Australian Government
Australian Institute of
Health and Welfare

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

Web report

Cat. no: IHW 227

Report release: 04 February 2022

Updated: 10 June 2022

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

Information from 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 release contains nKPI data up to the June 2021 collection and OSR data up to the 2020–21 collection. Data tables accompanying this release can be found on the AIHW website.

Contents

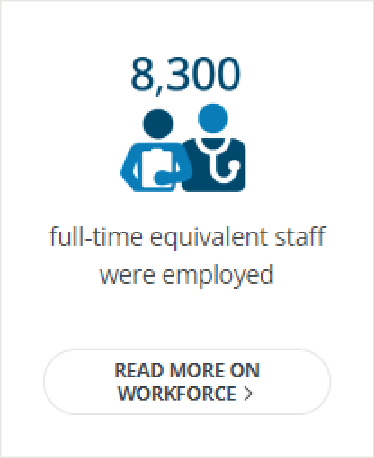
Key findings

1. 191 Indigenous-specific primary health care organisations employed about 8,300 full-time equivalent staff in 2020–21
2. Indigenous-specific primary health care organisations cared for around 454,000 clients in 2020–21
3. Clients of Indigenous-specific primary health care organisations had an average of 12.1 contacts in 2020–21
4. At June 2021, 38% of Indigenous regular clients aged 11 and over had never smoked
5. At June 2021, 86% of Indigenous babies born in the last year had a normal birthweight

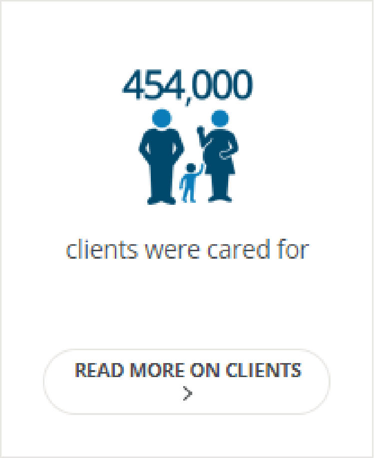
Summary

Aboriginal and Torres Strait Islander specific primary health care organisations play a critical role in improving the health of Indigenous Australians. In 2020–21:

191 organisations provided Indigenous-specific primary health care



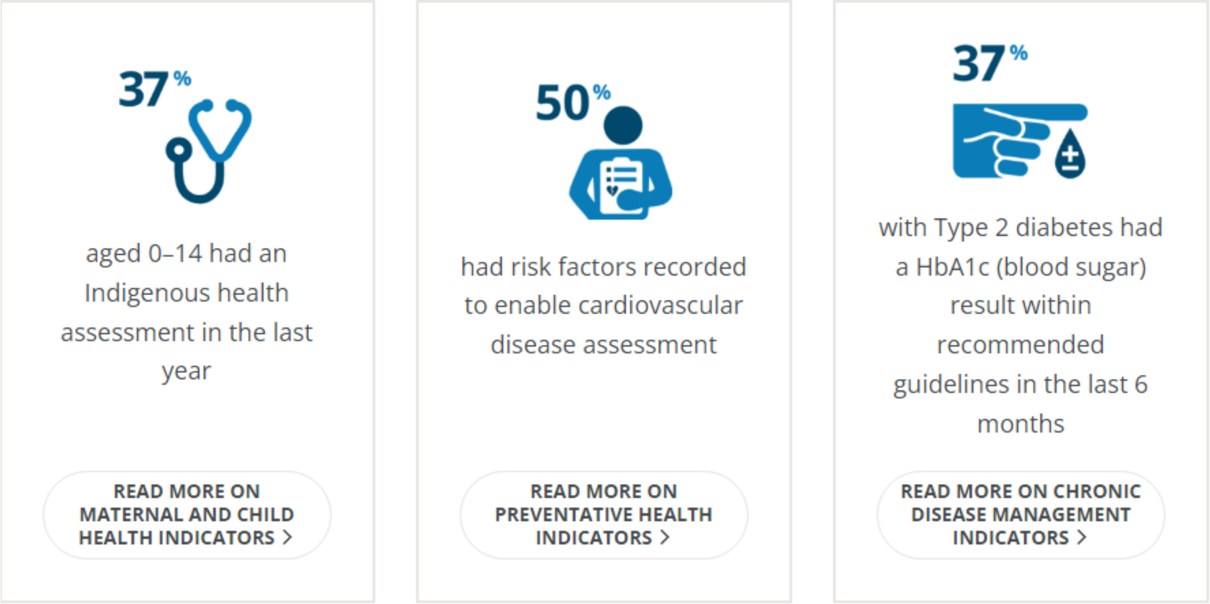
8,300 full-time equivalent staff were employed



454,000 clients were cared for

3.5million episodes of care were provided

Most of these organisations provide data on a set of process-of-care and health-status indicators for Indigenous Australians, focusing on maternal and child health, preventative health, and chronic disease management (see also Interpreting nKPI data). At June 2021, these showed that, for Indigenous regular clients (an Indigenous client who has visited a particular primary health care organisation 3 or more times in the previous 2 years):



37%

aged 0–14 had an Indigenous health assessment in the last year

50%

had risk factors recorded to enable cardiovascular disease assessment

37%

with Type 2 diabetes had a HbA1c (blood sugar) result within recommended guidelines in the last 6 months

In 2019–20 and 2020–21, some impact from the coronavirus disease 2019 (COVID-19) pandemic (the pandemic) can be seen in results from the OSR and nKPI collections. However, variations cannot be tied to this alone and it is likely that a combination of factors affected the results. For example, variation may reflect: changes in organisation or client behaviour as a result of the pandemic (such as reluctance of clients to attend or use telehealth; or restrictions on travel for clients and staff); the voluntary nature of reporting for those periods (and the associated decrease in the number of reporting organisations); or general changes in the types or characteristics of reporting organisations (for example, the organisations reporting to the collection vary each period, an organisation may close or open a site, or an organisation may change their internal data recording processes). See Impact of COVID-19 and Technical notes for information on interpreting results over time.

Introduction

Indigenous-specific primary health care organisations play a critical role in improving the health of Aboriginal and Torres Strait Islander people (hereafter referred to as Indigenous Australians). Indigenous Australians may access either mainstream or Indigenous-specific primary health care organisations (hereafter referred to as organisations).

Information on organisations funded by the Australian Government under its Indigenous Australians' Health Programme (IAHP) is available through two data collections, the Online Services Report (OSR) and the national Key Performance Indicators (nKPI):

- **OSR**—collects contextual information annually (covering the period 1 July–30 June) on the organisations, such as client numbers, client contacts, episodes of care, and staffing levels
- **nKPI**—collects information twice a year (with census dates at 30 June and 31 December) from the organisations on a set of process-of-care and health-status indicators for Indigenous Australians, focusing 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 national health goals set out in the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023.

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

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

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 reporting period for the nKPI (see nKPI - introduction) and the financial year reporting period for the OSR (see OSR - introduction).

b. Unlike in previous years, for 2019–20 and 2020–21, reporting to the collections 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. OSR data presented in this report exclude these organisations unless otherwise noted. See OSR - summary over time for selected data from these organisations, and Interpreting OSR data for more information.

Note: See also Technical notes and Impact of COVID-19 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. These organisations can be split into two main types—Aboriginal Community Controlled Health Organisations (ACCHOs) and non- Aboriginal Community Controlled Health Organisations (non-ACCHOs).

ACCHOs are initiated and operated by their local Aboriginal communities through locally elected Boards of Management. Non-ACCHOs are a mix of government-run organisations (such as local health districts) and non-government organisations (such as not-for-profit charitable health services). ACCHOs generally deliver a set of services deemed to be ‘comprehensive health care’ while non-ACCHOs may offer limited or a full range of services. As such, these types of organisations can have very different profiles (Table 2) and caution should be used when interpreting the OSR and nKPI data by organisation type presented in this report. For more information on interpreting data in this report, see Technical notes and Glossary.

Table 2: Selected measures from the OSR collection, by organisation type, 2020–21

Clients	ACCHO	Non-ACCHO	Total
Mean	3,093	1,098	2,390
Median	2,314	650	1,656

Indigenous clients	ACCHO	Non-ACCHO	Total
Mean	2,498	898	1,934
Median	1,923	550	1,238

Client contacts	ACCHO	Non-ACCHO	Total
Mean	39,572	8,845	28,794
Median	33,478	6,444	17,707

Episodes of care	ACCHO	Non-ACCHO	Total
Mean	24,934	6,893	18,572
Median	19,952	5,115	12,777

Employed health full time equivalent (FTE) staff	ACCHO	Non-ACCHO	Total
Mean	35.0	7.0	25.2
Median	22.8	4.5	13.8

Number of organisations	ACCHO	Non-ACCHO	Total
Total	**124**	**67**	**191**

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.

OSR—introduction

Comprehensive and culturally appropriate primary health care services play a key role in improving the health and wellbeing of Indigenous Australians through prevention, early intervention, health education, and the timely identification and management of physical and psychological issues (Griew et al. 2008).

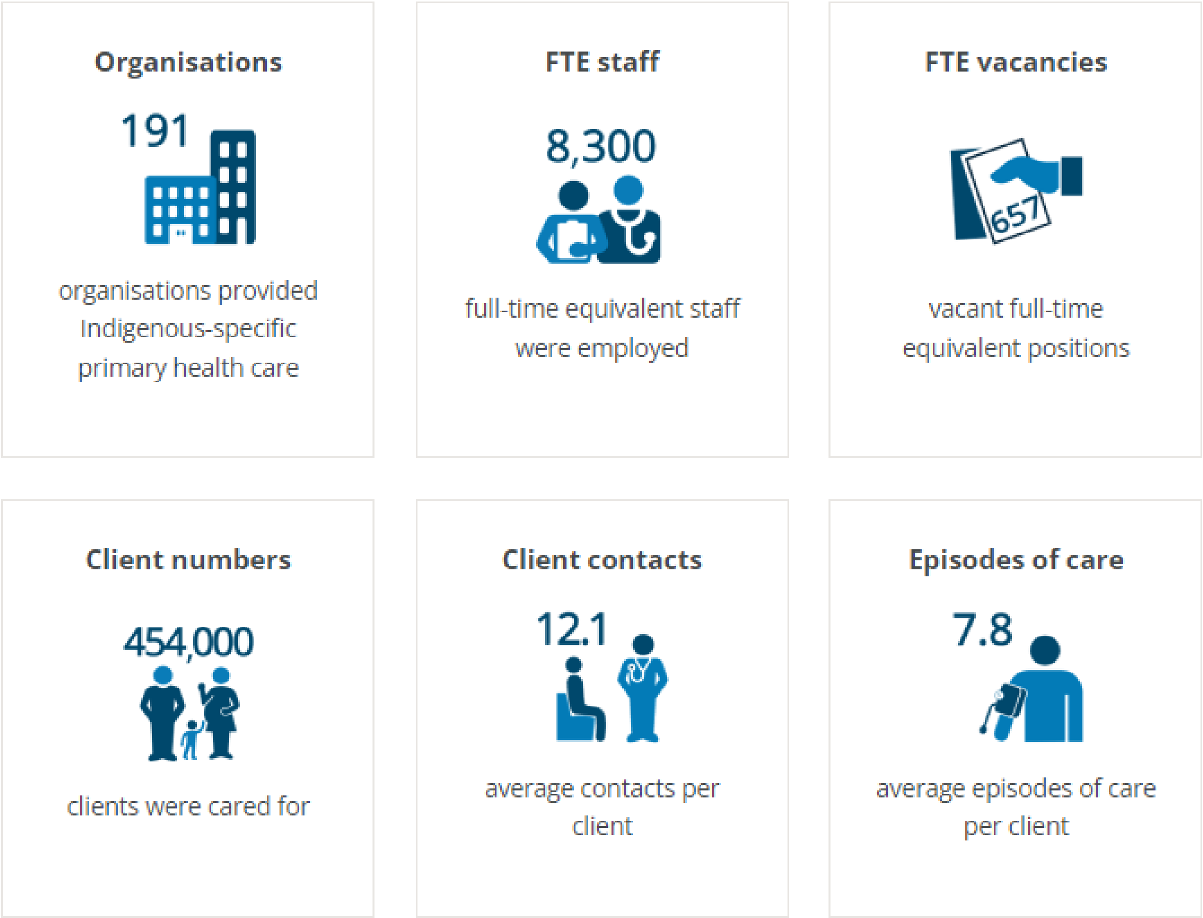
To this end, the Australian Government provides funding through its Indigenous Australians' Health Programme (IAHP) to organisations delivering Indigenous-specific primary health care services (referred to hereafter as organisations). These organisations, designed to be accessible to Indigenous clients, are administered and run by:

- Aboriginal Community Controlled Health Organisations (ACCHOs)
- non-ACCHOs:
  - state/territory/local health services
  - non-government organisations (NGOs) (a small proportion of services).

They vary in size, location, governance structure, length of time in operation, workforce composition, additional sources of funding, the services they offer, the ways in which they operate (for example, stand-alone or part of a consortium), and the needs of their clients (see also Introduction). What they all share in common is a holistic approach to meeting the needs of their Indigenous clients, which often involves addressing a complex mix of health conditions.

Each organisation provides contextual information about their organisation to the Online Services Report (OSR) collection once each financial year (covering the period 1 July–30 June). 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).

The following boxes show key results for 2020–21. Clicking on a box will go to more information on the selected topic.



Organisations

191

organisations provided Indigenous-specific primary health care

FTE staff

8,300

full-time equivalent staff were employed

FTE vacancies

657

vacant full-time equivalent positions

Client numbers

454,000

clients were cared for

Client contacts

12.1

average contacts per client

Episodes of care

7.8

average episodes of care per client

Reference

Griew R, Tilton E, Cox W, Thomas D (2008) The link between primary health care and health outcomes for Aboriginal and Torres Strait Islander Australians, Waverly, NSW: Robert Griew Consulting.

OSR—summary over time

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

See Technical notes and Impact of COVID-19 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]
Organisations	198	210	196	191
Clients	483,073	498,206	468,500	454,047
Indigenous clients	391,860	393,101	382,607	367,409
Full-time equivalent (FTE) staff[b]	8,215	8,343	7,634	8,557
Health FTE staff[b]	4,938	4,824	4,509	5,021
Employed FTE staff	7,945	7,981	7,352	8,310
Employed Health FTE staff	4,695	4,495	4,258	4,811
Employed Indigenous FTE staff	4,254	4,130	3,817	4,315
Health FTE per 1,000 clients	10.2	9.9	9.6	11.1
Average contacts per client	12.6	12.2	11.6	12.1
Average episodes of care per client	7.5	7.6	7.5	7.8

(a) Unlike in previous years, for 2019–20 and 2020–21, reporting to the collection 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 Technical notes and Impact of COVID-19 for information on interpreting changes over time.

Source: AIHW analysis of OSR data collection.

Maternal and child health organisations reporting to the OSR

Results presented in this report exclude data from the OSR organisations that received funding only for maternal and child health services. Selected data from these organisations are presented in Table 2.

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

	2018–19	2019–20[(a)]	2020–21[(a)]
Organisations	22	19	20
Clients	7,964	8,018	7,411
Indigenous clients	5,723	5,387	5,941
Full-time equivalent (FTE) staff	119.4	99.9	125.2
Health FTE staff	86.6	76.6	89.2
Employed FTE staff	116.4	95.7	120.0
Employed Health FTE staff	83.9	72.7	84.7
Employed Indigenous FTE staff	68.1	38.3	53.1

	2018–19	2019–20[(a)]	2020–21[(a)]
Health FTE per 1,000 clients	10.9	9.6	11.2
Average contacts per client	8.9	5.9	10.8
Average episodes of care per client	4.2	4.5	4.7

(a) Unlike in previous years, for 2019–20 and 2020–21, reporting to the collection was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19.

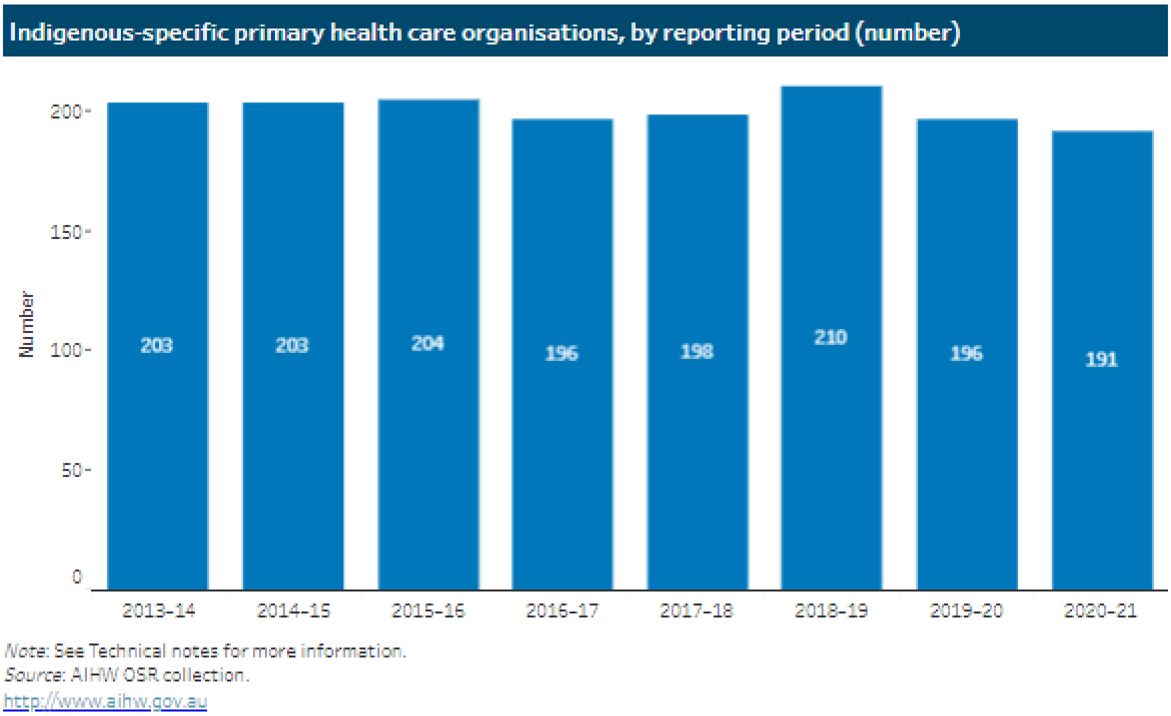
Note: See also Technical notes and Impact of COVID-19 for information on interpreting changes over time.

Source: AIHW analysis of OSR data collection.

OSR—organisations

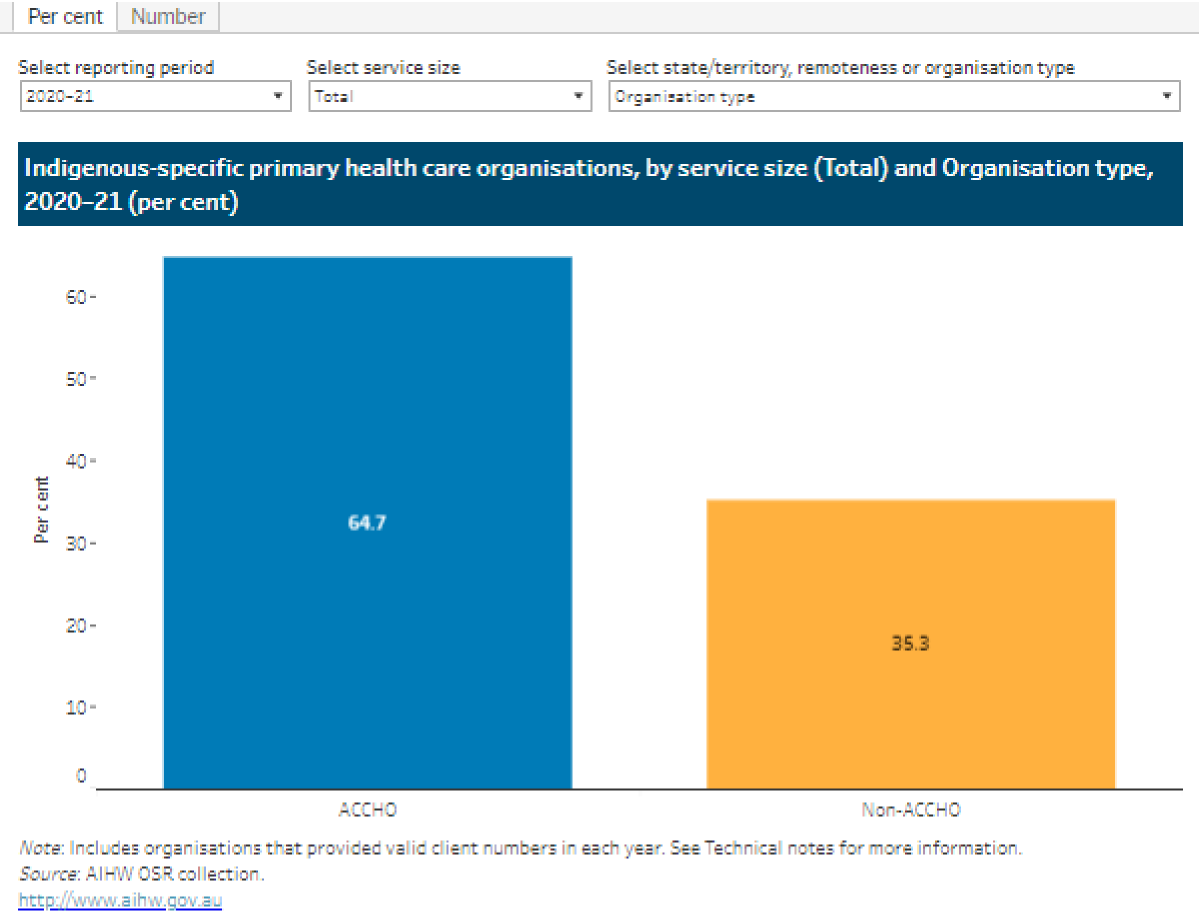
In 2020–21, 191 organisations reported to the Online Services Reporting (OSR) collection. Of these:

- over one-third (34% or 65) were in the Northern Territory
- over one-third (36% or 68) were in *Very remote* areas
- around two-thirds (65% or 124) were Aboriginal Community Controlled Health Organisations (ACCHOs).


Indigenous-specific primary health care organisations, by reporting period (number)

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 (see also [Introduction]).



Select reporting period: 2020–21

Select service size: Total

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

Indigenous-specific primary health care organisations, by service size (Total) and Organisation type, 2020–21 (per cent)

Note: Includes organisations that provided valid client numbers in each year. 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 reporting period
- vacant positions—how many vacant positions there were at 30 June.

The following boxes show key results for 2020–21. Clicking on a box will go to more information on the selected topic.

FTE (employed staff)

Indigenous staff

52%

of employed full-time equivalent staff were Indigenous

Health staff

58%

of employed full-time equivalent staff were health staff

Remoteness

37%

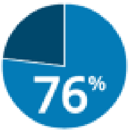
of employed full-time equivalent staff were in *Remote* or *Very remote* areas

Vacant FTE positions

Indigenous vacancies

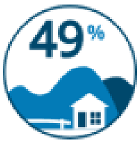
of vacant full-time equivalent positions were for Aboriginal and Torres Strait Islander health workers and practitioners

Health vacancies



of full-time equivalent vacancies were for health staff

Remoteness



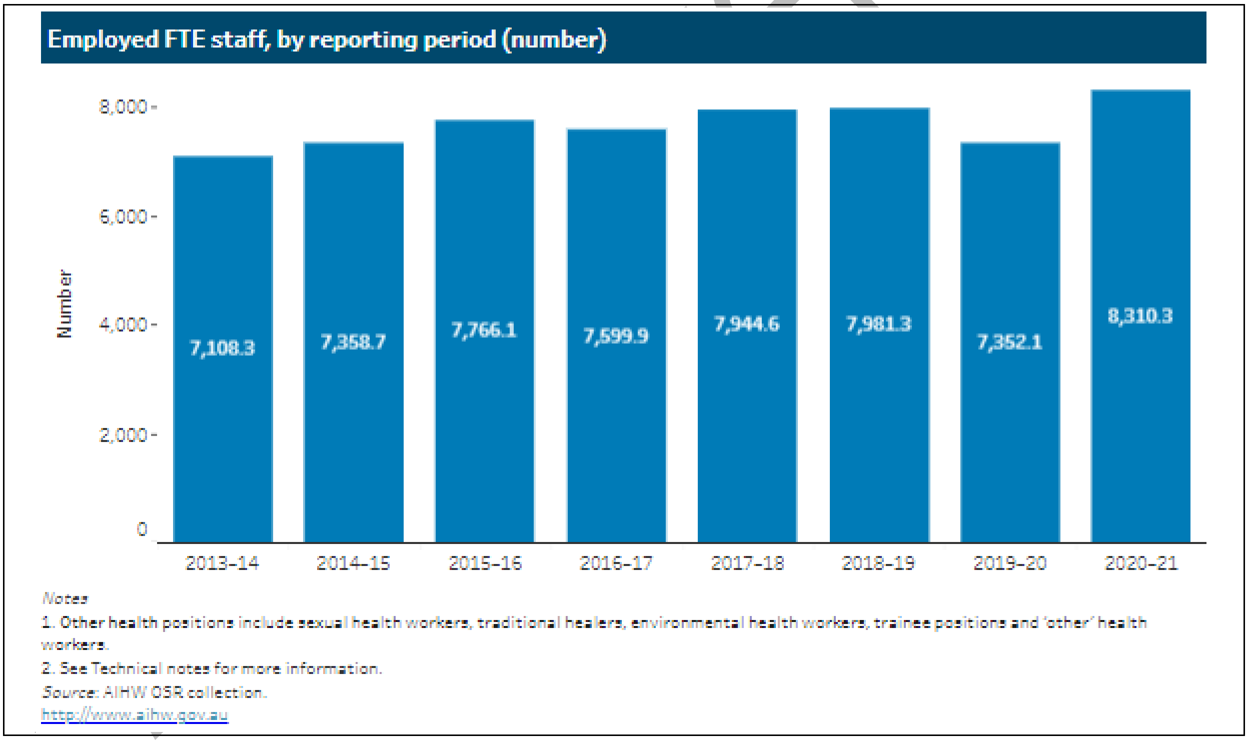
of full-time equivalent vacancies were in *Remote* or *Very remote* areas

Staffing (FTE)

At 30 June 2021, organisations employed around 8,300 full-time equivalent (FTE) staff. They also had around 247 visiting FTE staff not paid for by the organisations themselves.

Of the employed FTE staff around:

- 58% (or 4,800 FTE) were health staff, with 14% being nurses and midwives, 11% being Aboriginal and Torres Strait Islander health workers and practitioners, and 7% being general practitioners (GPs)
- 52% (or 4,300 FTE) were Indigenous
- 27% (or 2,200 FTE) were in Queensland
- 22% (or 1,800 FTE) were in *Major cities*
- 91% (or 7,600 FTE) were at Aboriginal Community Controlled Health Organisations (ACCHOs).



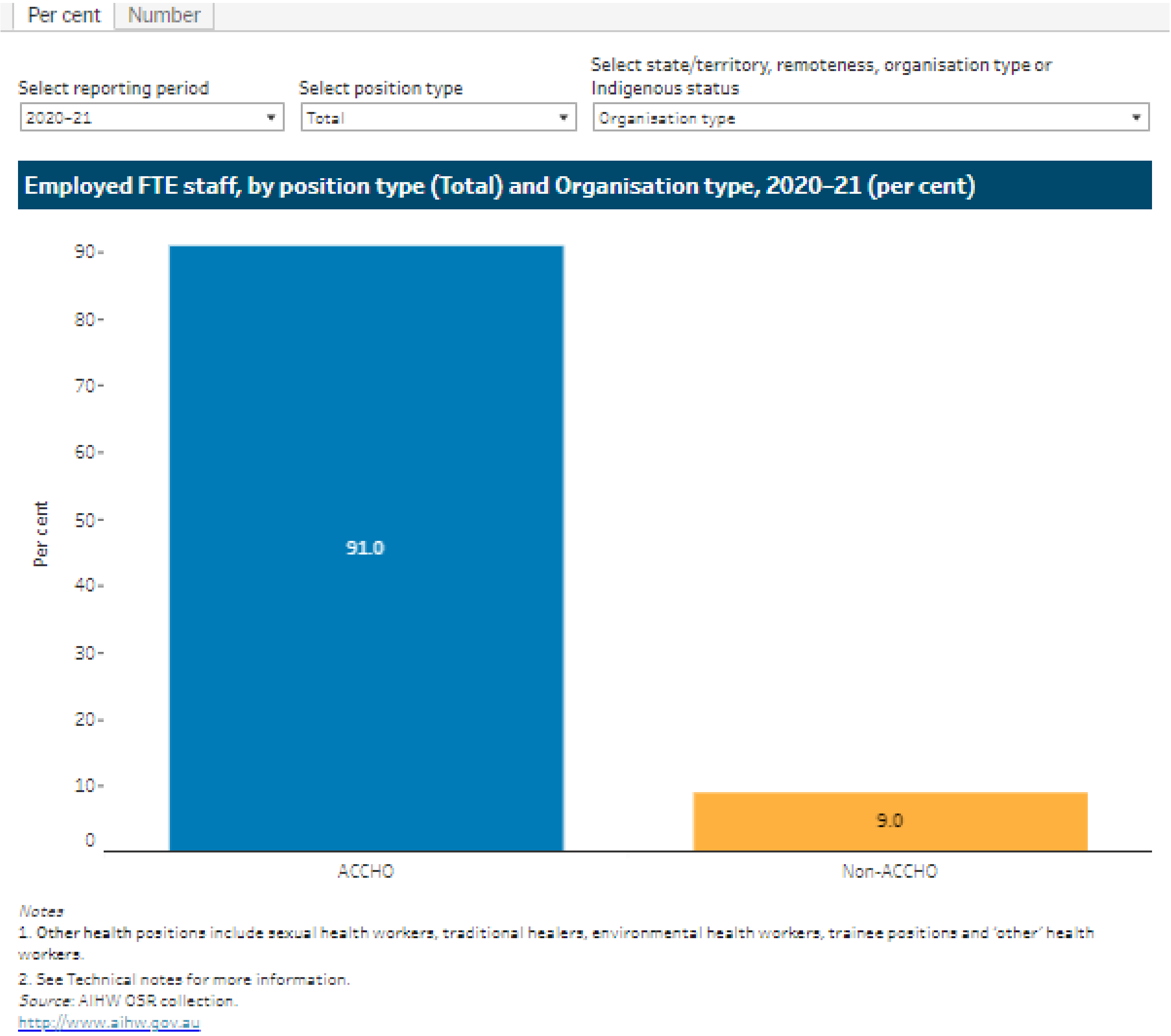
Employed FTE staff, by reporting period (number)

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
2020–21

Select position type
Total

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

Employed FTE staff, by position type (Total) and Organisation type, 2020–21 (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.

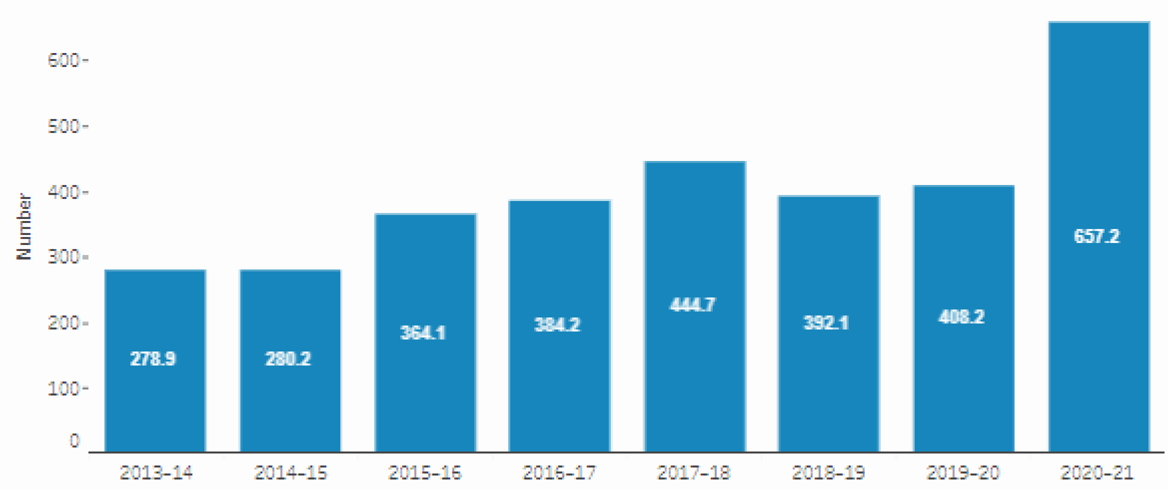
http://www.aihw.gov.au

Vacancies (FTE)

At 30 June 2021, organisations had around 657 vacant full-time equivalent (FTE) positions. Of these around:

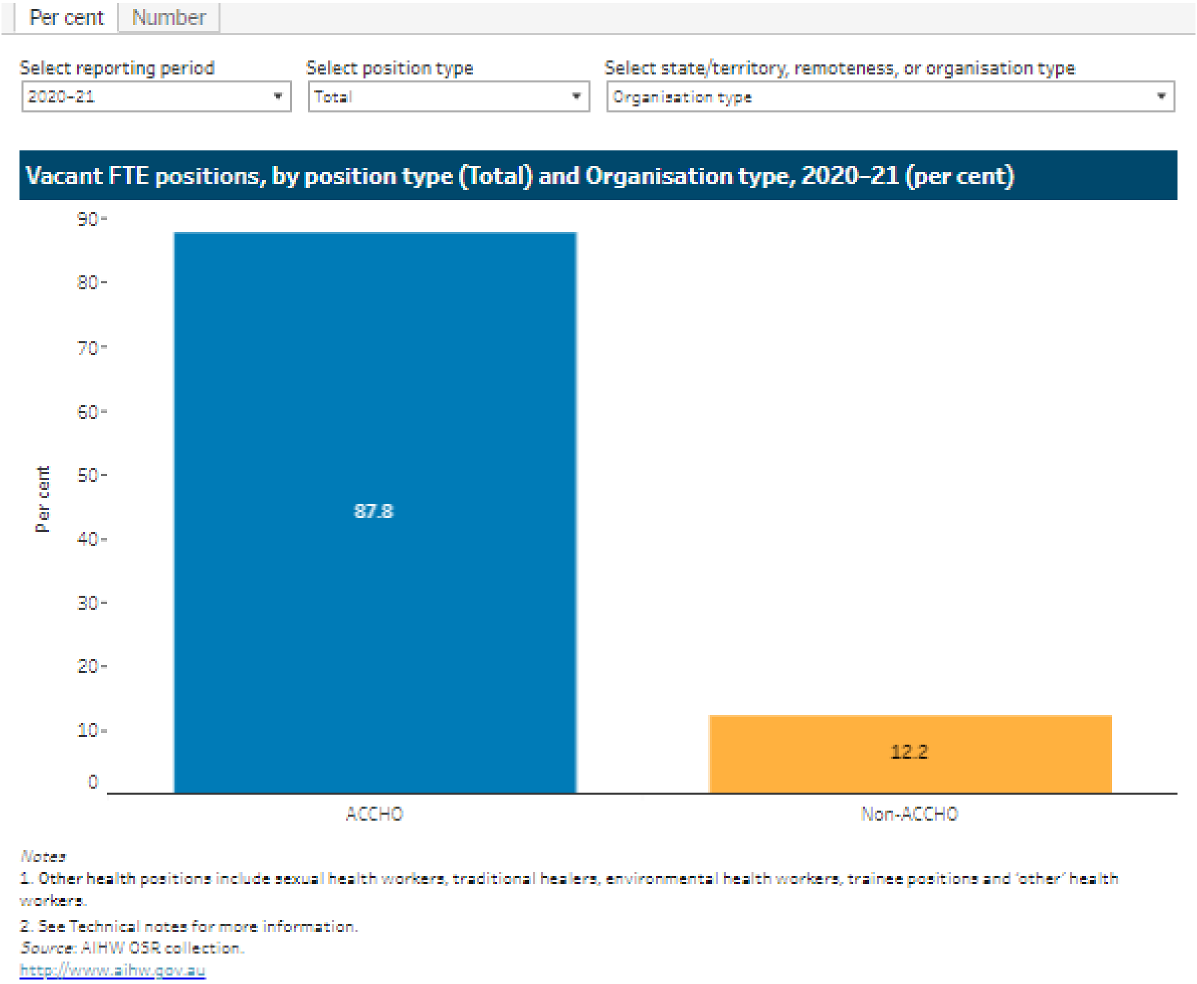
- 76% (or 500) were for health positions
- 37% (or 245) were in the Northern Territory
- 26% (or 170) were in *Very remote* areas
- 18% (or 115) were for nurses and midwives, 14% (or 90) were for Aboriginal and Torres Strait Islander health workers and practitioners
- 88% (or 580) were at Aboriginal Community Controlled Health Organisations (ACCHOs).

Vacant FTE positions, by reporting period (number)



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

At 30 June 2021, there was an increase in the number of vacant FTE positions. It is difficult to be definitive about the reasons for this, however, as many of the organisations (63%) with increased vacancies also had an increase in employed FTEs, it is likely that these vacancies relate to new services rather than to existing services. Some of this change may have been a result (direct or indirect) of the coronavirus disease 2019 (COVID-19) pandemic (the pandemic). However, looking at the comments organisations provided for variations in these numbers (reported for organisations with a 20% or more increase or decrease in main data items), not all organisations with an increase clearly linked it to the pandemic. Changes may also result from other factors unrelated to the pandemic, for example, general changes in funding, direction, structure or size resulting in more or different services being delivered.



Select reporting period: 2020–21

Select position type: Total

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

Vacant FTE positions, by position type (Total) and Organisation type, 2020–21 (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 reporting 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 Regular client in 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.

Counts of client contacts in 2016–17 were affected by changes to episodes of care in that year. See also Episodes of care and 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. See also Client contacts and Technical notes.

The following boxes show key results for 2020–21. Clicking on a box will go to more information on the selected topic.

Client numbers

Organisation type

84%

of clients (380,000) were seen by Aboriginal Community Controlled Health Organisations

Indigenous clients

81%

of clients (367,000) were Indigenous

Remoteness

163,000

clients (36%) were seen in *Remote* or *Very remote* areas

Client contacts

Organisation type

4.9 million

client contacts (89%) at Aboriginal Community Controlled Health Organisations

Indigenous clients

31%

of Indigenous client contacts (1.7 million) were with a nurse/midwife

Remoteness

2.0 million

client contacts (37%) in *Remote* or *Very remote* areas

Episodes of care

Organisation type

3.1 million

episodes of care (87%) by Aboriginal Community Controlled Health Organisations

Indigenous clients

85%

of episodes of care (3.0 million) were with Indigenous clients

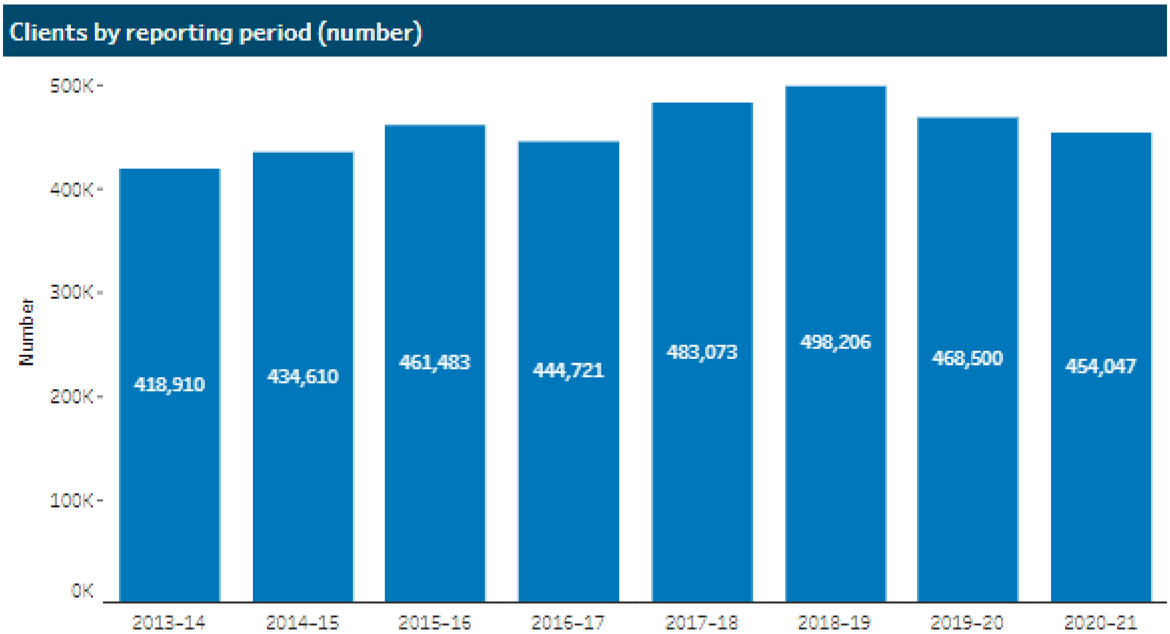
Remoteness

1.3 million

episodes of care (38%) provided in *Remote* or *Very remote* areas

Clients

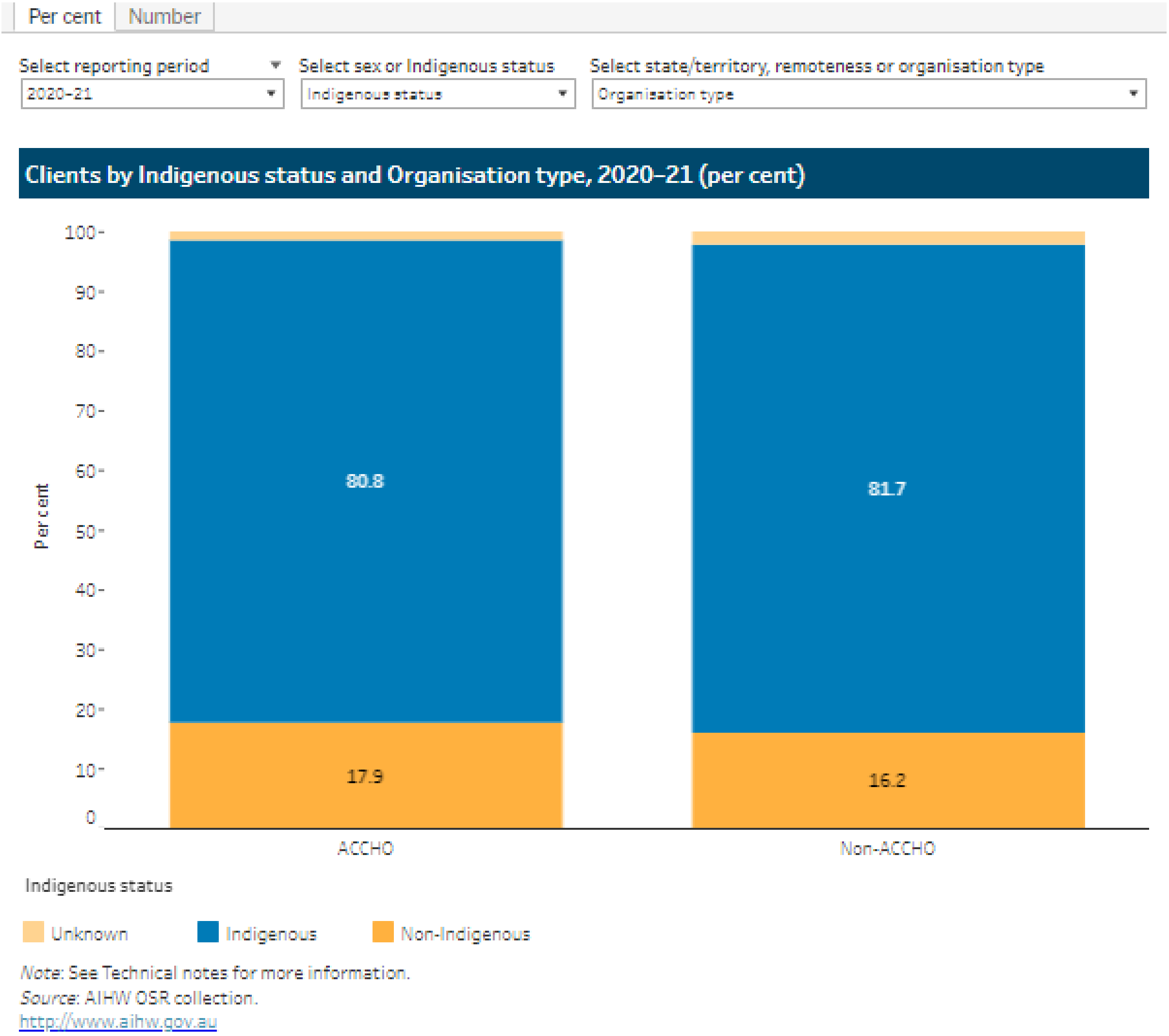
In 2020–21, organisations saw around 454,000 clients.


Clients by reporting period (number)

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

Of these around:

- 54% (244,000) were female
- 81% (367,000) were Indigenous
- 57% (258,000) were aged under 35
- 26% (119,000) were seen in Queensland
- 36% (163,000) were seen in *Remote* or *Very remote* areas
- 84% (380,000) were seen by Aboriginal Community Controlled Health Organisation (ACCHOs).



Select reporting period: 2020–21

Select sex or Indigenous status: Indigenous status

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

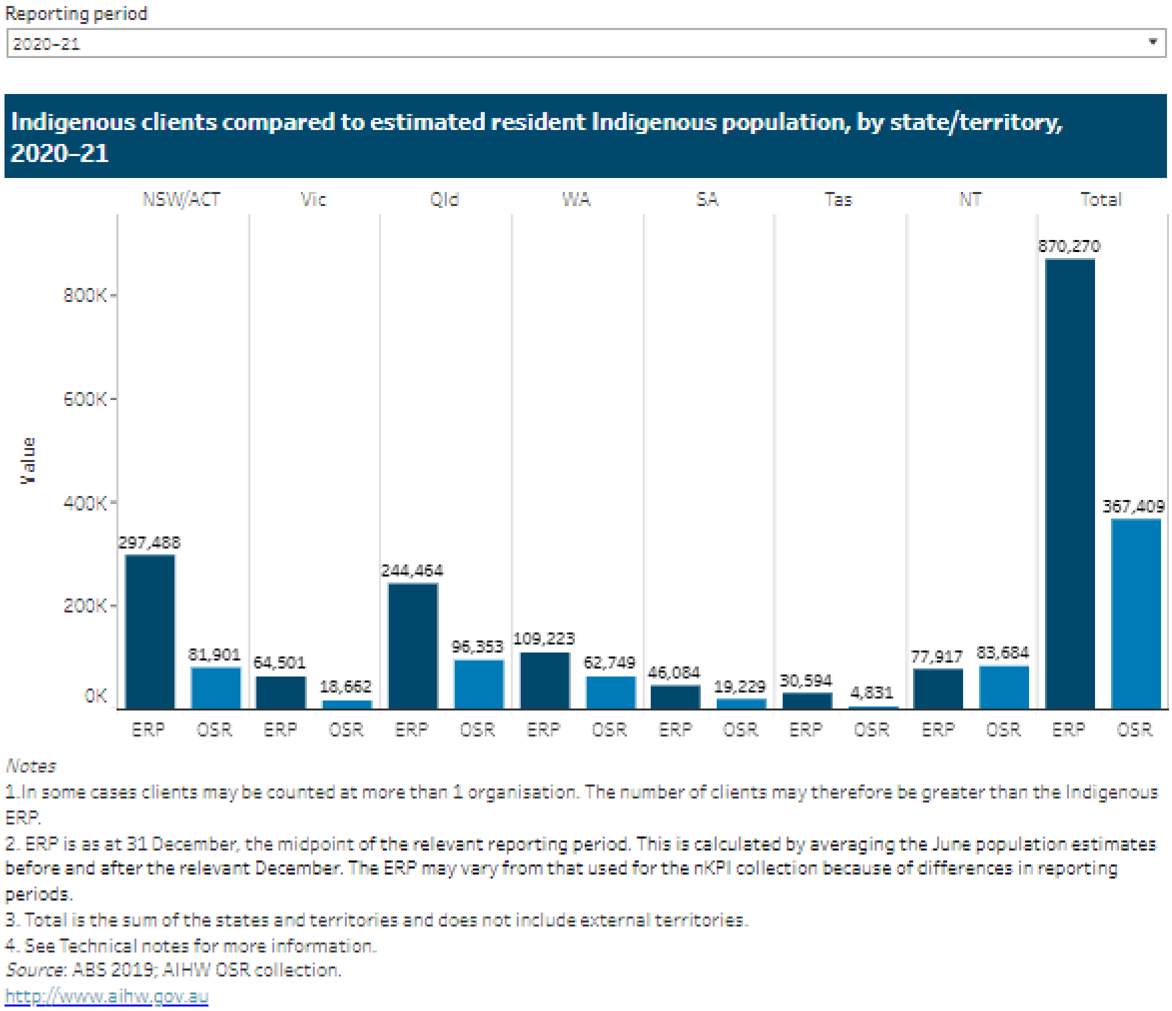
Clients by Indigenous status and Organisation type, 2020–21 (per cent)

Indigenous status

🟨 Unknown 🟦 Indigenous 🟧 Non-Indigenous

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

In 2020–21, around 42% (367,000) of the estimated resident Indigenous population (870,000) were Indigenous clients of organisations reporting to the OSR collection.



Reporting period

2020–21

Indigenous clients compared to estimated resident Indigenous population, by state/territory, 2020–21

Notes

1.In some cases clients may be counted at more than 1 organisation. The number of clients may therefore be greater than the Indigenous ERP.

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

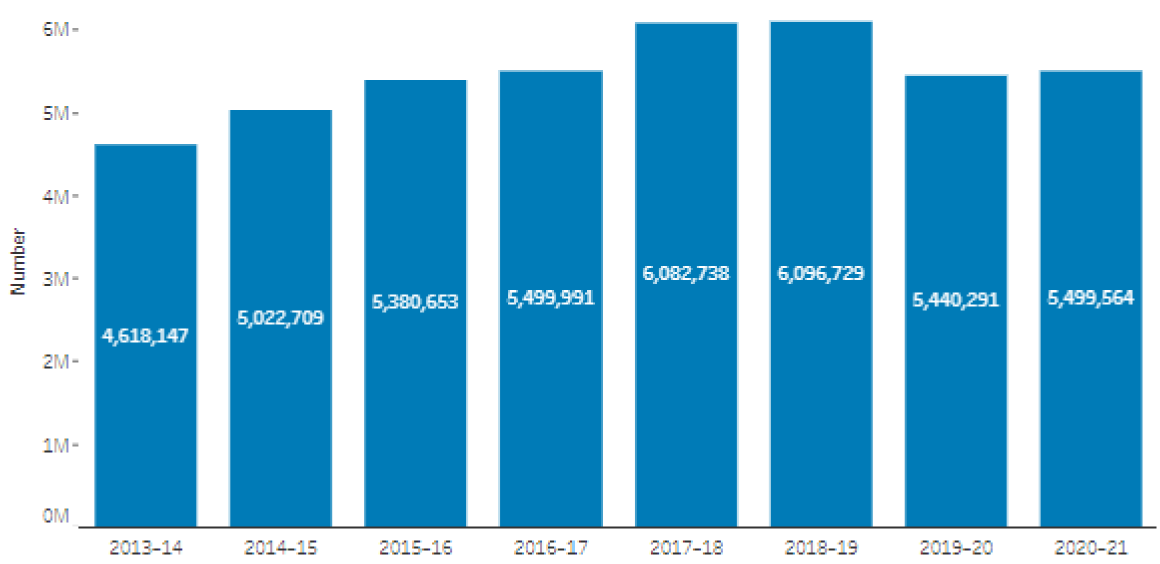
Reference

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 2020–21, organisations had around 5.5 million client contacts.

Client contacts by reporting period (number)



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

Of these around:

- 85% (4.7 million) were with Indigenous clients
- 26% (1.4 million) were provided in Queensland
- 22% (1.2 million) were provided in *Outer regional* areas
- 89% (4.9 million) were provided by Aboriginal Community Controlled Health Organisations (ACCHOs)
- 31% (1.7 million) were made by nurses and midwives
- 31% (1.7 million) were made by a general practitioner (GP)
- 13% (715,000) were made by Aboriginal and Torres Strait Islander health workers and practitioners.

Select Reporting period: 2020–21

Select contact type: AHP/AHW

Select State/territory, remoteness, organisation type or Indigenous status: Organisation type

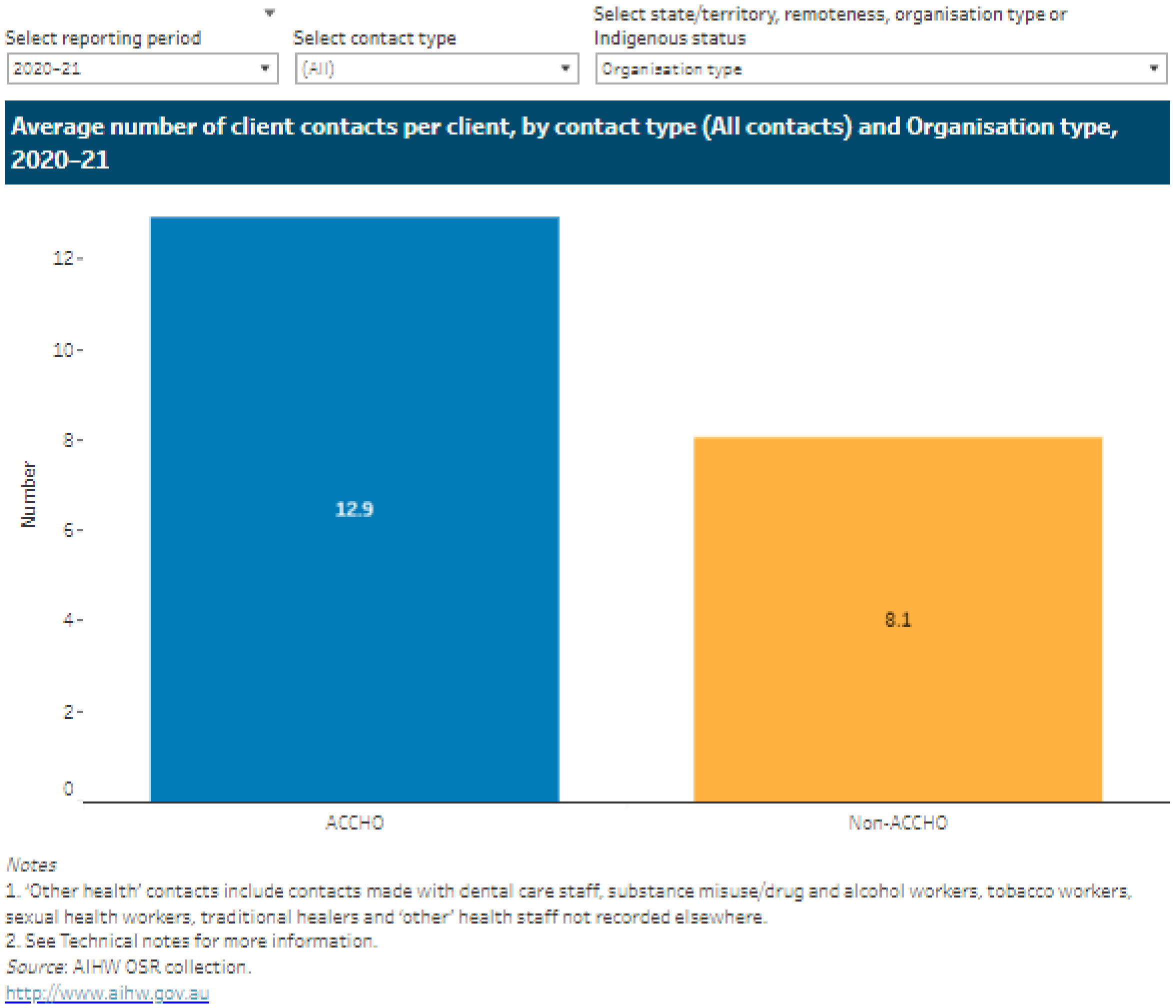
Client contacts, by contact type (AHP/AHW) and Organisation type, 2020–21 (per cent)

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 12.1 contacts per client.



Select reporting period: 2020–21

Select contact type: (All)

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

Average number of client contacts per client, by contact type (All contacts) and Organisation type, 2020–21

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.

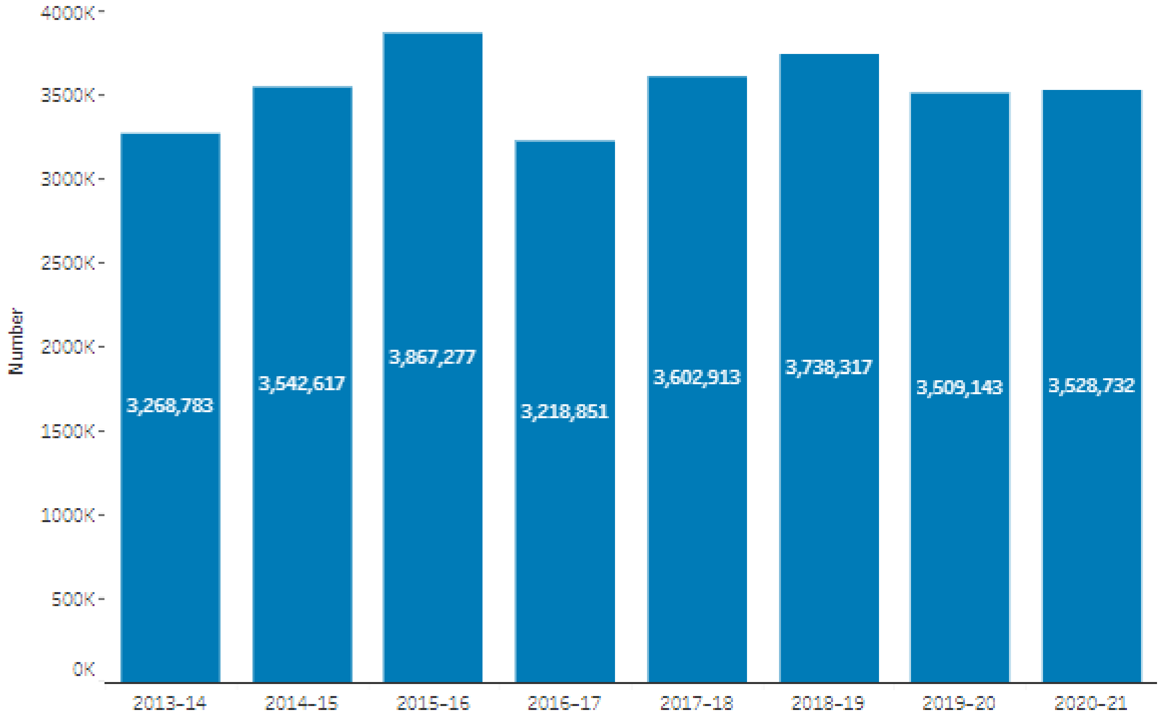
Source: AIHW OSR collection.

http://www.aihw.gov.au

Episodes of care

In 2020–21, organisations provided around 3.5 million episodes of care.

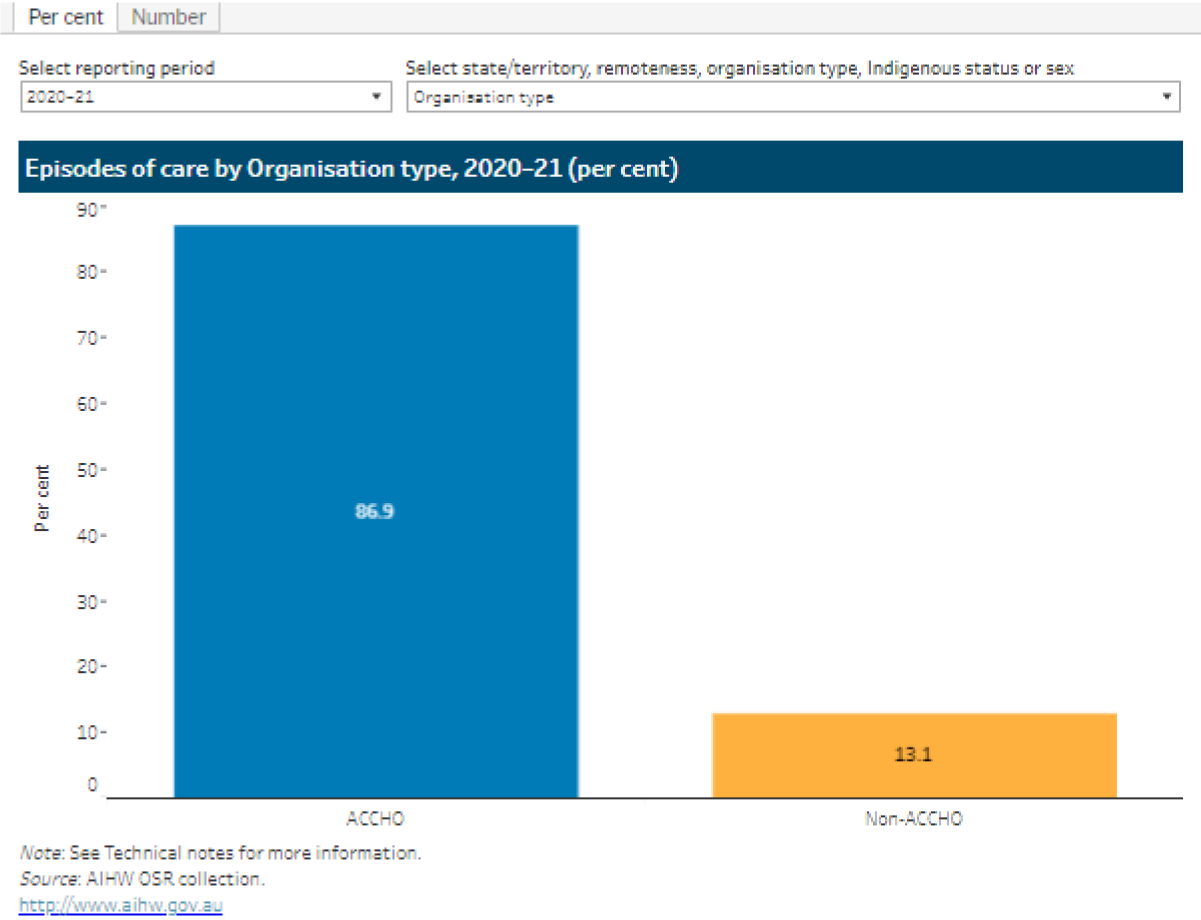
Episodes of care by reporting period (number)



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

Of these around:

- 85% (3.0 million) were with Indigenous clients
- 59% (2.1 million) were with female clients
- 27% (942,000) were provided in Queensland
- 22% (767,000) were provided in *Major cities*
- 87% (3.1 million) were provided by Aboriginal Community Controlled Health Organisations (ACCHOs).



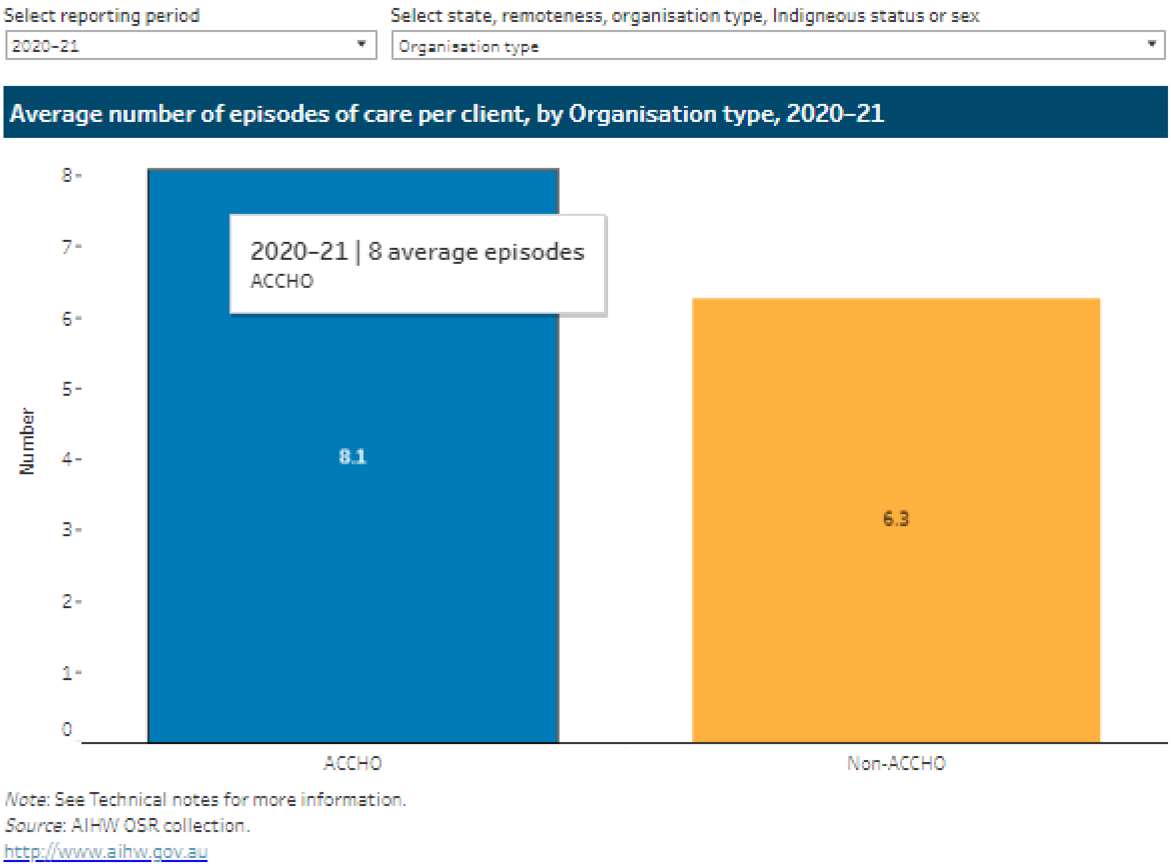
Select reporting period: 2020–21

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

Episodes of care by Organisation type, 2020–21 (per cent)

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

There was an average of 7.8 episodes of care per client.



Select reporting period
2020–21

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

Average number of episodes of care per client, by Organisation type, 2020–21

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

nKPI—introduction

The national Key Performance Indicators (nKPI) collection is a set of indicators provided by organisations receiving funding under the Indigenous Australians' Health Programme (IAHP) to deliver comprehensive and culturally appropriate primary health care services to Indigenous Australians. Some indicators have more than one part (for example, an indicator might be collected by different types of chronic diseases).

Data are supplied on the Indigenous regular clients of each organisation twice a year, with census dates in June and December. The period of data covered varies by indicator. For example, for the June 2021 census date, data provided covers, depending on the indicator:

- 6 months up to the census date, that is, from, 1 January 2021 to 30 June 2021, or
- 12 months up to the census date, that is, from 1 July 2020 to 30 June 2021, or
- 24 months up to the census date, that is, from 1 July 2019 to 30 June 2021, or
- 5 years up to the census date (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. Only data for Indigenous regular clients are included in the nKPI collection.

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.

The nKPI collection consists of a set of process-of-care and health-status indicators 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). While the process-of-care indicators are largely (but not completely) under the control of organisations and indicate good practice in primary health care, broader health status and outcomes 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 viewed in context of the broader environment in which organisations operate and in which the data are collected. In particular, it is important to acknowledge that the indicators capture only a subset of the important work that organisations do each day. Data from this collection, however, can make an important contribution when used by health service providers at the local level to identify opportunities and to measure progress towards achieving change, or when used by policy makers to inform policy decisions.

Reference

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

nKPI—summary over time

There have been changes over time to the specifications of the indicators that make up the national Key Performance Indicators (nKPI) collection. As such, trends for some measures cannot be calculated or should be interpreted with caution (Table 1). For information on interpreting changes over time for the national Key Performance Indicators (nKPI) collection, including as a result of changes to indicator specifications and other factors, see Technical notes and Impact of COVID-19.

Table 2 presents trends for selected measures. Trends are calculated as a linear trend across all available data points. Data points for December periods are not shown in the table but are available in the Data tables accompanying this report. Of the 27 measures presented (noting some of the 22 indicators have, or are split into, more than one part), 11 have improved, 2 have had no (or limited) change, 6 have not improved, and trends for 8 cannot be calculated.

Table 1: Selected measures: key changes to indicator specifications

Maternal and child health indicators

Measure	Summary of change to indicator specification[(a)]	Impact of change to indicator specification
PI13: First antenatal visit before 14 weeks	Change to antenatal visit timing	Data from June 2021 on cannot be compared with previous periods
PI01: Birthweight recorded	Change to definition of in-scope babies	Data can be compared between periods with caution
PI02: Low birthweight	Change to definition of in-scope babies, inclusion of multiple births	Data can be compared between periods with caution
PI11: Smoking during pregnancy—current smoker	Age range expanded, change to time period for inclusion of smoking status results	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

Measure	Summary of change to indicator specification[(a)]	Impact of change to indicator specification
		can be compared with caution.
PI03: Indigenous health assessment—aged 0–14	Age range and included MBS items expanded	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.

Preventative health indicators

Measure	Summary of change to indicator specification[(a)]	Impact of change to indicator specification
PI09: Smoking status recorded	Age range expanded	Data from June 2021 on cannot be compared with previous periods for the total. Data for ages 15 and over can be compared.
PI10: Current smoker	Age range expanded	Data from June 2021 on cannot be compared with previous periods for the total. Data for ages 15 and over can be compared.
PI16: Alcohol consumption status recorded	—	—
PI17: AUDIT-C—result of high-risk	—	—
PI03: Indigenous health assessment—aged 15 and over	Age range and included MBS items expanded	Data from December 2021 on cannot be compared with previous period for ages 15–24 or the total. Ages 25 and over can be compared with caution
PI20: Risk factors to enable CVD assessment	—	—

Measure	Summary of change to indicator specification[(a)]	Impact of change to indicator specification
PI21: High absolute cardiovascular risk	—	—
PI22: Cervical screening	Changes to age groups, test type and test period	Data can be compared between periods with caution
PI14: Immunised against influenza	Age range expanded	Data from December 2021 on cannot be compared with previous periods
PI12: BMI classified as overweight or obese	—	—

Chronic disease indicators

Measure	Summary of change to indicator specification[(a)]	Impact of change to indicator specification
PI07: Chronic Disease Management Plan—type 2 diabetes	Included MBS items expanded	Data can be compared between periods with caution
PI23: Blood pressure result recorded—type 2 diabetes	—	—
PI24: Blood pressure result of ≤140/90mmHg—type 2 diabetes	Target blood pressure value changed	Data from June 2021 on cannot be compared with previous periods
PI05: HbA1c result recorded (previous 6 months)—type 2 diabetes	—	—

Measure	Summary of change to indicator specification(a)	Impact of change to indicator specification
PI06: HbA1c result of ≤53 mmol/mol—type 2 diabetes	—	—
PI18: Kidney function test recorded—type 2 diabetes	—	—
PI19-A: Kidney test, eGFR result of ≥60 mL/min/1.73 m2—type 2 diabetes	—	—
PI19-B: Kidney test, ACR result of <2.5 (Males) or <3.5 (Females)—type 2 diabetes	—	—
PI18: Kidney function test recorded—CVD	—	—
PI19-A: Kidney test, eGFR result of ≥60 mL/min/1.73 m2—CVD	—	—
PI15: Immunised against influenza—type 2 diabetes	—	—
PI15: Immunised against influenza—COPD	—	—

(a) See Interpreting nKPI data for more information on changes to indicator specifications.

Note: See Technical notes and Impact of COVID-19 for information on interpreting data over time.

Table 2: Selected measures: trends

Maternal and child health indicators

Measure	June 2017	June 2018	June 2019	June 2020	June 2021	Trend
PI13: First antenatal visit before 14 weeks(b)	*Previously first antenatal visit before 13 weeks*				46.3	Not calculated
PI01: Birthweight recorded(b)	69.5	73.7	71.1	77.9	78.8	√
PI02: Low birthweight(b)	11.4	13.2	11.6	11.1	11.9	√
PI11: Smoking during pregnancy—current smoker(b)	*Previously ages 15 and over*				45.5	Not calculated
PI03: Indigenous health assessment—aged 0–14(b)	*Previously ages 0–4*				36.6	Not calculated

Preventative health indicators

Measure	June 2017	June 2018	June 2019	June 2020	June 2021	Trend
PI09: Smoking status recorded(b)	*Previously ages 15 and over*				72.5	Not calculated

Measure	June 2017	June 2018	June 2019	June 2020	June 2021	Trend
PI10: Current smoker[(b)]	*Previously ages 15 and over*				47.3	Not calculated
PI16: Alcohol consumption status recorded	59.4	61.7	62.0	61.5	61.9	√
PI17: AUDIT-C—result of high-risk	49.0	47.9	48.9	45.8	45.1	√
PI03: Indigenous health assessment—aged 15 and over[(b)]	*Previously ages 25 and over*				52.0	Not calculated
PI20: Risk factors to enable CVD assessment	46.1	48.7	50.3	49.9	50.2	√
PI21: High absolute cardiovascular risk	35.6	34.7	35.1	34.3	34.1	√
PI22: Cervical screening[(b)]	43.9	46.7	42.5	42.4	40.3	×
PI14: Immunised against influenza[(b)]	*Previously ages 50 and over*				19.0	Not calculated
PI12: BMI classified as overweight or obese	71.0	70.8	71.2	72.3	73.5	×

Chronic disease management indicators

Measure	June 2017	June 2018	June 2019	June 2020	June 2021	Trend
PI07: Chronic Disease Management Plan—type 2 diabetes(b)	53.6	56.2	56.1	54.8	55.2	√
PI23: Blood pressure result recorded—type 2 diabetes	64.0	66.2	66.8	63.7	64.5	≈
PI24: Blood pressure result of ≤140/90mmHg—type 2 diabetes(b)	*Previously ≤130/90mmHg*				65.4	Not calculated
PI05: HbA1c result recorded (previous 6 months)—type 2 diabetes	48.9	52.0	52.2	49.8	49.9	≈
PI06: HbA1c result of ≤53 mmol/mol—type 2 diabetes	38.3	38.9	38.6	36.4	37.3	×
PI18: Kidney function test recorded—type 2 diabetes	n.a.	62.0	64.0	63.1	63.1	√

Measure	June 2017	June 2018	June 2019	June 2020	June 2021	Trend
PI19-A: Kidney test, eGFR result of ≥60 mL/min/1.73 m2—type 2 diabetes	n.a.	81.9	81.3	80.2	80.1	×
PI19-B: Kidney test, ACR result of <2.5 (Males) or <3.5 (Females)—type 2 diabetes	n.a.	41.2	43.7	43.6	42.7	√
PI18: Kidney function test recorded—CVD	n.a.	58.9	62.0	62.3	61.6	√
PI19-A: Kidney test, eGFR result of ≥60 mL/min/1.73 m2—CVD	n.a.	76.2	77.3	76.6	76.8	√
PI15: Immunised against influenza—type 2 diabetes	30.6	33.8	36.0	38.7	23.2	×
PI15: Immunised against influenza—COPD	31.9	37.2	38.1	41.6	27.3	×

(a) Unlike in previous periods, 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.

(b) There have been changes to the specification of this indicator over time. See Table 1 and Technical notes for more information.

Notes:

1. Key: ✓ = improved; × = not improved; ≈ = little or no change.

2. Trend is calculated as a linear trend between the June 2017 and June 2021 reporting periods, including the December reporting periods. December data points are not shown in this table but are available in the Data tables accompanying this report.

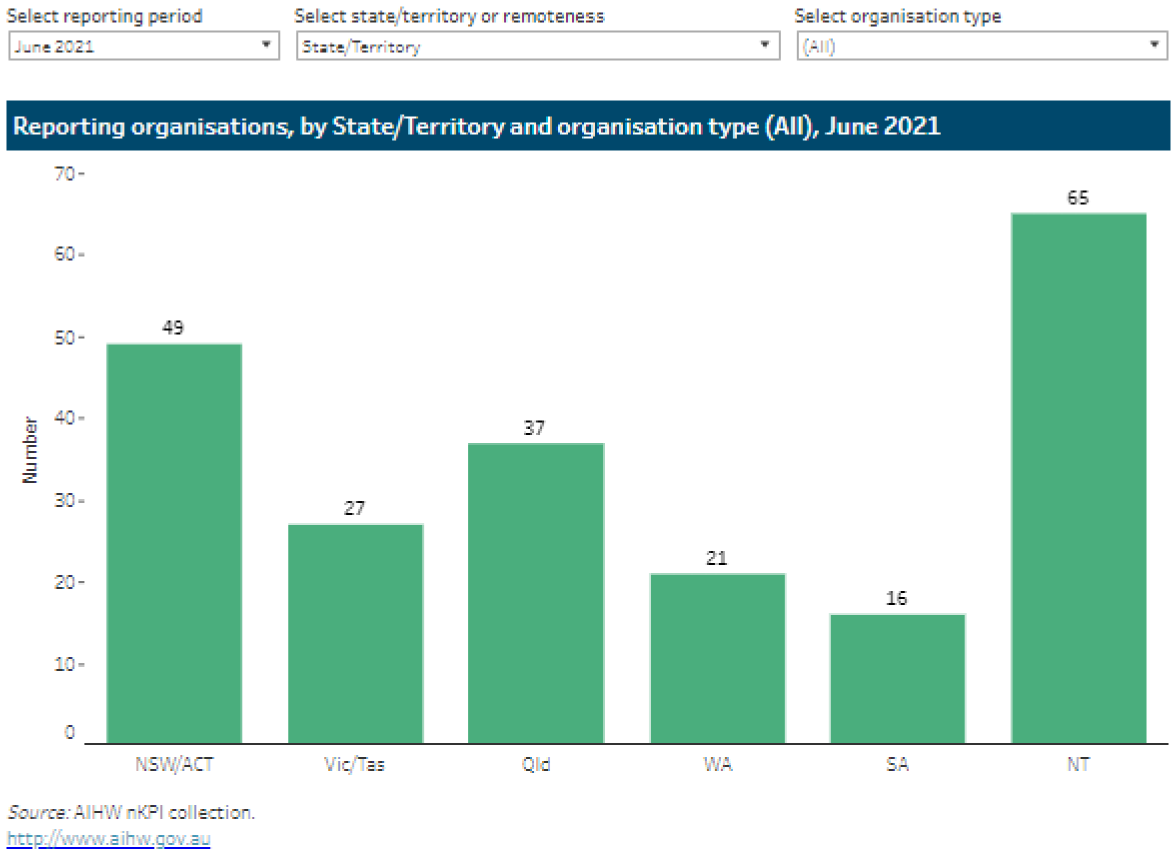
3. See Technical notes and Impact of COVID-19 for information on interpreting data over time.

Source: AIHW analysis of nKPI collection.

nKPI—organisations

At June 2021, 215 organisations reported to the national Key Performance Indicators (nKPI) collection. Of these:

- around one-third (30% or 65) were in the Northern Territory
- over one-third (34% or 73) were in *Very remote* areas
- 61% (or 131) were Aboriginal Community Controlled Health Organisations (ACCHOs), of which:
  - 26% were in Queensland, 25% were in New South Wales/the Australian Capital Territory (combined), 18% were in Victoria/Tasmania (combined), 12% were in Western Australia, 11% were in the Northern Territory, and 8% were in South Australia
  - 26% were in *Inner regional* areas, 24% were in *Outer regional* areas, 21% were in *Very remote* areas, 16% were in *Remote* areas, and 13% were in *Major cities*
- 39% (or 84) were organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs), of which:
  - 60% were in the Northern Territory, 19% were in New South Wales/the Australian Capital Territory (combined), 7% were in South Australia, 6% were in Western Australia, 5% were in Victoria/Tasmania (combined), and 4% were in Queensland
  - 54% were in *Very remote* areas, 14% were in *Inner regional* areas, 12% were in *Outer regional* areas, 11% were in *Major cities*, and 10% were in *Remote* areas.



Select reporting period: June 2021

Select state/territory or remoteness: State/Territory

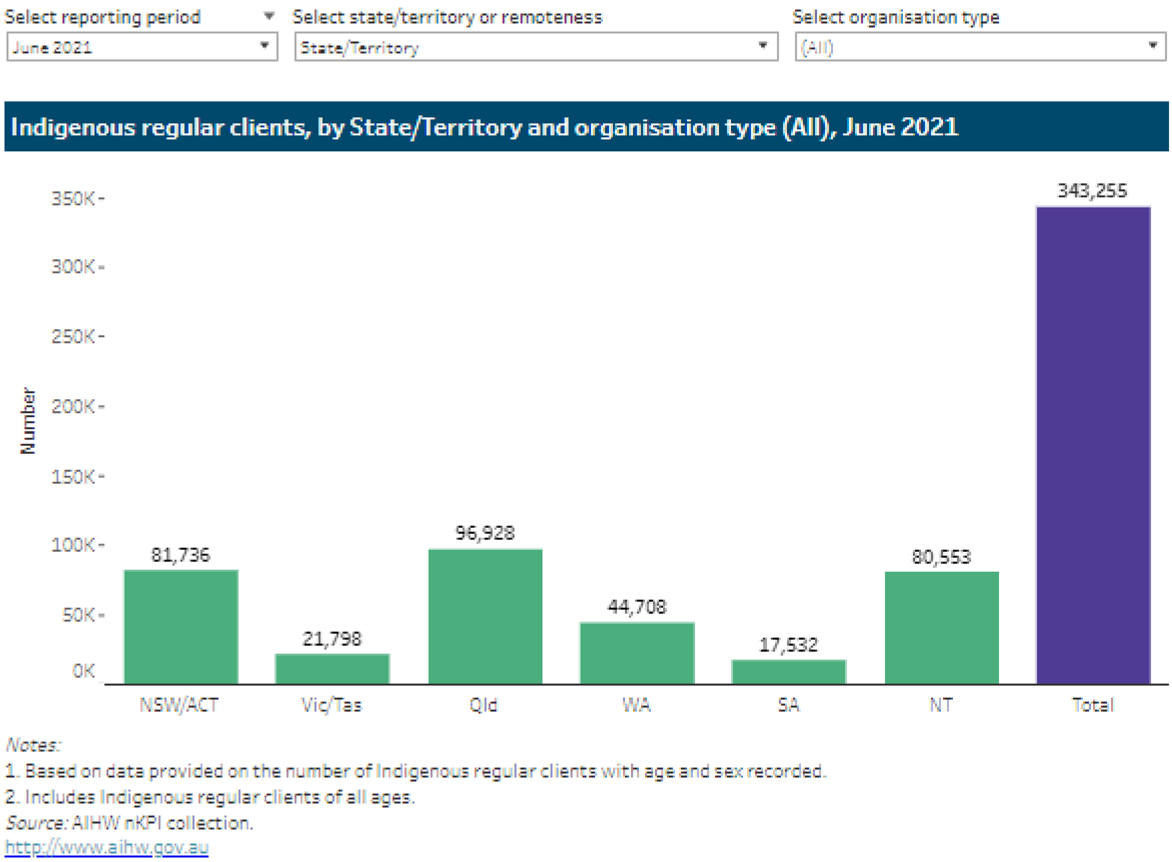
Select organisation type: (All)

Reporting organisations, by State/Territory and organisation type (All), June 2021

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

nKPI—clients

There were around 343,000 Indigenous regular clients at June 2021 (that is, Indigenous clients who had visited the organisation 3 or more times in the 2 years up to 30 June 2021). 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 2021

Select state/territory or remoteness: State/Territory

Select organisation type: (All)

Indigenous regular clients, by State/Territory and organisation type (All), June 2021

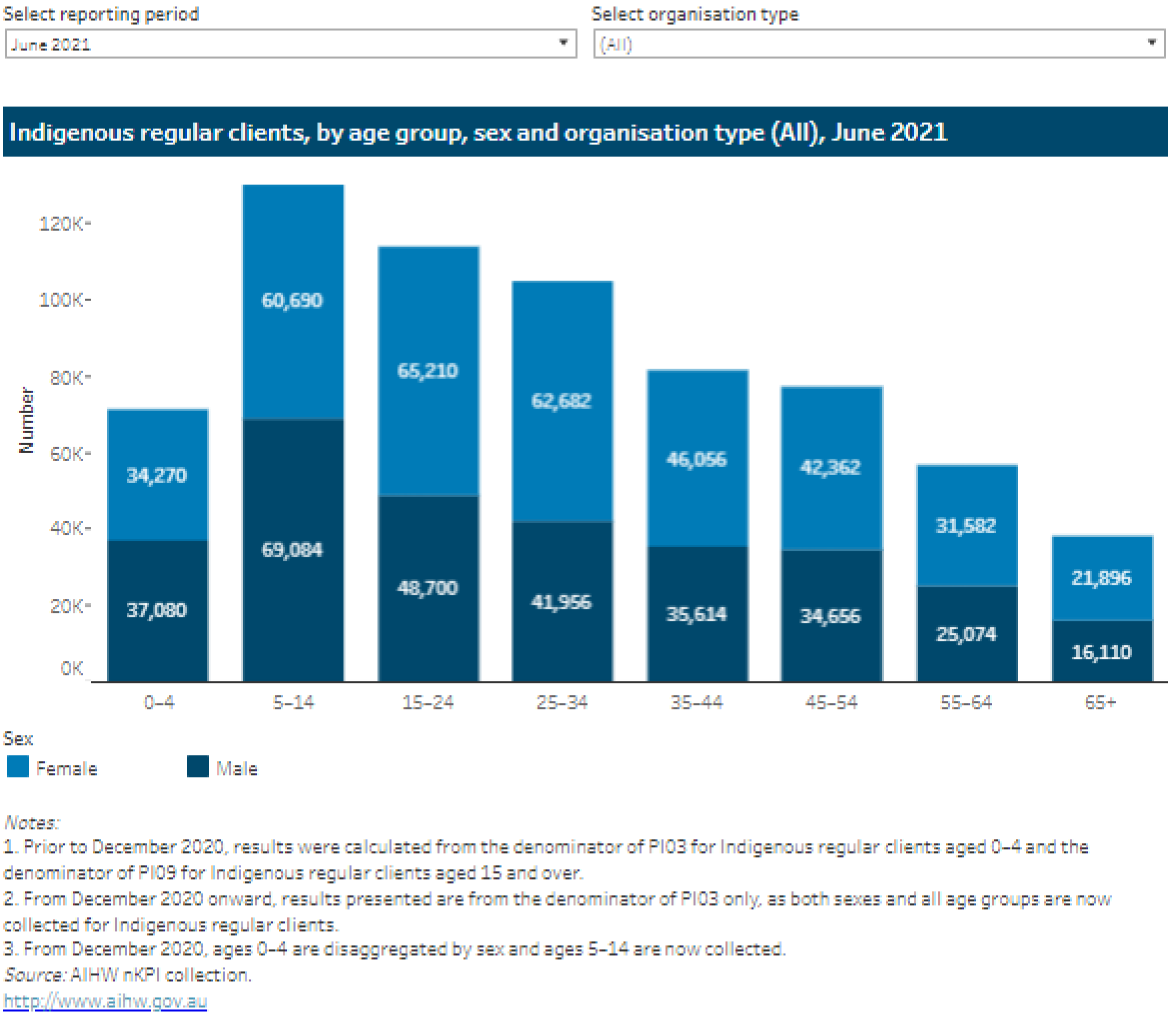
Notes:
1. Based on data provided on the number of Indigenous regular clients with age and sex recorded.
2. Includes Indigenous regular clients of all ages.

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

Of these:

- 28% (or around 96,900) were seen in Queensland
- 22% (or around 77,100) were seen in *Major cities*
- 83% (or around 283,300) were seen in Aboriginal Community Controlled Health Organisations (ACCHOs), of which:
  - 30% were seen in Queensland, 26% in New South Wales/the Australian Capital Territory (combined), 17% in the Northern Territory, 15% in Western Australia, 7% in Victoria/Tasmania (combined) and 6% in South Australia
  - 25% were seen in *Major cities*, 22% in *Outer regional* areas, 21% in *Inner regional* areas, 18% in *Remote* areas and 13% in *Very remote* areas
- 17% (or just under 60,000) were seen in organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs), of which:

- 56% were seen in the Northern Territory, 20% were seen in Queensland, 14% in New South Wales/the Australian Capital Territory (combined), 6% in Western Australia, 2% in South Australia and 2% in Victoria/Tasmania (combined)
- 58% were seen in *Very remote* areas, 13% in *Remote* areas, 13% in *Inner regional* areas, 9% in *Major cities* and 7% in *Outer regional* areas.



Select reporting period: June 2021

Select organisation type: (All)

Indigenous regular clients, by age group, sex and organisation type (All), June 2021

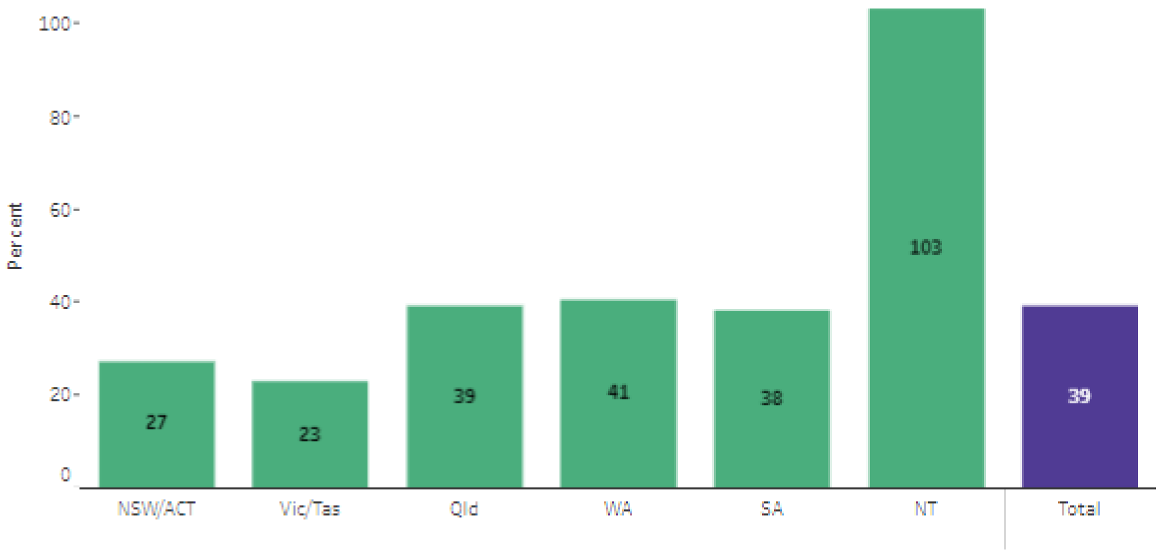
Notes:
1. Prior to December 2020, results were calculated from the denominator of PI03 for Indigenous regular clients aged 0–4 and the denominator of PI09 for Indigenous regular clients aged 15 and over.
2. From December 2020 onward, results presented are from the denominator of PI03 only, as both sexes 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 2021, 39% of the estimated resident Indigenous population were Indigenous regular clients of organisations reporting to the nKPI collection.

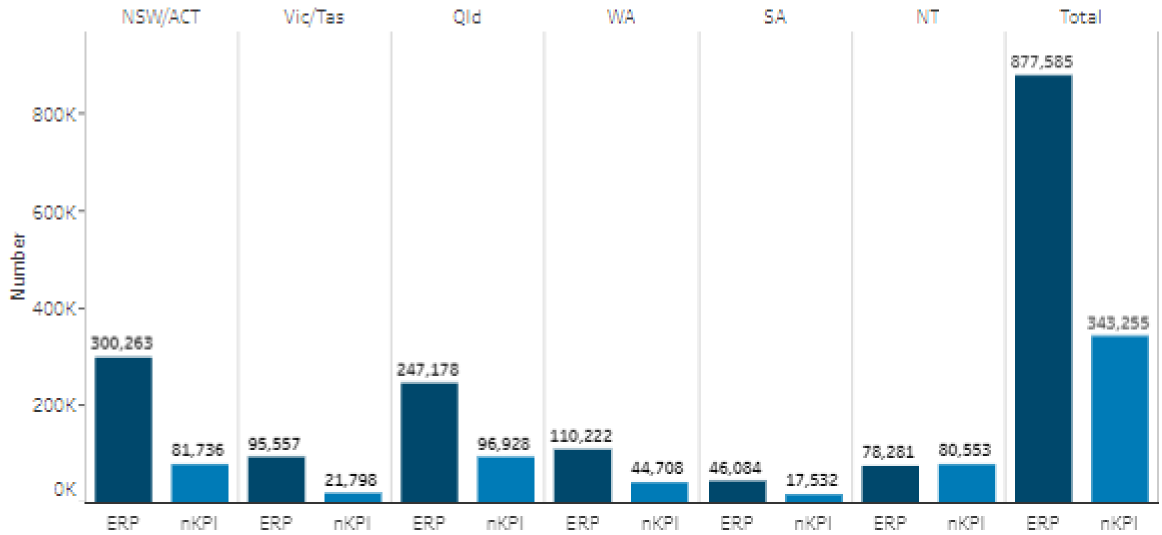
Indigenous regular clients as a proportion of the estimated resident Indigenous population, by State/Territory, June 2021



Note:
1. In some cases clients may be counted at more than one organisation. The number of clients may therefore be greater than the Indigenous ERP.
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 2021



Notes:

1. In some cases clients may be counted at more than one organisation. The number of clients may therefore be greater than the Indigenous ERP.
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

Maternal and child health indicators in the national Key Performance Indicators (nKPI) collection consist of 3 process-of-care and 2 health-status indicators.

The following boxes show key results for Indigenous regular clients at June 2021. Clicking on a box will go to more information on the associated indicator.

First antenatal visit

46%

who gave birth in the last year had their first antenatal visit before 14 weeks

Process-of-care indicator

Birthweight recorded

79%

born in the last year had their birthweight recorded

Process-of-care indicator

Birthweight result

86%

born in the last year had a normal birthweight

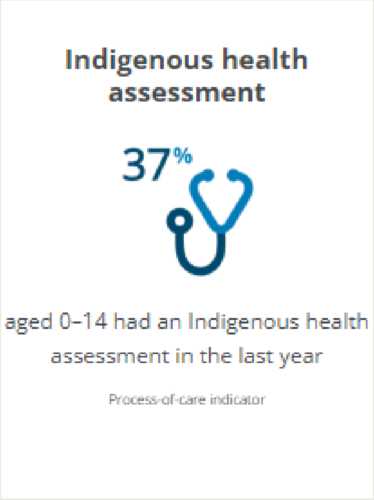
Health-status indicator

Smoking during pregnancy

46%

who gave birth in the last year were a current smoker in that time

Health-status indicator



Indigenous health assessment

37%

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 within the following periods:

- before 11 weeks
- 11–13 weeks
- 14–19 weeks
- 20 or more weeks
- not recorded or no visit.

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.

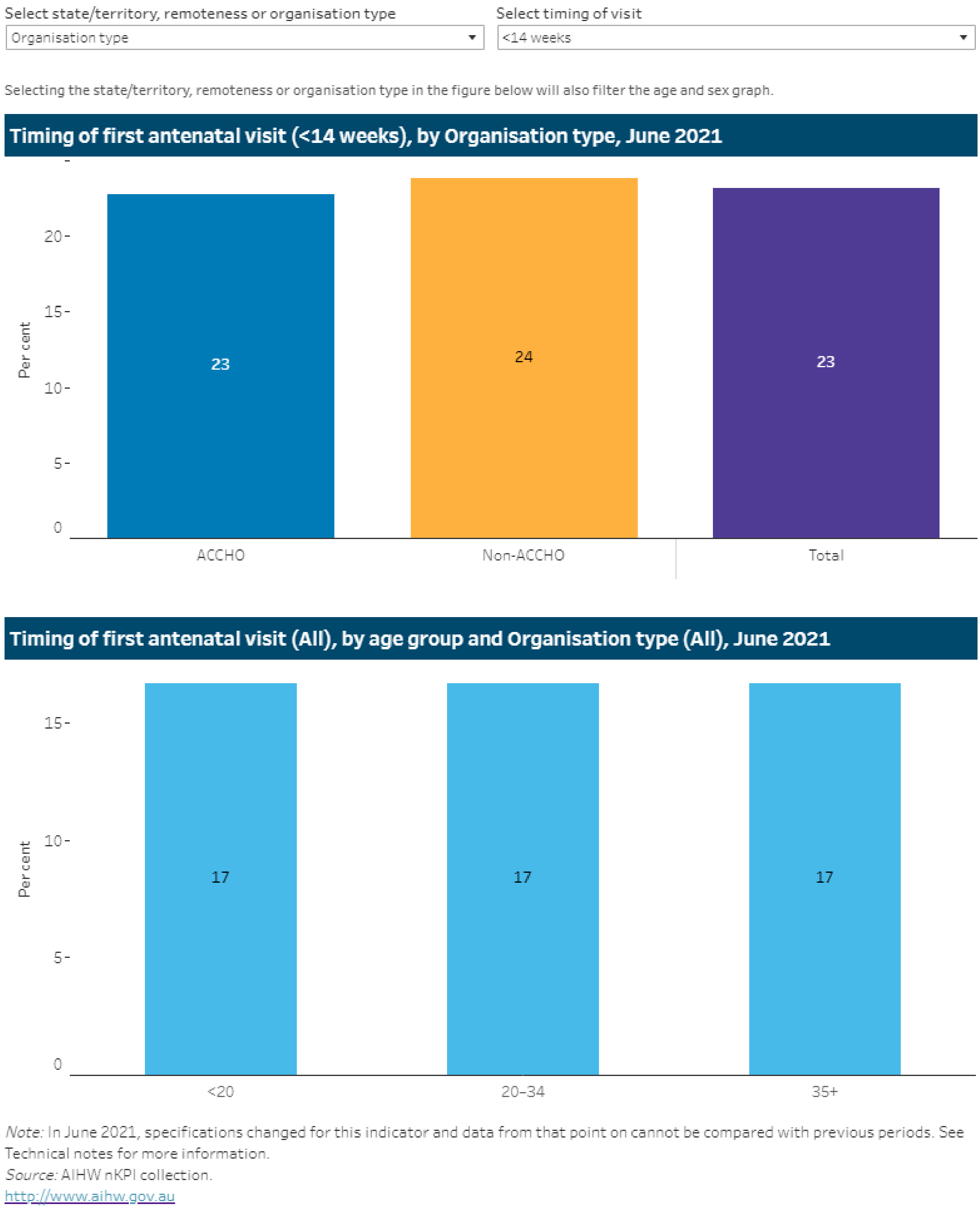
The proportion of Indigenous mothers attending an antenatal visit in the first trimester has increased over time. Indigenous mothers, however, are less likely than non-Indigenous mothers to have their first antenatal care visit in the first trimester (AIHW 2021).

At June 2021, 46% of female Indigenous regular clients who gave birth in the previous 12 months had their first antenatal visit in the first trimester (before 14 weeks gestational age).

Having the first antenatal visit in the first trimester was highest in:

- New South Wales/the Australian Capital Territory (combined) (54%)
- *Inner regional* areas (60%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (48%).

This indicator, however, is affected by the completeness of the recording of antenatal visits in each jurisdiction (see Technical notes for more information).



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

Select timing of visit: <14 weeks

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

Timing of first antenatal visit (<14 weeks), by Organisation type, June 2021

Timing of first antenatal visit (All), by age group and Organisation type (All), June 2021

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) (2021) Australia's mothers and babies—data visualisations, Cat. no. PER 101, Canberra: AIHW.

Birthweight (PI01 and PI02)

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

- the proportion of Indigenous babies born within the previous 12 months whose birthweight was recorded
- the proportion of Indigenous babies born within the previous 12 months 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 2020, 2021). There has been little change in this in recent years.

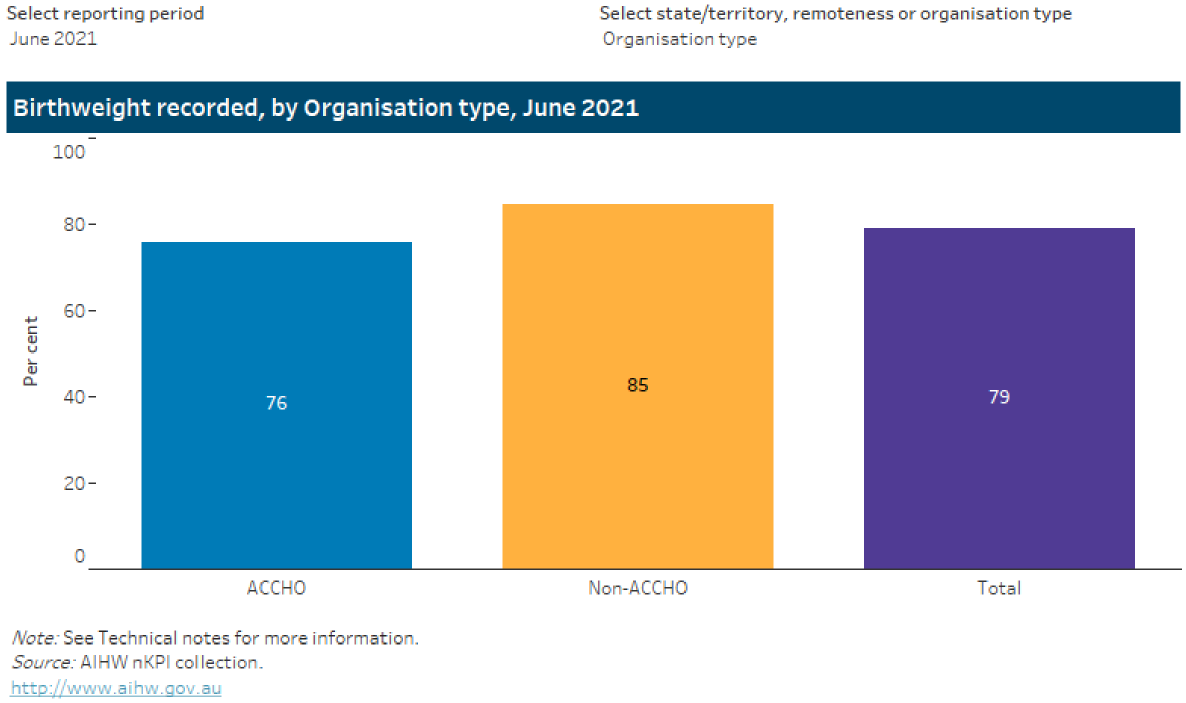
Birthweight recorded (PI01)

This indicator is the proportion of Indigenous babies born within the previous 12 months whose birthweight was recorded.

At June 2021, 79% of Indigenous babies born in the previous 12 months had their birthweight recorded.

Recording of birthweight was highest in:

- South Australia (86%)
- *Major cities* and *Inner regional* areas (both 88%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (85%).



Select reporting period
June 2021

Select state/territory, remoteness or organisation type
Organisation type

Birthweight recorded, by Organisation type, June 2021

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

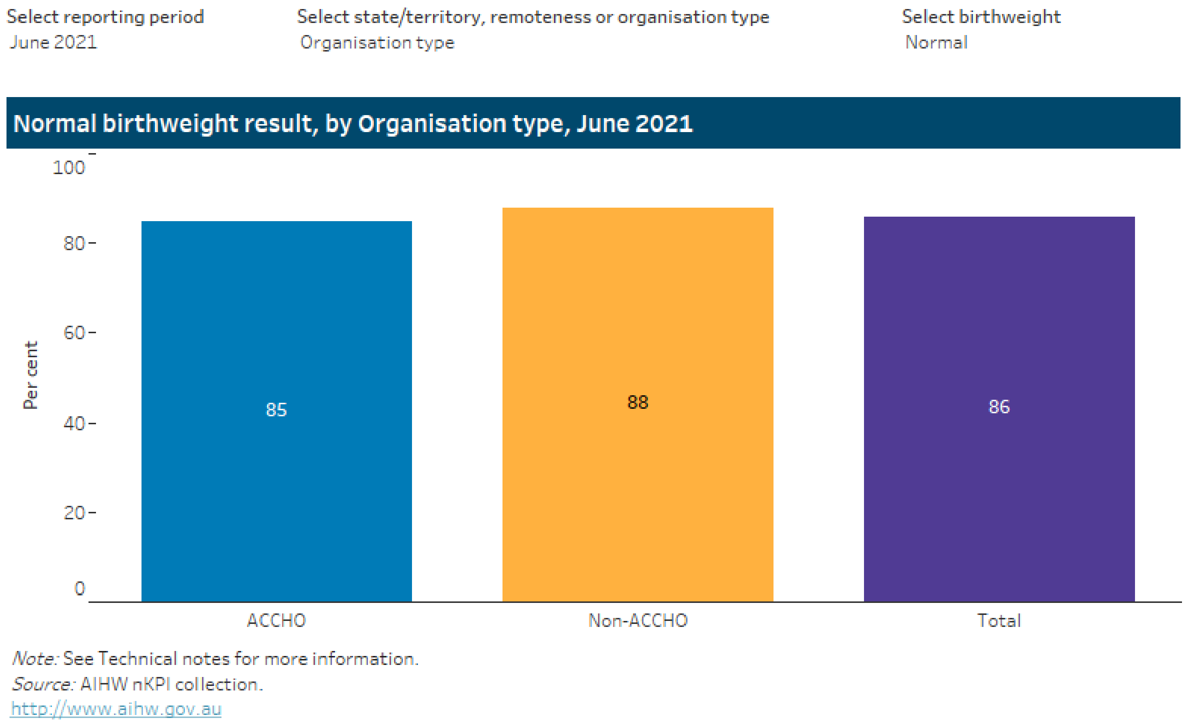
Birthweight result (PI02)

This indicator is the proportion of Indigenous babies born within the previous 12 months whose birthweight result was low, normal or high.

At June 2021, 86% of Indigenous babies born in the previous year had a normal birthweight.

Having a normal birthweight was highest in:

- Victoria/Tasmania (combined) (90%)
- *Major cities* (88%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (88%).



Select reporting period
June 2021

Select state/territory, remoteness or organisation type
Organisation type

Select birthweight
Normal

Normal birthweight result, by Organisation type, June 2021

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

References

AIHW (Australian Institute of Health and Welfare) (2020) Aboriginal and Torres Strait Islander Health Performance Framework: low birthweight, Canberra: AIHW.

AIHW (2021) Australia’s mothers and babies—data visualisations, Cat. no. PER 101, 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.

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 2021).

At June 2021, 46% of Indigenous regular clients who gave birth in the previous 12 months smoked at some point during pregnancy.

Smoking during pregnancy was lowest in:

- Victoria/Tasmania (combined) (36%)
- *Major cities* (35%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (40%).

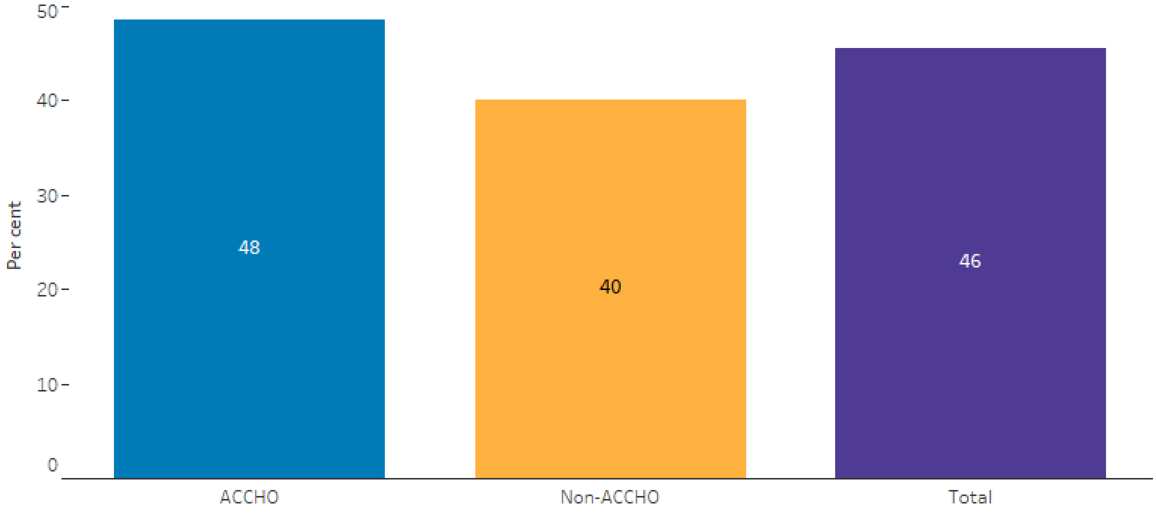
Select reporting period
June 2021

Select state/territory, remoteness or organisation type
Organisation type

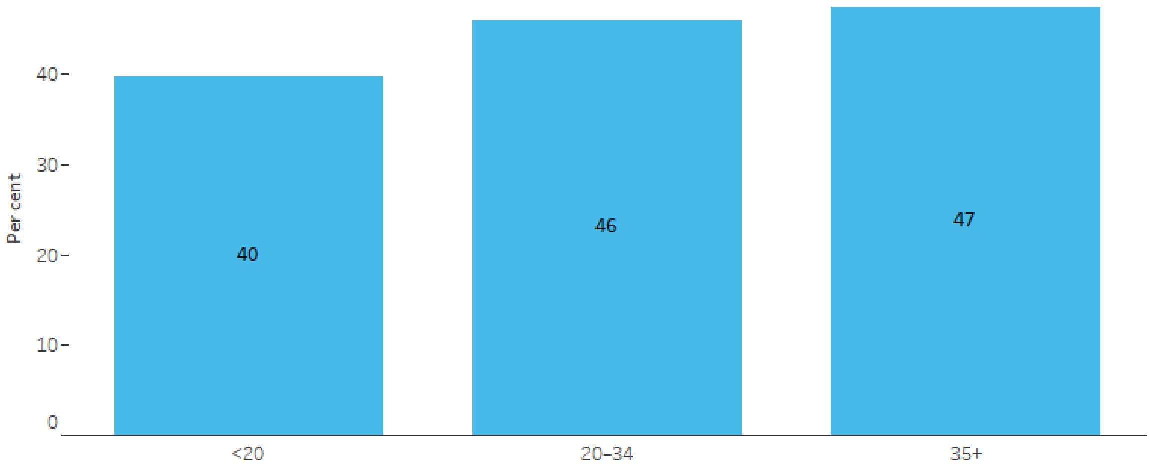
Select smoking status
Current smoker

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

Smoking during pregnancy, by smoking status (Current smoker) and Organisation type, June 2021



Smoking during pregnancy, by age group, smoking status (Current smoker) and Organisation type (All), June 2021



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

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

Reference

AIHW (Australian Institute of Health and Welfare) (2021) Australia's mothers and babies—data visualisations, Cat. no. PER 101, 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.

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

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

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 2021, 37% of Indigenous regular clients aged 0–14 had an Indigenous health assessment in the previous 12 months.

This was highest in:

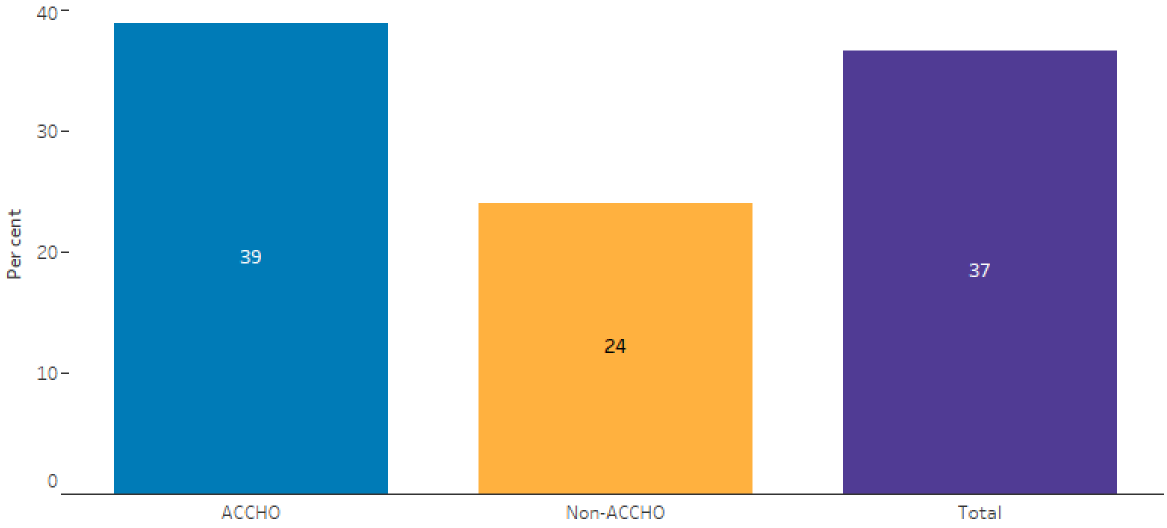
- Queensland (44%)
- *Major cities* (46%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (39%).

Select reporting period
June 2021

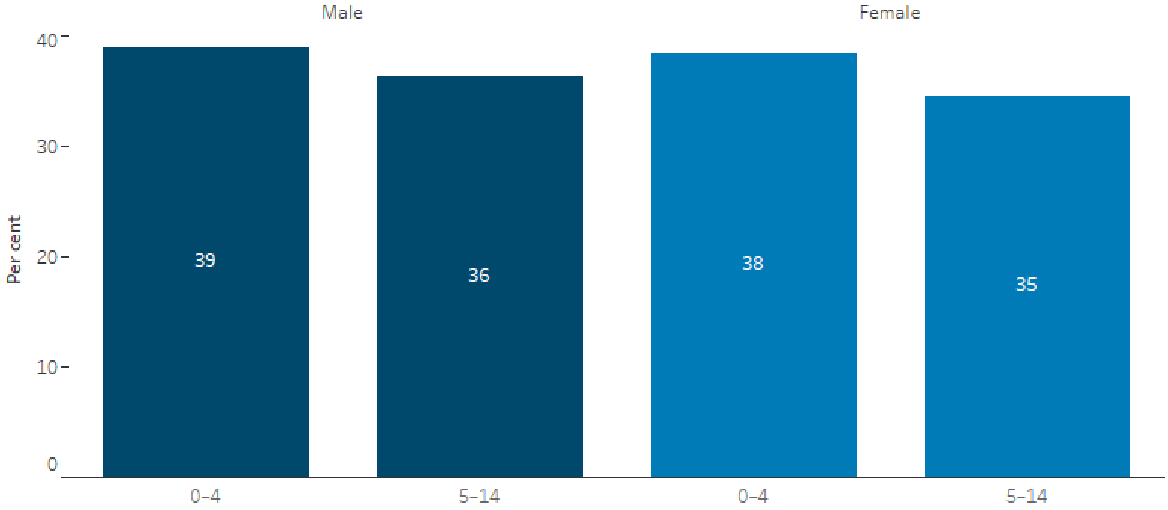
Select state/territory, remoteness or organisation type
Organisation type

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 2021



Indigenous health assessment—aged 0–14, by sex, age group and Organisation type (All), June 2021



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

Preventative health indicators in the national Key Performance Indicators (nKPI) collection consist of 6 process-of-care and 4 health-status indicators.

The following boxes show key results for Indigenous regular clients at June 2021. Clicking on a box will go to more information on the associated indicator.

Smoking status recorded

73%

had their smoking status recorded in the last year

Process-of-care indicator

Smoking status result

47%

were a current smoker in the last 2 years

Health-status indicator

Alcohol consumption recorded

62%

had their alcohol consumption status recorded in the last 2 years

Process-of-care indicator

AUDIT-C result

45%

had a high-risk AUDIT-C result in the last 2 years

Health-status indicator

Indigenous health assessment

52%

aged 15 and over had an Indigenous health assessment in the last 2 years

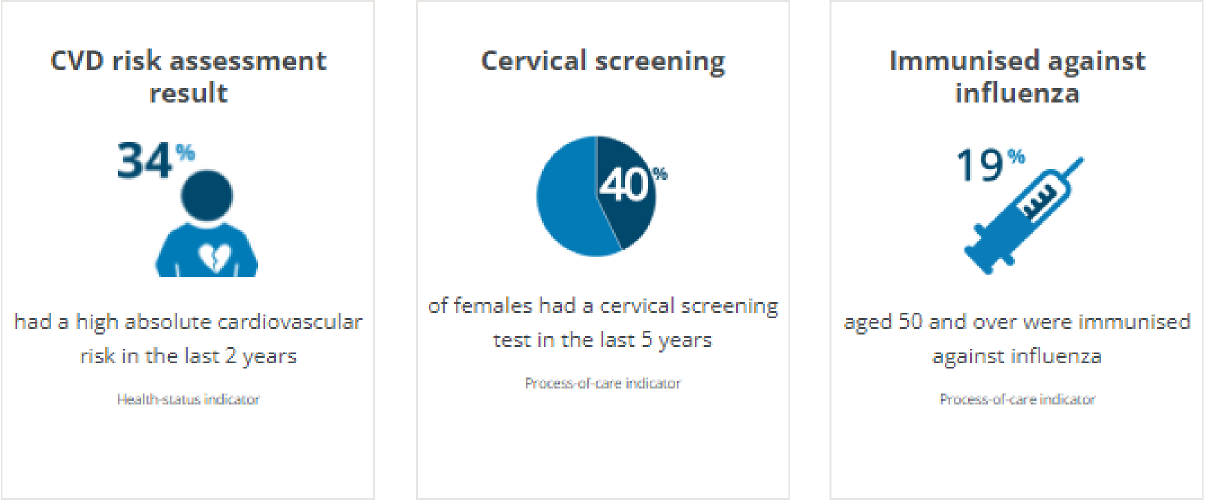
Process-of-care indicator

CVD risk assessment

50%

had risk factors recorded to enable CVD assessment

Process-of-care indicator



CVD risk assessment result

34%

had a high absolute cardiovascular risk in the last 2 years

Health-status indicator

Cervical screening

40%

of females had a cervical screening test in the last 5 years

Process-of-care indicator

Immunised against influenza

19%

aged 50 and over were immunised against influenza

Process-of-care indicator

BMI of overweight or obese

74%

had their BMI classified as overweight or obese 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:

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

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 2020).

Smoking status recorded (PI09)

This indicator is the proportion of Indigenous regular clients aged 11 and over whose smoking status was recorded within the previous 24 months.

It is collected for males and females in age groups:

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

At June 2021, 73% of Indigenous regular clients aged 11 and over had their smoking status recorded within the previous 24 months.

Recording of smoking status was highest in:

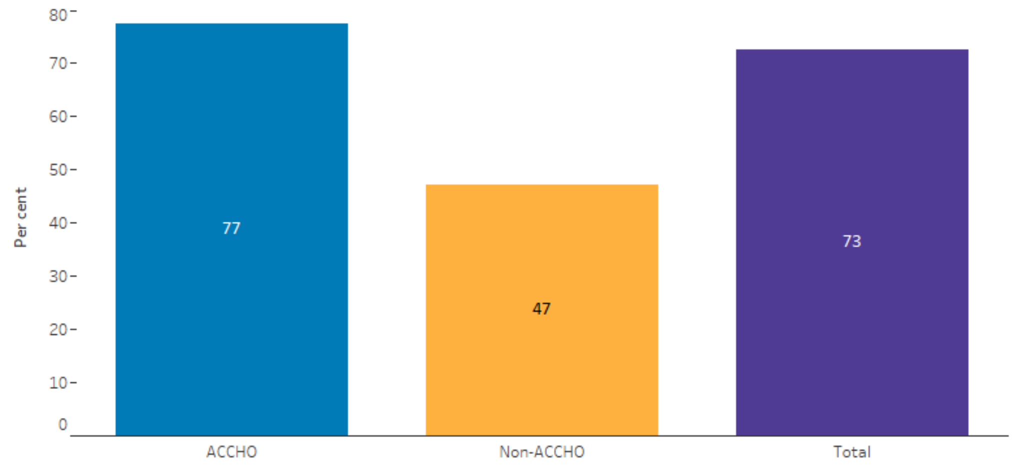
- New South Wales/the Australian Capital Territory (combined) (78%)
- *Inner regional* areas (80%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (77%).

Select reporting period
June 2021

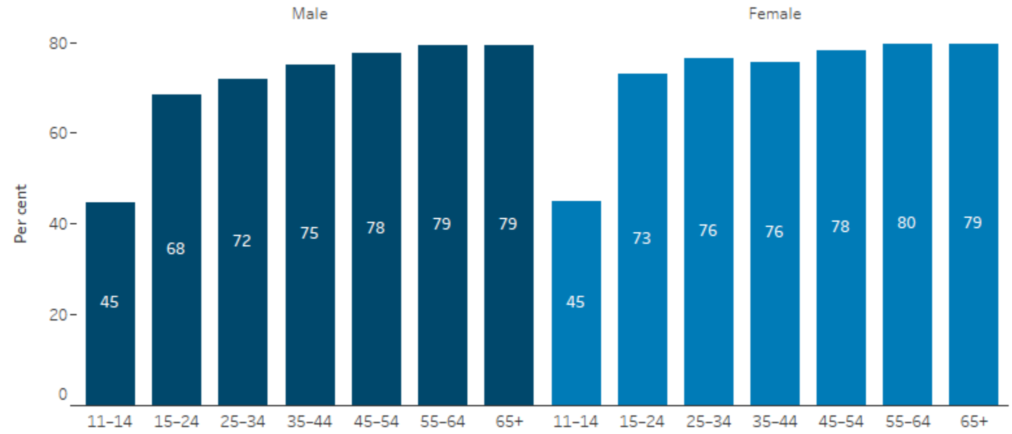
Select state/territory, remoteness or organisation type
Organisation type

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 2021



Smoking status recorded, by sex, age group and Organisation type (All), June 2021



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)

This indicator is the proportion of Indigenous regular clients aged 11 and over whose smoking status was recorded within the previous 24 months as:

- current smoker
- ex-smoker
- never smoked.

It is collected for males and females in age groups:

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

At June 2021, 47% of Indigenous regular clients aged 11 and over were current smokers, 38% had never smoked and 15% were ex-smokers.

Being a current smoker was lowest in:

- Queensland and New South Wales/the Australian Capital Territory (combined) (both 43%)
- *Inner regional* areas (42%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (47%).

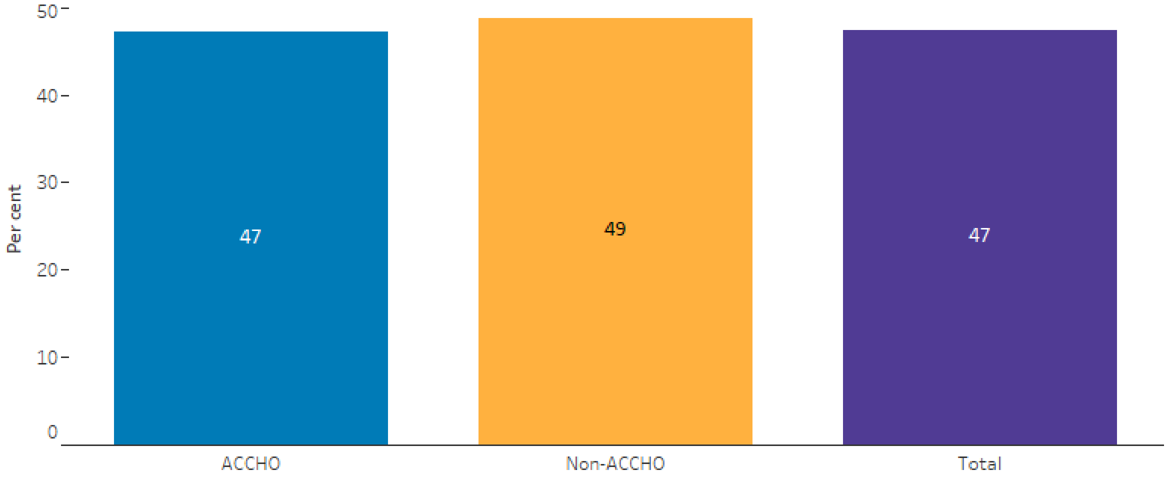
Select reporting period
June 2021

Select state/territory, remoteness or organisation type
Organisation type

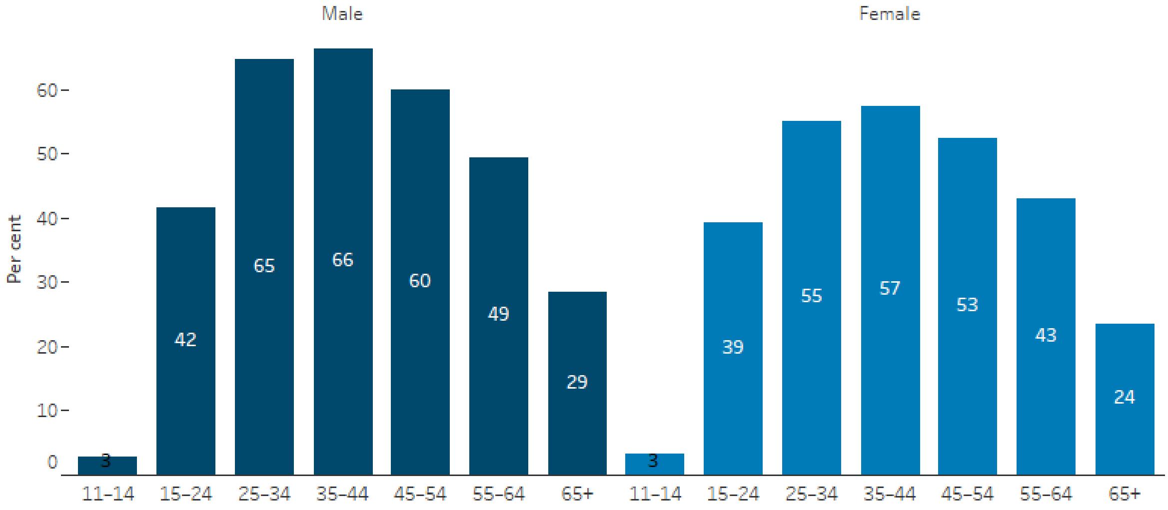
Select smoking status
Current smoker

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

Smoking status result, by smoking status (Current smoker) and Organisation type, June 2021



Smoking status result, by sex, age group, smoking status (Current smoker) and Organisation type (All), June 2021



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

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

Reference

AIHW (Australian Institute of Health and Welfare) (2020) 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:

- the proportion of Indigenous regular clients aged 15 and over who had their alcohol consumption status recorded within the previous 24 months
- 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)
  - low risk (less than 4 in males and 3 in females).

Why recording alcohol consumption and level 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.

AUDIT-C is a screening tool used to help identify hazardous drinking or active alcohol use disorders. It is scored on a scale of 0–12. Generally the higher the score, the more likely it is that the person's drinking is affecting their safety. A total score of 4 or more in males and 3 or more in females is considered to indicate an increased risk of hazardous or harmful drinking (RACGP 2015).

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 2020).

Alcohol consumption recorded (PI16)

This indicator is the proportion of Indigenous regular clients aged 15 and over who had their alcohol consumption status recorded 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.

At June 2021, 62% of Indigenous regular clients aged 15 and over had their alcohol consumption status recorded within the previous 24 months.

Recording of alcohol consumption was highest in:

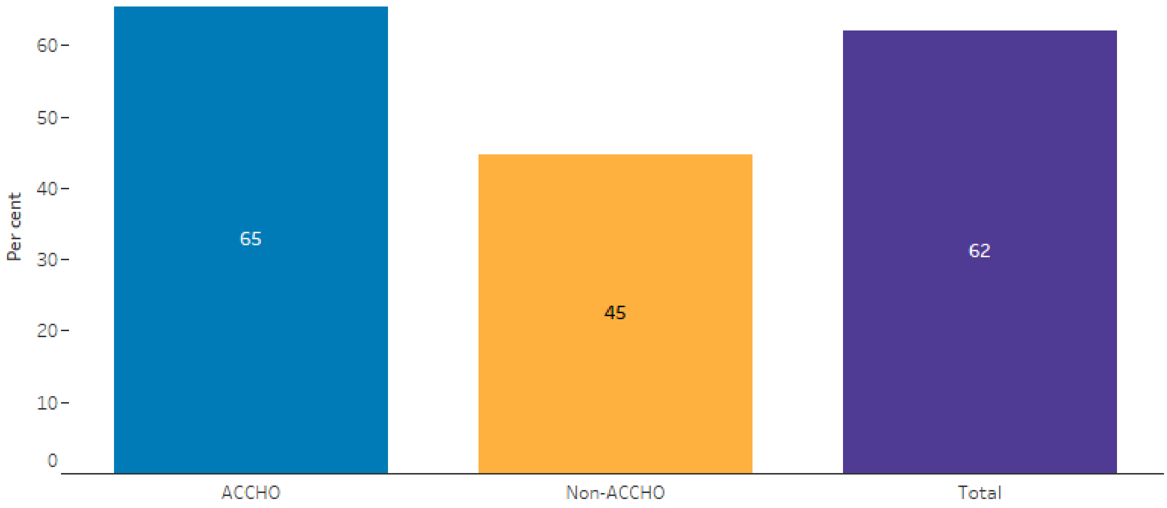
- Queensland and Western Australia (both 69%)
- *Major cities* (72%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (65%).

Select reporting period
June 2021

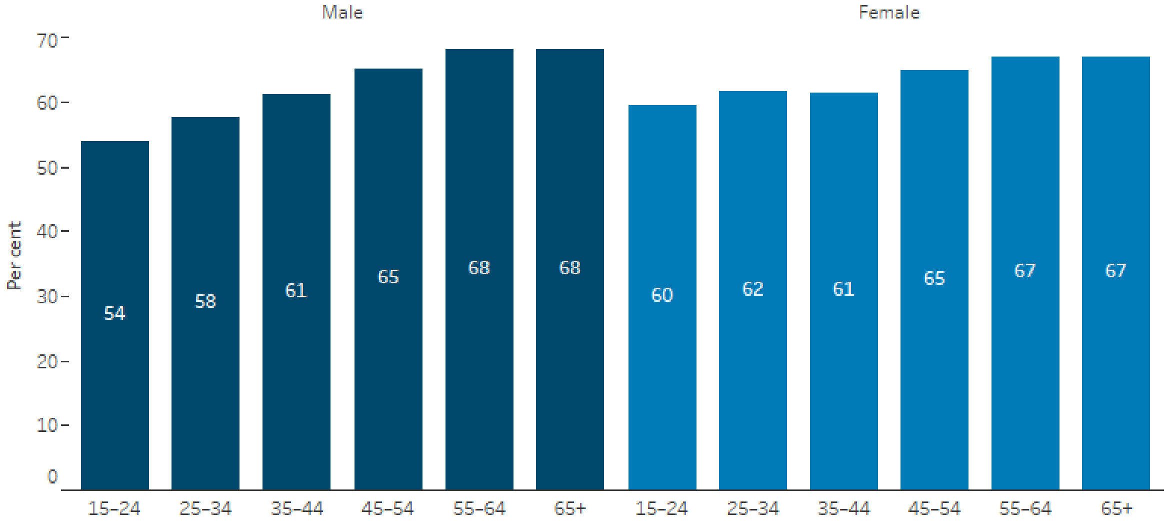
Select state/territory, remoteness or organisation type
Organisation type

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 2021



Alcohol consumption status recorded, by sex, age group and Organisation type (All), June 2021



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

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

AUDIT-C result (PI17)

This indicator is 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:

- high risk—4 or more in males and 3 or more in females
- low risk—less than 4 in males and less than 3 in females.

It is collected for males and females in age groups:

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

At June 2021:

- 55% of Indigenous regular clients aged 15 and over had an AUDIT-C result of low risk
- 45% had a result of high risk.

Having a low risk AUDIT-C result was highest in:

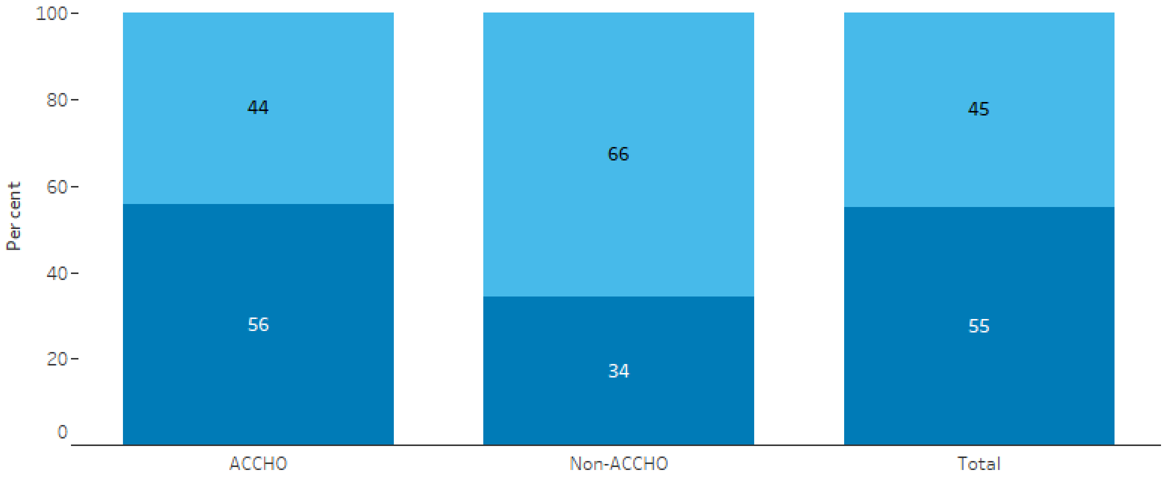
- Queensland (60%)
- *Major cities* (62%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (56%).

Select reporting period
June 2021

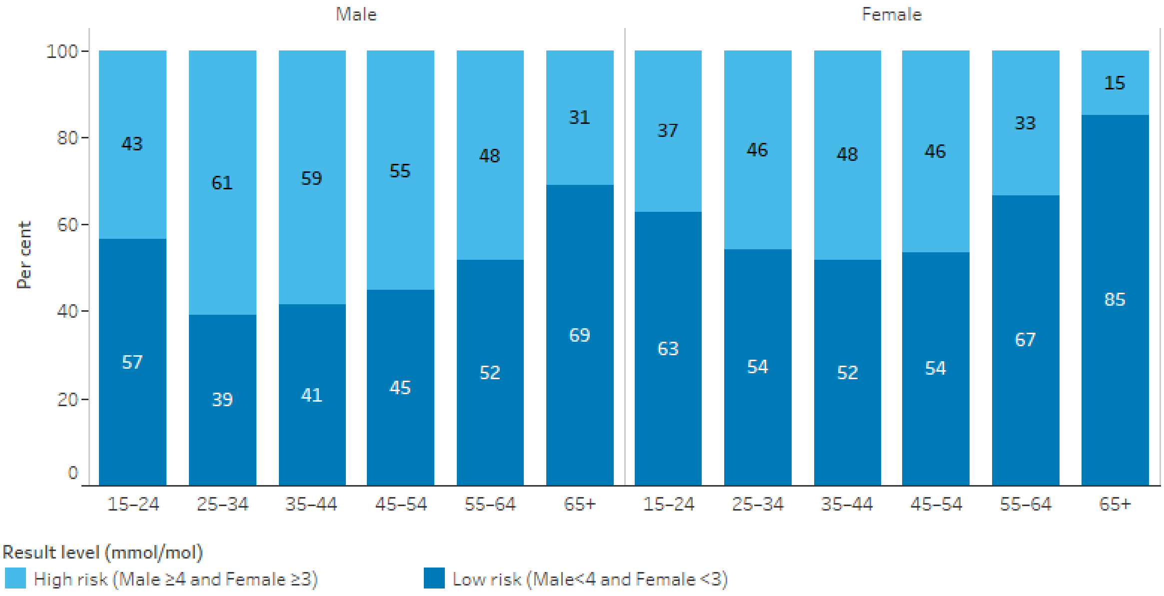
Select state/territory, remoteness or organisation type
Organisation type

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

AUDIT-C result, by AUDIT-C result and Organisation type, June 2021



AUDIT-C result, by sex, age group, AUDIT-C result (All) and Organisation type (All), June 2021



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

References

AIHW (Australian Institute of Health and Welfare) (2020) Aboriginal and Torres Strait Islander Health Performance Framework: risky alcohol consumption, Canberra: AIHW.

RACGP (The Royal Australian College of General Practitioners) (2015) Smoking, nutrition, alcohol, physical activity (SNAP): a population health guide to behavioural risk factors in general practice, 2nd edition, Melbourne: RACGP.

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.

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

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

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 2021, 52% of Indigenous regular clients aged 15 and over had an Indigenous health assessment completed within the previous 24 months.

This was highest in:

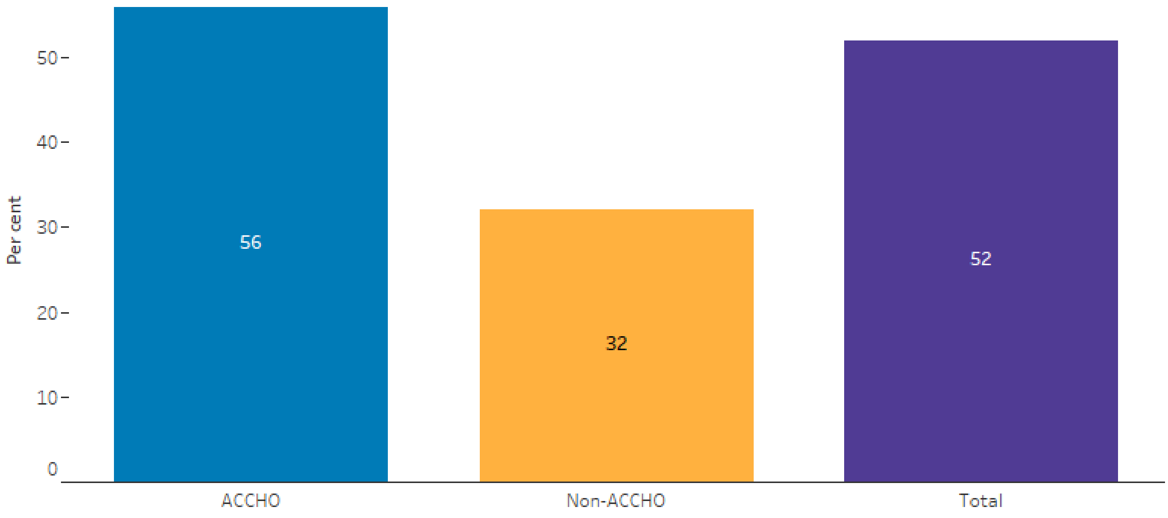
- Queensland (62%)
- *Major cities* (63%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (56%).

Select reporting period
June 2021

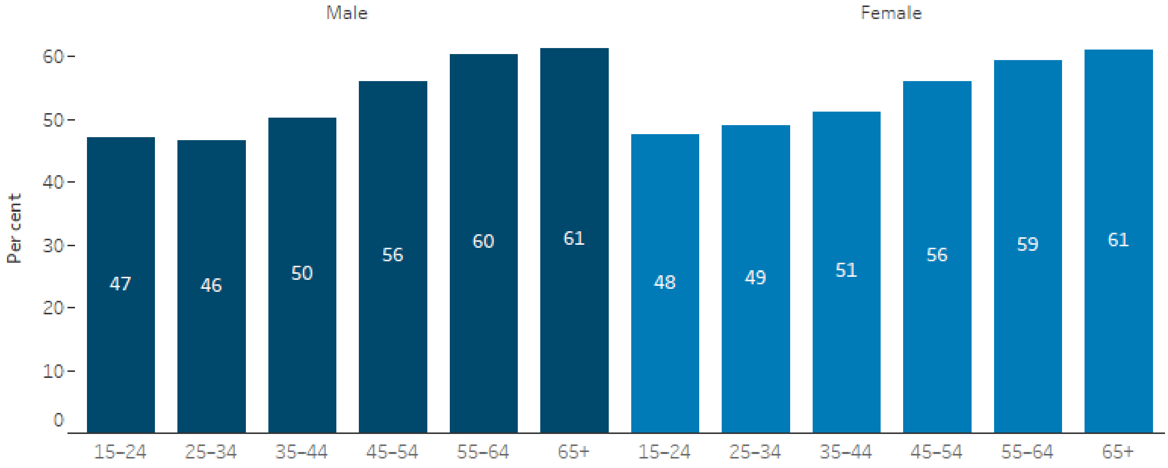
Select state/territory, remoteness or organisation type
Organisation type

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 2021



Indigenous health assessment—aged 15 and over, by sex, age group and Organisation type (All), June 2021



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 CVD risk assessment in the national Key Performance Indicators (nKPI) collection are:

- the proportion of Indigenous regular clients aged 35–74 with no known history of CVD who had information available to calculate their absolute CVD risk in the previous 24 months
- the proportion of Indigenous regular clients aged 35–74 with no known history of CVD who had an absolute CVD risk recorded as high, moderate or low in the previous 24 months.

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 2020).

Cardiovascular disease (CVD) risk assessment (PI20)

This indicator is the proportion of Indigenous regular clients aged 35–74 with no known history of CVD who had information available to calculate their absolute CVD risk in the previous 24 months.

It is collected for males and females in age groups:

- 35–44
- 45–54
- 55–64
- 65–74.

At June 2021, 50% of Indigenous regular clients aged 35–74 with no known history of CVD had information available to calculate their absolute CVD risk in the previous 24 months.

This was highest in:

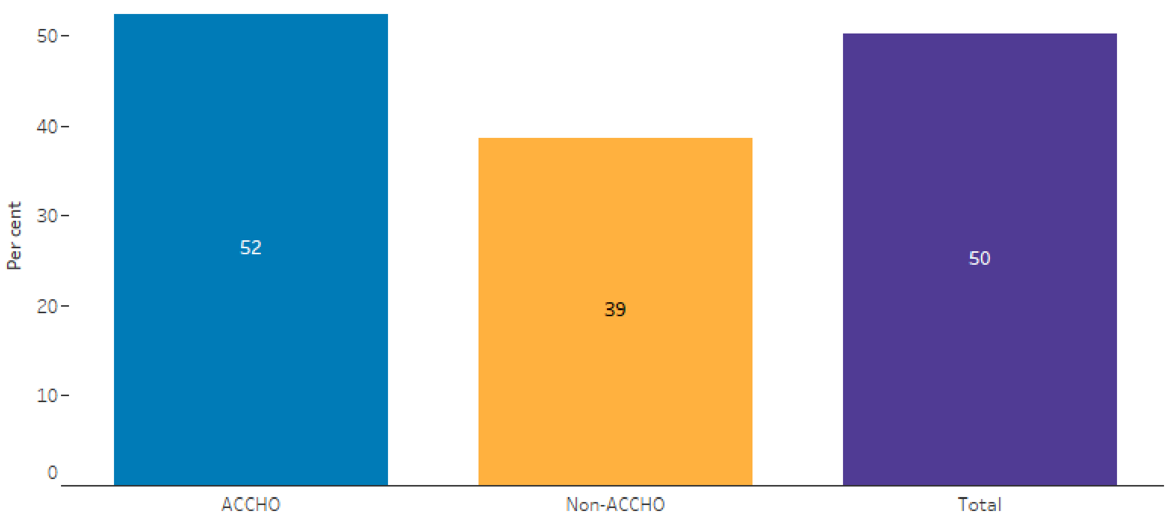
- Western Australia (57%)
- *Remote* areas (57%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (52%).

Select reporting period
June 2021

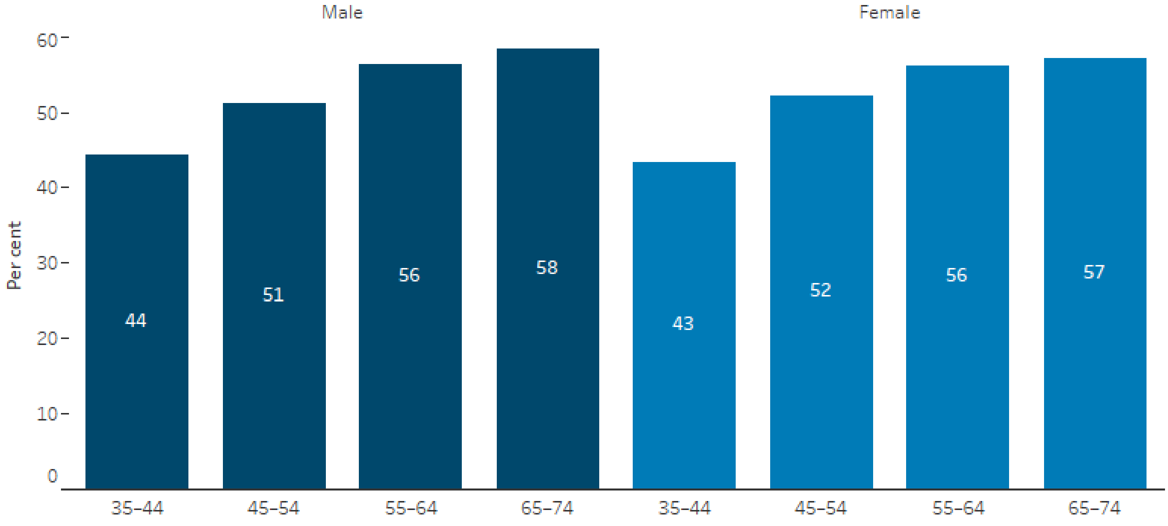
Select state/territory, remoteness or organisation type
Organisation type

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 2021



CVD risk assessment, by sex, age group and Organisation type (All), June 2021



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

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

Cardiovascular disease risk assessment result (PI21)

This indicator is the proportion 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 as:

- high—greater than 15% chance of a cardiovascular event in the next 5 years
- medium—10–15% chance of a cardiovascular event in the next 5 years
- low—less than 10% chance of a cardiovascular event in the next 5 years.

It is collected for males and females in age groups:

- 35–44
- 45–54
- 55–64
- 65–74.

At June 2021, 59% 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, 6% moderate, and 34% high.

Having a low absolute CVD risk was highest in:

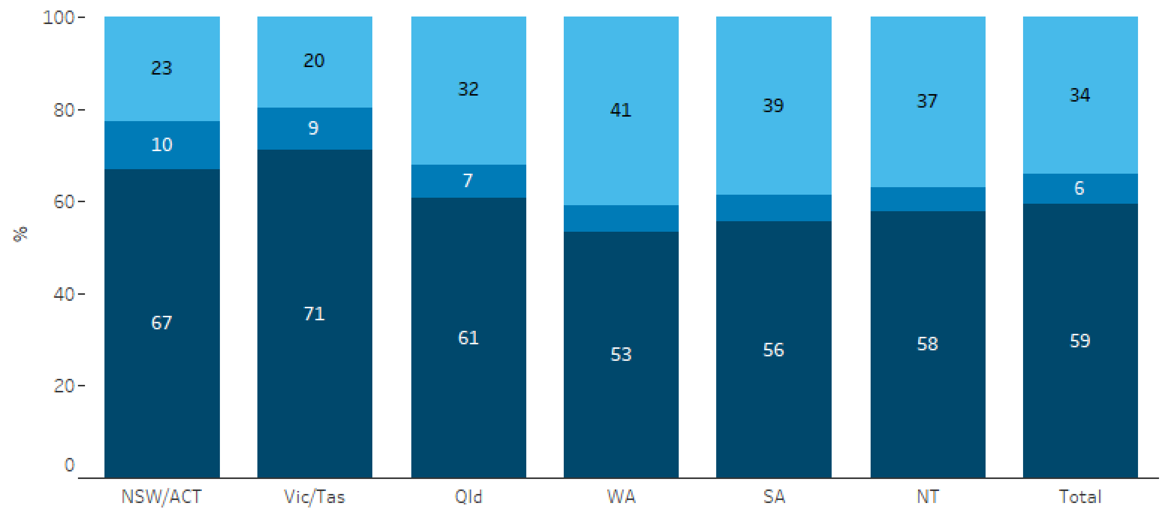
- Victoria/Tasmania (combined, 71%)
- *Inner regional* areas (68%).

Select reporting period
June 2021

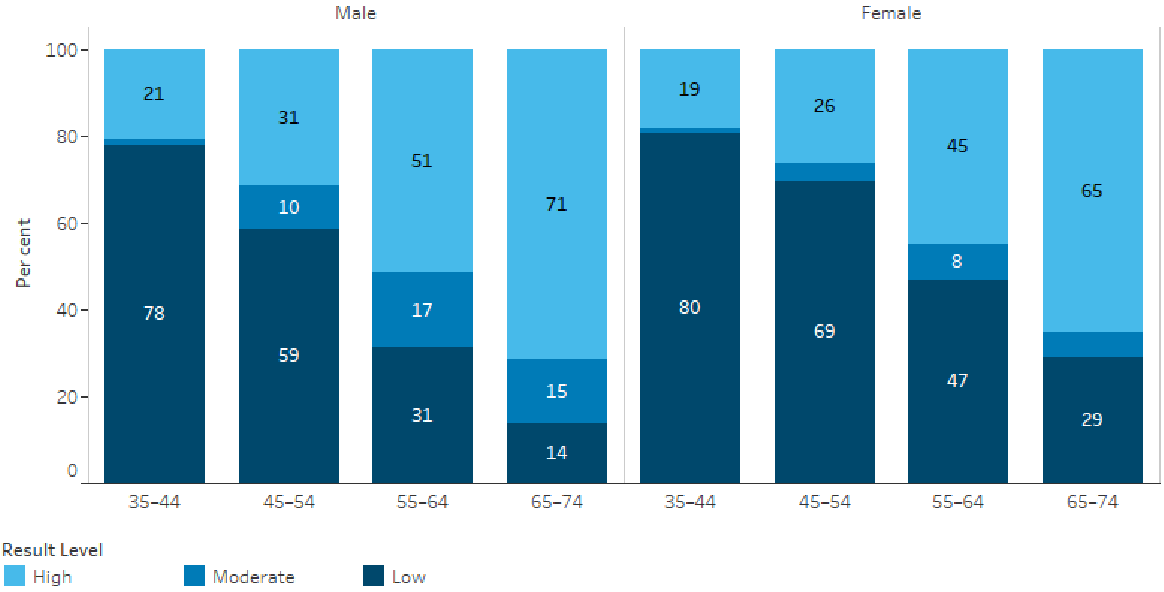
Select State/Territory, remoteness or organisation type
State/Territory

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

CVD risk assessment result, by State/Territory, June 2021



CVD risk assessment result (All), by sex, age group and State/Territory (All), June 2021



Note: Organisation type filter not available for data later than June 2019 due to data confidentialisation. See Technical notes for more infomation.
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 cervical screening 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 2019).

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 2021, 40% of female Indigenous regular clients aged 25–74 who have not had a hysterectomy had cervical screening within the previous 5 years.

This was highest in:

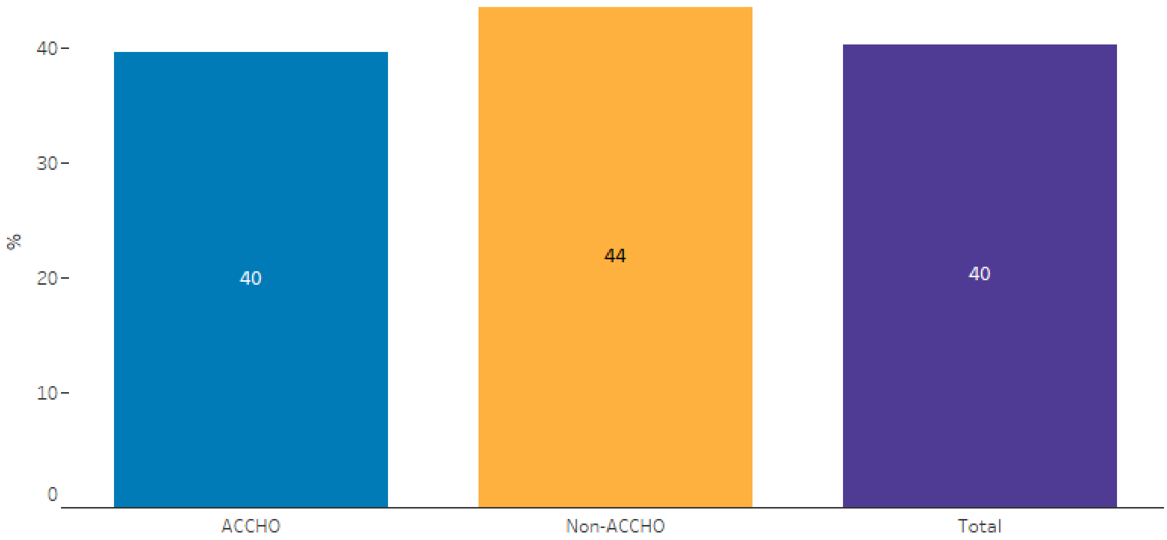
- the Northern Territory (50%)
- *Very remote* areas (47%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (44%).

Select reporting period
June 2021

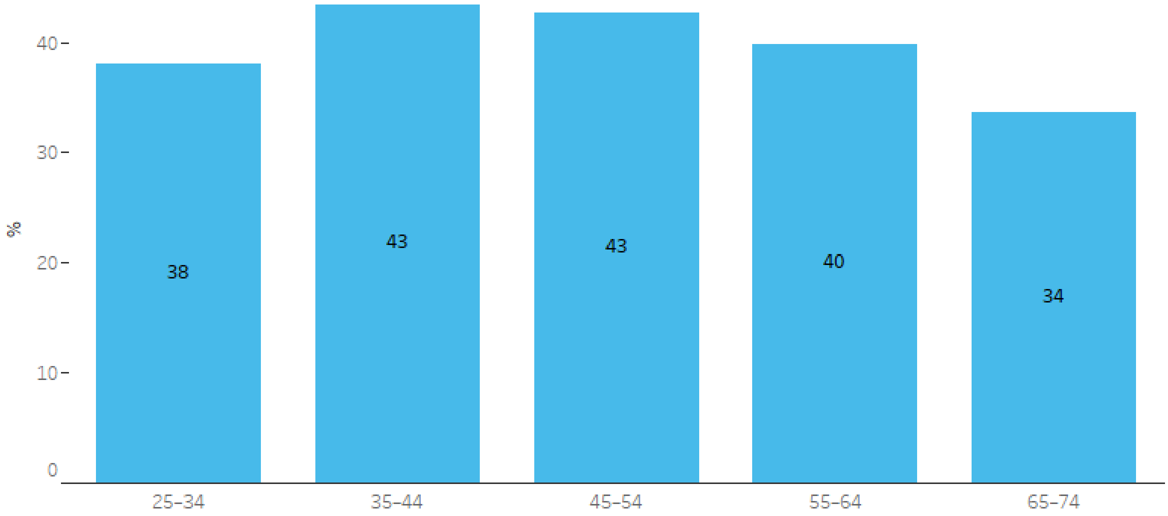
Select state/territory, remoteness or organisation type
Organisation type

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

Cervical screening within the last 5 years by Organisation type, June 2021



Cervical screening within the last 5 years by age and Organisation type (All), June 2021



Note:
Due to a change in indicator specifications, age data from December 2020 onwards only are available. See Technical notes for more information.

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

Reference

AIHW (Australian Institute of Health and Welfare) (2019) Cervical screening in Australia 2019, Cancer series no. 123, Cat. no. CAN 124, 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 had 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 2018).

At June 2021, 19% of Indigenous regular clients aged 6 months and over had an influenza immunisation within the previous 12 months.

At June 2021, there was a decrease in the proportion of clients receiving an influenza vaccination. Comments received by organisations who had a 20% or more decrease between December 2020 and June 2021 in the number of clients receiving an influenza vaccination provide some insight into the reasons for this. These include:

- COVID-19 restrictions and requirements reducing the number of clients attending the organisations overall, not only for influenza vaccination
- delivery of influenza vaccines to the organisations and then provision of influenza vaccines to clients being delayed because of the rollout and prioritisation of the COVID-19 vaccination program
- time interval required between COVID-19 and influenza vaccination
- clients being confused and hesitant about receiving vaccines, including influenza.

See also Impact of COVID-19.

Being immunised against influenza was highest in:

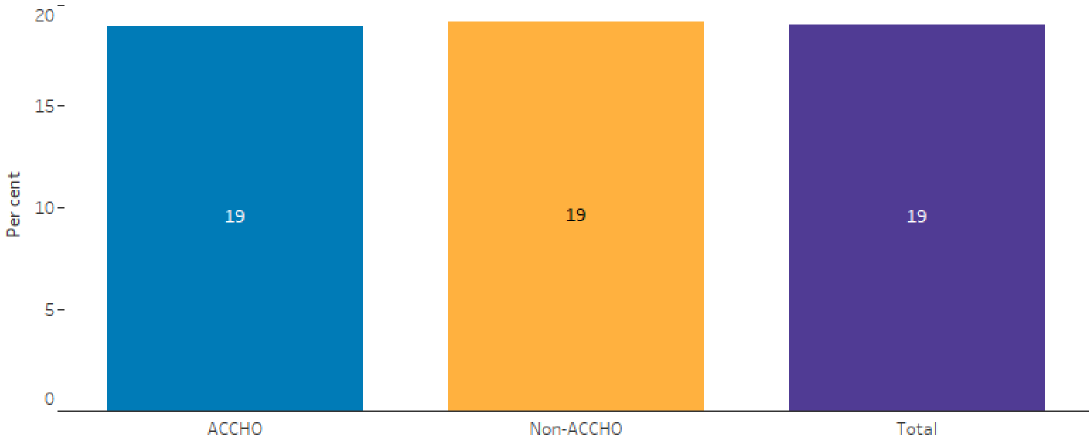
- the Northern Territory (25%)
- *Very remote* areas (22%).

Select reporting period
June 2021

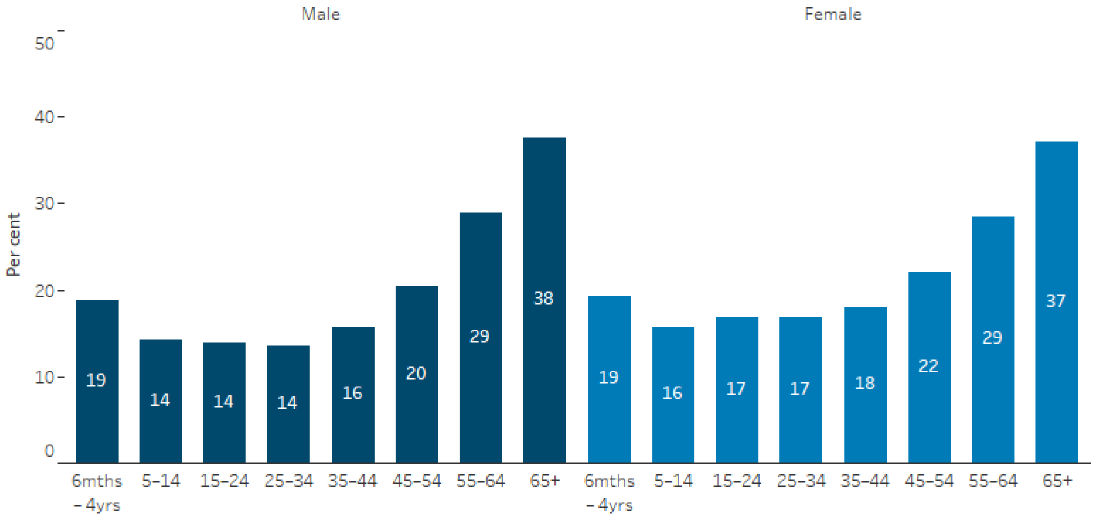
Select state/territory, remoteness or organisation type
Organisation type

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 2021



Influenza immunisation—aged 6 months and over, by sex, Organisation type (All), June 2021



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) 2018. Vaccine-preventable diseases fact sheets. Cat no. PHE 236. Canberra: AIHW.

Body Mass Index (BMI) classified as overweight or obese (PI12)

This indicator is the proportion of Indigenous regular clients aged 25 and over who had their Body Mass Index (BMI) classified as overweight or obese within the previous 24 months.

It is collected for males and females in age groups:

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

Why not being overweight or obese is important

Excess weight is a major risk factor for many diseases, such as cardiovascular disease, type 2 diabetes, some musculoskeletal conditions and some cancers. As the level of excess weight increases, so does the risk of developing these conditions. In addition, being overweight or obese can hamper the ability to control or manage chronic conditions.

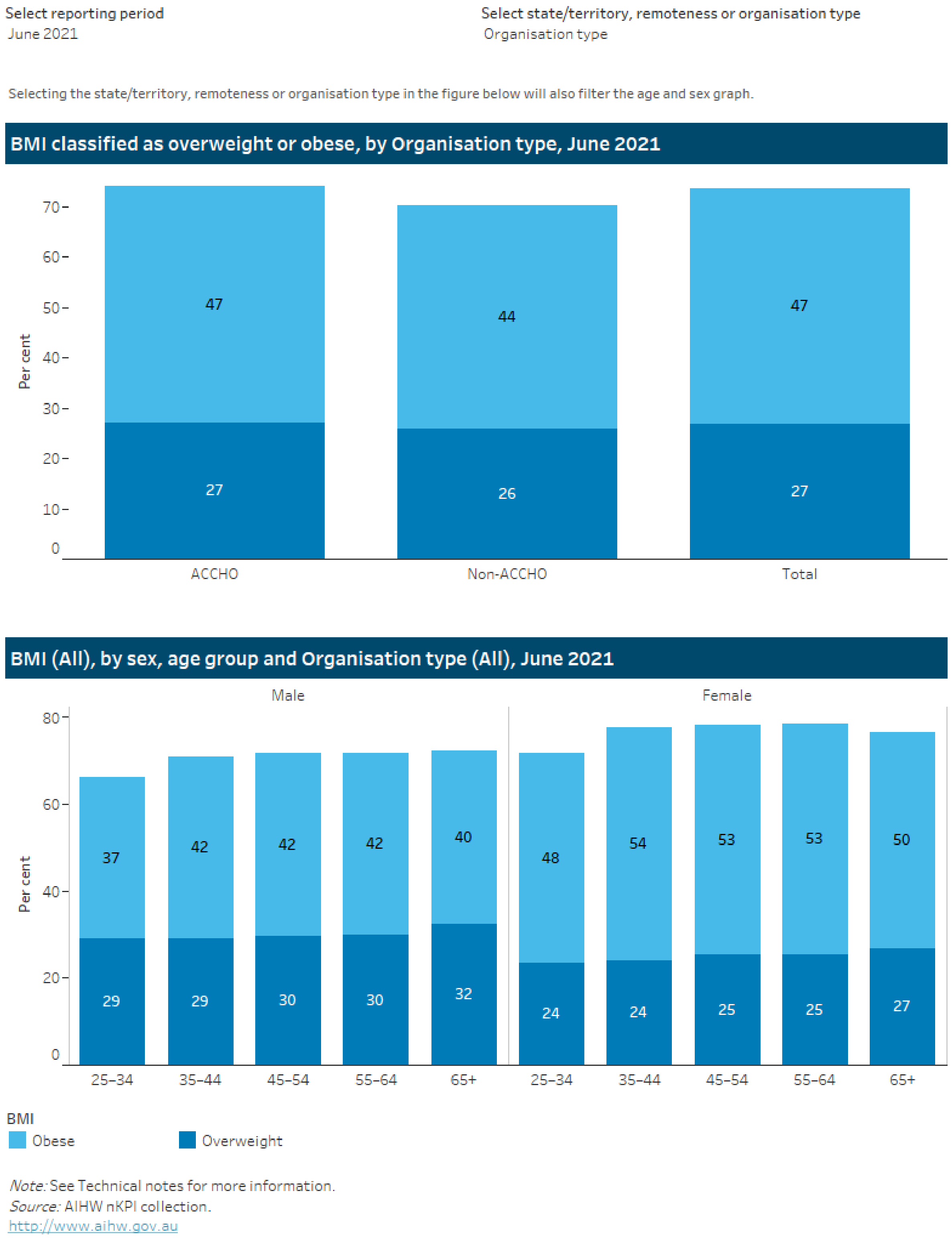
Indigenous Australians aged 15 and over are more likely to be overweight or obese than non-Indigenous Australians (AIHW 2020). The proportion of Indigenous Australians who are overweight or obese has increased over time.

At June 2021, 74% of Indigenous regular clients aged 25 and over had their BMI classified as overweight or obese within the previous 24 months:

- 27% as overweight
- 47% as obese.

Being overweight or obese was lowest in:

- the Northern Territory (64%)
- *Very remote* areas (67%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (70%).



Select reporting period
June 2021

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.

BMI classified as overweight or obese, by Organisation type, June 2021

BMI (All), by sex, age group and Organisation type (All), June 2021

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

Reference

AIHW (Australian Institute of Health and Welfare) 2020. Aboriginal and Torres Strait Islander Health Performance Framework: overweight and obesity. Canberra: AIHW.

nKPI—chronic disease management indicators

Chronic disease management indicators in the national Key Performance Indicators (nKPI) collection consist of 5 process-of-care and 3 health-status indicators. Some indicators have more than one part (for example, an indicator might be collected by different types of chronic diseases).

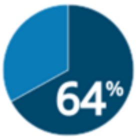
The following boxes show key results for Indigenous regular clients at June 2021. Clicking on a box will go to more information on the associated indicator.

Chronic Disease Management Plan

with type 2 diabetes had a Chronic Disease Management Plan in the last 2 years

Process-of-care indicator

Blood pressure result recorded



with type 2 diabetes had their blood pressure result recorded in the last 6 months

Process-of-care indicator

Blood pressure result

with type 2 diabetes had their blood pressure result within recommended guidelines in the last 6 months

Health-status indicator

HbA1c result recorded

with type 2 diabetes had their HbA1c result recorded in the last 6 months

Process-of-care indicator

HbA1c result

with type 2 diabetes had a HbA1c result within recommended guidelines in the last 6 months

Health-status indicator

Kidney function test recorded

with type 2 diabetes had a kidney function test recorded in the last year

Process-of-care indicator

Kidney function test recorded

62%

with CVD had a kidney function test recorded in the last year

Process-of-care indicator

Kidney function test result (eGFR)

80%

with type 2 diabetes had a normal eGFR test result in the last year

Health-status indicator

Kidney function test result (ACR)

43%

with type 2 diabetes had a normal ACR test result in the last year

Health-status indicator

Kidney function test result (eGFR)

77%

with CVD had a normal eGFR test result in the last year

Health-status indicator

Immunised against influenza

23%

with type 2 diabetes were immunised against influenza

Process-of-care indicator

Immunised against influenza

27%

with COPD were immunised against influenza

Process-of-care 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.

It is collected for males and females in age groups from 0–4 to 65 and over. It is 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 2021, 55% of Indigenous regular clients with type 2 diabetes had a Chronic Disease Management Plan prepared within the previous 24 months.

This was highest in:

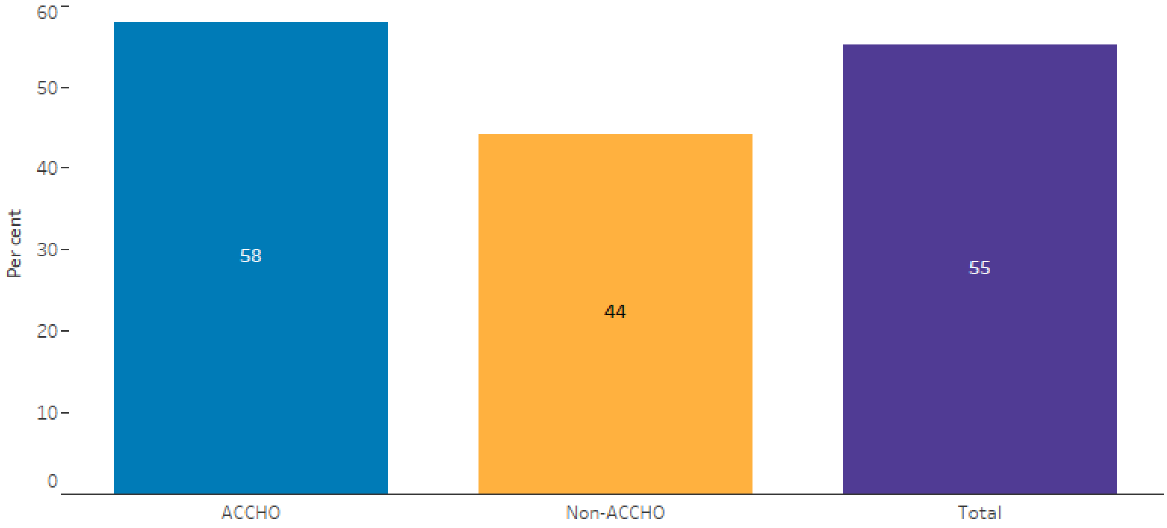
- Queensland (64%)
- *Major cities* (63%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (58%).

Select reporting period
June 2021

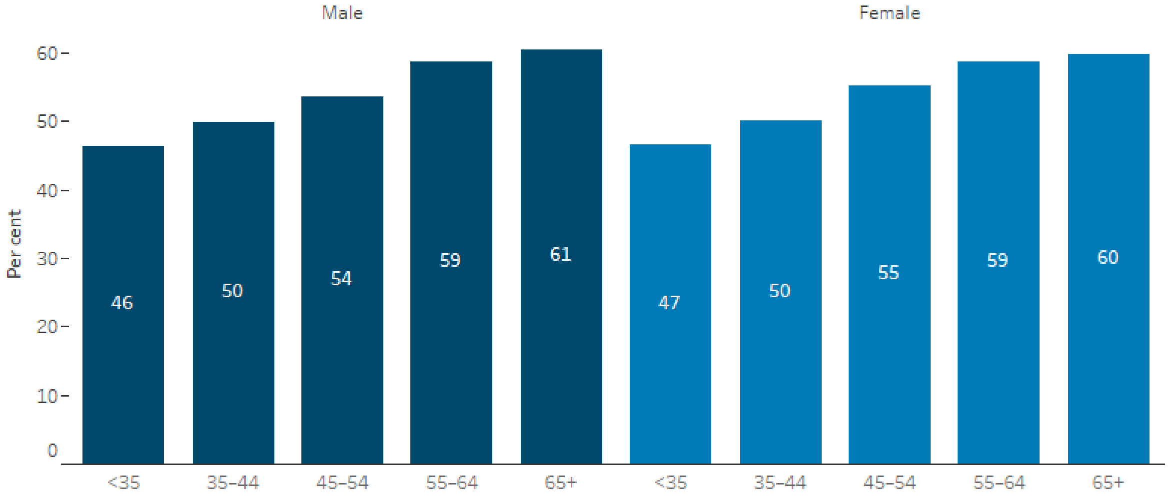
Select state/territory, remoteness or organisation type
Organisation type

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 2021



Chronic Disease Management Plan—type 2 diabetes, by sex, age group and Organisation type (All), June 2021



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

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

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

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

- The proportion of Indigenous regular clients with type 2 diabetes whose blood pressure result was recorded in the last 6 months.
- 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.

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)

This indicator is the proportion of Indigenous regular clients with type 2 diabetes whose blood pressure result was recorded in the last 6 months.

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

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

At June 2021, 64% of Indigenous regular clients with type 2 diabetes had their blood pressure result recorded in the last 6 months.

This was highest in:

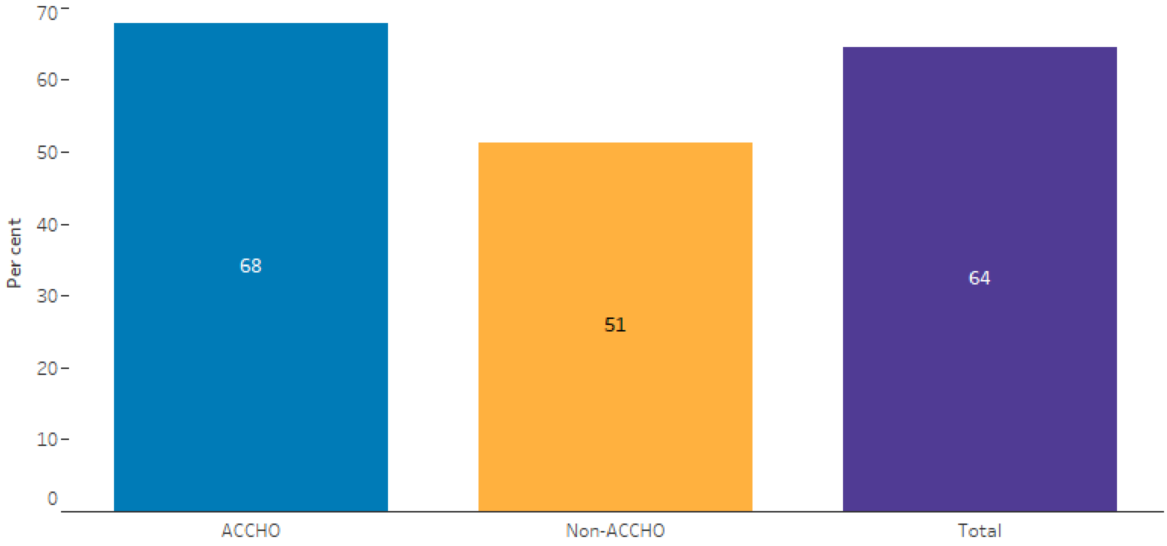
- Queensland (68%)
- *Major cities* (68%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (68%).

Select reporting period
June 2021

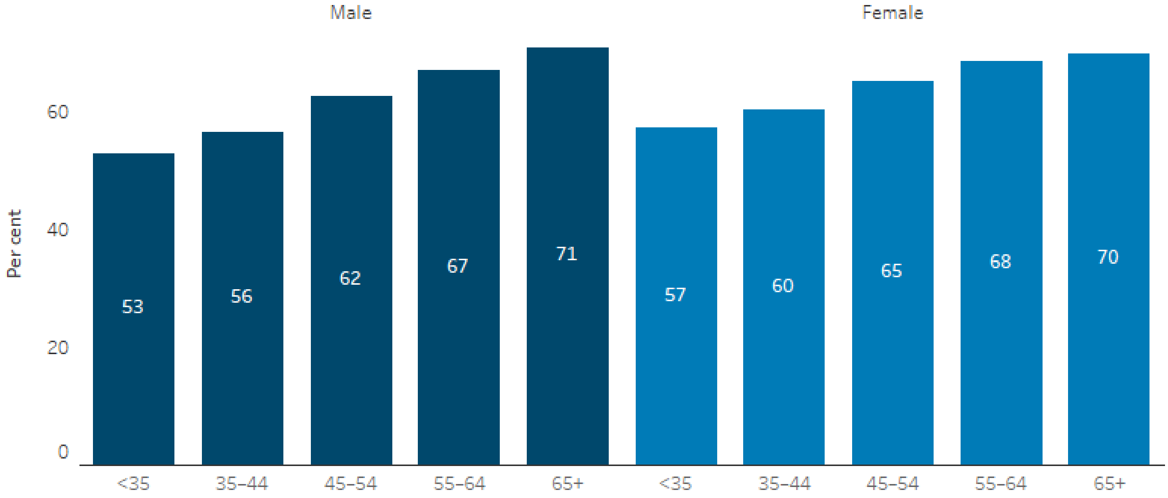
Select state/territory, remoteness or organisation type
Organisation type

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 2021



Blood pressure result recorded—type 2 diabetes, by sex, age group and Organisation type (All), June 2021



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

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

Blood pressure result—type 2 diabetes (PI24)

This indicator is 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.

It is collected for males and females in age groups:

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

At June 2021, 65% 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.

This was highest in:

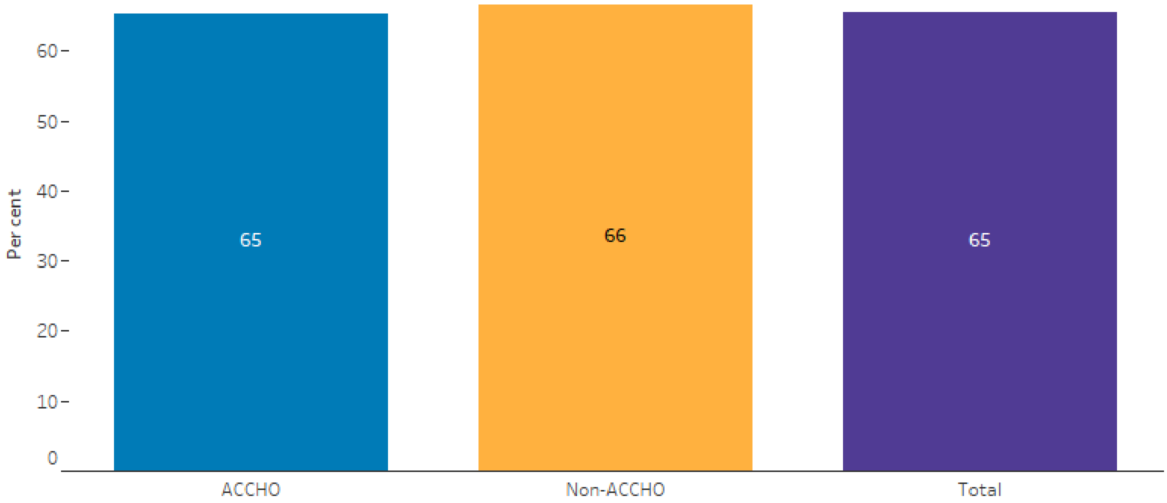
- the Northern Territory (67%)
- *Very remote* and *Outer regional* areas (both 66%)
- organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs) (66%).

Select reporting period
June 2021

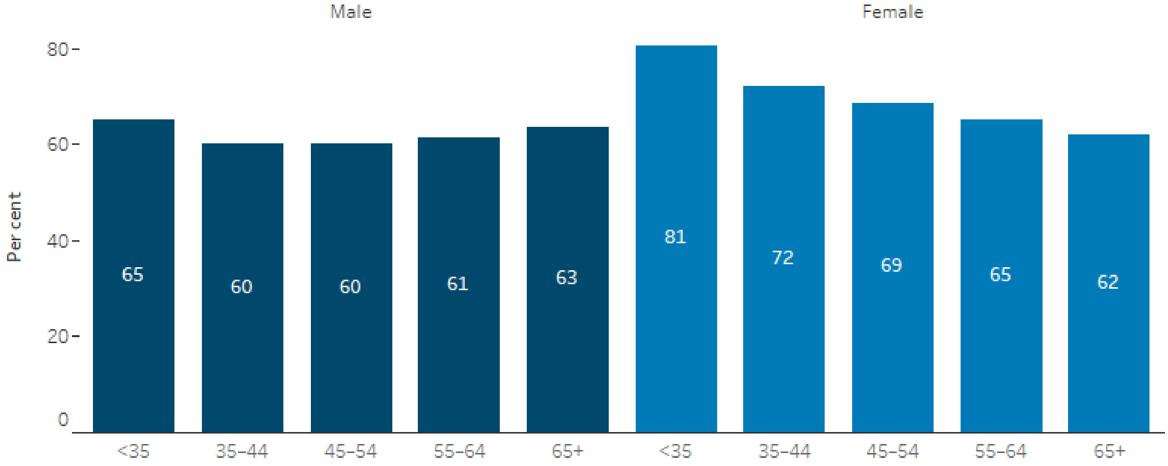
Select state/territory, remoteness or organisation type
Organisation type

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 2021



Blood pressure result ≤140/90mmHg—type 2 diabetes, by sex, age group and Organisation type (All), June 2021



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

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

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:

- 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
- 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 that was within specified ranges.

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)

This indicator is 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.

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

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

At June 2021:

- 50% of Indigenous regular clients with type 2 diabetes had a HbA1c measurement result recorded within the previous 6 months
- 66% of Indigenous regular clients with type 2 diabetes had a HbA1c measurement result recorded within the previous 12 months.

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

- Victoria/Tasmania (combined) and Western Australia (both 54%)
- *Major cities* and *Inner regional* areas (both 52%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (52%).

Having a HbA1c measurement result recorded within the previous 12 months was highest in:

- Western Australia (71%)
- *Major cities* (68%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (69%).

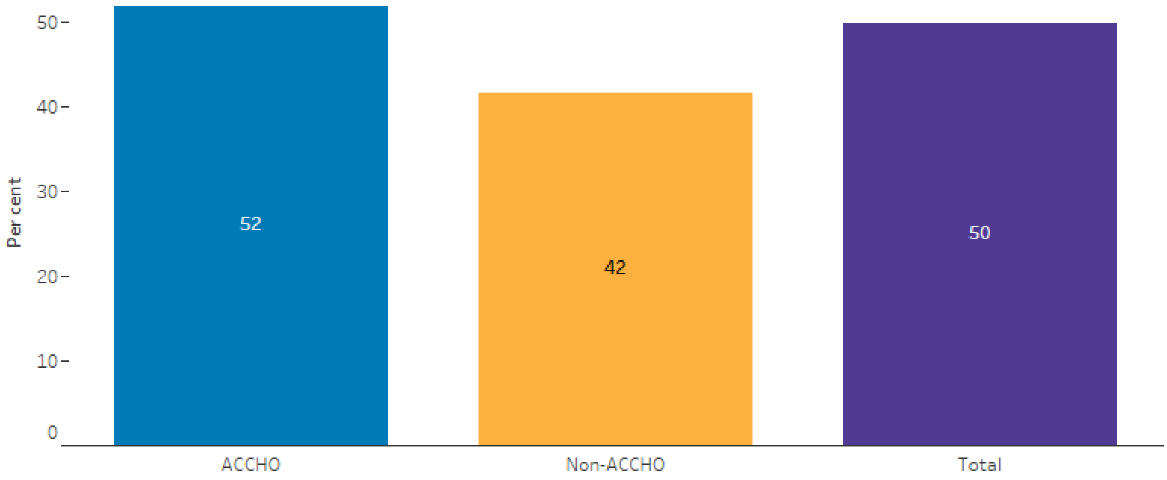
Select reporting period
June 2021

Select state/territory, remoteness or organisation type
Organisation type

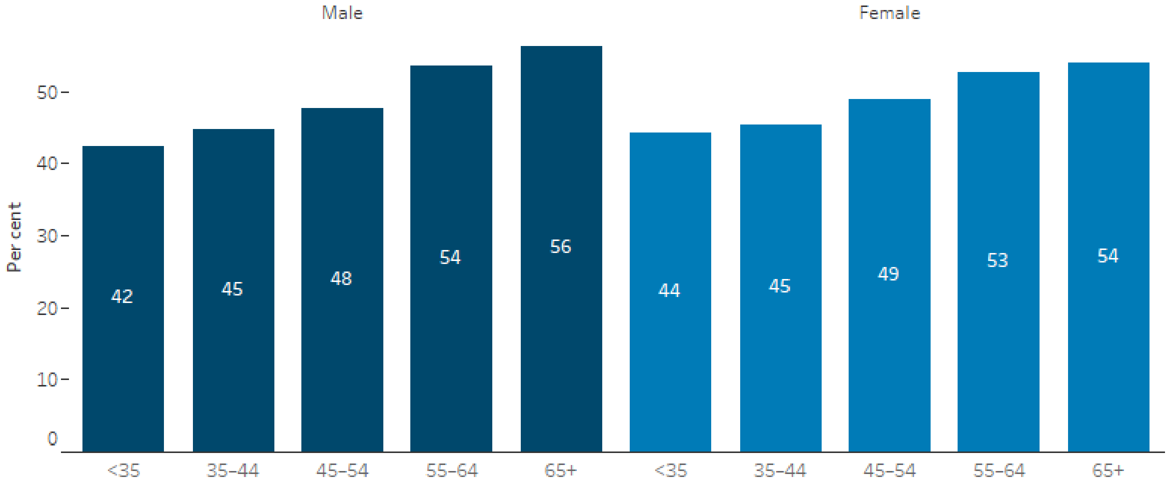
Select time period
6 months

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 2021



HbA1c result recorded—type 2 diabetes—within the previous 6 months, by sex, age group and Organisation type (All), June 2021



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

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

HbA1c result—type 2 diabetes (PI06)

This indicator is 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 (mmol/mol):

- ≤53 (≤7%)
- >53–≤64 (>7%–≤8%)
- >64–<86 (>8%–<10%)
- ≥86 (≤10%).

It is collected for males and females in age groups:

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

At June 2021:

- 37% of Indigenous regular clients with type 2 diabetes had a HbA1c measurement result of ≤53 mmol/mol recorded within the previous 6 months
- 38% had a HbA1c measurement result of ≤53 mmol/mol recorded within the previous 12 months.

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) (45%)
- *Inner regional* areas (44%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (38%).

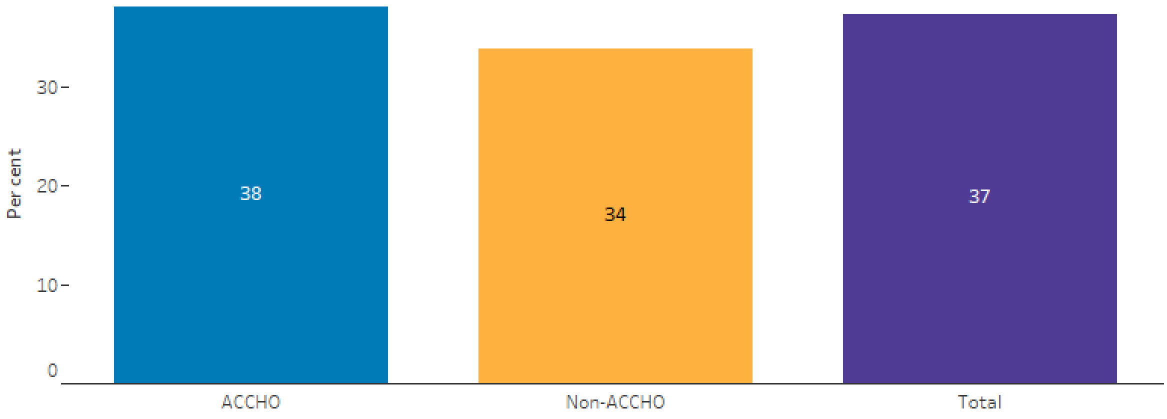
Having a HbA1c measurement result of ≤53 mmol/mol recorded within the previous 12 months was highest in:

- New South Wales/the Australian Capital Territory (combined) (46%)
- *Inner regional* areas (44%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (39%).

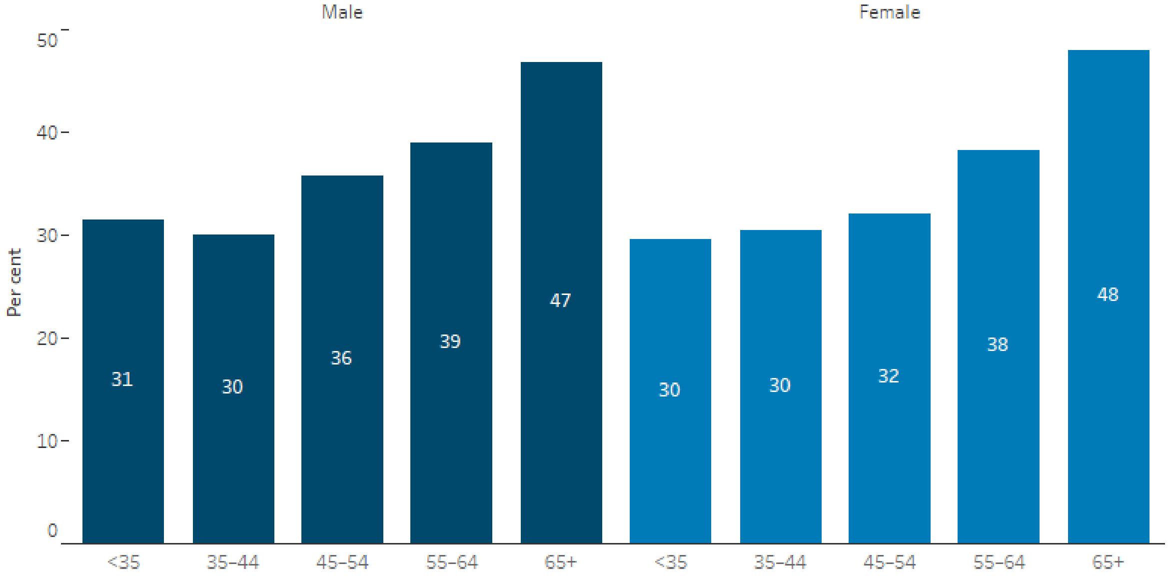
Select reporting period	Select state/territory, remoteness or organisation type	Select time period	Select result level (mmol/mol)
June 2021	Organisation type	6 months	≤53

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 2021



HbA1c result—type 2 diabetes—within the previous 6 months, by sex, age group, HbA1c result (≤53 mmol/mol) and Organisation type (All), June 2021



Notes:
1. A result of ≤53 mmol/mol is ideal.
2. 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 or CVD (PI18 and PI19)

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

- Type 2 diabetes:
  - the proportion of Indigenous regular clients aged 15 and over with type 2 diabetes who had an estimated glomerular filtration rate (eGFR) recorded and/or an albumin/creatinine ratio (ACR) or other micro albumin test result recorded within the previous 12 months
  - the proportion of Indigenous regular clients aged 15 and over with type 2 diabetes who had an eGFR recorded within the previous 12 months within a specified range
  - the proportion of Indigenous regular clients aged 15 and over with type 2 diabetes who had an ACR recorded within the previous 12 months within a specified range.
- Cardiovascular disease (CVD):
  - the proportion of Indigenous regular clients aged 15 and over with CVD who had an eGFR recorded within the previous 12 months
  - the proportion of Indigenous regular clients aged 15 and over with CVD who had an eGFR test recorded within the previous 12 months within a specified range.

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 an annual screening of kidney function in patients with CVD and type 2 diabetes for albuminuria by ACR (spot urine sample), and annual estimation of the eGFR (RACGP 2020).

A ‘normal’ eGFR result is considered to be ≥60 mL/min/1.73 m^2 (Kidney Health Australia 2020).

Very low values for ACR (<2.5 for males or <3.5 for females) generally indicate that kidney function is normal if other tests of kidney function also show no abnormality. A moderately increased ACR indicates an early phase of developing kidney disease. Very high values indicate that kidney disease is present in a more severe form.

Indigenous Australians are far more likely to develop, and to die from, chronic kidney disease than non-Indigenous Australians (AIHW 2020; Kidney Health Australia 2020).

Kidney function test recorded—type 2 diabetes or CVD (PI18)

This indicator is:

- the proportion of Indigenous regular clients aged 15 and over with type 2 diabetes who had an eGFR and/or ACR or other micro albumin test result recorded within the previous 12 months; and
- the proportion of Indigenous regular clients aged 15 and over with CVD who had an eGFR recorded within the previous 12 months.

It is collected for males and females in age groups from 15–24 to 65 and over. It is presented here for males and females in age groups:

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

At June 2021:

- 63% of Indigenous regular clients aged 15 and over with type 2 diabetes had an eGFR recorded and/or ACR or other micro albumin test result recorded within the previous 12 months
- 62% of Indigenous regular clients aged 15 and over with CVD had an eGFR recorded test result recorded within the previous 12 months.

Having an eGFR and/or ACR or other micro albumin test result recorded within the previous 12 months for clients with type 2 diabetes was highest in:

- Western Australia (68%)
- *Major cities* (67%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (67%).

Having an eGFR test result recorded within the previous 12 months for clients with CVD was highest in:

- Western Australia (68%)
- *Major cities* (65%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (64%).

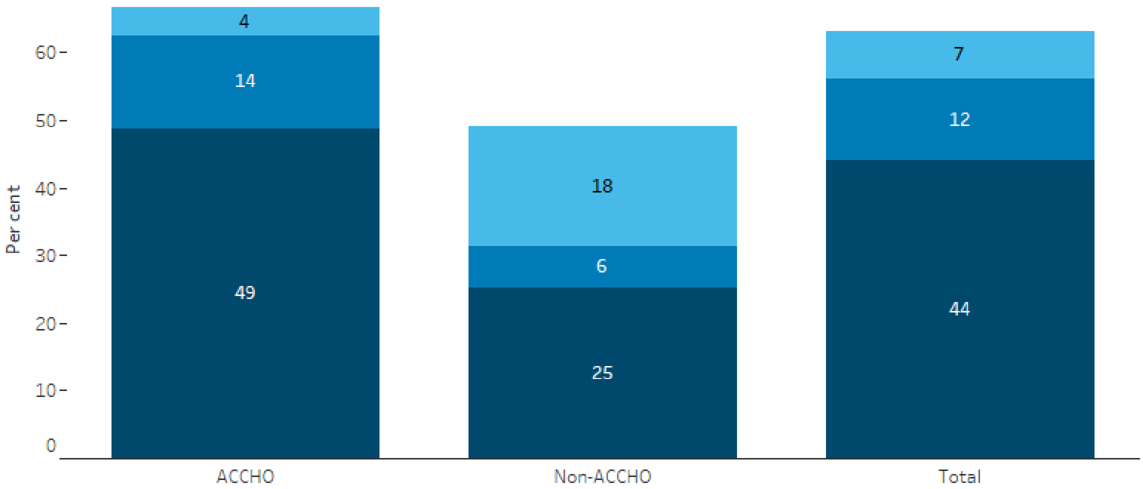
Select reporting period
June 2021

Select state/territory, remoteness or organisation type
Organisation type

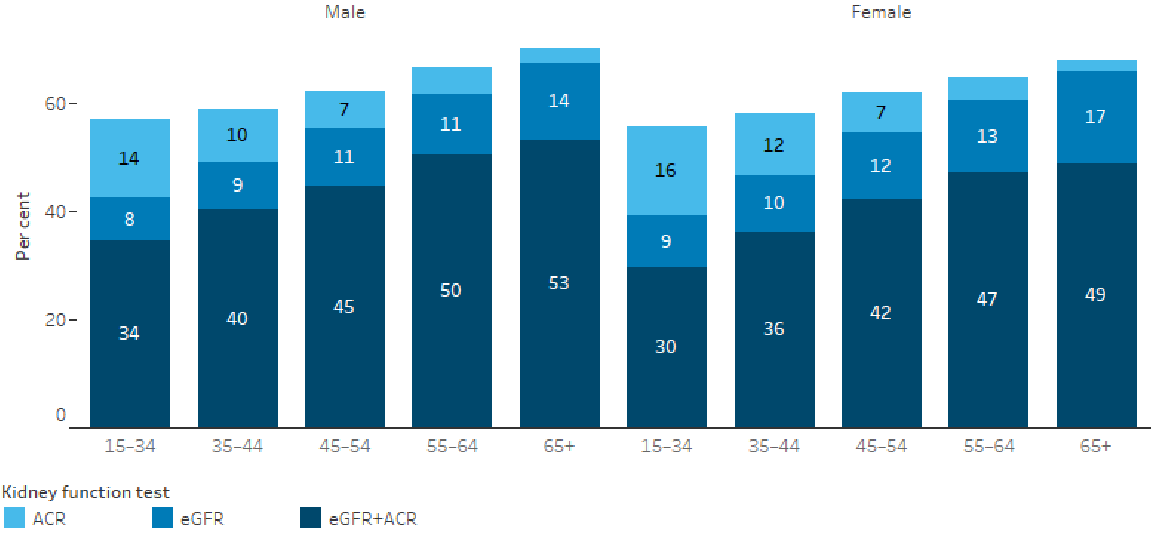
Select chronic disease
Type 2 diabetes

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

Kidney function test recorded—type 2 diabetes, by test type and Organisation type, June 2021



Kidney function test recorded—type 2 diabetes, by sex, age group, test type (All), Organisation type (All), June 2021



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

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

Kidney function test result (eGFR)—type 2 diabetes or CVD (PI19-A)

This indicator is the proportion of Indigenous regular clients aged 15 and over with type 2 diabetes or CVD who had an eGFR test result recorded within the previous 12 months of (mL/min/1.73m^2):

- ≥90
- ≥60–<90
- ≥45–<60
- ≥30–<45
- ≥15–<30
- <15.

It is collected for males and females in age groups from 15–24 to 65 and over. It is presented here for all Indigenous regular clients aged 15 and over.

At June 2021:

- 80% of Indigenous regular clients aged 15 and over with type 2 diabetes had an eGFR test result recorded within the previous 12 months of ≥60 mL/min/1.73m^2
- 77% of Indigenous regular clients aged 15 and over with CVD had an eGFR test result recorded within the previous 12 months of ≥60 mL/min/1.73m^2.

Having an eGFR result of ≥60 mL/min/1.73m^2 within the previous 12 months for clients with type 2 diabetes was highest in:

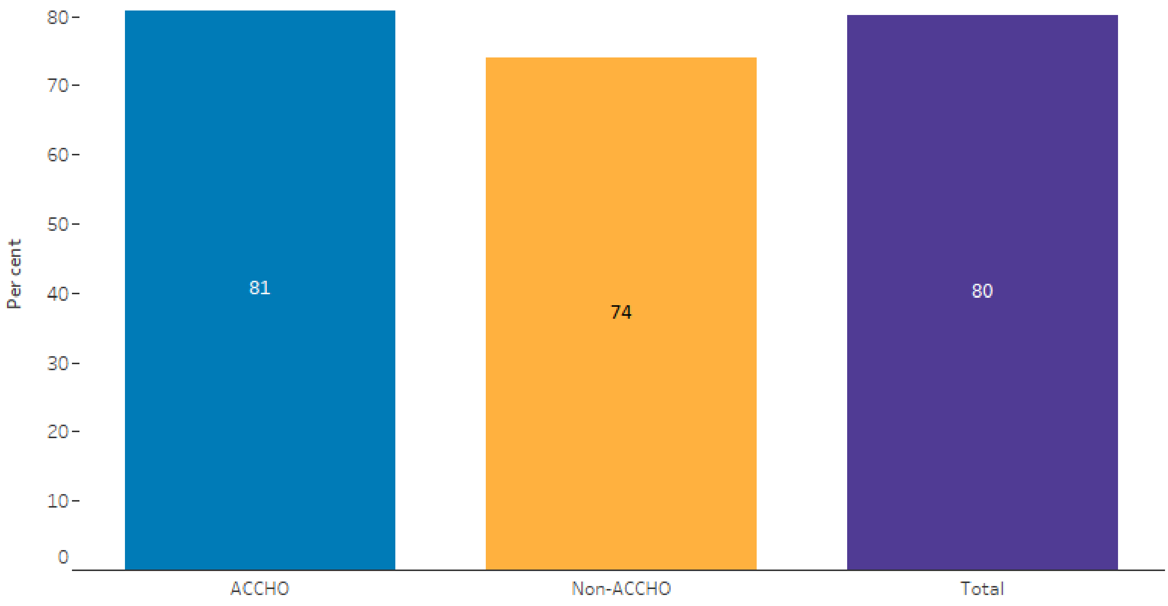
- South Australia (84%)
- *Major cities* (85%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (81%).

Having an eGFR result of ≥60 mL/min/1.73m^2 within the previous 12 months for clients with CVD was highest in:

- Victoria/Tasmania (combined) and Queensland (both 78%)
- *Major cities* (81%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (77%).

Select reporting period	Select state/territory, remoteness or organisation type	Chronic Disease	Result level (mL/min/1.73m²)
June 2021	Organisation type	Type 2 diabetes	≥60

Kidney function test result (eGFR)—type 2 diabetes, by result level (≥60 mL/min/1.73m²) and Organisation type, June 2021



Notes:
1. A result of ≥60 mL/min/1.73m² is ideal.
2. See Technical notes for more information.

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

Kidney function test result (ACR)—type 2 diabetes (PI19-B)

This indicator is:

- the proportion of male Indigenous regular clients aged 15 and over with type 2 diabetes who had an albumin/creatinine ratio (ACR) recorded within the previous 12 months of (mg/mmol):
  - <2.5
  - ≥2.5–≤25
  - >25; and

- the proportion of female Indigenous regular clients aged 15 and over with type 2 diabetes who had an albumin/creatinine ratio (ACR) recorded within the previous 12 months with a result of (mg/mmol):
  - <3.5
  - ≥3.5–≤35
  - >35.

It is collected for males and females in age groups from 15–24 to 65 and over. It is presented here for all Indigenous regular clients aged 15 and over.

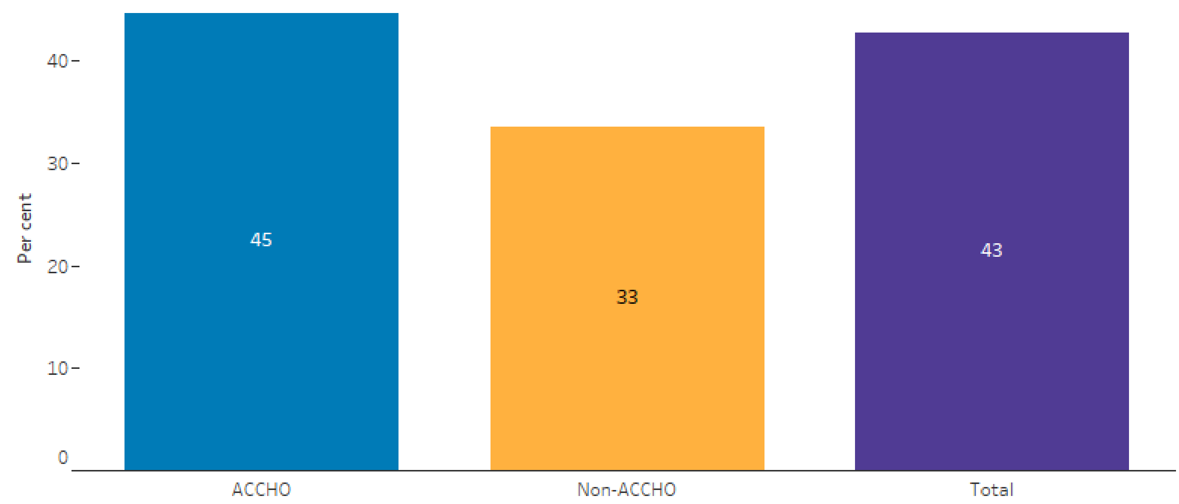
At June 2021, 43% of Indigenous regular clients aged 15 and over with type 2 diabetes had an albumin/creatinine ratio (ACR) recorded within the previous 12 months of <2.5 for males or <3.5 for females.

This was highest in:

- New South Wales/the Australian Capital Territory (combined) (54%)
- *Inner regional* areas and *Major cities* (both 54%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (45%).

Select reporting period	Select state/territory, remoteness or organisation type	Result level (mmol/mol)
June 2021	Organisation type	<2.5 Male and <3.5 Female

Kidney function test result (ACR)—Type 2 diabetes, by ACR result (<2.5 Male and <3.5 Female mg/mmol) and Organisation type, June 2021



Notes:
1. A result of <2.5 mg/mmol for Males and <3.5 mg/mmol for Females is ideal.
2. See Technical note for more information.

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

References

AIHW (Australian Institute of Health and Welfare) (2020) 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.

Immunised against influenza—type 2 diabetes or COPD (PI15)

This indicator is the proportion of Indigenous regular clients aged 15–49 with type 2 diabetes or chronic obstructive pulmonary disease (COPD) who had an influenza immunisation within the previous 12 months.

It is collected for males and females in age groups from 15–24 to 45–49. It is presented here for males and females in age groups:

- under 35
- 35–44
- 45–49.

See also Immunised against influenza—aged 6 months and over (PI14).

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 vaccination is the best way to prevent severe infections, hospitalisation and death due to influenza.

While immunisation against influenza is recommended for all Indigenous Australians aged 6 months and over, it is particularly important for those who are at a greater risk of complications, such as those with diabetes and COPD. Influenza vaccination substantially reduces the risk of hospitalisation and death from influenza and pneumonia for people with type 2 diabetes and COPD (AIHW 2018).

At June 2021:

- 23% of Indigenous regular clients aged 15–49 with type 2 diabetes had an influenza immunisation within the previous 12 months
- 27% of Indigenous regular clients aged 15–49 with COPD had an influenza immunisation within the previous 12 months.

Influenza immunisation for those with type 2 diabetes was highest in:

- South Australia (29%)
- *Inner regional* and *Very remote* areas (both 25%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (24%).

Influenza immunisation for those with COPD was highest in:

- South Australia (41%)
- *Major cities* (31%)
- Aboriginal Community Controlled Health Organisations (ACCHOs) (28%).

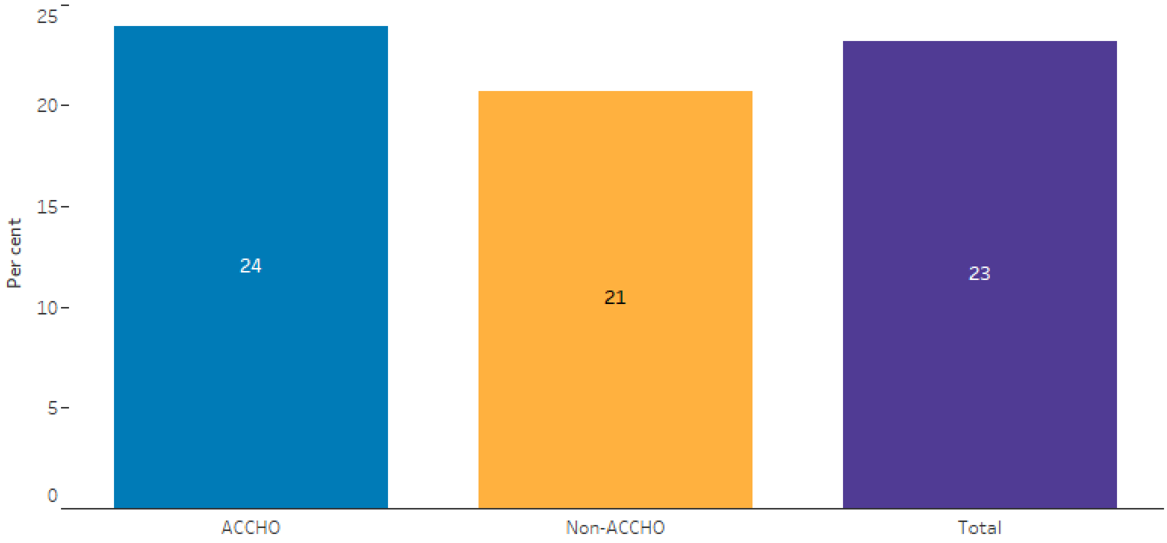
Select reporting period
June 2021

Select state/territory, remoteness or organisation type
Organisation type

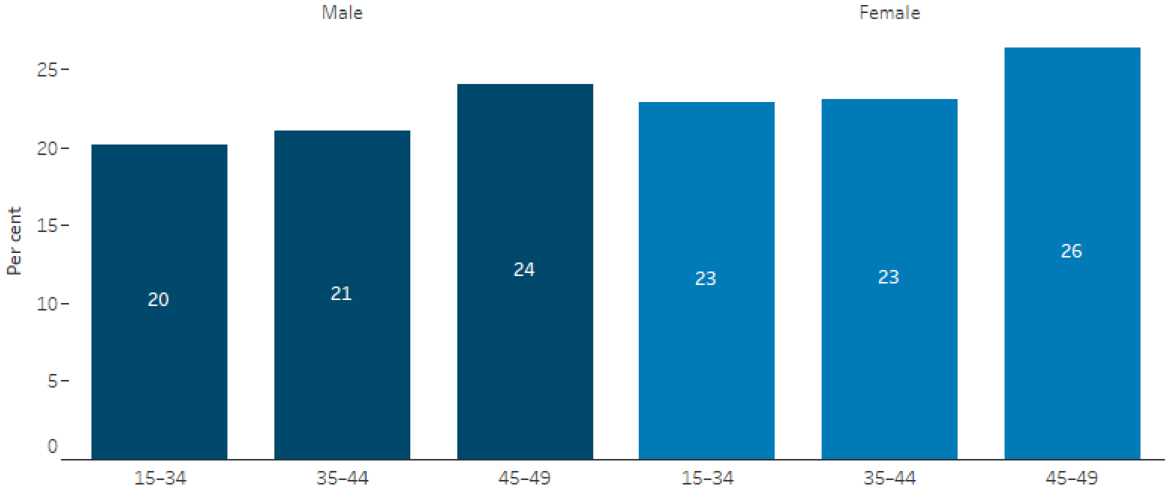
Select chronic disease
Type 2 diabetes

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

Immunised against influenza—type 2 diabetes, by Organisation type, June 2021



Immunised against influenza—type 2 diabetes, by sex, age group and Organisation type (All), June 2021



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

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

Reference

AIHW (Australian Institute of Health and Welfare) (2018) Vaccine-preventable diseases fact sheets, Cat no. PHE 236, Canberra: AIHW.

Impact of COVID-19

Assessing the impact of the coronavirus disease 2019 (COVID-19) pandemic (the pandemic) on organisations is complex, but some insights can be found by examining comments organisations record in the Online Services Report (OSR) collection about changes in their activity levels prior to and during the pandemic.

The analysis on this page focuses on changes to the activities of organisations as seen through the OSR collection. Information that provides context about the impact the pandemic had on indicators contained in the nKPI collection, such as influenza vaccination, can be found in PI14 (immunised against influenza) and the forthcoming Australia's Health 2022.

Method

To assess the impact of the pandemic on the activities of organisations, a dataset was created which included only the 161 organisations with no identified data issues that reported to the OSR in all 3 of the most recent periods, spanning:

- pre-COVID-19—the 2018–19 OSR
- start of COVID-19—the 2019–20 OSR (noting, however, that only the final quarter 01 March–30 June 2020 would have been affected)
- full year of COVID-19—the 2020–21 OSR.

This dataset included 3 variables capturing organisational activity levels (number of clients, client contacts, episodes-of-care), along with comments recorded by the organisations to explain variations in these data (recorded for those with a 20% or more increase or decrease between periods). For some items (such as clients and episodes of care) the validation rules look at the total only. For others (such as client contacts), there are validation rules for the total and the individual components which comprise the total (for example, values for Indigenous females). For the purposes of this analysis, the focus was on changes in the high-level totals, but other relevant comments are included if they applied to a particular component and were related to COVID-19. For each of the 3 organisational activities, the dataset was used to examine:

- aggregate changes across the 3 periods
- the percentage change at the organisational level between the periods, by categorising organisations into whether they had a greater than 20% increase or decrease in their values (or whether the variation was less than 20%)

- whether those organisations with more than a 20% change from the previous period cited COVID-19 as a reason.

While these data provide some insight, it must be noted that assessing whether changes in the activities of organisations are directly or indirectly related to the impact of the pandemic is complex and has some limitations because:

- OSR data are for 12 month periods and cannot be disaggregated within that (for example, by quarter)
- pandemic related restrictions and outbreaks varied across geographic areas and time periods
- some amount of change across reporting periods is normal and may be unrelated to the pandemic (for example, an organisation may open a new clinic site or may improve their internal data recording processes).

As such, caution should be used when interpreting results for the selected organisations, especially over time. Caution should also be used when extrapolating the results for selected organisation to the full data that includes all reporting organisations in each period (see also Technical notes). Summary information about the included organisations, as well as those who were excluded, are included in Characteristics of included and excluded organisations and in the supplementary data tables (see Data).

This analysis indicates that the pandemic did have an impact on organisations. For example, for the selected organisations:

- the indirect impact led to a decrease in the number of client contacts and episodes of care delivered because of factors such as lockdowns (which also affected whether face-to-face services were available and whether clients felt comfortable using them), staffing issues, and the recording of telehealth consultations
- the direct impact of having to pivot services towards COVID-19 testing and/or vaccinations meant an increase in clients or services delivered, while for others it meant fewer available resources for direct primary care activity.

While the results on this page are for selected organisations only, some inferences can also be cautiously made about changes in the full data (that is, data for all reporting organisations). For example, comments recorded for the selected organisations may explain, at least in part, some of the overall changes seen in the Indigenous status of clients since the start of the pandemic. For such data, however, it is difficult to be definitive and it is likely that a combination of factors affected the results. For example, variation may reflect: changes in organisation or client behaviour as a result of the pandemic (such as reluctance of clients to attend or use telehealth; or restrictions on travel for clients and staff); the voluntary nature of reporting for those periods (and the associated decrease in the number of reporting organisations); or general changes in the types or characteristics of reporting organisations (for example, the organisations reporting to the collection vary each period, an organisation may close or open a site, or an organisation may change their internal data recording processes). See also Technical notes.

Included and excluded organisations

Of the 218 organisations in-scope to report in 2020–21:

- 27 did not report in 2020–21 (excluded organisations)
- 191 did report in 2020–21, of which:

- 161 reported in all 3 periods—2018–19, 2019–20 and 2020–21—and had no data issues (included organisations)

- 24 did not report in at least 1 of the previous 2 periods (2018–19 and/or 2019–20) (excluded organisations)

- 6 reported in all 3 periods but were excluded because of issues with comparability of their data over time, such as a result of a change in counting rules or using a new Clinical Information System (CIS) (excluded organisations).

Based on information provided to the Department of Health, the main reasons cited by organisations that did not report in 2020–21 were related to:

- the additional pressures on organisations as a result of the pandemic, such as lockdowns and the vaccination push
- other priorities
- staff not trained, for example, staff turnover resulting in staff who are not familiar with the data process.

The characteristics of the organisations contained in the analysis dataset (included organisations), as well as those excluded from analysis (excluded organisations), provide important context for interpreting the results on this page, as well as when applying these result to the full reporting dataset. Further information on the characteristics of these organisations is included in the supplementary data tables (see Data).

Clients

Overall, the total number of clients seen by the included organisations increased over the 3 periods, from approximately 388,000 in 2018–19 to nearly 395,000 in 2020–21. There was a much smaller numerical increase between 2020–21 and 2019–20 than between 2019–20 and 2018–19 (Table 1).

Table 1. Number of clients and number of organisations who cited the pandemic as a reason for variation in numbers between periods, by degree of variation from previous period

Table 1A. 2019–20 compared with 2018–19

	Clients 2019–20	Clients 2018–19	Difference in clients between periods	Organisations who cited pandemic 2019–20	Organisation who did not cite pandemic 2019–20	Total organisations 2019–20
Organisations with 20% or more decrease	6,707	8,933	–2,226	3	2	5
Organisations with 20% or more increase	29,678	22,285	7,393	—	11	11
Organisations with less than 20% change	356,761	356,900	–139	n.a.	n.a.	145
Total	393,146	388,118	5,028	3	13	161

Table 1B. 2020–21 compared with 2019–20

	Clients 2020–21	Clients 2019–20	Difference in clients between periods	Organisations who cited pandemic 2020–21	Organisation who did not cite pandemic2020–21	Total organisations 2020–21
Organisations with 20% or more decrease	12,959	17,287	–4,328	—	10	10
Organisations with 20% or more increase	31,480	23,524	7,956	—	11	11
Organisations with less than 20% change	350,508	352,335	–1,827	n.a.	n.a.	140
Total	394,947	393,146	1,801	—	21	161

Notes:

1. Organisations that reported to the OSR collection in 2018–19, 2019–20, and 2020–21 and had no identified issues in the comparability of their data over time.

2. For clients, the validation rules trigger for 20% change in the total only.

Source: AIHW analysis of the OSR collection.

At the organisation level:

- comparing 2019–20 with 2018–19 (Table 1A), 5 organisations had more than a 20% decrease in their number of clients (with a total of around 2,200 fewer clients than in the previous period), and 11 organisations had more than a 20% increase in their client numbers (with a total of around 7,400 more clients).

- comparing 2020–21 with 2019–20 (Table 1B), there were 10 organisations with more than a 20% decrease in their client numbers (with a total of around 4,300 fewer clients), while 11 organisations had more than a 20% increase in their client numbers (with a total of around 8,000 more clients).

Three of the 5 organisations whose 2019–20 client numbers had decreased by 20% or more compared with 2018–19 stated that the pandemic had played a role in the decrease, however they provided little detail on how the pandemic affected their numbers. None of the 11 organisations with more than a 20% increase in client numbers cited the pandemic as an explanation.

None of the 21 organisations in 2020–21 with more than a 20% variation in their client numbers from 2019–20 cited the pandemic as an explanation for the changes.

Further analysis by Indigenous status showed that:

- the number of Indigenous clients increased between 2018–19 and 2019–20 (from around 319,000 to 324,000), but then decreased in 2020–21 (to around 321,000)
- the number of non-Indigenous clients increased across all three periods, from around 61,000 in 2018–19, to around 62,000 in 2019–20, and to around 69,600 in 2020–21.

Part of the increase in the number of non-Indigenous clients in 2020–21 is likely due to a significant decrease in the number of clients with their Indigenous status not recorded (for example, better recording practices). There were also indications from some organisations in their comments about client contacts and episodes-of-care that they were seeing more non-Indigenous clients than usual because they were running testing and/or vaccination clinics that were open to all or that they were the only source of primary health care available. Half of the 38 organisations with a 20% more increase in the number of non-Indigenous clients were in the Northern Territory.

Client contacts

The total number of client contacts dropped by nearly 93,000 between 2018–19 and 2019–20 (which included the first 4 months of the pandemic), from approximately 4.6 million to 4.5 million. The total number of client contacts was then stable between 2020–21 and 2019–20 (Table 2).

Underpinning these aggregate numbers were considerable variations at the organisation level:

- Comparing 2019–20 with 2018–19 (Table 2A), 12 organisations had more than a 20% decrease in their client contacts (with a total of around 158,000 fewer client contacts than in the previous period), while 18 organisations had more than a 20% increase in their client numbers (with a total of around 93,100 more client contacts).

- Comparing 2020–21 with 2019–20 (Table 2B), there were 25 organisations with more than a 20% decrease in their client contacts. Even though this was a higher number of organisations with a 20% or more decrease in client contacts, the total reduction in client contacts was lower (around 69,400 fewer client contacts). Sixteen organisations had more than a 20% increase in client contacts (with a total of around 120,000 more client contacts).

Table 2. Number of client contacts (excluding transport) and number of organisations who cited the pandemic as a reason for variation in numbers between periods, by degree of variation from previous period

Table 2A. 2019–20 compared with 2018–19

	Client contacts 2019–20	Client contacts 2018–19	Difference in client contacts between periods	Organisations who cited pandemic 2019–20	Organisation who did not cite pandemic 2019–20	Total organisations 2019–20
Organisations with 20% or more decrease	157,035	315,208	–158,173	6	6	12
Organisations with 20% or more increase	363,442	270,367	93,075	2	16	18
Organisations with less than 20% change	4,008,035	4,034,576	–26,541	—	130	130
Total	4,528,512	4,620,151	–91,639	8	152	160

Table 2B. 2020–21 compared with 2019–20

	Client contacts 2020–21	Client contacts 2019–20	Difference in client contacts between periods	Organisations who cited pandemic 2020–21	Organisation who did not cite pandemic2020–21	Total organisations 2020–21
Organisations with 20% or more decrease	189,222	258,633	–69,411	7	18	25
Organisations with 20% or more increase	545,344	424,872	120,472	3	13	16
Organisations with less than 20% change	3,798,898	3,845,007	–46,109	261	93	119
Total	4,533,464	4,528,512	4952	37	124	160

Notes:

1. Organisations that reported to the OSR collection in 2018–19, 2019–20, and 2020–21 and had no identified issues in the comparability of their data over time. One organisation was excluded from the client contacts analysis because their data for one of the collections was excluded.

2. For client contacts, the validation rules trigger for 20% change in individual subcategories as well as the total. Thus, an organisation's overall total may represent less than a 20% variation from their previous total, but they may have made a comment against an individual value.

Source: AIHW analysis of the OSR collection.

Organisations' comments showed that the pandemic did have an effect on the client contacts for at least 7 organisations in 2019–20 and 26 in 2020–21.

The pandemic's role in decreasing client contacts was related to a combination of:

- lockdowns and travel restrictions which reduced mobility of both clients and staff (combination of fewer available staff and inability/reluctance of clients to attend)
- re-orientation of staff and resources towards pandemic specific activities (such as vaccination or testing clinics)
- whether telehealth consultations were included as contacts in clients' records, with some organisations reporting that they were not.

The pandemic was also cited as a reason for increased activities, particularly in the 2020–21 period:

- some organisations experienced a 'rebound' effect, where they provided additional appointments and services to make up for those that had been restricted during the first wave of the pandemic
- the need to pre-screen clients for respiratory symptoms or COVID-19 prior to their attendance face-to-face led to increased contacts, as well as increased activities of those running screening services
- opening of vaccination clinics to both Indigenous and non-Indigenous clients.

Additionally, one organisation reported that they had an increase in the presentation of Indigenous clients seeking culturally safe services because of their concerns about COVID-19.

Episodes of care

The total number of episodes of care increased by around 61,000 between 2018–19 and 2019–20 and increased again more modestly in 2020–21by around 13,400 (Table 3).

Looking at changes in episodes of care at the organisational level shows that:

- Comparing 2019–20 with 2018–19 (Table 3A), 15 organisations had more than a 20% decrease in episodes of care (with a total of around 38,400 fewer episodes of care than in the previous period), while 19 organisations had more than a 20% increase in episodes of care (with a total of around 69,700 more episodes of care).

- Comparing 2020–21 with 2019–20 (Table 3B), there were 27 organisations with more than a 20% decrease in episodes of care, with a combined reduction of around 61,500 episodes of care. Eighteen organisations had more than a 20% increase in episodes of care (with a total of around 81,700 more episodes of care).

The pandemic was cited as a contributing factor to the decreases in episodes of care by 9 of the 15 organisations in 2019–20 and 8 of the 27 organisations in 2020–21 who had experienced more than a 20% decrease in episodes of care. The explanations given by the organisations were similar to those around client contacts, focusing on the role of travel restrictions, lockdowns, and changes in staffing.

Six organisations who had experienced more than a 20% increase in their episodes of care from the previous period stated that the pandemic played a role, citing factors such as increased populations in the area, greater clinical needs among their clients, and screening or vaccination clinics.

Table 3. Number of episodes of care and number of organisations who cited the pandemic as a reason for variation in numbers between periods, by degree of variation from previous period

Table 3A. 2019–20 compared with 2018–19

	Episodes of care 2019–20	Episodes of care 2018–19	Difference in episodes of care between periods	Organisations who cited pandemic 2019–20	Organisation who did not cite pandemic 2019–20	Total organisations 2019–20
Organisations with 20% or more decrease	102,478	140,872	–38,394	9	6	15
Organisations with 20% or more increase	266,347	196,629	69,718	4	15	19
Organisations with less than 20% change	2,660,992	2,631,319	29,673	n.a.	n.a.	127
Total	3,029,817	2,968,820	60,997	13	148	161

Table 3B. 2020–21 compared with 2019–20

	Episodes of care 2020–21	Episodes of care 2019–20	Difference in episodes of care between periods	Organisations who cited pandemic 2020–21	Organisation who did not cite pandemic2020–21	Total organisations 2020–21
Organisations with 20% or more decrease	191,091	252,577	–61,486	8	19	27
Organisations with 20% or more increase	392,739	311,074	81,665	2	16	18
Organisations with less than 20% change	2,459,337	2,466,166	–6,829	n.a.	n.a.	116
Total	3,043,167	3,029,817	13,350	10	151	161

Notes:

1. Organisations that reported to the OSR collection in 2018–19, 2019–20, and 2020–21 and had no identified issues in the comparability of their data over time.

2. For episodes of care, the validation rules trigger for 20% change in the total only.

Source: AIHW analysis of the OSR collection.

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) indicator specifications and data quality statements
- 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.

Many CIS 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 reporting 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 and 2020–21, reporting was made voluntary in acknowledgement of the additional pressures on organisations because of the coronavirus disease 2019 (COVID-19) pandemic. This also affected the organisations reporting to the collections in a variety of other ways. See Impact of COVID-19 for more information. Additional information, including important context for interpreting changes in results in the nKPI collection, can be found in the forthcoming Australia's Health 2022.

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 collection and reporting period is determined based on what is considered to be the most representative population for each.

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

Reporting 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

Reporting 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

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

Table 2: OSR primary health care organisation participation rate

Reporting 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

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

Reporting 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

(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

Reporting 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
2015–16	9	204	4.4	26

Reporting period	Number of organisations with unresolved issues	Total number of organisations that reported data	Organisations with unresolved issues (%)	Data items excluded
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

(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 in what they report 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

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: BMI classified as overweight or obese
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-A: Kidney function test eGFR result—type 2 diabetes or CVD
PI18: Kidney function test recorded—type 2 diabetes or CVD	PI19-B: Kidney function test result ACR result—type 2 diabetes
PI15: Immunised against influenza—type 2 diabetes or COPD	

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

Reporting period	In-scope to report data	Reported data	Participation rate (%)
June 2017	228	228	100.0
December 2017	231	231	100.0

Reporting period	In-scope to report data	Reported data	Participation rate (%)
June 2018	236	233	98.7
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

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

Reporting 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	—
June 2020	3	220	1.4

Reporting period	Number of organisations with unresolved issues	Total number of organisations that reported data	Organisations with unresolved issues (%)
December 2020	6	218	2.8
June 2021	3	215	1.4

(a) June 2019 was the first reporting 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* (it previously captured 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 (it 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 not collected from the December 2020 nKPI collection onwards.
- 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 not collected from the December 2020 nKPI collection onwards.
- 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’).
- 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 (it previously captured only ages 50 and over).
- 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’ (it was 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): Health services operated by local Indigenous communities to deliver comprehensive, holistic and culturally appropriate health care to their communities. They range from large services with several medical practitioners who provide a range of services, to small services that rely on nurses and/or Aboriginal health workers to provide most services, and are controlled through a locally elected board of management. 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 6 remoteness areas in this structure:

- *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
- *Migratory*—composed of offshore, shipping and migratory CDs.

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 OSR collection, this refers to contacts made by clients of an organisation during the reporting period. 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 reporting 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