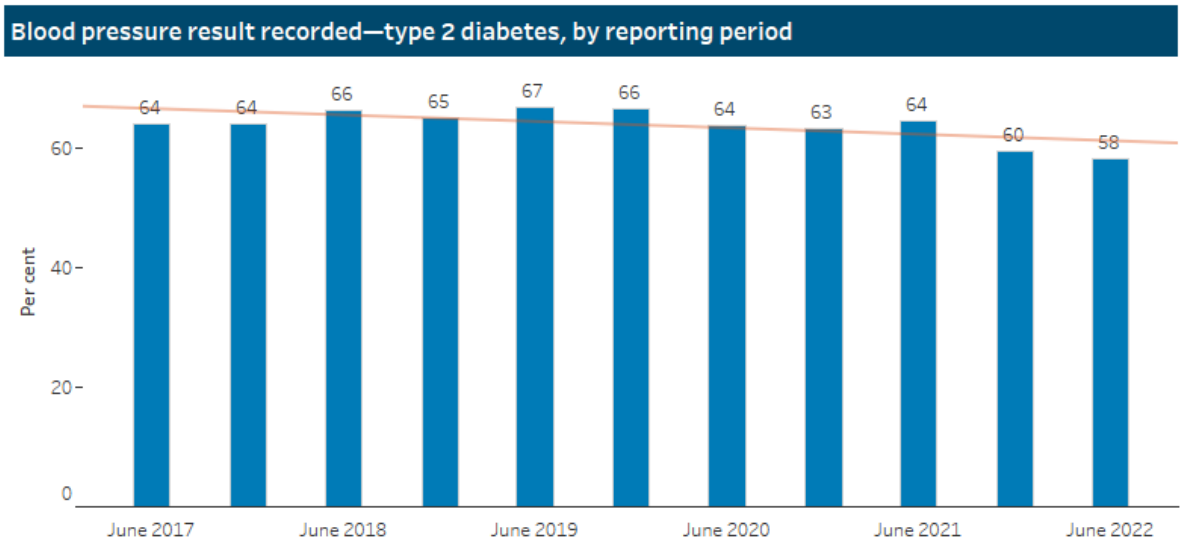
Why blood pressure result is important

Blood pressure is the force exerted by the blood on the walls of the arteries and is written as systolic/diastolic (for example, 120/80 mmHg, stated as '120 over 80'). High blood pressure – also known as hypertension – is a risk factor for chronic conditions, including stroke, coronary heart disease, heart failure and chronic kidney disease. Managing a healthy blood pressure can reduce the risk and slow the progression of chronic conditions, such as cardiovascular disease, nephropathy, and diabetic eye disease.

People with type 2 diabetes have a higher risk of developing high blood pressure. The Royal Australian College of General Practitioners (RACGP) diabetes management guidelines note that the general target blood pressure for people with type 2 diabetes is generally less than or equal to 140/90 mmHg (RACGP 2020).

Blood pressure result recorded – type 2 diabetes (PI23)

At June 2022, 58% (or around 28,600) of Indigenous regular clients with type 2 diabetes had their blood pressure result recorded in the last 6 months.



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

This was highest in:

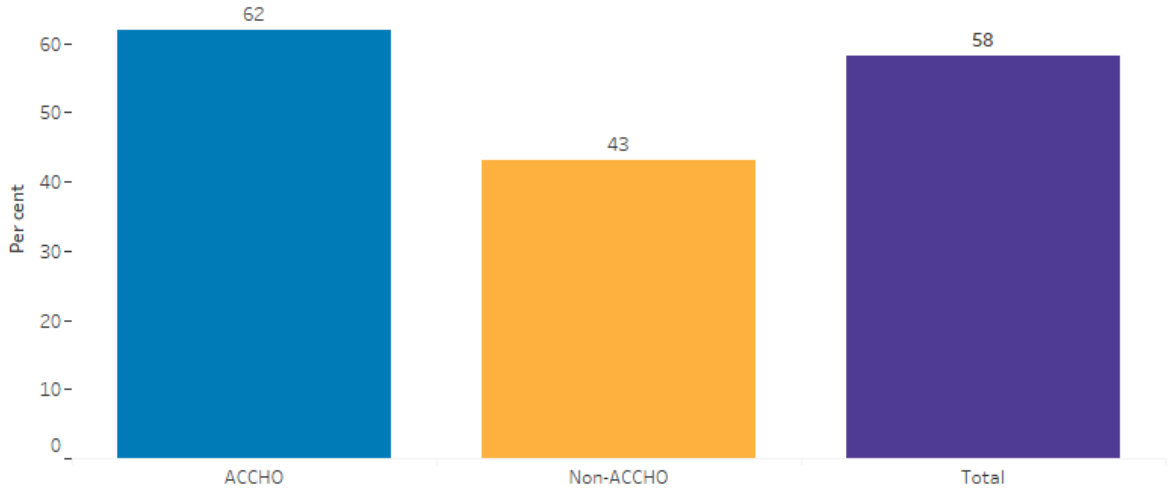
- Queensland (62%)
- *Major cities* (62%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (62%).

Select reporting period
June 2022

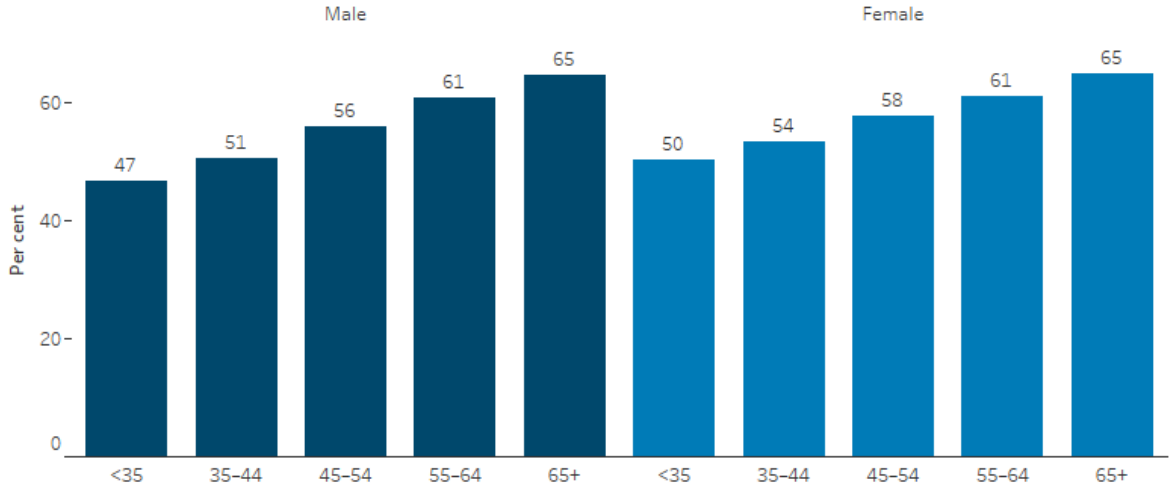
Select state/territory, remoteness or organisation type
Organisation type

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

Blood pressure result recorded—type 2 diabetes, by Organisation type, June 2022



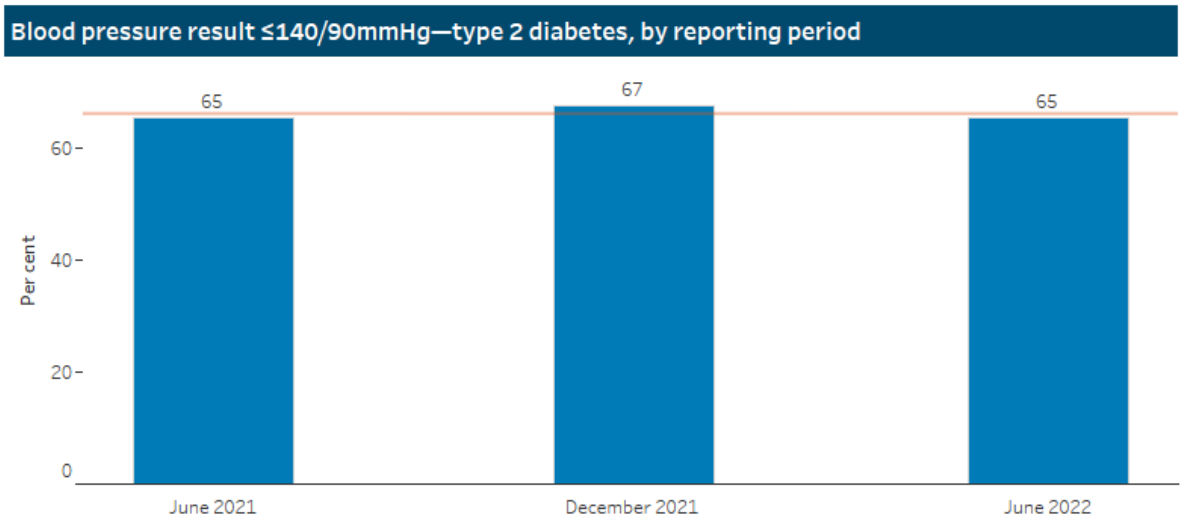
Blood pressure result recorded—type 2 diabetes, by sex, age group and Organisation type (All), June 2022



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

Blood pressure result – type 2 diabetes (PI24)

At June 2022, 65% (or around 18,700) of Indigenous regular clients with type 2 diabetes had a blood pressure result recorded in the last 6 months of less than or equal to 140/90mmHg.



Note: In June 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

This was highest in:

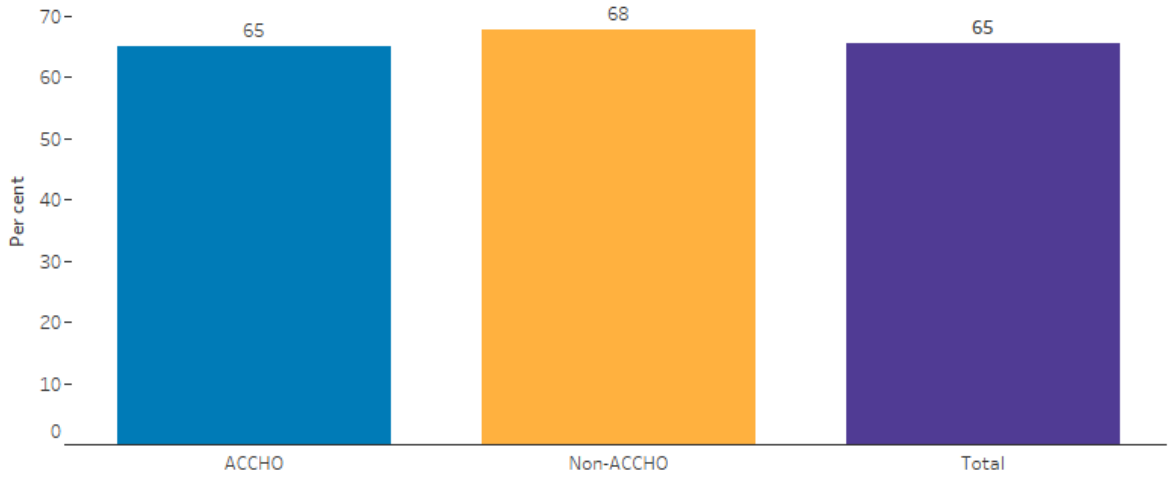
- Victoria/Tasmania (combined) (70%)
- *Very remote* areas (68%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (68%).

Select reporting period
June 2022

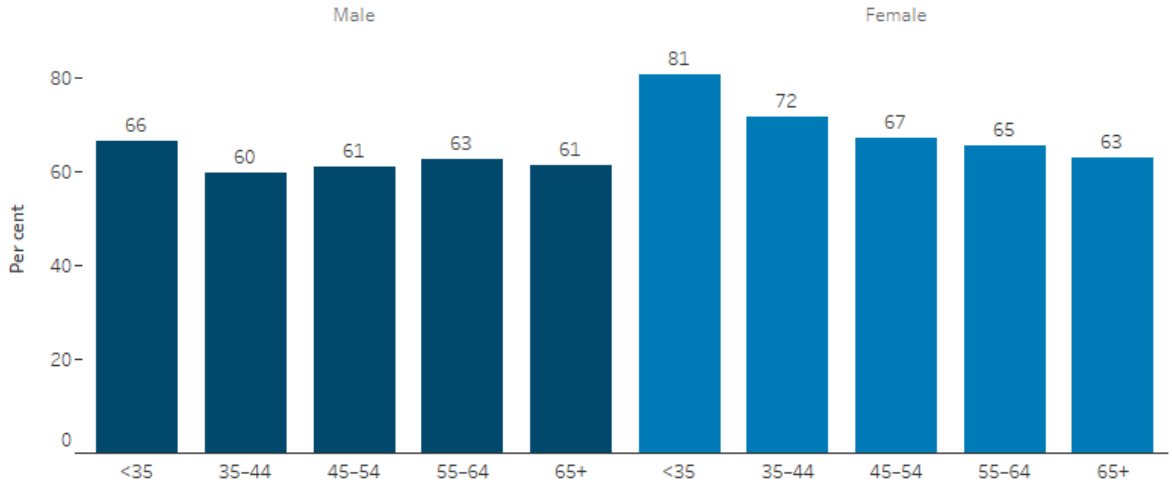
Select state/territory, remoteness or organisation type
Organisation type

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

Blood pressure result ≤140/90mmHg—type 2 diabetes, by Organisation type, June 2022



Blood pressure result ≤140/90mmHg—type 2 diabetes, by sex, age group and Organisation type (All), June 2022



Note: In June 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

Reference

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

HbA1c measurement – type 2 diabetes (PI05 and PI06)

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

- HbA1c result recorded – type 2 diabetes (PI05): the proportion of Indigenous regular clients with type 2 diabetes who had a HbA1c measurement result recorded within the previous 6 months or within the previous 12 months
- HbA1c result – type 2 diabetes (PI06): the proportion of Indigenous regular clients with type 2 diabetes who had a HbA1c measurement result recorded within the previous 6 months or within the previous 12 months as either (mmol/mol):
  - ≤53 (≤7%)
  - >53–≤64 (>7%–≤8%)
  - >64–<86 (>8%–<10%)
  - ≥86 (≥10%).

PI05 and PI06 are collected for males and females in age groups from 0–4 to 65 and over, and presented here for males and females in age groups:

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

Why HbA1c is important

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

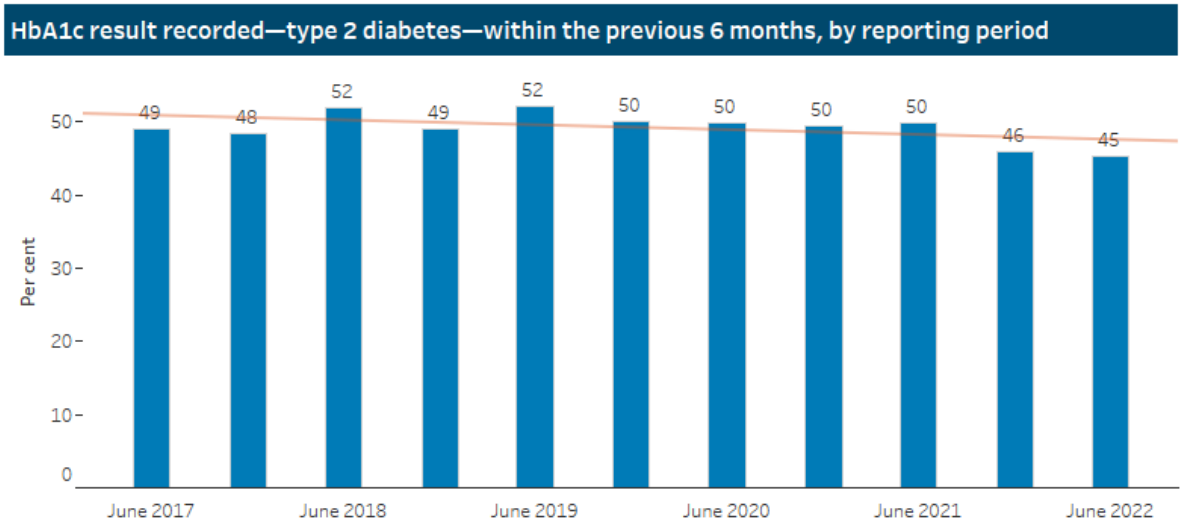
People who have diabetes need this test regularly to see if their levels are staying within range and whether they need to adjust their diabetes management. The general glycated haemoglobin (HbA1c) target in people with type 2 diabetes is ≤53 mmol/mol (≤7%) (RACGP 2020).

HbA1c result recorded – type 2 diabetes (PI05)

At June 2022, of Indigenous regular clients with type 2 diabetes:

- 45% (or around 22,200) had a HbA1c measurement result recorded within the previous 6 months
- 62% (or around 30,500) had a HbA1c measurement result recorded within the previous 12 months.

Select time period
6 months



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

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

- Victoria/Tasmania (combined) (52%)
- *Major cities* (49%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (47%).

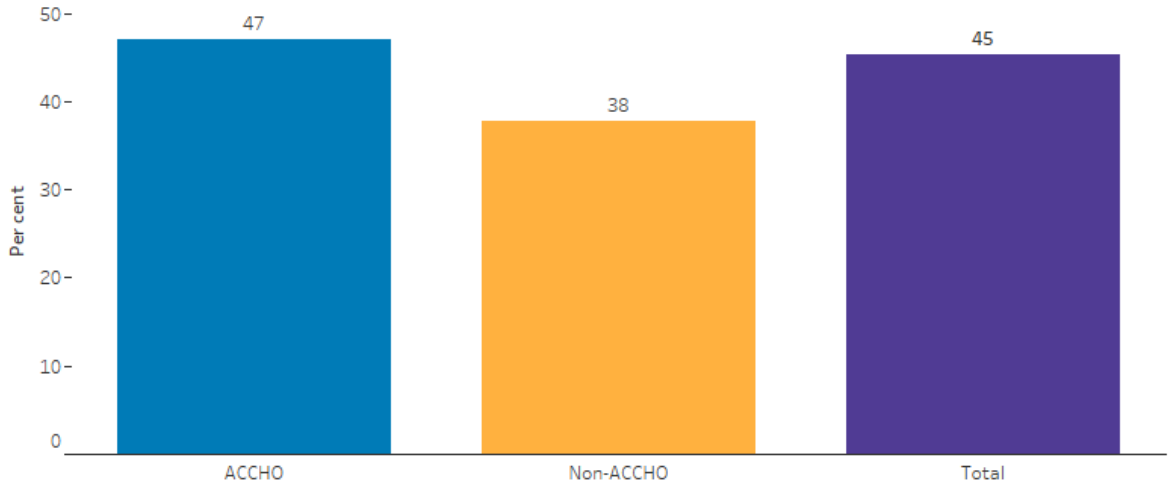
Select reporting period
June 2022

Select state/territory, remoteness or organisation type
Organisation type

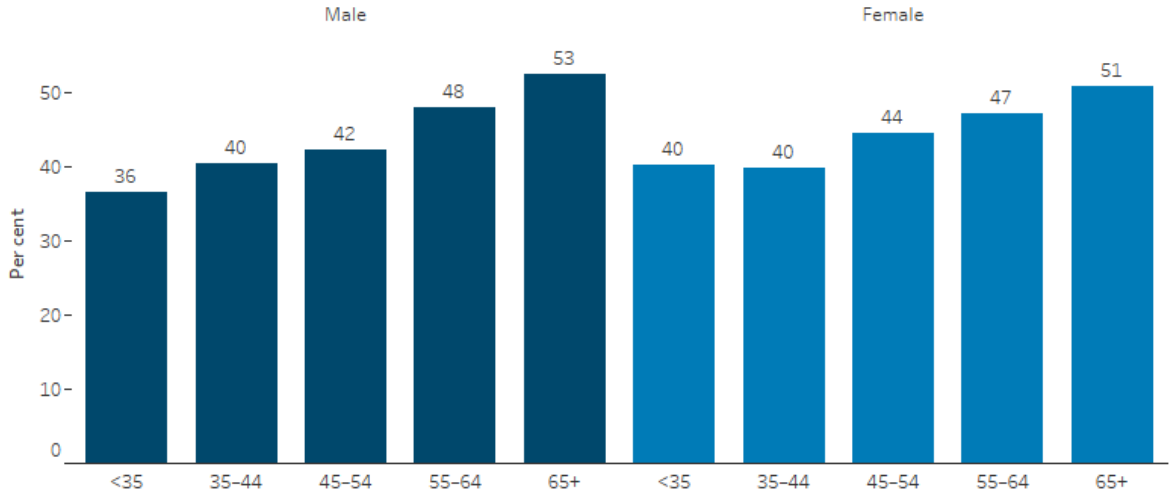
Select time period
6 months

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

HbA1c result recorded—type 2 diabetes—within the previous 6 months, by Organisation type, June 2022



HbA1c result recorded—type 2 diabetes—within the previous 6 months, by sex, age group and Organisation type (All), June 2022



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

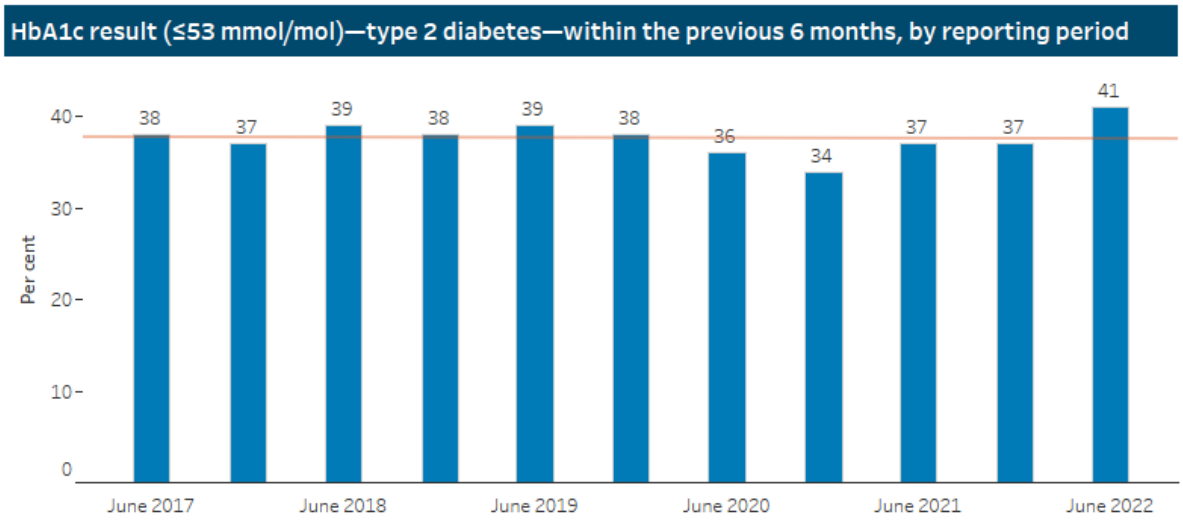
HbA1c result – type 2 diabetes (PI06)

At June 2022:

- 41% (or around 9,100) of Indigenous regular clients with type 2 diabetes had a HbA1c measurement result of ≤53 mmol/mol recorded within the previous 6 months
- 40% (or around 12,300) had a HbA1c measurement result of ≤53 mmol/mol recorded within the previous 12 months.

Select time period
6 months

Select result level (mmol/mol)
≤53



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

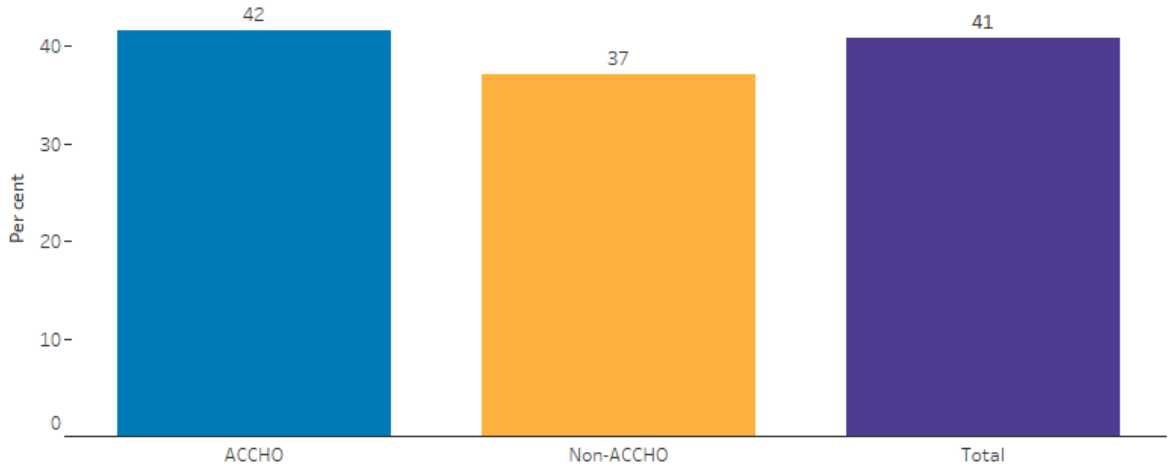
Having a HbA1c measurement result of ≤53 mmol/mol recorded within the previous 6 months was highest in:

- New South Wales/the Australian Capital Territory (combined) (48%)
- *Inner regional* areas (48%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (42%).

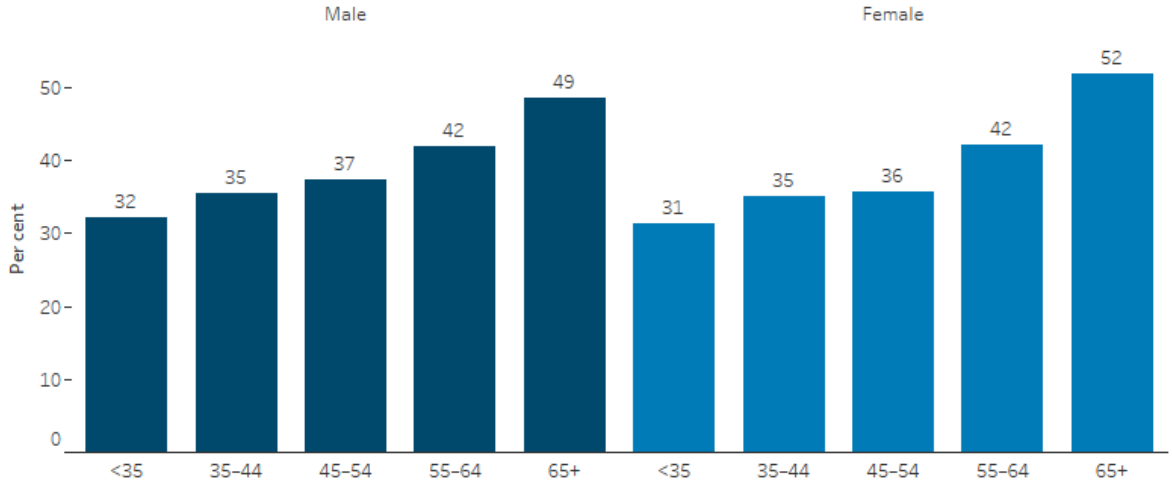
Select reporting period	Select state/territory, remoteness or organisation type	Select time period	Select result level (mmol/mol)
June 2022	Organisation type	6 months	≤53

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

HbA1c result—type 2 diabetes—within the previous 6 months, by HbA1c result (≤53 mmol/mol) and Organisation type, June 2022



HbA1c result—type 2 diabetes—within the previous 6 months, by sex, age group, HbA1c result (≤53 mmol/mol) and Organisation type (All), June 2022



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

Reference

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

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

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

- Kidney function test type – type 2 diabetes and/or CVD (PI18): the proportion of Indigenous regular clients with type 2 diabetes and/or cardiovascular disease (CVD) who, within the previous 12 months, had:
  - both an estimated glomerular filtration rate (eGFR) AND an albumin/creatinine ratio (ACR) test result recorded
  - only an eGFR test result recorded
  - only an ACR test result recorded
  - neither an eGFR nor an ACR test result recorded.
- Kidney function test result (risk category) – type 2 diabetes and/or CVD (PI19): the proportion of Indigenous regular clients with type 2 diabetes and/or CVD who had both an eGFR and ACR test result recorded within the previous 12 months as either:
  - normal risk
  - low risk
  - moderate risk
  - high risk.

PI18 and PI19 are collected for males and females in age groups:

- 18–24
- 25–34
- 35–44
- 45–54
- 55–64
- 65 and over.

There have been changes to the specification of these indicators over time. See Technical notes for more information.

Why testing kidney function is important

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

The Royal Australian College of General Practitioners (RACGP) guidelines recommend screening kidney function annually for patients with type 2 diabetes and every 1–2 years for patients with CVD. This screening checks urine albumin/creatinine ratio (ACR) for albuminuria, and estimated glomerular filtration rate (eGFR) (Kidney Health Australia 2020, RACGP 2020).

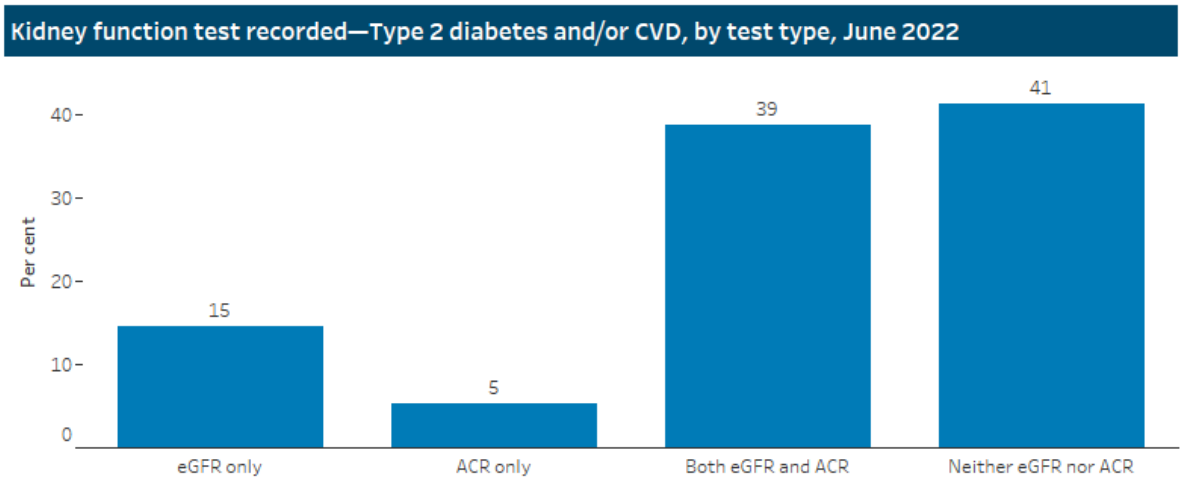
Indigenous Australians are far more likely to develop, and to die from, chronic kidney disease than non-Indigenous Australians (AIHW 2022).

Kidney function test type – type 2 diabetes and/or CVD (PI18)

At June 2022, both an eGFR and an ACR test result was recorded within the previous 12 months for:

- 41% (or around 20,100) of Indigenous regular clients aged 18 and over with type 2 diabetes
- 36% (or around 6,700) of Indigenous regular clients aged 18 and over with CVD
- 39% (or around 22,200) of Indigenous regular clients with type 2 diabetes and/or CVD.

Select chronic disease
Type 2 diabetes and/or CVD



Note: In June 2022, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

For Indigenous regular clients with type 2 diabetes, having both an estimated glomerular filtration rate (eGFR) and an albumin/creatinine ratio (ACR) test result recorded in the previous 12 months was highest in:

- Western Australia (50%)
- *Major cities* (44%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (43%).

For Indigenous regular clients with CVD, having both an estimated glomerular filtration rate (eGFR) and an albumin/creatinine ratio (ACR) test result recorded in the previous 12 months was highest in:

- Western Australia (45%)
- *Very remote* areas (43%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (37%).

For Indigenous regular clients with type 2 diabetes and/or CVD, having both an estimated glomerular filtration rate (eGFR) and an albumin/creatinine ratio (ACR) test result recorded in the previous 12 months was highest in:

- Western Australia (48%)
- *Major cities* and *Very remote* areas (both 41%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (40%).

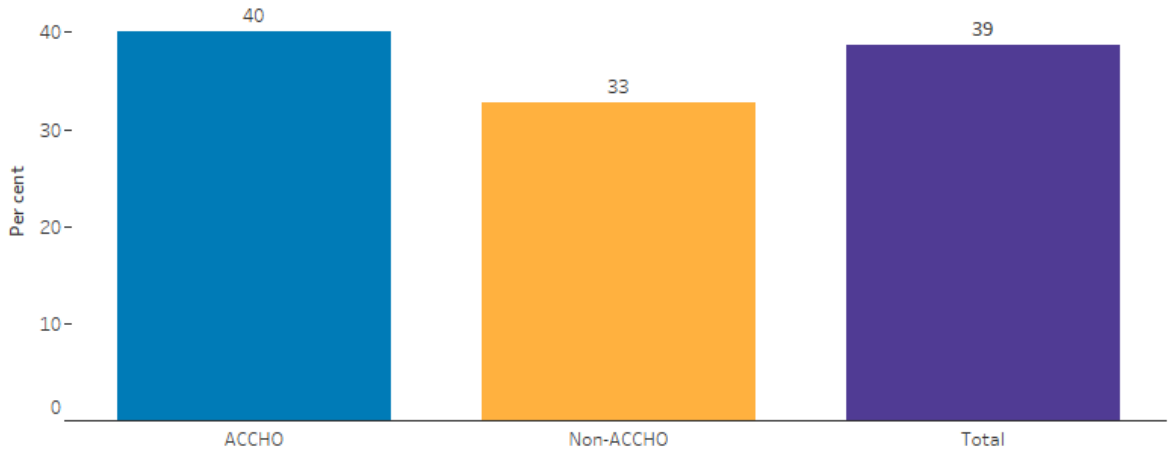
Select state/territory, remoteness or organisation type
Organisation type

Select chronic disease
Type 2 diabetes and/or CVD

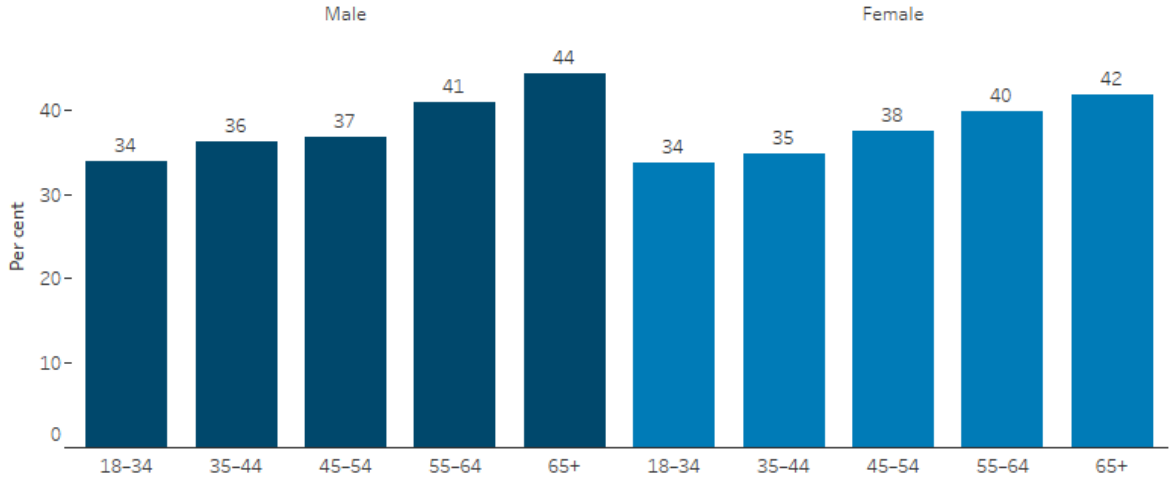
Select kidney test
Both eGFR and ACR

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

Both eGFR and ACR kidney function test recorded – type 2 diabetes and/or CVD, by Organisation type, June 2022



Both eGFR and ACR kidney function test recorded – type 2 diabetes and/or CVD, by Organisation type (All), June 2022



Note: In June 2022, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

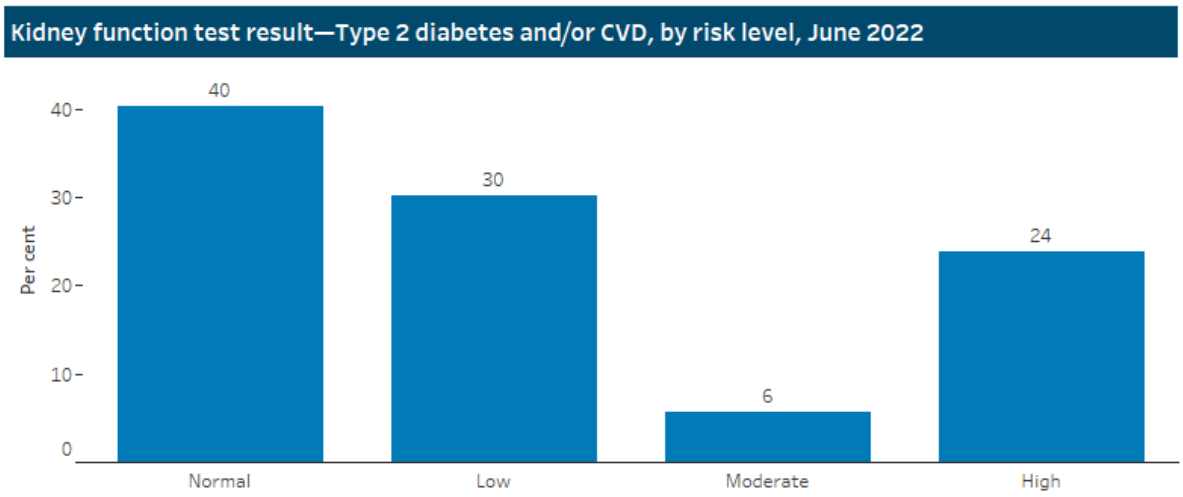
Kidney function test result (risk category) – type 2 diabetes and/or CVD (PI19)

At June 2022, a risk category of 'normal' was recorded within the previous 12 months for:

- 38% (or around 7,600) of Indigenous regular clients aged 18 and over with type 2 diabetes

- 40% (or around 2,600) of Indigenous regular clients aged 18 and over with CVD
- 40% (or around 8,800) of Indigenous regular clients with type 2 diabetes and/or CVD.

Select chronic disease
Type 2 diabetes and/or CVD



Note: In June 2022, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

For clients with type 2 diabetes, having a risk category of 'normal' recorded within the previous 12 months was highest in:

- Victoria/Tasmania (combined) (48%)
- *Major cities* (49%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (40%).

For clients with CVD, having a risk category of 'normal' recorded within the previous 12 months was highest in:

- Victoria/Tasmania (combined) (49%)
- *Major cities* (48%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (41%).

For clients with type 2 diabetes and/or CVD, having a risk category of 'normal' recorded within the previous 12 months was highest in:

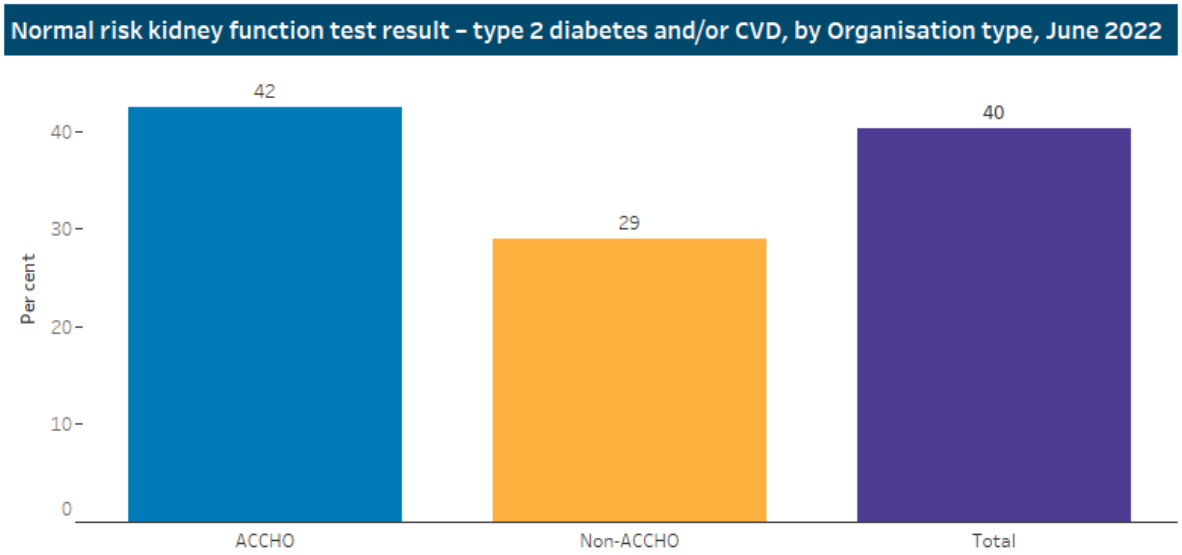
- Victoria/Tasmania (combined) (50%)
- *Major cities* (51%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (42%).

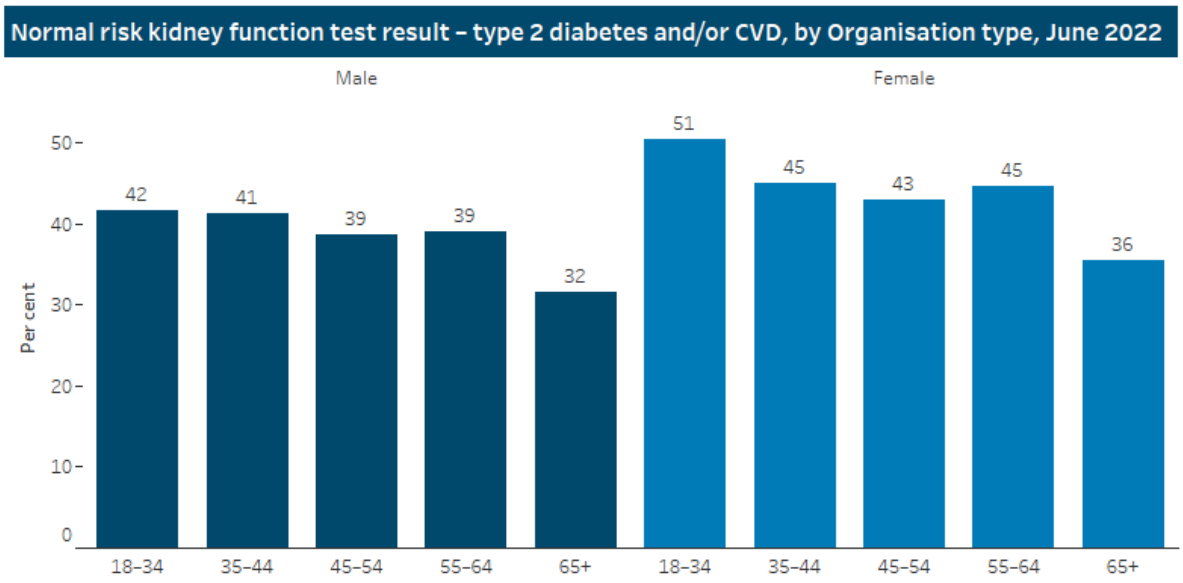
Select state/territory, remoteness or organisation type
Organisation type

Select chronic disease
Type 2 diabetes and/or CVD

Select result risk level
Normal

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





Note: In June 2022, specifications changed for this indicator and data from that point on cannot be compared with previous periods. See Technical notes for more information.
Source: AIHW nKPI collection.
http://www.aihw.gov.au

References

AIHW (Australian Institute of Health and Welfare) (2022) Aboriginal and Torres Strait Islander Health Performance Framework: kidney disease, Canberra: AIHW.

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

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

Technical notes

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

Where to go for more information

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

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

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

In both collections:

- A client may attend more than one organisation. The extent to which this occurs is not known and is not adjusted for.
- Aboriginal Community Controlled Health Organisations (ACCHOs) report all activity (regardless of funding source). Non-ACCHOs should only report activity funded under the Indigenous Australians Health Programme (IAHP) but some report all activity. The extent to which this occurs is not known and may vary by period.

Data collection and submission

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

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

Most CIS used by Indigenous-specific primary health care organisations are able to extract, aggregate and upload the de-individualised data directly to the HDP through a direct-load process. Organisations with systems unable to complete the direct-load

process can manually enter aggregate data directly into a web-based form through the HDP.

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

- for the OSR collection, differences of more than 20% are flagged
- for the nKPI collection, differences of 25% to 100% are flagged, depending on the size of the numerator/denominator.

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

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

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

Comparisons over time

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

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

national reporting. As such, the number of organisations submitting valid data, on the whole or for a particular data item, vary between periods.

Also, unlike in previous years where reporting to the OSR and nKPI collections was a mandatory condition of receiving funding, for 2019–20, 2020–21 and 2021–22 reporting was made voluntary in acknowledgement of the additional pressures on organisations because of the COVID-19 pandemic. COVID-19 also affected the organisations reporting to the collections in a variety of other ways. See Summary and Australia's Health 2022 for more information.

Estimated resident population (ERP)

The estimated resident population (ERP) used as comparison for the OSR and nKPI client cohorts varies. The ERP chosen, or calculated, for each period is determined based on what is considered to be the most representative population for that period.

As the nKPI collection is based on census dates at 30 June and 31 December each year, the most appropriate ERP to use for comparison with Indigenous regular clients is the ERP at the same date as the census date.

As the OSR collection covers a financial year, and estimates as at 30 June not considered appropriate for use when calculating rates based on financial year data, estimates for 31 December (that is, the midpoint of the financial year) are needed.

While the Australian Bureau of Statistics (ABS) produces estimates for the overall Australian population for two time points each year – namely, as at 30 June and 31 December – they only produce estimates for the Indigenous population as at 30 June. As such, ERP at 31 December are calculated by averaging the June population estimates before and after the relevant December. For example, 31 December 2020 estimate = (30 June 2020 estimate + 30 June 2021 estimate)/2.

Interpreting OSR data

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

Where to go for more information

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

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

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

Organisational participation and data exclusions

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

Table 1: OSR organisation participation rate

Collection period	In-scope to report data	Reported data	Participation rate (%)
2013–14	273	270	98.8
2014–15	279	278	99.6
2015–16	277	277	100.0
2016–17	275	266	96.7
2017–18	278	266	95.7

Collection period	In-scope to report data	Reported data	Participation rate (%)
2018–19	232	232	100.0
2019–20	235	215	91.5
2020–21	238	211	88.7
2021–22	234	230	98.3

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

Table 2: OSR primary health care organisation participation rate

Collection period	In-scope to report data	Reported data	Participation rate (%)
2013–14	204	204	100.0
2014–15	203	203	100.0
2015–16	204	204	100.0
2016–17	201	196	97.5
2017–18	203	198	97.5
2018–19	210	210	100.0
2019–20	215	196	91.2
2020–21	218	191	87.6
2021–22	215	211	98.1

Note: Excludes maternal and child health organisations.

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

Table 3: OSR organisations with unresolved data quality issues

Collection period	Number of organisations with unresolved issues	Total number of organisations that reported data	Organisations with unresolved issues (%)	Data items excluded
2013–14	36	270[(a)]	13.3	49
2014–15	21	278	7.6	40
2015–16	13	277	4.7	32
2016–17	16	266	6.0	32
2017–18	20	266	7.5	40
2018–19	5	232	2.2	10
2019–20	2	215	0.9	3
2020–21	6	211	2.8	6
2021–22	15	230	6.5	20

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

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

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

Collection period	Number of organisations with unresolved issues	Total number of organisations that reported data	Organisations with unresolved issues (%)	Data items excluded
2013–14	29	204[(a)]	14.2	38
2014–15	16	203	7.9	26

Collection period	Number of organisations with unresolved issues	Total number of organisations that reported data	Organisations with unresolved issues (%)	Data items excluded
2015–16	9	204	4.4	26
2016–17	11	196	5.6	22
2017–18	15	198	7.6	30
2018–19	4	210	1.9	5
2019–20	2	196	1.0	3
2020–21	6	191	3.1	6
2021–22	15	211	7.1	20

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

Note: Excludes maternal and child health organisations.

Maternal and child health organisations

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

MCH organisations reporting to the OSR are significantly different from organisations funded for comprehensive primary health care (PHC), both in the purpose of the funding and, prior to 2018–19, in what they reported in the OSR. For example, MCH organisations are funded only for specific maternal and child health programs (such as those based within a hospital or health service) and only report on their funded program.

Changes to collection content in 2018–19

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

Also, collections prior to 2018–19 had maternal and child health (MCH) questions in a separate module to preventative health. In 2018–19 these were combined but the data range MCH services were required to report was only focused on what they received

MCH funding for, not through all types of preventative health services the health organisation offered.

Changes to episodes of care in 2016–17

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

Interpreting nKPI data

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

Where to go for more information

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

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

The national Key Performance Indicators (nKPI) collection is a set of process-of-care and health-status indicators organised under three domains (Table 1).

Table 1: Indicators by domain and type, June 2022

Process-of-care indicators	Health-status indicators
Maternal and child health indicators	
PI13: First antenatal visit	PI02: Birthweight result
PI01: Birthweight recorded	PI11: Smoking during pregnancy
PI03: Indigenous health assessment – aged 0–14	
Preventative health indicators	
PI09: Smoking status recorded	PI10: Smoking status result
PI16: Alcohol consumption recorded	PI12: Body Mass Index (BMI)
PI03: Indigenous health assessment – aged 15 and over	PI17: AUDIT-C result
PI20: CVD risk assessment recorded	PI21: CVD risk assessment result
PI22: Cervical screening	

Process-of-care indicators	Health-status indicators
PI14: Immunisation against influenza – aged 6 months and over	
Chronic disease management indicators	
PI07: Chronic Disease Management Plan – type 2 diabetes	PI24: Blood pressure result – type 2 diabetes
PI23: Blood pressure recorded – type 2 diabetes	PI06: HbA1c result – type 2 diabetes
PI05: HbA1c result recorded – type 2 diabetes	PI19: Kidney function test result (risk category) – type 2 diabetes and/or CVD
PI18: Kidney function test type – type 2 diabetes and/or CVD	

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

Organisational participation and data exclusions

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

Table 2: nKPI organisation participation rate

Collection period	In-scope to report data	Reported data	Participation rate (%)
June 2017	228	228	100.0
December 2017	231	231	100.0
June 2018	236	233	98.7

Collection period	In-scope to report data	Reported data	Participation rate (%)
December 2018	242	238	98.3
June 2019	240	234	97.5
December 2019	241	237	98.3
June 2020	236	220	93.2
December 2020	231	218	94.4
June 2021	232	215	92.7
December 2021	230	230	100.0
June 2022	230	230	100.0

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

Table 3: nKPI organisations with unresolved validation issues

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

Collection period	Number of organisations with unresolved issues	Total number of organisations that reported data	Organisations with unresolved issues (%)
June 2020	3	220	1.4
December 2020	6	218	2.8
June 2021	3	215	1.4
December 2021	17	230	7.4
June 2022	8	230	3.5

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

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

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

Changes to data extraction methods

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

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

Variations between CIS

There are variations between CIS and how each capture and extract results, in general and also between periods. For example, the PI09 smoking status recorded and PI10 smoking status result indicators specify that if a record does not have an assessment date assigned within the CIS, the record should be treated as current (that is, as having been updated within the previous 24 months). Whether the CIS capture all results or only those results updated within the previous 24 months varies between CIS. In particular, in June 2021, some CIS modified the inclusions for these indicators. The full impact of this has not been quantified but resulted in large decreases for some organisations between December 2020 and June 2021.

Changes in indicators

Indicator specifications may be revised over time (for example, to reflect the latest clinical and best-practice guidelines). In particular, in 2020, in response to issues identified during the AIHW's *Review of the two national Indigenous specific primary health care datasets: OSR and nKPI*, all indicators current as of June 2020 underwent a review by a clinical and technical working group sitting under, and convened by, the (Indigenous) Health Services Data Advisory Group (HS DAG). As a result, HS DAG approved a series of changes to the indicators to be rolled out progressively during 2020–21.

Key changes to indicators over time include:

- PI01 and PI02 (birthweight): from June 2021, the definition for these indicators was adjusted to capture Indigenous babies born in the previous 12 months *who had more than one visit* (previously included all Indigenous babies born in the previous 12 months). From June 2021, multiple births were included in PI02 (previously these were only included in PI01).
- PI03 (Indigenous health assessment): from December 2020, the age range captured by this indicator was expanded to include all ages (previously did not include ages 5–24); disaggregation by sex for ages 0–4 was added; and included MBS items were expanded (from only MBS Item 715) to contain:
  - in-person MBS items 715 and 22
  - telehealth MBS items 92004, 92016, 92011 and 92023.

- PI04 (childhood immunisation): this indicator has been retired and was last collected in the June 2020 nKPI collection.
- PI07 (Chronic Disease Management Plan): from December 2020, included MBS items were expanded (from only MBS Item 721) to contain:
  - in-person MBS items 721 and 229
  - telehealth MBS items 92024, 92068, 92055, and 92099.
- PI08 (Team Care Arrangement): this indicator has been retired and was last collected in the June 2020 nKPI collection.
- PI09 and PI10 (smoking): from June 2021, the age range captured by these indicators was expanded to include ages 11–14.
- PI11 (smoking during pregnancy): from June 2021, the definition of this indicator was adjusted to include only the latest smoking status recorded prior to the completion of the latest pregnancy (previously smoking status result was as recorded within the previous 12 months); and the lower age captured was expanded (age groupings changed to 'less than 20', '20–34' and '35 and older' from '15–19', '20–24', '25–34', and '35 and older').
- PI12 Body Mass Index (BMI): from December 2021, the age range captured by this indicator was expanded to include ages 18–24 (previously ages 25 and over); and additional BMI categories were added for 'underweight (<18.50)', 'normal weight (18.50–24.99)', and 'not calculated' (previously overweight and obese only).
- PI13 (first antenatal visit): from June 2021, grouping of gestational age at first visit changed to 'before 11 weeks', '11–13 weeks', '14–19 weeks' and '20 weeks or later' 'did not have gestational age recorded', and 'did not attend an antenatal care visit' (previously 'less than 13 weeks', '13–less than 20 weeks', '20 weeks or later', 'no result recorded', and 'did not attend an antenatal care visit').
- PI14 (influenza immunisation): from December 2020, the age range captured by this indicator was expanded to ages 6 months and over (previously ages 50 and over only).
- PI15 (influenza immunisation – type 2 diabetes and/or COPD): this indicator has been retired and was last collected in the June 2021 nKPI collection.
- PI18 (kidney function test type):
  - in December 2021, the age range for this indicator was expanded to be for all ages (previously ages 15 and over), and the test types recorded were revised
  - in June 2022, the age range for this indicator was changed to ages 18 and over.
- PI19 (kidney function test result):

  - in December 2021 this indicator was not collected while modifications were made to its specifications
  - in June 2022, specifications for this indicator were adjusted to add the requirement for both an eGFR and an ACR result to be recorded, add a client group category for 'type 2 diabetes and/or CVD', revise the age range to ages 18 and over (previously ages 15 and over), and revise the kidney function test result categories.
- PI22 (cervical screening):
  - From June 2018 to June 2020 – transitional changes were made to align with revised requirements under the National Cervical Screening Program (NCSP). The key changes were to include clients who had either a Papanicolaou smear (Pap test) conducted prior to 1 December 2017 or a human papillomavirus (HPV test) conducted from 1 December 2017; revise the age range to 20–74 to accommodate the former reporting age range (20–69) and the new age range (25–74).
  - From December 2020 – the indicator was revised to collect only HPV tests conducted in the last 5 years where the test occurred on or after 1 December 2017.
- PI24 (blood pressure result): from June 2021, the target blood pressure value was changed to 'less than or equal to 140/90mmHg' (previously 'less than or equal to 130/80 mmHg').

Maternal and child health organisations

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

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

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

References

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

Glossary

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

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

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

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

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

There are 5 remoteness areas from this structure reported in the OSR and nKPI collections:

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

- *Outer regional* areas – CDs with an average ARIA index value greater than 2.4 and less than or equal to 5.92
- *Remote* areas – CDs with an average ARIA index value greater than 5.92 and less than or equal to 10.53
- *Very remote* areas – CDs with an average ARIA index value greater than 10.53.

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

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

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

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

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

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

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

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

client contact: In the Online Services Report collection, this refers to a count of the contacts between clients and each type of health worker in an organisation (both employed and visiting health staff). Client contacts do not include administrative contacts or those relating to groups and residential care. See also Clients and Technical notes pages.

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

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

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

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

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

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

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

indicator: See definition for national Key Performance Indicators.

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

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

linear trend: A linear trendline is used to show if something is increasing or decreasing at a steady rate. It uses the least squares method to seek the slope and intercept coefficients such that: $y = bx + a$, where b is the slope of a trendline and a is the y-intercept (which is the expected mean value of y when all x variables are equal to 0). The R-squared value measures the trendline reliability – generally the nearer R-squared is to 1, the better the trendline fits the data (noting, however, that small R-squared values are not always a problem, and high R-squared values are not always good). R-squared is the percentage of the dependent variable variation that a linear model explains.

mean: Average of a group of numbers.

median: Midpoint of a list of observations ranked from smallest to largest.

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

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

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

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

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

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

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

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

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

Symbols

n.a.	not available
n.p.	not published
—	nil or rounded to zero