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AIHW

Indigenous health checks and follow-ups

Web report

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Through Medicare, Aboriginal and Torres Strait Islander people can receive Indigenous-specific health checks from their doctor, as well as referrals for Indigenous-specific follow-up services.

- In 2019–20, 239,000 Indigenous Australians had one of these health checks (28%).
- The proportion of Indigenous health check patients who had an Indigenous-specific follow-up service within 12 months of their check increased from 12% to 47% between 2010–11 and 2018–19.

COVID-19

The report presents data on Indigenous health checks for a time period up until the end of June 2020 (i.e. overlapping with the COVID-19 period). It also includes data on telehealth MBS items that were introduced in 2020 as part of the response to COVID-19.

Key findings:

- In 2019–20, 4% of Indigenous-specific health check patients had a health check via phone or video-conference
- 47% of Indigenous-specific health check patients in 2018–19 had an Indigenous-specific follow-up within 12 months
- 62% of Indigenous Australians received at least 1 Indigenous-specific health check in the 5-year period to 30 June 2020
- Between 2010–11 and 2019–20, the proportion of Indigenous Australians who had an Indigenous health check nearly tripled.

Summary

Aboriginal and Torres Strait Islander people can receive an annual health check, designed specifically for Indigenous Australians and funded through Medicare

(Department of Health 2021). This Indigenous-specific health check was 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—for example, diabetes and heart disease.

During the health check, a doctor—or a multidisciplinary team led by a doctor—will assess a person's physical, psychological and social wellbeing (Department of Health 2021). The doctor can then provide the person with information, advice, and care to maintain and improve their health.

The doctor may also refer the person to other health care professionals for follow-up care, as needed—for example, physiotherapists, podiatrists or dieticians.

As part of the Australian Government's COVID-19 response, temporary telehealth items were introduced in March 2020 to help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers.

This report presents information on the use of:

- health checks provided under the Indigenous-specific Medicare Benefits Schedule (MBS) items 715 and 228; and
- follow-up services provided under Indigenous-specific MBS items 10987 and 81300 to 81360;

as well as telehealth:

- health checks provided under the Indigenous-specific Medicare Benefits Schedule (MBS) items 92004, 92016, 92011 and 92023; and
- follow-up services provided under Indigenous-specific MBS items 93200, 93202, 93048 and 93061.

The data include all Indigenous-specific health checks and follow-ups billed to Medicare by Aboriginal Community Controlled Health services or other Indigenous health services, as well as by mainstream GPs and other health professionals.

Note that the data are limited to Indigenous-specific MBS items, so do not provide a complete picture of health checks and follow-ups provided to Indigenous Australians. For example, Indigenous Australians may receive similar care through other MBS items (that is, items that are not specific to Indigenous Australians), or through a health care provider who is not eligible to bill Medicare (see also Data sources and notes). These have not been included in this report.

Throughout the report, 'Indigenous-specific health checks' is used interchangeably with 'health checks' to assist readability. Similarly, 'Indigenous-specific follow-ups' is used interchangeably with 'follow-ups'.

This report differs from the previous edition, due to: new 2018–19 data and 2019–20 data; the introduction of new MBS items, including telehealth items; the use of population projections and backcasts based on the 2016 Census to calculate rates; new

Indigenous Region-level analysis; new analysis of time between consecutive health checks; and minor changes to the treatment of age and geographic information.

The impacts of COVID-19 on numbers of Indigenous-specific health checks are touched on in AIHW 2020. That report discusses the number of MBS items processed each month from July 2018 to June 2020, by state/territory and age group.

Rate of health checks

28% of Indigenous Australians (about 239,000 people) had an Indigenous-specific health check in 2019–20

State and Territory rates

In 2019–20, the rates of Indigenous-specific health checks were highest in Queensland (35%) and the Northern Territory (34%)

Indigenous-specific follow-up services

Among Indigenous Australians who had an Indigenous-specific health check in 2018–19, 47% had at least 1 follow-up service within 12 months of the health check

References

Australian Institute of Health and Welfare (AIHW) 2020. Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023. Cat. no. IHW 201. Canberra: AIHW. Viewed 4 June 2021.

Department of Health 2021. Annual Health Assessment for Aboriginal and Torres Strait Islander People. Canberra: Department of Health. Viewed 4 June 2021.

Number of health checks

In 2019–20, there were about 247,000 Indigenous-specific health checks provided to about 239,000 Aboriginal and Torres Strait Islander people. The minimum time allowed between checks is 9 months, and so people can receive more than 1 health check in a year. Data from the Indigenous primary health care national Key Performance Indicators (nKPIs) data collection suggest that, in spite of only making about 1.8% of fulltime-equivalent general practitioners (GPs), GPs at Aboriginal Community Controlled Health Organisations conduct nearly half of all Indigenous-specific health checks (AIHW 2020).

Between 2010–11 and 2018–19, the number of Indigenous Australians receiving a health check more than tripled—from about 71,000 to 241,000 patients. Due to the impacts of COVID-19 (AIHW 2020), the number of health check patients dropped slightly in 2019–20 (by about 1% or 2,300 people), ending 8 years of increasing numbers of health checks (Figure 1).

Figure 1: Number of Indigenous-specific health check patients and services by sex and telehealth status, 2010–11 to 2019–20

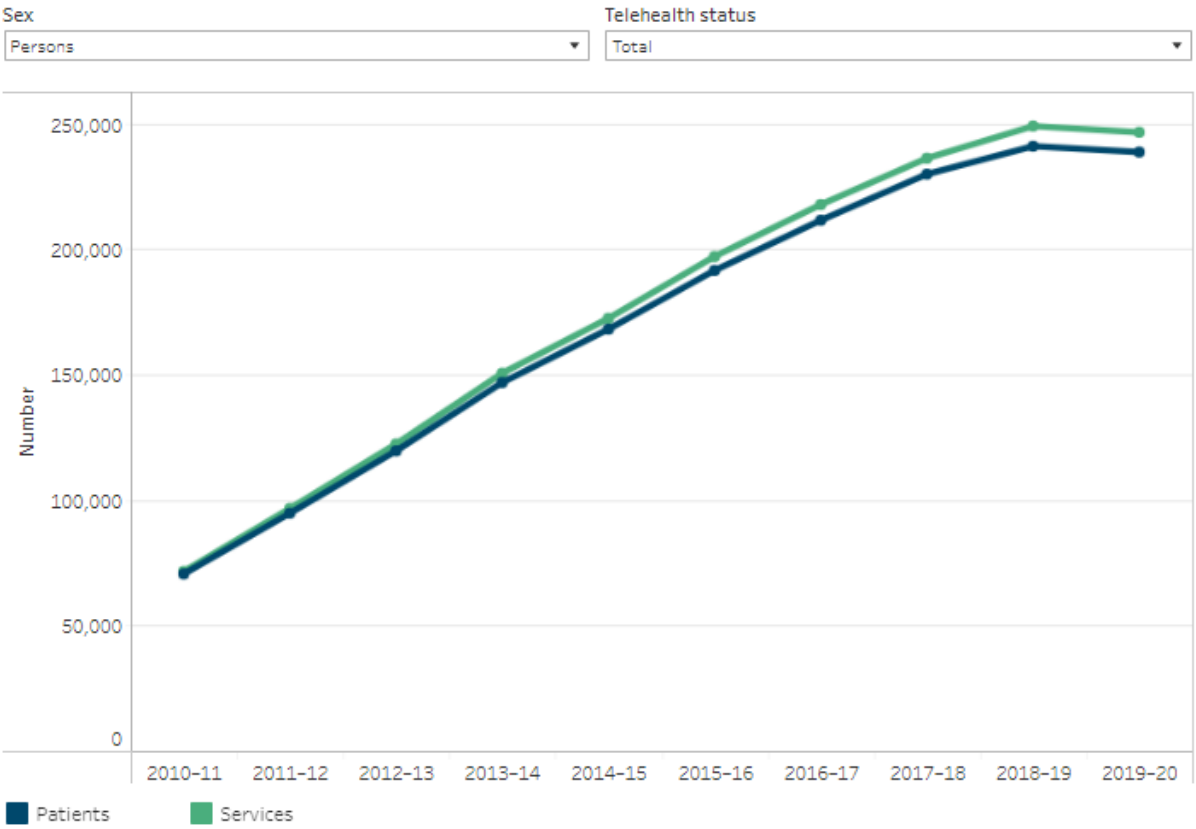


Figure 1: Number of Indigenous-specific health check patients and services by sex and telehealth status, 2010–11 to 2019–20

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2021.
2. Telehealth items were introduced in March 2020, in response to COVID-19 and associated restrictions.
3. See 'Data sources and notes' for additional information.
4. Refer to table 'HC01' in data tables

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

References

Australian Institute of Health and Welfare (AIHW) 2020. Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023. Cat. no. IHW 201. Canberra: AIHW. Viewed 4 June 2021.

Rate of health checks

This section looks at the rate of Indigenous-specific health checks among the Aboriginal and Torres Strait Islander population, including:

- national rates in 2018–19 and 2019–20, and differences by sex and age
- differences by geographic area in 2018–19 and 2019–20
- patterns of use over a 5-year period from 1 July 2015 to 30 June 2020
- time between health checks
- trends in the annual rate of checks, from 2010–11 to 2019–20.

Rates have been calculated using ABS Indigenous population estimates and projections based on the 2016 Census. For certain geographic breakdowns, Indigenous population estimates have been derived by disaggregating available ABS data (see Box 1).

Box 1: Population data used in rate calculations

The ABS's estimated resident population (ERP) is the official measure of the Australian population. The ERP is based on results of the 5-yearly Census of Population and Housing, with adjustments for net undercount as measured by the Post Enumeration Survey.

ERP estimates for Indigenous Australians based on the 2016 Census are available for 30 June 2016 (ABS 2018a). The ABS also produces projections of the Indigenous population for post-Census years based on assumptions about fertility, mortality and migration. These span the period 30 June 2017 to 30 June 2031 and are available for Australia, States and Territories, Indigenous Regions and combined Remoteness Areas (ABS 2019). A similar method was used by the ABS to update Indigenous population estimates for years 2010 to 2015, to incorporate improved Indigenous identification for 2016. The ABS makes no attempt to predict future changes in Indigenous identification when modelling these projections, though increased identification has had large impacts in the past (ABS 2018b).

In this report, annual rates of health checks are based on averages of the ABS' outputs, e.g. population denominators for 2019–20 are the average of 30 June 2019 and 30 June 2020 projections. For Statistical Areas Level 3 (SA3), Primary Health Networks (PHN) and expanded Remoteness Areas (RA), projections have been approximated by the AIHW using Iterative Proportional Fitting, supported by 2016 Census counts. This technique produces estimates that match the ABS' published outputs when summed back up to larger areas. Uncertainty in these estimates would be difficult to quantify, since there are many sources of error, but generally, areas with larger population estimates would be more reliable.

Note that COVID-19 strongly affected Australia's population growth in 2020, due mainly to negative net overseas migration between April and June (ABS 2020). Overseas migration has a much smaller impact on Indigenous population growth, compared to natural increase (births and deaths), so should not considerably affect the accuracy of projections (ABS 2018b). Internal migration patterns may have changed unpredictably though, which would affect the reliability of sub-national population estimates.

See Data sources and notes for additional information.

The Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 set national goals for increasing the use of Indigenous-specific health checks (see also national goals for health checks). Information about progress against the goals can be found in AIHW 2020.

Note: Rates in this section differ from rates used to assess progress towards the Implementation Plan goals due to different data specifications. Rates in this report are calculated using numbers of patients (while the national goals are based on number of services, which are higher than the number of patients), and presented according to the date the service was provided (while the national goals are based on the date the service was processed). Age of patients is also calculated differently for the national goals. See Data sources and notes – section 'National goals for health checks' for additional information.

References

Australian Bureau of Statistics (ABS) 2018a. Estimates of Aboriginal and Torres Strait Islander Australians, June 2016. Canberra: ABS.

ABS 2018b. Census of Population and Housing: Understanding the Increase in Aboriginal and Torres Strait Islander Counts. Canberra: ABS.

ABS 2019. Estimates and Projections, Aboriginal and Torres Strait Islander Australians. Canberra: ABS.

ABS 2020. Population and COVID-19. Canberra: ABS.

Australian Institute of Health and Welfare (AIHW) 2020. Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023. Cat. no. IHW 201. Canberra: AIHW. Viewed 4 June 2021.

National rates by sex and age

In 2019–20, 28% (238,700) of Aboriginal and Torres Strait Islander people had an Indigenous-specific health check. Around 4% (9,900) of health checks were conducted at least partly via phone or video-conference—noting that telehealth options were only available during the final 3–4 months of 2019–20.

The rate of Indigenous-specific health checks was higher for Indigenous females than males—30% compared with 26%. Across age groups, the difference between males and females in the rate of checks was largest for those aged 25–34 (30% of Indigenous females, compared with 19% of Indigenous males) (Figure 2). Among total health check patients of each sex, females engaged with telehealth services slightly more than males (4.4% of females patients compared to 3.9% of male patients).

In 2019–20, the rate of Indigenous-specific health checks was:

- highest among those aged 65 and over, for both males and females—41% of Indigenous females and 37% of Indigenous males in this age group received a health check
- lowest among those aged 15–24 for males (19%) and those aged 5–14 for females (24%).

Figure 2: Indigenous-specific health check rates, by sex, age and telehealth status, 2018–19 and 2019–20

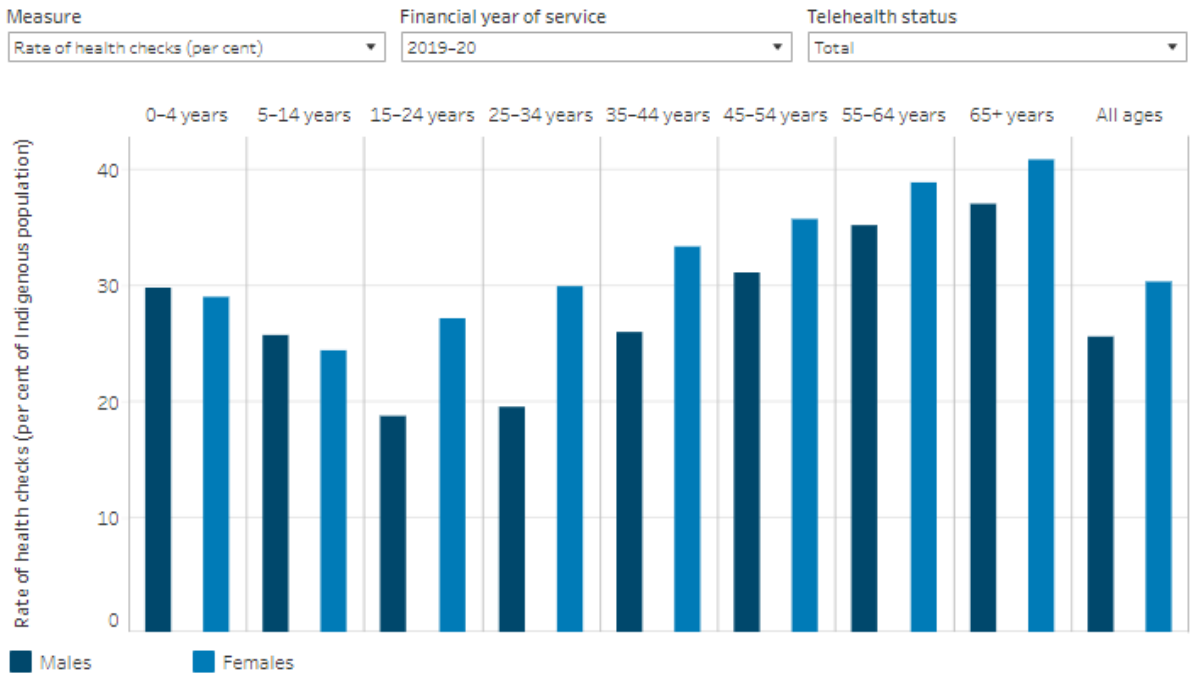


Figure 2: Indigenous-specific health check rates, by sex, age and telehealth status, 2018–19 and 2019–20

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2021.
2. Telehealth items were introduced in March 2020, in response to COVID-19 and associated restrictions.
3. See 'Data sources and notes' for additional information.
4. Refer to table 'HC02' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

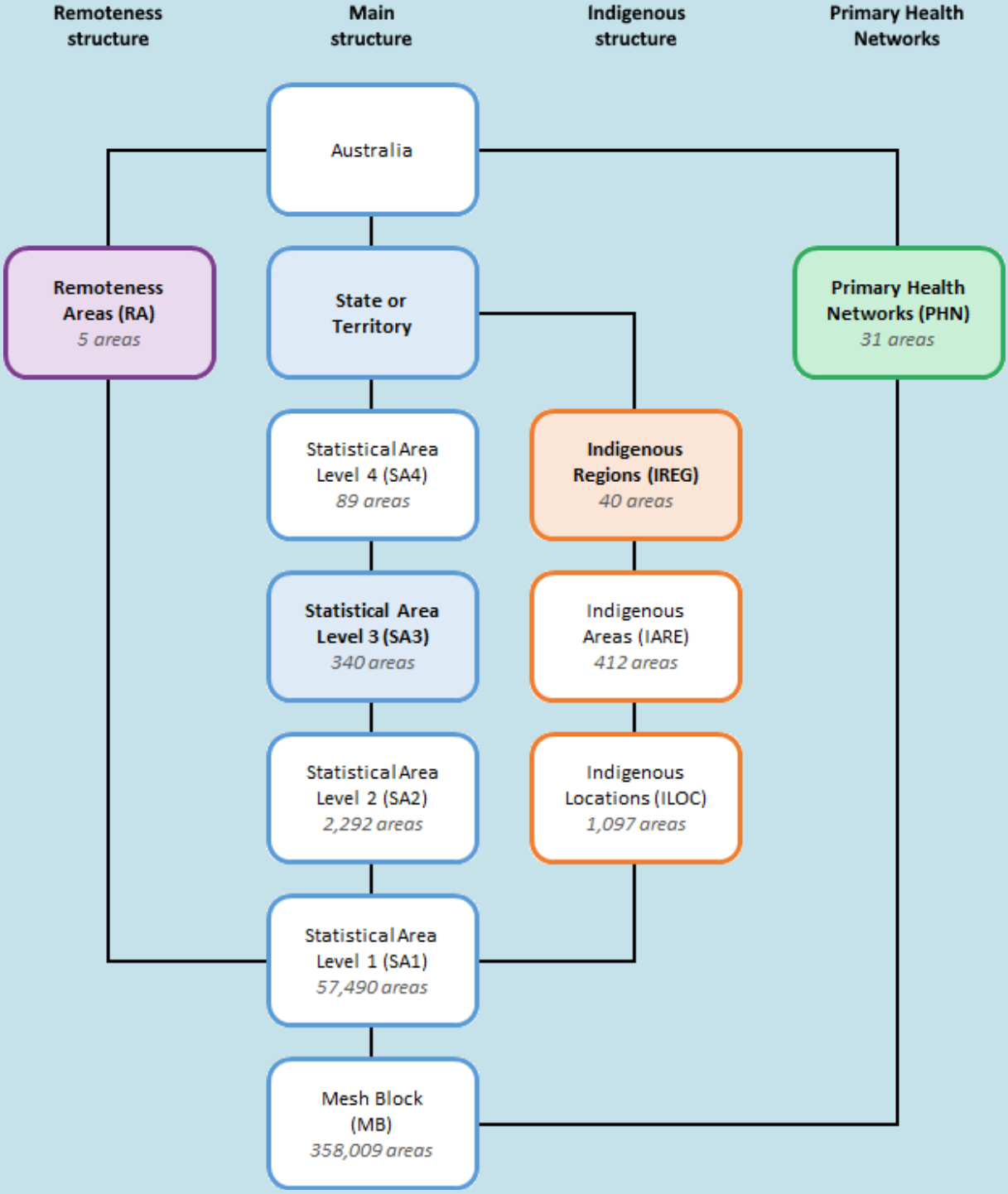
Geographic variation

Figure 3 shows the rate of Indigenous-specific health checks by 5 different geographic classifications—state/territory, remoteness area, Primary Health Network (PHN), Indigenous Regions (IREG) and Statistical Areas Level 3 (SA3). See Box 2 for information about the reporting of geographic data.

Box 2: Geographic reporting

Geographic region types

The geographic areas presented in this report relate to one another as depicted below:



Notes:

- The Main structure, Indigenous structure, and Remoteness structure refer to the Australian Bureau of Statistics' hierarchy of areas included in the 2016 Australian Statistical Geography Standard (ASGS).
- Remoteness Areas divide Australia into 5 classes of remoteness based on a measure of relative access to services in 2016. Access to services was measured using the Accessibility and Remoteness Index of Australia (ARIA+), produced by the Hugo Centre for Population and Migration Studies at the University of Adelaide.
- Primary Health Networks (PHNs) were established in 2015 by the Australian Department of Health. Some PHNs cross state/territory borders—most notably, the Victorian PHN, Murray, covers Albury (NSW). For more information, see the Department of Health's website.

Postcode data

This analysis is based on the postcode of the patient's given mailing address. As a result, the data may not reflect where the person actually lived—particularly for people who use PO Boxes. This is likely to impact some areas more than others, and will also have a generally greater impact on the SA3 data than on the larger geographic classifications. See Box 5 in Data sources and notes for information on areas most likely to be affected.

Metropolitan classification

To distinguish different geographic regions based on their level of urban development, certain bar charts in Figures 3 and 15 depict areas as:

- **Metropolitan** where at least 80% of the total estimated resident population lived in Major Urban centres at 30 June 2016 (cities with 100,000 residents or more, according to the ABS' Section of State boundaries)
- **Non-metropolitan** where at least 80% of the total estimated resident population lived outside of Major Urban centres at 30 June 2016
- **Combination** where between 20% and 80% (exclusive) of the total estimated resident population lived in Major Urban centres at 30 June 2016.

In 2019–20:

- Across states and territories, Queensland had the highest rate of Indigenous-specific health checks (with 35% of the Aboriginal and Torres Strait Islander population receiving an Indigenous health check), followed by the Northern Territory (34%). Victoria had the lowest rate (15%).
- Across PHNs, the rate of Indigenous-specific health checks ranged from 5% (in Northern Sydney) to 39% (in Western Queensland).

Figure 3: Indigenous-specific health check rates by geography and telehealth status, 2018–19 and 2019–20

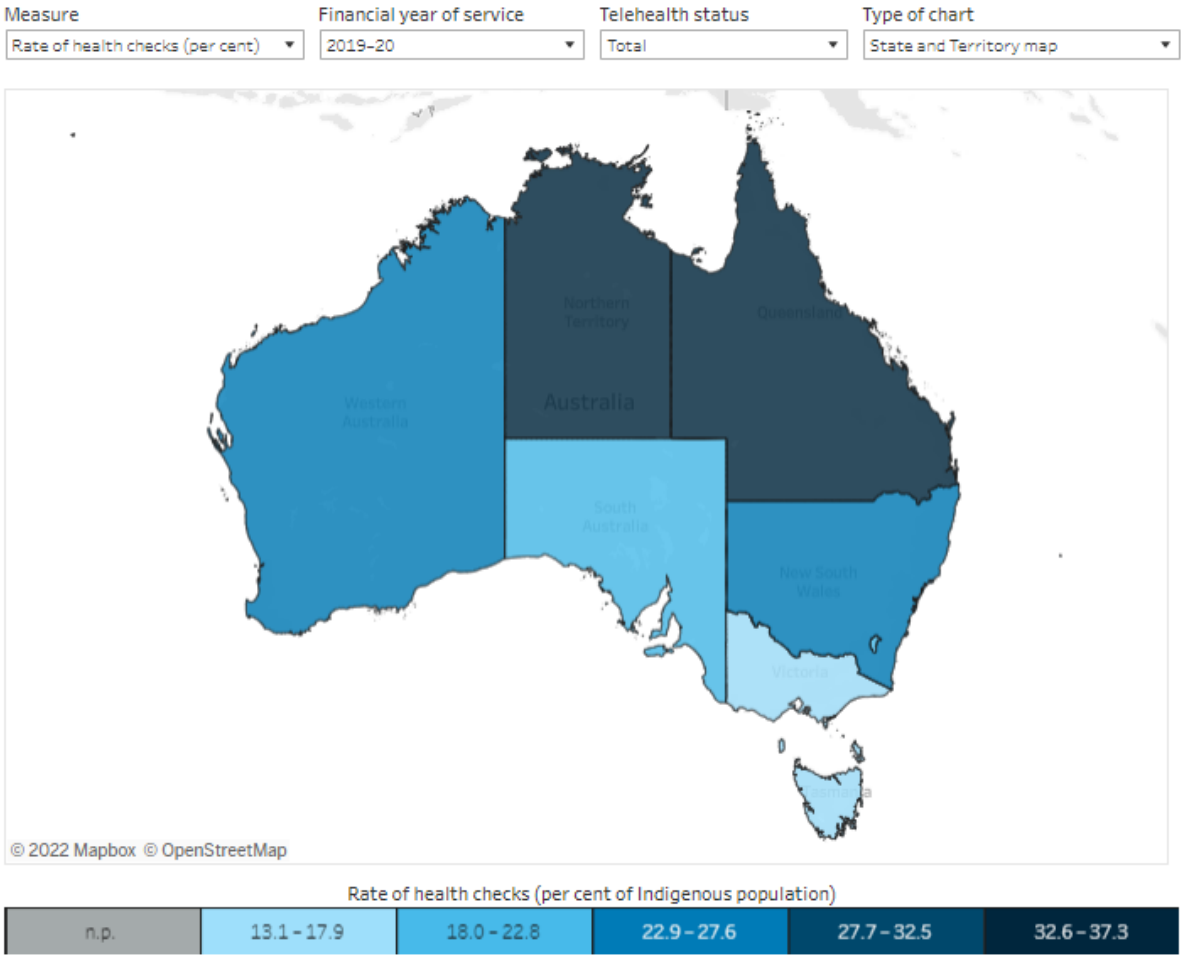


Figure 3: Indigenous-specific health check rates by geography and telehealth status, 2018–19 and 2019–20
n.p. not published because of small numbers, confidentiality or other concerns about the quality of the data.
Notes
1. Analysis is based on date of service, for services processed on or before 30/04/2021.
2. Telehealth items were introduced in March 2020, in response to COVID-19 and associated restrictions.
3. See 'Data sources and notes' for additional information.
4. Refer to tables 'HC03' to 'HC07' in data tables.
Source: AIHW analysis of Medicare Benefits Schedule data.
https://www.aihw.gov.au

Across the 5 remoteness areas, the rate of Indigenous-specific health checks in 2019–20 was generally higher in more remote areas—increasing from 24% in *Major cities* to 34% in *Outer regional* and *Remote* areas. *Very remote* areas were the exception to this general pattern, with a rate of 27%. This may be partly due to the use of mailing address to derive these rates—in particular, where a person lives in a *Very remote* area, but has mail delivered to a PO Box in a less remote location, the health check will be counted in the less remote location. Another explanatory factor would be the availability of GPs in more remote areas (RACGP 2020).

Across Indigenous Regions, the rate of Indigenous-specific health checks was highest in *Alice Springs* (55%) and lowest in *Melbourne* (10%) (Figure 3). Note that the rate in *Alice Springs* is likely to be inflated, since many residents of Central Australia use PO Boxes

located in Alice Springs for receiving mail. This means some of the health checks counted in *Alice Springs* probably belong to residents of *Apatula* (IREG).

Across SA3s, the rate of Indigenous-specific health checks ranged from 3% to 56% in 2019–20 (Figure 3; analysis relates to 328 areas for which rates could be reported).

On average, the rate of Indigenous-specific health checks was higher in SA3s with larger Indigenous populations. For example, the rate of health checks, when averaged across the SA3s in 2019–20, was:

- 16% in SA3s with fewer than 1,000 Indigenous Australians (114 SA3s)
- 26% in SA3s with between 1,000 and 4,999 Indigenous Australians (173 SA3s)
- 33% in SA3s with 5,000 or more Indigenous Australians (41 SA3s).

In 2019–20, about 7 in 10 SA3s (69%, or 226 areas) had a rate below the national average (that is, a rate lower than 27.9%). This is because SA3s with larger populations—which tended to have higher rates of health checks—contribute more to the national rate than the smaller SA3s.

Change between 2018–19 and 2019–20

Most states and territories saw a drop in rates of Indigenous-specific health checks between 2018–19 and 2019–20. In Victoria, which experienced a second COVID-19 outbreak and resulting lockdown, the proportion of the Indigenous population who received an Indigenous-specific health check fell from 16.1% in 2018–19 to 14.7% in 2019–20. This was the largest decrease in relative terms among the states and territories (down almost 9%). Conversely, Tasmania and New South Wales saw increased rates of Indigenous-specific health checks over the same period—Tasmania's rate increasing from 13.1% to 15.4% (up 17% in relative terms) (Figure 4).

Figure 4: Change in Indigenous-specific health check rates by geography, 2018–19 and 2019–20

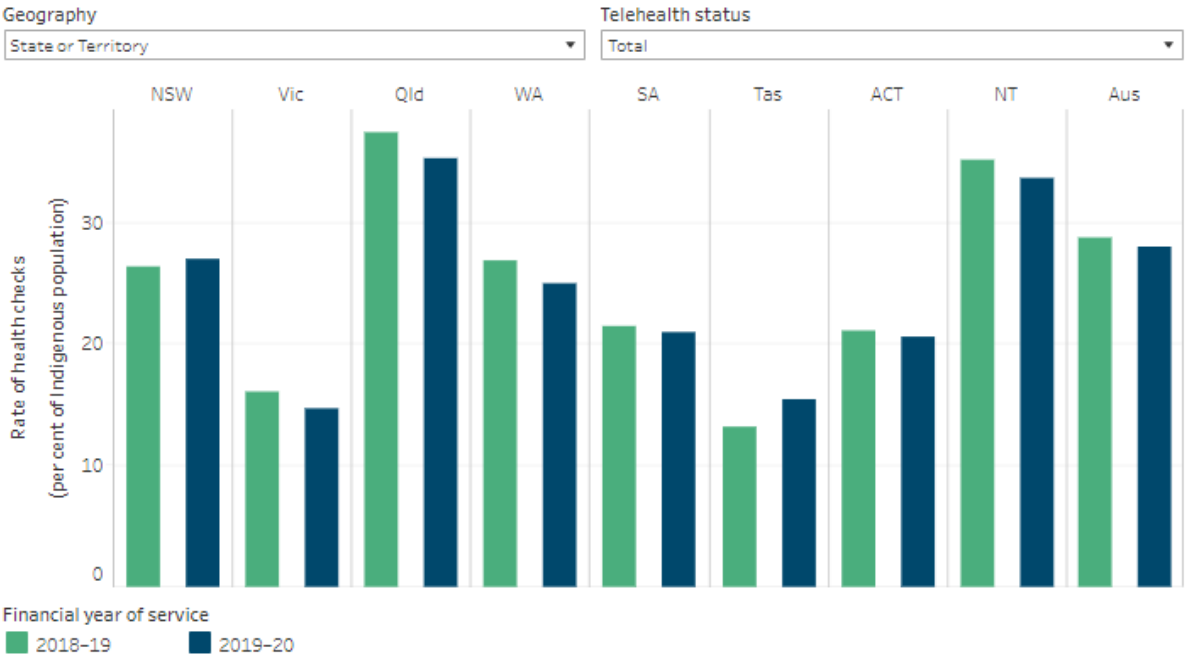


Figure 4: Change in Indigenous-specific health check rates by geography, 2018–19 and 2019–20

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2021.
2. Telehealth items were introduced in March 2020, in response to COVID-19 and associated restrictions.
3. See 'Data sources and notes' for additional information.
4. Refer to tables 'HC03' and 'HC05' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Among remoteness areas in 2018–19, *Remote Australia* had the highest annual rate of Indigenous-specific health checks, with 38.2% of the Indigenous population having received a health check that year. In 2019–20, however, only 34.3% of the Indigenous population received a health check (down over 10% in relative terms). Rates also dropped among *Outer regional* and *Very remote* Indigenous populations (down 6% and 5% respectively, in relative terms).

Populations living in *Major cities* and *Inner regional* areas, however, both saw rates of Indigenous-specific health checks stay about the same across the 2 financial years (Figure 4). This was partly because the use of telehealth health checks was highest in *Major cities* and *Inner regional* areas—despite falls in face-to-face health check rates in all remoteness areas between 2018–19 and 2019–20 (Figure 4). Figure 5 shows that around 5% of patients living in *Major cities* and *Inner regional* areas had Indigenous-specific health checks delivered via telehealth (claimed as MBS Items 92004, 92011, 92016 or 92023), compared with 2–3% of patients living in more remote areas.

Figure 5: Proportion of health check patients who used telehealth by remoteness, 2019–20

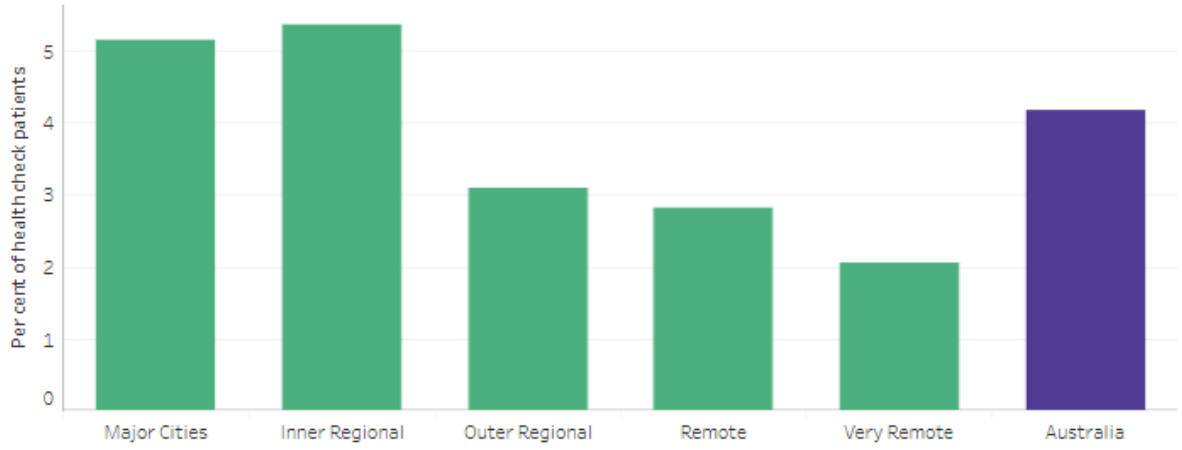


Figure 5: Percentage of Indigenous-specific health check patients who used telehealth, by Remoteness Area, 2019–20
Notes
1. Analysis is based on date of service, for services processed on or before 30/04/2021.
2. Telehealth items were introduced in March 2020, in response to COVID-19 and associated restrictions.
3. Percentages calculated as the *number of patients who had at least 1 Indigenous-specific health check delivered via telehealth* as a proportion of the *total number of patients who had an Indigenous-specific health check.*
4. See 'Data sources and notes' for additional information.
5. Refer to table 'HC05' in data tables.
Source: AIHW analysis of Medicare Benefits Schedule data.
https://www.aihw.gov.au

References

Royal Australian College of General Practitioners (RACGP) 2020. General Practice: Health of the Nation 2020. East Melbourne: RACGP.

Patterns over a 5-year period

Over a 5-year period from 1 July 2015 to 30 June 2020, about 533,000 Aboriginal and Torres Strait Islander people received at least one Indigenous-specific health check. This is equivalent to over half (62%) of the Indigenous population at 30 June 2020, acknowledging that a small proportion of those patients may have either died or moved overseas during the 5-year period.

The 533,000 Indigenous-specific health check patients included around:

- 216,000 people who received 1 health check during the 5 year period (equivalent to 25% of the Indigenous population)
- 140,000 people who received 2 health checks (16%)
- 93,200 people who received 3 health checks (11%)
- 56,200 people who received 4 health checks (7%)
- 28,400 people who received 5 or more health checks (3%) (Figure 6).

Indigenous females were more likely than Indigenous males to have received at least one Indigenous-specific health check during the 5-year period—equivalent to 65% of the Indigenous female population compared with 59% of the Indigenous male population.

Figure 6: Indigenous-specific health check patients, by number of checks, 2015–16 to 2019–20 combined

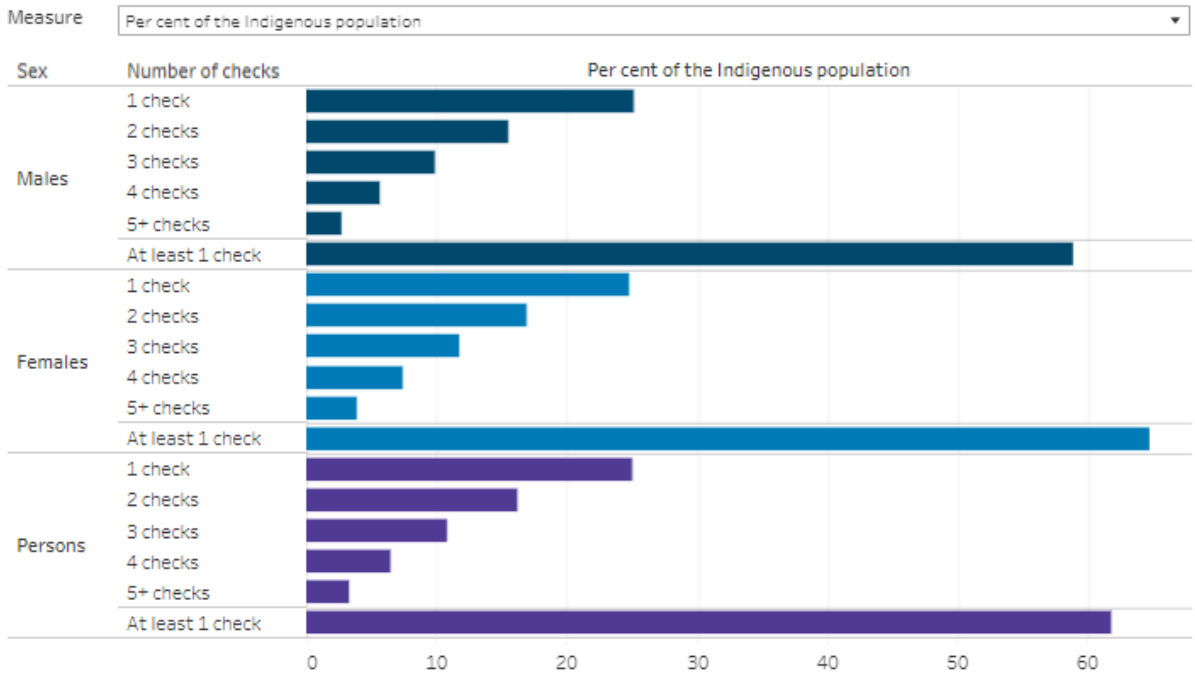


Figure 6: Indigenous-specific health check patients, by number of checks, 2015–16 to 2019–20 combined

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2021.
2. Denominator used for percentage was the projected Indigenous population at 30 June 2020.
3. See 'Data sources and notes' for additional information.
4. Refer to table 'HC08' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Over the 5-year period from 1 July 2015 to 30 June 2020, across states and territories, the proportion of the Indigenous population who received:

- at least one Indigenous-specific health check was highest in the Northern Territory (equivalent to 76%), followed by Queensland (75%); the rate was lowest in Tasmania (31%).
- 5 or more Indigenous-specific health checks was highest in Queensland (5.8%), and lowest in Tasmania (0.7%) (Figure 7).

Figure 7: Indigenous-specific health check patients, by state and territory, and number of checks, 2015–16 to 2019–20 combined

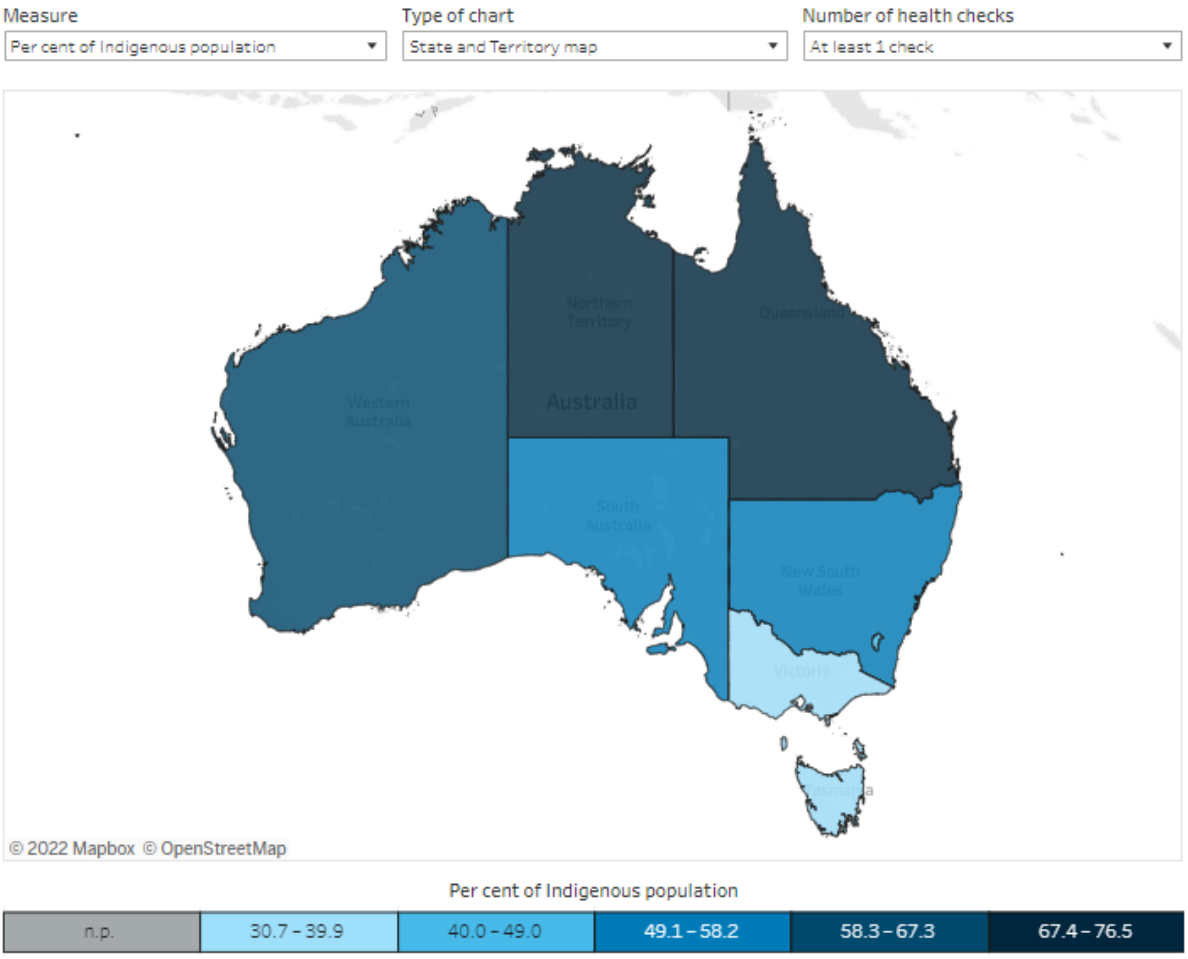


Figure 7: Indigenous-specific health check patients, by state and territory, and number of checks, 2015–16 to 2019–20 combined
n.p. not published because of small numbers, confidentiality or other concerns about the quality of the data.
Notes
1. Analysis is based on date of service, for services processed on or before 30/04/2021.
2. Denominator used for percentage was the projected Indigenous population at 30 June 2020.
3. See 'Data sources and notes' for additional information.
4. Refer to table 'HC09' in data tables.
Source: AIHW analysis of Medicare Benefits Schedule data.
https://www.aihw.gov.au

Time between health checks

This section looks at the group of Aboriginal and Torres Strait Islander people who had at least one Indigenous-specific health check between July 2018 and June 2020, and describes the amount of time (in whole calendar months) between their most recent health check in that period and their previous most recent health check, where applicable, back to July 2010.

Proportions in this section refer to the population who had at least one Indigenous-specific health check in 2018–19 or 2019–20, and not to the total estimated Indigenous population. For additional information, see Data sources and notes.

Overall, nearly 374,000 people had at least one Indigenous-specific health check in 2018–19 or 2019–20 (Figure 8). Of these:

- 72,500 people (19%) had their most recent prior health check less than 12 months earlier.
- 63,000 people (17%) had their most recent prior health check 12 to 14 months earlier.
- Another 73,700 people (20%) had their most recent prior health check 15 to 23 months earlier.
- 80,600 people (22%) had no prior history of Indigenous-specific health checks.
  - Note that this includes children under 5 years old, 47% (21,300) of whom had no prior Indigenous-specific health checks (Figure 9).

Figure 8: Indigenous-specific health check patients who received a health check between July 2018 and June 2020, by time between most recent 2 health checks, by sex, July 2010 to June 2020

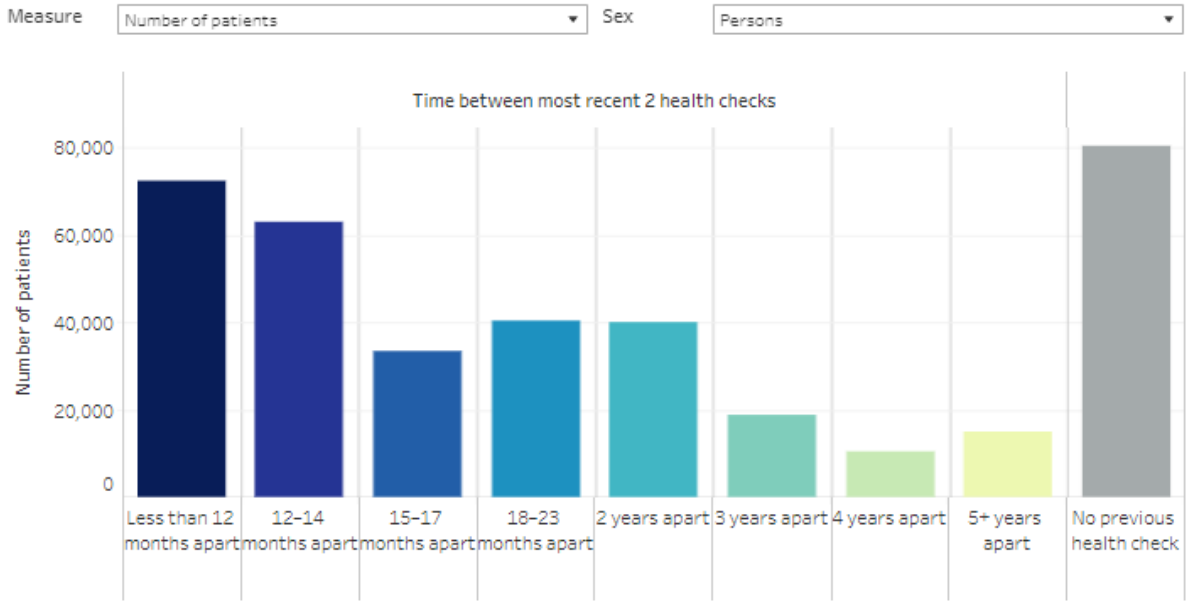


Figure 8: Indigenous-specific health check patients who received a health check between July 2018 and June 2020, by time between most recent 2 health checks, by sex, July 2010 to June 2020

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2021.
2. Analysis includes only patients who had at least one Indigenous-specific health check between July 2018 and June 2020 (the reference period).
3. The time between health checks refers to the number of calendar months that elapsed between a patient's most recent health check in the reference period and their next most recent (previous) health check, on record, back to July 2010.
4. Patients who only had one Indigenous-specific health check on record are shown as having 'no previous health check'.
5. Percentages refer to the proportion of patients in each column.
6. See 'Data sources and notes' for additional information.
7. Refer to table 'HC10' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Looking at broad age groups, young children (0–4 years) were the most distinct group, since nearly half of those counted (47%) had only 1 Indigenous-specific health check on record, compared with 13–22% in other age groups (Figure 9). This is of course partly because some infants will be too young to have received a second health check.

Among those aged 5 and over:

- Indigenous youth (15–24 years) were the age group with the longest time period between health checks (24 months on average), and highest proportion of patients with only 1 health check on record (22%).
- Indigenous people aged 55 years and over had the shortest average time period between their 2 most recent health checks (18 months), and lowest proportion of patients with only 1 health check on record (13%) (Figure 9).

Figure 9: Indigenous-specific health check patients who received a health check between July 2018 and June 2020, by time between most recent 2 health checks, by age group, July 2010 to June 2020

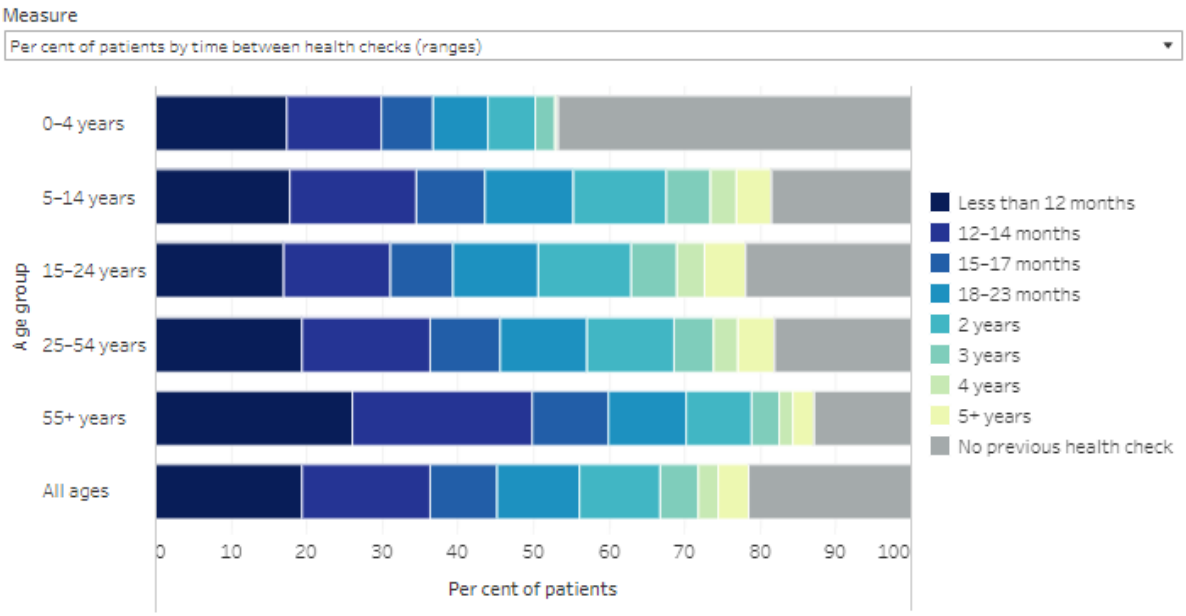


Figure 9: Indigenous-specific health check patients who received a health check between July 2018 and June 2020, by time between most recent 2 health checks, by age group, July 2010 to June 2020

Notes
1. Analysis is based on date of service, for services processed on or before 30/04/2021.
2. Analysis includes only patients who had at least one Indigenous-specific health check between July 2018 and June 2020 (the reference period).
3. The time between health checks refers to the number of calendar months that elapsed between a patient's most recent health check in the reference period and their next most recent (previous) health check, on record, back to July 2010.
4. Patients who only had one Indigenous-specific health check on record are shown as having 'no previous health check'.
5. Percentages refer to the proportion of patients in each grouping.
6. Age calculated at the date of service of each patient's most recent health check in the reference period.
7. See 'Data sources and notes' for additional information.
8. Refer to table 'HC11' in data tables.
Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Looking at the states and territories:

- The Northern Territory had the lowest proportion of patients with only 1 health check on record (13%), but had one of the highest average time periods between health checks (23 months) (Figure 10).
- Queensland had a relatively low proportion of patients with only 1 health check on record (19%), and had the lowest average time period between health checks (20 months).
- Tasmania had the highest proportion of patients with only 1 health check on record (37%) but a relatively low average time period between health checks (21 months).

Among remoteness areas:

- Indigenous-specific health check patients living in the 3 non-remote area classifications had the same average time period between health checks (21

months), however, there were many more patients in *Major cities* with only 1 health check on record, compared with *Outer regional* areas (28% and 17%, respectively).

- Patients living in *Remote* and *Very remote* areas had the longest average time periods between health checks (22 months and 24 months, respectively), but relatively few patients had only 1 health check on record (14% in *Remote* areas and 15% in *Very remote* areas).

Figure 10: Indigenous-specific health check patients who received a health check between July 2018 and June 2020, by time between most recent 2 health checks, by geography, July 2010 to June 2020

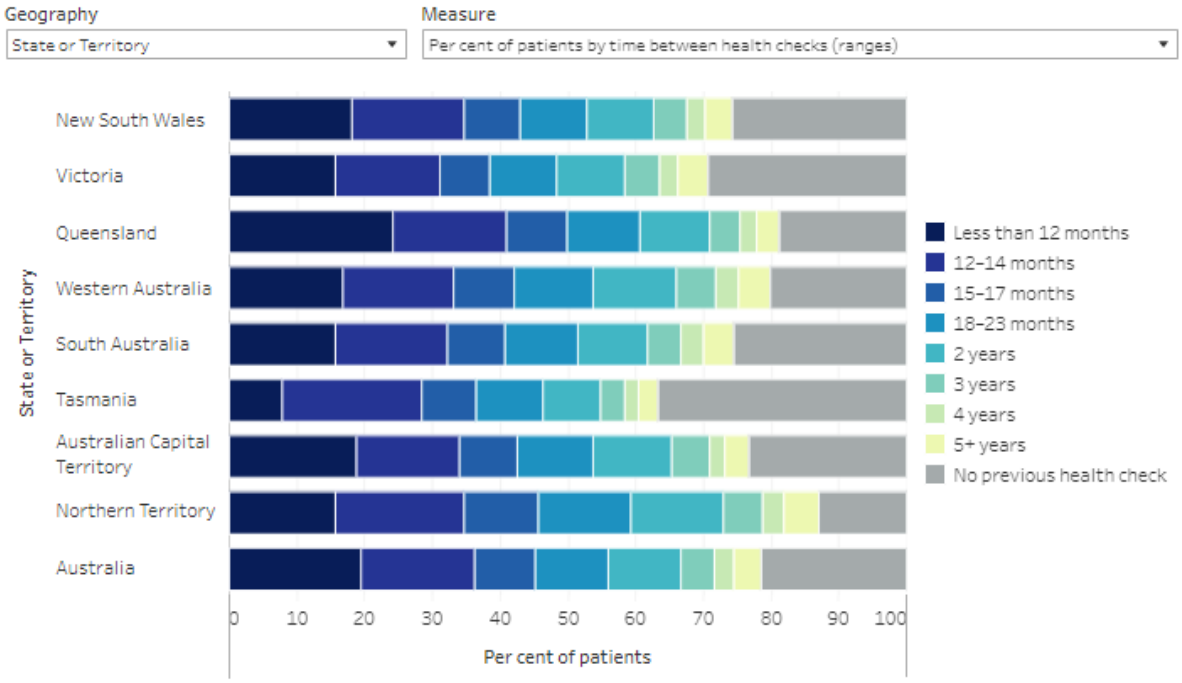


Figure 10: Indigenous-specific health check patients who received a health check between July 2018 and June 2020, by time between most recent 2 health checks, by geography, July 2010 to June 2020

Notes
1. Analysis is based on date of service, for services processed on or before 30/04/2021.
2. Analysis includes only patients who had at least one Indigenous-specific health check between July 2018 and June 2020 (the reference period).
3. The time between health checks refers to the number of calendar months that elapsed between a patient's most recent health check in the reference period and their next most recent (previous) health check, on record, back to July 2010.
4. Patients who only had one Indigenous-specific health check on record are shown as having 'no previous health check'.
5. Percentages refer to the proportion of patients in each grouping.
6. Geography determined at the date of service of each patient's most recent health check in the reference period.
7. See 'Data sources and notes' for additional information.
8. Refer to tables 'HC12' and 'HC13' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Trends in annual rate of health checks

This section looks at how the proportion of Aboriginal and Torres Strait Islander people who receive at least one Indigenous-specific health check in a year has changed over time.

Between 2010–11 and 2018–19, the proportion of Indigenous Australians who had an Indigenous-specific health check grew each year—from 10% in 2010–11 to 29% in 2018–19. In 2019–20, that proportion dropped for the first time, with only 28% of Indigenous Australians receiving a health check (Figure 11).

Figure 11: Rate of Indigenous-specific health checks, 2010–11 to 2019–20

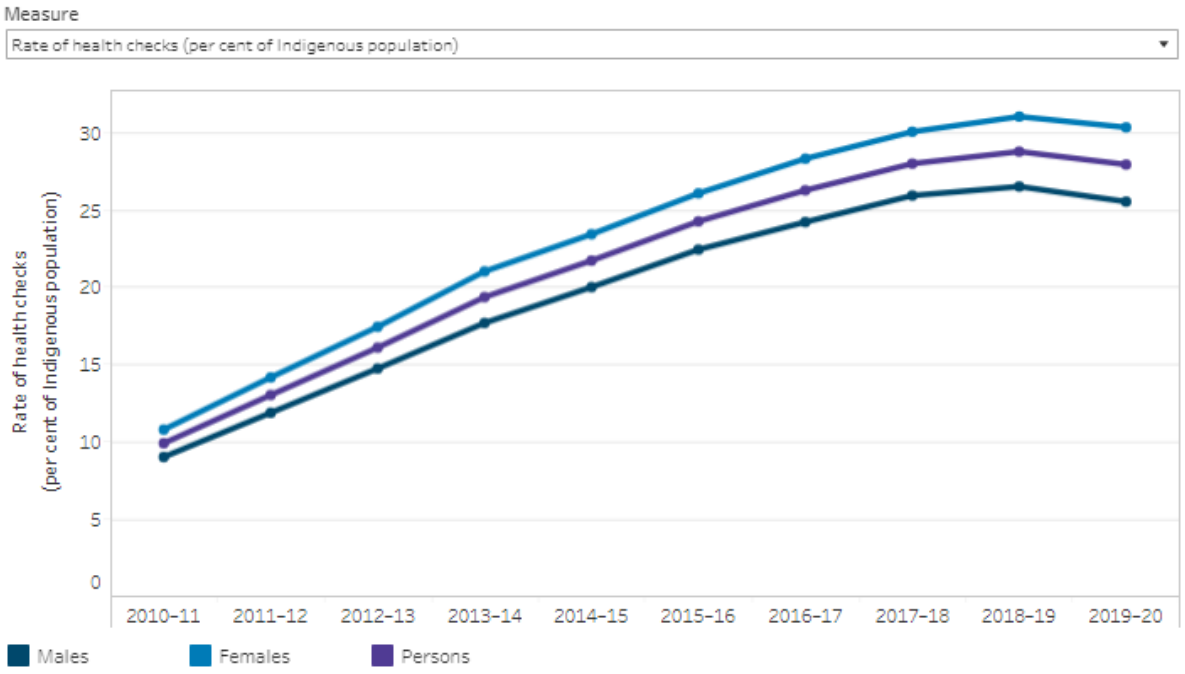


Figure 11: Rate of Indigenous-specific health checks, 2010–11 to 2019–20

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2021.
2. 'Change in rate' calculated as the rate of health checks in the reference year minus the rate of health checks in the previous year.
3. See 'Data sources and notes' for additional information.
4. Derived from table 'HC01' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Over the course of the decade, a higher proportion of Indigenous females received an Indigenous-specific health check each year, compared with Indigenous males (Figure 11). In both sexes, however, the rate of increase had been slowing—even before 2019–20:

- In 2011–12, the health check rate was 3.1 percentage points higher than in 2010–11 (Figure 11).
- By 2017–18, the health check rate was only 1.7 percentage points higher than the previous year.

- In 2018–19, the health check rate was 0.8 percentage points higher than in 2017–18.
- In 2019–20, the health check rate dropped 0.8 percentage points, compared to 2018–19.

Number of follow-ups

Health checks are useful for finding health issues; however, improving health outcomes also requires appropriate follow-up of any issues identified during a health check (Bailie et al. 2014, Dutton et al. 2016).

Based on needs identified during a health check, Aboriginal and Torres Strait Islander people can access Indigenous-specific follow-up services—from allied health workers, practice nurses, or Aboriginal and Torres Strait Islander Health practitioners—through MBS items 10987, 81300–81360, and telehealth items 93048, 93061, 93200 and 93202 (see also Box 3).

Indigenous Australians may receive follow-up care through other MBS items that are also available to non-Indigenous patients. For example, if a person is diagnosed with a chronic health condition, the GP might prepare a GP Management Plan, or refer the person to a specialist. Data in this report relate to Indigenous-specific items only.

In 2019–20, there were about 402,000 Indigenous-specific follow-up services provided to 165,000 Indigenous Australians. This was an increase from around 18,400 follow-ups provided to 9,900 patients in 2010–11 (Figure 12).

Figure 12: Number of Indigenous-specific follow-up services and patients, 2010–11 to 2019–20

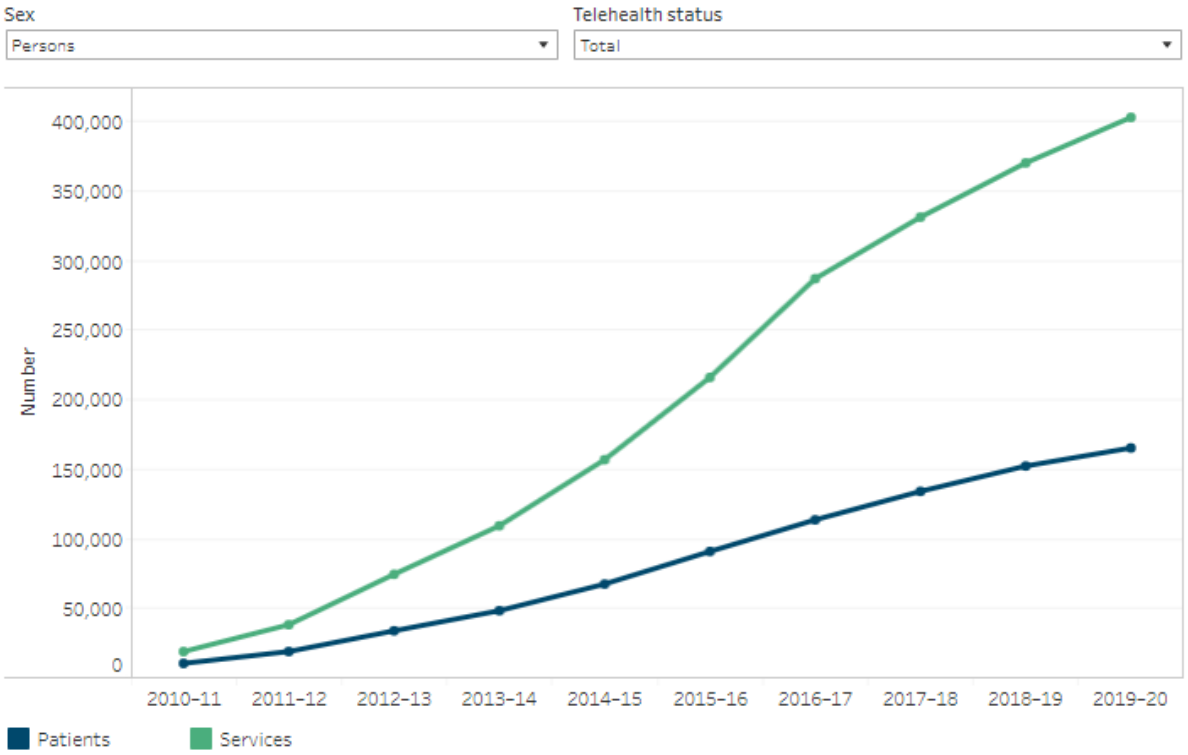


Figure 12: Number of Indigenous-specific follow-up services and patients by sex and telehealth status, 2010–11 to 2019–20

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2021.
2. Telehealth items were introduced in March 2020, in response to COVID-19 and associated restrictions.
3. See 'Data sources and notes' for additional information.
4. Refer to table 'FS01' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Box 3: MBS Indigenous-specific health checks follow-up items

Based on health needs identified during an Indigenous-specific health check (MBS items 715, 228, 92004, 92011, 92016 and 92023), people can access a range of Indigenous-specific follow-up services—these are described below. The MBS item number indicates the type of provider, but not always the type of service received, as some provider types—such as Indigenous health practitioners—can provide a mix of services.

Follow–up services provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner (MBS item 10987, 93200 and 93202)

Indigenous Australians who have received an Indigenous-specific health check can access up to 10 follow–up services per calendar year provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner, where the service is provided on behalf of and under the supervision of a medical practitioner. These MBS items (numbers 10987, 93200 and 93202) may be used to provide a range of services, including:

- examinations/interventions indicated as necessary by the health check;
- education regarding medication compliance and associated monitoring;

- checks on clinical progress and service access;
- education, monitoring and counselling activities and lifestyle advice;
- taking medical history; and
- prevention advice for chronic conditions, and associated follow up.

Data on the specific type of services provided to each person under this MBS item are not available from the MBS data set.

MBS items 93200 and 93202 are telehealth items, which were added in March 2020.

Allied health follow-up services (MBS items 81300–81360, 93048 and 93061)

Indigenous Australians who have received an Indigenous-specific health check can access up to 5 follow-up allied health services per calendar year, provided by either:

- an Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker, following referral by the GP (MBS items 81300, 93048 and 93061); or
- an allied health worker, following referral by the GP (MBS items 81305–81360, 93048 and 93061).

Most item numbers relate to 1 eligible allied health professional only (see Table 2 in Data sources and notes). For items 81305–81360, this provides an indication of the type of services received (for example, item 81335 relates to a physiotherapy service provided by a physiotherapist); however item 81300 could include a range of allied health service types.

MBS items 93048 and 93061 are telehealth items, which were added in March 2020. These may be delivered by any of the allied health professionals eligible to claim items 81300–81360.

References

Bailie J, Schierhout GH, Kelaher MA, Laycock AF, Percival NA, O'Donoghue LR et al. 2014. Follow-up of Indigenous-specific health assessments—a socioecological analysis. Medical Journal of Australia 200: 653–657.

Dutton T, Stevens W & Newman J 2016. Health assessments for Indigenous Australians at Orange Aboriginal Medical Service: health problems identified and subsequent follow up. Australian Journal of Primary Health 22: 233–238.

Type of follow-ups

In 2019–20, of Indigenous-specific follow-up services, there were:

- 320,000 services provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to 149,000 Indigenous Australians
- 83,000 allied health services provided to 33,000 Indigenous Australians.

Of the allied health services follow-up services, the most common were those provided by:

- physiotherapists (about 33,400 services)
- podiatrists (12,500 services)
- Aboriginal health workers or Aboriginal and Torres Strait Islander health practitioners (about 11,300 services) (Table 1).

Table 1: Number of Indigenous-specific follow-up services and patients, by type of follow-up, 2018–19 and 2019–20

Financial year of service

2019–20

Category	Practitioner type	Telehealth status	Number of follow-up patients	Number of follow-up services
Aboriginal Health Practitioner or Practice Nurse	Aboriginal Health Practitioner or Practice Nurse	Face-to-face	147,401	315,940
		Telehealth	3,593	3,858
		Total	149,220	319,798
Allied health	Aboriginal Health Worker or Ab...	Face-to-face	9,041	11,346
	Audiologist	Face-to-face	1,213	1,324
	Chiropractor	Face-to-face	1,319	4,115
	Diabetes Educator	Face-to-face	1,460	2,152
	Dietician	Face-to-face	2,734	3,659
	Exercise Physiologist	Face-to-face	1,636	2,815
	Mental Health Worker	Face-to-face	81	150
	Occupational Therapist	Face-to-face	1,510	2,556
	Osteopath	Face-to-face	149	402
	Physiotherapist	Face-to-face	8,508	33,380
	Podiatrist	Face-to-face	7,110	12,479
	Psychologist	Face-to-face	604	1,162
	Speech Pathologist	Face-to-face	1,610	3,385
	Allied health (unspecified)	Telehealth	2,733	3,770
	Total Allied health	Total	32,862	82,695
Total follow-ups	Total follow-ups	Face-to-face	162,550	394,865
		Telehealth	6,243	7,628
		Total	164,838	402,493

Table 1: Number of Indigenous-specific follow-up services and patients, by type of follow-up, 2018–19 and 2019–20

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2021.
2. The number of patients by type will not add to the total number of patients, as patients can receive more than one type of follow-up.
3. Telehealth items were introduced in March 2020, in response to COVID-19 and associated restrictions.
4. See 'Data sources and notes' for additional information.
5. Refer to table 'FS02' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Follow-up rates

This section looks at the proportion of Aboriginal and Torres Strait Islander people who received an Indigenous-specific follow-up service within 12 months of an Indigenous-specific health check. This includes information on:

- national rates, and differences by sex and age—focusing on people who had a health check in 2018–19
- patient counts by number and broad type of follow-ups received—inform 2010–11 to 2018–19
- differences by geographic area—for people who had a health check in 2018–19
- trends in the national rate of follow-up—from 2010–11 to 2018–19.

Note that because of the 12-month follow-up window, this measure is not available at the time of writing for everyone who received an Indigenous-specific health check in 2019–20.

See Box 4 for key notes about the method used, including data limitations.

Box 4: Calculating rates of follow-up: method and limitations

One outcome of an Indigenous-specific health check (MBS item 715 or 228 only, since telehealth items were not available in 2018–19) can be referral for Indigenous-specific follow-up services under Indigenous-specific MBS items 10987, 81300–81360, 93200, 93202, 93048 and 93061. This report looks at the proportion of Indigenous Australians who receive one of these follow-up items within 12 months of their health check.

An overview of the method used to calculate rates of health checks, including key limitations, is described in this Box. See Data sources and notes for additional information.

Calculating rates

Rates were calculated using the total number of people who had an Indigenous-specific health check as the denominator, while the numerator was people who received an Indigenous-specific follow-up within 12 months of a health check. For example, for 2018–19 data:

- The denominator was people who received an Indigenous-specific health check between 1 July 2018 and 30 June 2019.
- The numerator was people who received an Indigenous-specific health check between 1 July 2018 and 30 June 2019 **and** received a follow-up within 12 months of the health check (which could occur anytime between 1 July 2018 and 30 June 2020, depending on the date of the health check).
- The rate was calculated as the numerator divided by the denominator and multiplied by 100.

Limitations

Key limitations of the analysis include:

- No information is available from the MBS data set on the outcomes of a health check, and so it is not known how many people actually require follow-up care. Not all Indigenous Australians who have a health check will need follow-up services. Consequently, variation in follow-up rates (for example, by age group or geographic regions), may partly reflect differences in health status and need for follow-up care.
- The data relate only to Indigenous-specific follow-up items provided by an Aboriginal and Torres Strait Islander health practitioner, practice nurse, or allied health professional (MBS items 10987, 81300–81360, 93200, 93202, 93048 and 93061; see also Box 2). Indigenous Australians may receive other MBS-rebated services after a health check that are also available to non-Indigenous patients.

National rates by sex and age

In 2018–19, 241,000 Aboriginal and Torres Strait Islander people received an Indigenous-specific health check—of these people, 47% (112,700) received an Indigenous-specific follow-up within 12 months of their health check.

Among people who had a health check in 2018–19:

- The follow-up rate was slightly higher among Indigenous females (48%) than Indigenous males (45%). This pattern was seen in most age groups, except among children aged 0–4, where the follow-up rates were slightly higher for boys than girls.
- For both males and females, the follow-up rate was highest among those aged 65 and over (54% and 57%, respectively).
- For males, the follow-up rate was lowest among those aged 15–24 (38%).
- For females, the follow-up rate was lowest among those aged 5–14 (41%) (Figure 13).

The variation in follow-up rates may partly reflect differences in the need for follow-up care among different age groups (see also Box 4). For example, in general, older people have higher health care needs than younger people, and so are likely to have a greater need for follow-up services.

Figure 13: Indigenous-specific health check patients who received an Indigenous-specific follow-up service in the 12 months following the health check, by year of health check, sex and age, 2010–11 to 2018–19

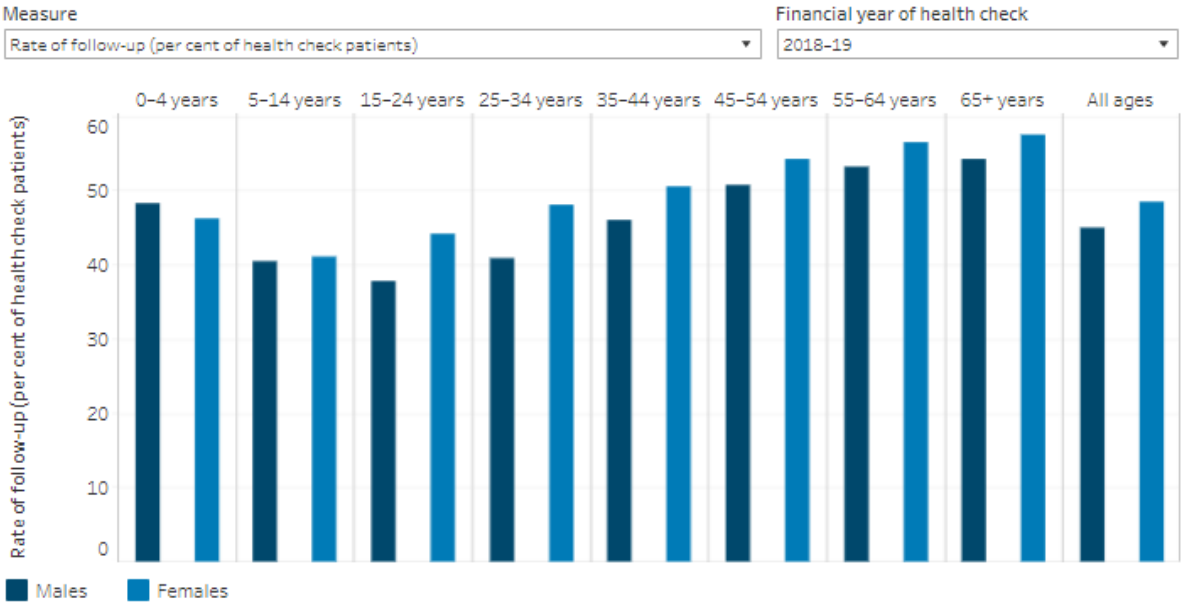


Figure 13: Indigenous-specific health check patients who received an Indigenous-specific follow-up service in the 12 months following the health check, by year of health check, sex and age, 2010–11 to 2018–19

Notes

1. Analysis is based on date of service, for services processed before 30/04/2021.
2. Data are presented according to the financial year in which the health check was provided.
3. The number of follow-up patients refers to the number of people who received a follow-up within 12 months of a health check. The follow-up rate is calculated by dividing the number of follow-up patients by the number of health check patients.
4. See 'Data sources and notes' for additional information.
5. Refer to table 'FS03' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Number and type of follow-ups

Among Aboriginal and Torres Strait Islander people who had an Indigenous-specific health check in 2018–19:

- 20% had 1 Indigenous-specific follow-up within 12 months of the health check.
- 10% had 2 follow-ups.
- 5% had 3 follow-ups.
- 3% had 4 follow-ups.
- 9% had 5 or more follow-ups (Figure 14).

Indigenous Australians who had an Indigenous-specific health check in 2018–19 were more likely to receive follow-up care from a practice nurse or Aboriginal and Torres Strait Islander health practitioner than from an allied health service provider:

- 43% had at least one follow-up service from a practice nurse of Indigenous health practitioner.
- 11% had at least one allied health follow-up service.

Figure 14: Indigenous-specific health check patients, by number of follow-ups received in the 12 months following the health check, by year of health check and type of follow-up, 2010–11 to 2018–19

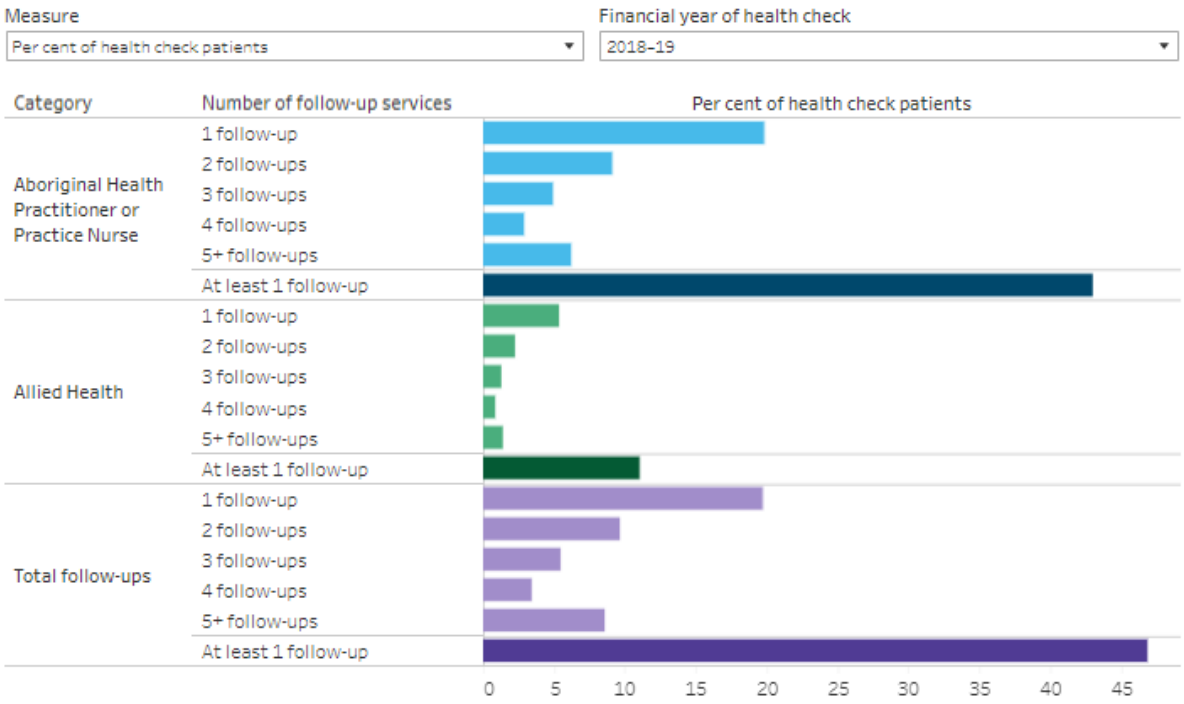


Figure 14: Indigenous-specific health check patients, by number of follow-ups received in the 12 months following the health check, by year and type of follow-up, 2010–11 to 2018–19

Notes

1. Analysis is based on date of service, for services processed before 30/04/2021.
2. Data are presented according to the financial year in which the health check was provided.
3. The number of follow-up patients refers to the number of people who received a follow-up within 12 months of a health check. The per cent of health check patients is calculated by dividing the number of follow-up patients by the number of health check patients.
4. See 'Data sources and notes' for additional information.
5. Refer to table 'FS04' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Geographic variation

Figure 15 shows the number and proportion of Aboriginal and Torres Strait Islander people who received an Indigenous-specific follow-up within 12 months of a health check, by 5 different geographic classifications—state/territory, remoteness area, Primary Health Network (PHN), Indigenous Region (IREG) and Statistical Areas Level 3 (SA3s). See Box 2 for more information about the geographic classifications.

This analysis is based on the postcode of the patient's mailing address. As a result, the data may not reflect where the person actually lived—particularly for people who use PO Box addresses. This is likely to impact some areas more than others, and will also have a generally greater impact on the SA3 data than the larger geographic classifications. See Box 5 in Data sources and notes for information on areas most likely to be affected.

Among Aboriginal and Torres Strait Islander people who had an Indigenous-specific health check in 2018–19:

- Across states and territories, the follow-up rate varied from 16% in the Australian Capital Territory to 61% in the Northern Territory.
- Across remoteness areas, the follow-up rate ranged between 45% and 46% in non-remote areas, and between 52% and 53% in remote areas.
- Across PHNs, the follow-up rate varied from 16% in the Australian Capital Territory to 68% in Brisbane North.
- Across IREGs, the follow-up rate ranged between 16% in the Australian Capital Territory and 76% in *Alice Springs*.
- Across 306 SA3s for which follow-up rates could be reported, the follow-up rate ranged from 10% to 75%. Of these SA3s, 72% (219 areas) had a rate below the national average (that is, less than 46.8%).

Figure 15: Indigenous-specific health check patients in 2018–19 who received an Indigenous-specific follow-up service in the 12 months following the health check, by geographic area

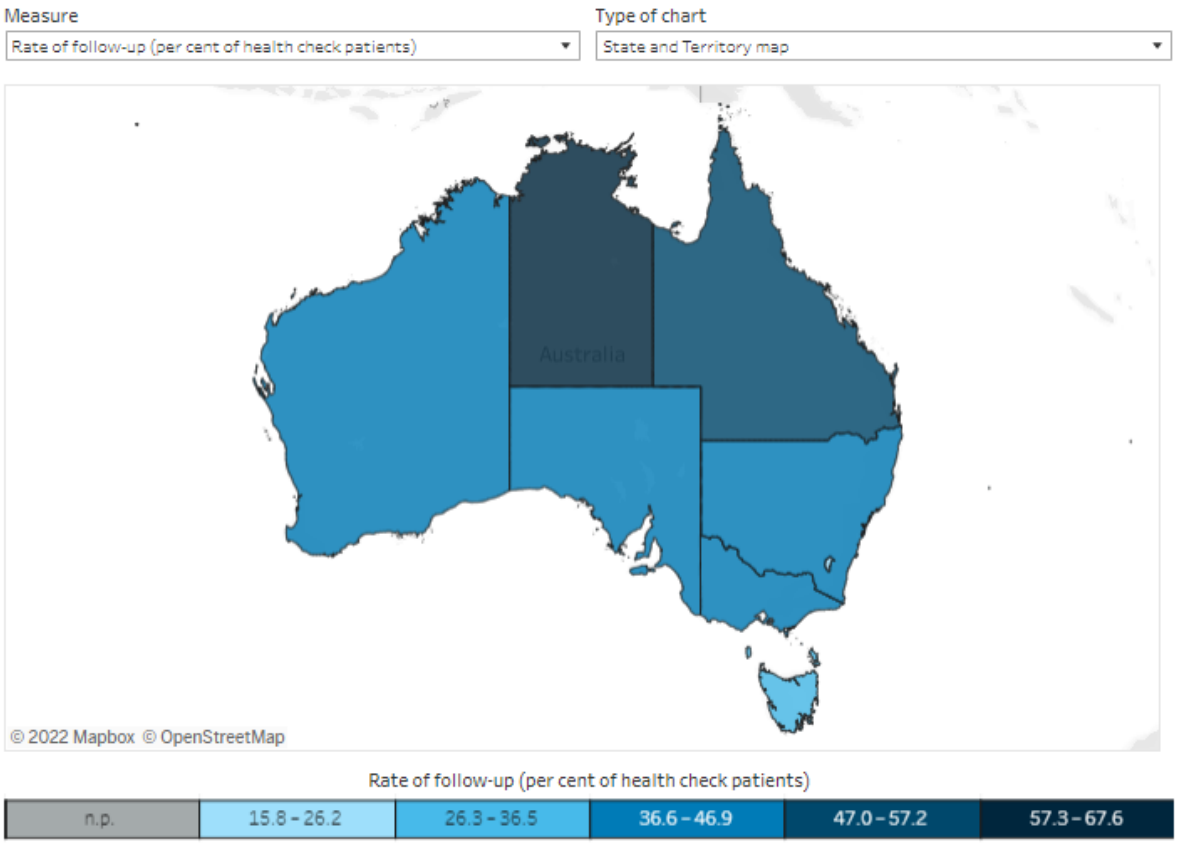


Figure 15: Indigenous-specific health check patients in 2018–19 who received an Indigenous-specific follow-up service in the 12 months following the health check, by geographic area

n.p. not published because of small numbers, confidentiality or other concerns about the quality of the data.
Notes
1. Analysis is based on date of service, for services processed before 30/04/2021.
2. Data are presented according to the financial year in which the health check was provided.
3. The number of follow-up patients refers to the number of people who received a follow-up within 12 months of a health check. The follow-up rate is calculated by dividing the number of follow-up patients by the number of health check patients.
4. See 'Data sources and notes' for additional information.
5. Refer to tables 'FS05' to 'FS09' in data tables.
Source: AIHW analysis of Medicare Benefits Schedule data.
https://www.aihw.gov.au

Reasons for variation between regions could be partly related to variation in the general health and need for follow-up care among different population groups (see also Box 4). However, there are likely also other contributing factors.

Research indicates that a broad range of factors can limit the use of Indigenous-specific follow-up services, such as a practitioners' lack of awareness of item numbers; staffing issues; ineffective use of clinical information systems (e.g. for patient recall and reminders); communication and transport challenges for patients; and billing against non-Indigenous-specific items (Bailie et al. 2014). Also, some types of follow-up care cannot be billed to Medicare. For example, group services may offer increased cultural safety and improve the likelihood of patients attending follow-up care; however,

patients cannot access rebates for some allied health services provided in a group setting (Department of Health 2018).

References

Bailie J, Schierhout GH, Kelaher MA, Laycock AF, Percival NA, O'Donoghue LR et al. 2014. Follow-up of Indigenous-specific health assessments—a socioecological analysis. Medical Journal of Australia 200: 653–657.

Department of Health 2018. Report from the Aboriginal and Torres Strait Islander Health Reference Group. Medicare Benefits Schedule Review Taskforce. Canberra: Department of Health. Viewed 16 May 2019.

Trends in follow-up rate

Between 2010–11 and 2018–19, the proportion of Indigenous-specific health check patients who had an Indigenous-specific follow-up within 12 months increased from 12% to 47% (Figure 16). Young Indigenous children (aged 0–4) saw the largest uptick in follow-up service rates among reported age groups over the period, increasing from 8% of health check patients in 2010–11 to 47% in 2018–19 (Figure 16).

Figure 16: Indigenous-specific health check patients who received an Indigenous-specific follow-up service in the 12 months following the health check, by sex, age and year of health check, 2010–11 to 2018–19

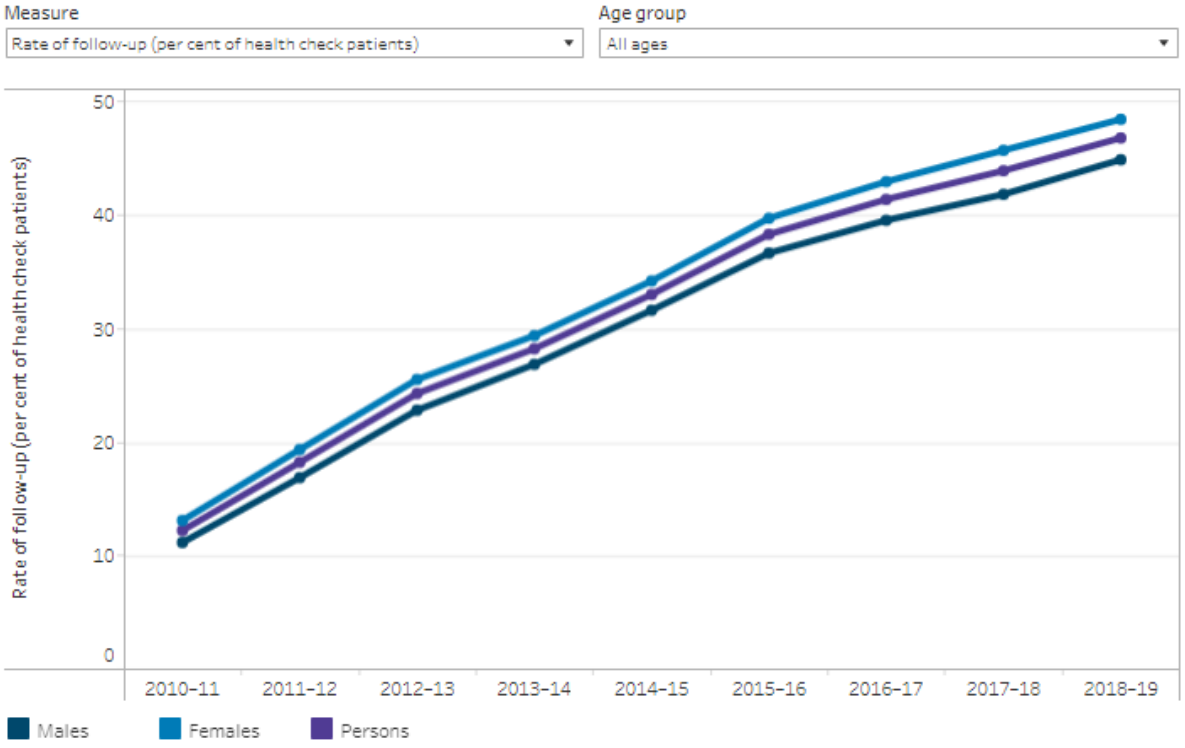


Figure 16: Indigenous-specific health check patients who received an Indigenous-specific follow-up service in the 12 months following the health check, by sex, age and year of health check, 2010–11 to 2018–19

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2021.
2. Data are presented according to the financial year in which the health check was provided.
3. The number of follow-up patients refers to the number of people who received a follow-up within 12 months of a health check. The follow-up rate is calculated by dividing the number of follow-up patients by the number of health check patients.
4. See 'Data sources and notes' for additional information.
5. Refer to table 'FS03' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Data sources and notes

This page provides:

- information about the MBS data used to analyse the use of Indigenous health checks and follow-ups
- information about the population data used to calculate rates of health checks
- key technical notes about the analyses
- a timeline of major developments in health check implementation
- information about national goals for health check use.

Medicare Benefits Schedule data

The MBS is a listing of Medicare services that are subsidised by the Australian Government. It is part of the Medicare Program that is managed by the Department of Health, and administered by the Department of Human Services.

The statistics in this publication are based on AIHW analysis of the Medicare Benefits Schedule data, accessed through the Department of Health's Enterprise Data Warehouse.

In this report, data are presented for:

- Indigenous-specific health checks—listed as items 715, 228, 92004, 92011, 92016 and 92023 on the MBS.
- Indigenous-specific health check follow-up services—listed as items 10987, 81300–81360, 93048 and 93061 on the MBS.

The data presented on these items do not provide a complete picture of all health checks and associated follow-up care provided to Indigenous Australians. Some Indigenous Australians may be receiving similar primary health care through other MBS items (that is, items that are not specific to Indigenous Australians). A person may also be provided with equivalent care from a health care provider who is not eligible to bill Medicare—for example, through state- or territory-funded primary health care services and public hospitals, which are ordinarily not eligible to bill to Medicare.

MBS Indigenous-specific health checks

All Indigenous Australians, regardless of age, are eligible for an Indigenous-specific health check. There are 6 Indigenous-specific health check items listed on the MBS:

- MBS item 715 (available from 1 May 2010)
- MBS item 228 (available from 1 July 2018)
- Video-conference MBS items 92004 and 92011 (available from 30 March 2020 through to 30 June 2021)
- Telephone MBS items 92016 and 92023 (available from 30 March 2020 through to 30 June 2021)

MBS items 715, 92004 and 92016 relate to health checks provided by a general practitioner (GP), while items 228, 92011 and 92023 relate to health checks provided by other medical practitioners (excluding specialist or consultant physicians). In all cases, suitably qualified health professions can assist under the supervision of the practitioner. The requirements of an Indigenous-specific health check, which are set out in the relevant sections of the MBS, include an assessment of the patient's health, including their physical, psychological and social wellbeing. The check also assesses what preventive health care, education and other help should be offered to the patient to improve their health and wellbeing.

Although the use of a specific form to record results of a health check is not mandatory, proformas for Indigenous-specific health checks are available from the Department of Health website (with separate forms for children aged 0–4, people aged 15–54, and people aged 55 and over). A guide to Medicare for Indigenous health services—designed to support staff working in organisations that provide Medicare services to Indigenous Australians—is available from the Department of Human Services website. In 2021, with support from the Department of Health, the National Aboriginal Community Controlled Health Organisation (NACCHO) and Royal Australian College of General Practitioners (RACGP) released 5 Indigenous-specific health check templates for testing, designed for different age groups, and downloadable from the RACGP website.

Indigenous Australians can receive an Indigenous-specific health check once in a 9-month period. If the GP or medical practitioner bulk bills the item, there is no charge to the patient.

For the data period presented in this report, note that telehealth items were introduced late in 2019–20.

MBS Indigenous-specific follow-up services

Indigenous-specific follow-up items were added to the MBS in November 2008 to support the Indigenous-specific health check, as checks alone have limited capacity to improve health outcomes. Based on health needs identified during an Indigenous-specific health check, people can access the following:

- MBS item 10987: Follow-up services provided by a practice nurse or registered Aboriginal and Torres Strait Islander health practitioner on behalf of a GP after a health check to a maximum of 10/calendar year (increased from 5/calendar year in 2009).
- MBS items 81300-81360: Allied health follow-up services after a health check to a maximum of 5/calendar year. There are 13 separate items, 1 for each eligible allied health profession shown in Table 2. The professionals need to meet specific eligibility requirements, be in private practice and register with Medicare Australia in order to claim the follow-up items.
- Telehealth MBS items 93200 and 93202: Video-conference or telephone follow-up services provided by a practice nurse or registered Aboriginal and Torres Strait Islander health practitioner on behalf of a GP after a health check to a maximum of 10/calendar year (available from 20 April 2020 through to 30 June 2021).

- Telehealth MBS items 93048 and 93061: Allied health follow-up services after a health check to a maximum of 5/calendar year, delivered via video-conference or telephone (available from 30 March 2020 through to 30 June 2021).

For the data period presented in this report, note that telehealth items were introduced late in 2019–20.

Table 2: Eligible allied health professionals and relevant MBS item numbers

Eligible allied health professionals	MBS items number
Aboriginal health worker/Aboriginal and Torres Strait Islander health practitioner	81300
Diabetes Educator	81305
Audiologist	81310
Exercise physiologist	81315
Dietician	81320
Mental health workers	81325
Occupational therapist	81330
Physiotherapist	81335
Podiatrist	81340
Chiropractor	81345
Osteopath	81350
Psychologist	81355
Speech pathologist	81360
Any eligible allied health professional (telehealth)	93048, 93061

Population data

The ABS's estimated resident population (ERP) is the official measure of the Australian population. ERP estimates are based on results of the 5-yearly Census of Population and Housing, with adjustments for net undercount as measured by the Post Enumeration Survey. The ABS also estimates how the Indigenous population would change, projected forward, based on various sets of assumptions. The most recent available projections cover the period from 30 June 2017 to 30 June 2031 (ABS 2019). Populations in years prior to the 2016 Census were also revised or 'backcast' by applying assumptions back in time, to create a smooth data series.

In this report, most rates were calculated based on the available ABS' 30 June estimates and (series B) projections—averaged to approximate the midpoints of the various financial years. For certain geographies (Remoteness, PHN, SA3), the ABS did not publish the required population data, so the AIHW approximated these from available data.

Remoteness, PHN and SA3 estimates

To derive population data for remoteness, PHN and SA3, the AIHW undertook a method for disaggregating higher-level ABS projections (state/territory, combined remoteness areas), called Iterative Proportional Fitting. This was supported by 2016 Census counts downloaded from ABS TableBuilder, and small area ERPs for 30 June 2016, where available.

Technical notes about the analysis

Counting services and people

This report presents data using 2 different counting units:

- services—that is, the number of health checks (or follow-ups, as applicable) provided in the specified period
- patients—that is the number of people who received 1 or more health checks (or follow-ups, as applicable) in the specified period.

In any given period (for example, 12 months), the number of health check patients may be smaller than the number of services provided. This occurs when patients have received more than 1 health check in that period.

In this report, most figures and explanatory text relate to the number of patients (rather than services). Rates have been calculated using the number of patients only.

Patient information in the MBS data set is attached to each service. Thus, when analysing data for patients, there can be more than 1 service from which age and location can be derived. In this report, different tactics were used for different analyses:

- For *annual rates of health checks* and for *health check patients who received a follow-up service in the 12 months following the health check*: where patients had more than 1 health check in a financial year, age was calculated from the date of the first health check for odd-numbered Patient Identifier Numbers (PINs) and from the last health check for even-numbered PINs in that financial year.
  - This tactic was used to reduce bias in the derivation of age, and was used to select from multiple patient postcodes as well. Upward bias on age is introduced when age is calculated at the date of the last health check in a financial year for patients with more than 1 health check, because birthdays are likely to have passed by the time of the second health check. A PIN's final digit is effectively random, so this tactic splits the patient records into 2 groups, with upward bias on half and downward bias on the other half. Age could otherwise have been calculated at the 31st of December to reduce bias, but then a separate tactic would need to be used for managing multiple postcodes.

- For *numbers of health checks between July 2015 and June 2020*: where patients had more than 1 health check over the period, age was calculated from the date of the last health check in the reference period.
  - This tactic was used to better align with the population structure at the end of the reference period.

Dates and reference periods

The MBS data set includes information on the date the service was provided, as well as the date that the claim was processed by Medicare. These dates can differ due to a time lag between when a service is provided and when the claim for that service is processed by Medicare Australia.

The data in this report relate to services provided between 1 July 2010 and 30 June 2020, which were processed on or before 28 February 2021. Data are reported by date of service as this more accurately reflects when the service was provided. Due to lags between date of service and date of processing, there will be a small proportion of services provided during the reference period that are not captured in these data. For example, if a service was provided on 29 June 2020, but not processed until 1 May 2021, it will not be included in the data.

Data in this report are presented for financial years (1 July to 30 June). These are written with the second year abbreviated—for example, 2019–20 refers to the period from 1 July 2019 to 30 June 2020.

Location

Geographic correspondences (sometimes referred to as concordances or mapping files) can be used where the location information in an original data is not available at the geographic level required for analysis and reporting. Geographic correspondences are a mathematical method for reassigning data from one geographic classification (for example, a postcode) to a new geographic classification (for example, remoteness area).

Geographic correspondences enable postcode data to be reported at various other geographic levels. However, there are various limitations associated with the use of postcode data for this purposes. Key issues include:

- postcodes do not fit neatly into the boundaries of geographic areas typically used for statistical reporting
- defining geographic boundaries for postcodes is an imprecise process—postcodes can also change over time
- people may not keep their postcode information up-to-date with Medicare
- postcodes linked to patient records may belong to PO boxes, making correspondence to small geographic areas less accurate (see Box 5).

Due to these issues, various decisions need to be made about how best to allocate the postcode data to geographic regions. There will be some degree of inaccuracy in the resultant estimates, which will affect data in certain areas more than others—see Box 5.

For this report, postcodes were re-assigned to 5 different geographies (based on the 2016 Australian Statistical Geography Standard)—Statistical Areas Level 3 (SA3s), Indigenous Regions (IREGs), Primary Health Networks (PHNs), remoteness areas and state and territories. Where postcodes fell across the boundaries of multiple areas (for example, multiple SA3s), data were apportioned based on the population distribution of Indigenous Australians, according to AIHW analysis of ABS population estimates at 30 June 2016.

For patients who had more than one health check in a given reference period, the same selection process was followed as described in the 'Counting services and people' section earlier.

See Box 2 for information about how the different geographic areas in this report relate to one another and how areas have been classified as Metropolitan, Non-metropolitan and Combination in certain figures.

Box 5: Limitations of using postcode data to derive health check and follow-up rates

There are various limitations associated with the use of postcode data for analysing the use of health checks and follow-ups in sub-national regions.

A key issue is that postcodes do not fit neatly into the boundaries of geographic areas typically used for statistical reporting. For example, a single postcode can fall across multiple PHN boundaries. In such cases, the data for a single postcode need to be split across multiple areas—this requires decisions around how to divide the data across multiple areas that are normally made based on what is known about the population distribution within the area covered by the postcode. This method relies on the assumption that rates of health checks do not vary within postcodes, which will result in some inaccuracy.

Another key issue is that some patients provide postcode details belonging to a PO Box address. Patients who use PO Box addresses may not necessarily live close to the post office where the PO Box is located. When performing the analysis, decisions needed to be made about how to allocate data for non-residential areas.

These issues and analysis decisions are likely to have a greater impact on some areas more so than others. Within the geographic areas presented in this report, the areas most likely to be impacted are:

- the following SA3s: Alice Springs (NT), Barkly (NT), Darwin City (NT), Melbourne City (Vic), Adelaide City (SA), Perth City (WA), East Arnhem (NT), Katherine (NT), Darwin Suburbs (NT), Daly - Tiwi - West Arnhem (NT), Parramatta (NSW), Palmerston (NT), Sydney Inner City (NSW), Goldfields (Qld), Canning (WA), and Swan (WA).
- the following IREGs: Alice Springs (NT), Apatula (NT), Tennant Creek (NT), Katherine (NT), Nhulunbuy (NT), Darwin (NT), Jabiru - Tiwi (NT).
- *Remote* and *Very remote* areas in the analysis by remoteness.

Time between Indigenous-specific health checks

To report the time interval between consecutive Indigenous-specific health checks, the number of fully elapsed calendar months were calculated—where a calendar month has fully elapsed when the day's date returns to or surpasses the same-numbered day in consecutive months.

For example, a patient who received a health check on both 01/01/2018 and 01/01/2019 saw 12 calendar months elapse between health checks, whilst a patient who received a health check on both 01/01/2018 and 31/12/2018 saw only 11 calendar months elapse between health checks.

Means and medians calculated from the resulting discrete data may have been slightly different if they had been calculated from continuous interval data.

Comparisons with other reports

As described in the 'Dates and reference periods' section, the data in this report are based on the date of service (rather than date of processing), as this more accurately reflects when the service was provided. Data in this report may differ to those published elsewhere based on date of processing, including previous editions of this report. It may also differ to data published elsewhere based on date of service, where the date of processing cut-off is different. Age and location were also determined in a slightly different way to some other reports (see 'Counting services and people' and 'Location', presented earlier).

In addition, as described in 'population data', this report primarily uses population estimates and projections, based on the 2016 Census, when calculating rates. The rates will differ from the previous edition (2019), which mainly used the estimated resident population at 30 June 2016 and some 2011 Census-based projections. The rates may also differ to those released in future updates of this report (or in other reports) when revised estimates based on the 2021 Census are available (see also 'population data').

Timeline of major developments in health check implementation

The timeline of major developments in health checks shows the increase in uptake from the date of implementation and highlights relevant major developments (described further in Table 3).

Table 3: Major developments in health check implementation

When?	What?	Why?
November 1999	55 years & over annual health check (MBS item 704) introduced	The first Indigenous-specific health check established as the Indigenous equivalent of health checks for non-Indigenous people aged 75 years and over

When?	What?	Why?
May 2004	15–54 years 2-yearly adult health check (MBS item 710) introduced	The extension of health checks to adults recognised that the conditions responsible for early deaths of Aboriginal and Torres Strait Islander people started before the age of 55.
May 2006	0–14 years annual child health check (MBS item 708) introduced	With this addition, Aboriginal and Torres Strait Islander people of all ages were eligible for preventive health checks.
December 2008	National Partnership Agreement implemented	The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes included the Indigenous Chronic Disease Package. This package was funded by the Australian Government over 4 years from 2009–2013 and included a number of elements relevant to improving uptake of Indigenous-specific health measures.
July 2009	Medicare Local Closing the Gap workforce established	Part of the Indigenous Chronic Disease Package, this workforce comprised: • 86 full-time equivalent Indigenous outreach workers to support Aboriginal and Torres Strait Islander people access primary health-care services and follow-ups • 86 full-time equivalent Indigenous health project officers to lead Aboriginal and Torres Strait Islander health issues within Medicare Locals, and raise awareness of Closing the Gap initiatives relevant to mainstream primary care. This workforce assisted with the delivery of the Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care programs.
March 2010	Practice Incentive Program Indigenous Health Incentive introduced	Part of the Indigenous Chronic Disease Package, the Indigenous Health Incentive was included under the Practice Incentives Program.
May 2010	Health check items 704, 708 and 710 combined	The 3 separate item numbers were replaced by a single item: MBS item 715. The frequency of health checks was standardised to annual, so Aboriginal and Torres Strait Islander people aged 15–54 were able to have a health check every year, instead of every 2 years.
2010	Indigenous status required by Royal	Existing requirements were strengthened, so practices seeking accreditation had to demonstrate

When?	What?	Why?
	Australian College of General Practitioners Standards	they were routinely recording Aboriginal and Torres Strait Islander status in their active patient records.
July 2011–12	Divisions of General Practice transitioned to Medicare Locals	Divisions of General Practice (n = 112), as well as their national and jurisdiction level support structures (the Australian General Practice Network and 8 state-based organisations) were replaced with Medicare Locals (n = 62), as part of the National Health Reform Agenda.
2013	National Aboriginal and Torres Strait Islander Health Plan 2013–2023	As part of our efforts to close the gap, since 2011, the Australian Government worked with Aboriginal and Torres Strait Islander people to produce the National Aboriginal and Torres Strait Islander Health Plan, providing an opportunity to collaboratively set out a 10 year plan for the direction of Indigenous health policy
June 2014	Australian Medicare Local Alliance abolished	Australian Medicare Local Alliance (the national coordination body for Medicare Locals) was abolished. Regional coordination and support of the Closing the Gap workforce undertaken by the Alliance also ceased.
2015	Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023	The Implementation Plan outlines the actions to be taken by the Australian Government and other key stakeholders to give effect to the vision, principles, priorities and strategies of the Health Plan, including goals for increasing the use of Indigenous-specific health checks.
July 2015	Medicare locals replaced by Primary Health Networks	Medicare Locals (n = 62) were replaced by Primary Health Networks (n = 31). In 2015–16, funding for the Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care programs was provided through Primary Health Networks.
July 2016	Integrated Team Care Activity started	Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care program funding was combined into new Integrated Team Care Activity.
July 2018	MBS health check item, 228, introduced for non-VR Medical Practitioners	Allows eligible non-vocationally recognised medical practitioners (other than GPs and specialists) to claim MBS subsidies for Indigenous-specific health checks.

When?	What?	Why?
March 2020	COVID-19 temporary telehealth health check and follow-up items introduced	To help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers (available until 30 June 2021).
December 2020	COVID-19 temporary health check items, 93470 and 93479, introduced for Residential Aged Care Facilities	To improve access to multidisciplinary care for residents of residential aged care facilities (RACF) during the COVID-19 pandemic (available until 30 June 2022).
2021	Health check templates	The National Aboriginal Community Controlled Health Organisation (NACCHO) and Royal Australian College of General Practitioners (RACGP) released 5 Indigenous-specific health check templates for testing, designed for different age groups, and downloadable from the RACGP website.

National goals for health checks

Established in 2015, the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 set goals for increasing the use of Indigenous-specific health checks by 2023 (Table 4).

See Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023 for additional data and information about these goals.

Table 4: 2023 Implementation Plan (IP) goals and national 2019–20 health check rates (per cent)

Age	2023 IP goal health check rate (%)	2019–20 health check rate (%) – counting health checks by date of processing	2019–20 health check rate (%) – counting patients by date of service
0–4	69	27	29
5–14	46	26	25
15–24	42	24	23
25–54	63	30	29
55 and over	74	41	38

Note: Data for the IP goals are based on date of processing, age determined from date of service and false date of birth (1 January of birth-year), and calculated using the number of health checks. Thus, the goals do not align with the rates shown elsewhere in this report (which are based on date of service, and relate to the number of people who received at least 1 health check). Both rates are shown in Table 4, for comparison.

References

Australian Bureau of Statistics (ABS) 2019. Estimates and Projections, Aboriginal and Torres Strait Islander Australians. Canberra: ABS.

References

Australian Bureau of Statistics (ABS) 2018a. Estimates of Aboriginal and Torres Strait Islander Australians, June 2016. Canberra: ABS.

ABS 2018b. Census of Population and Housing: Understanding the Increase in Aboriginal and Torres Strait Islander Counts. Canberra: ABS.

ABS 2019. Estimates and Projections, Aboriginal and Torres Strait Islander Australians. Canberra: ABS.

ABS 2020. Population and COVID-19. Canberra: ABS.

Australian Institute of Health and Welfare (AIHW) 2020. Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023. Cat. no. IHW 201. Canberra: AIHW. Viewed 4 June 2021

Bailie J, Schierhout GH, Kelaher MA, Laycock AF, Percival NA, O'Donoghue LR et al. 2014. Follow-up of Indigenous-specific health assessments—a socioecological analysis. Medical Journal of Australia 200: 653–657.

Department of Health 2018. Report from the Aboriginal and Torres Strait Islander Health Reference Group. Medicare Benefits Schedule Review Taskforce. Canberra: Department of Health. Viewed 16 May 2019.

Department of Health 2021. Annual Health Assessment for Aboriginal and Torres Strait Islander People. Canberra: Department of Health. Viewed 4 June 2021.

Dutton T, Stevens W & Newman J 2016. Health assessments for Indigenous Australians at Orange Aboriginal Medical Service: health problems identified and subsequent follow up. Australian Journal of Primary Health 22: 233–238.

Royal Australian College of General Practitioners (RACGP) 2020. General Practice: Health of the Nation 2020. East Melbourne: RACGP.