National Health Performance Authority

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Healthy Communities:

GP care for patients with chronic conditions in 2009–2013

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Summary

Chronic conditions are responsible for about 85% of the total burden of disease in Australasia.[1] Conditions such as heart disease, diabetes and mental illness are among the top 10 causes of premature death.[2] People with chronic conditions account for a large share of the 635,000 potentially avoidable hospitalisations in 2011–12.[3]

Worldwide, the number of people living with chronic health conditions is increasing and placing greater demands on health care systems.[4,5]

In local communities, health professionals play a critical role in assisting people in the management of their chronic conditions. Strong primary health systems are associated with better health outcomes, fewer hospital admissions and reduced health system costs.[6]

The Australian Government has announced that in 2015, Primary Health Networks (PHNs) will be established to better coordinate health services. PHNs are intended to ensure that patients, particularly those with complex chronic conditions, receive the right care, at the right place and right time.[7] While doctors will be working towards the consistent delivery of appropriate care in line with recommended guidelines, opportunities may exist to optimise the management of chronic conditions.[8–10]

Accordingly, the aim of this report is to deepen understanding of how management of chronic conditions differs across local areas, and to support health professionals and PHNs, particularly GP-led Clinical Councils, target improvements in services to maintain people's health and keep people out of hospital.

The report presents information on patients with one or multiple diagnosed chronic conditions, and focuses on patients with some of the most common conditions managed in general practice, including selected cardiovascular risk conditions, depression, anxiety, arthritis and chronic back pain.

This is the first report to give a local-level breakdown of the care of patients with chronic conditions by determining how many of these patients there are, how often and in what ways their GP manages these conditions.

Findings are described for 61 local areas and for seven clusters of similar areas called peer groups. Results are presented from data collected by the Bettering the Evaluation and Care of Health (BEACH) program, conducted by the University of Sydney, during the period from 2005 to 2013.

Key findings

Marked differences were found in both the frequency with which GPs manage patients' chronic conditions and in the clinical actions GPs take to care for those conditions.

Among **all people who visit the GP** at least once in a year, the percentage of people with **one or more** selected chronic conditions ranged from 44% to 56% across local areas. The percentage was slightly higher in regional areas, particularly in lower-income regional areas, than in metropolitan areas.

In comparison, the percentage of **all GP consultations** that involved patients who had **one or more** selected chronic conditions was only slightly higher (51% to 60%) across metropolitan and rural areas, and higher still (60% to 66%) across regional areas.

Across local areas, the percentage of all GP consultations in which **one or more** chronic conditions was **actively managed** ranged from 34% of GP consultations in Sydney North Shore & Beaches to 50% of consultations in Hume (Vic/NSW) **(Figures 3a and 3b, pages 12 and 13)**.

The findings also indicate that irrespective of variation in how often GPs saw patients with **three or more** chronic conditions (19% to 30% of consultations across peer groups), they **actively managed** three or more chronic conditions at about the same frequency (2% to 3% of consultations). This indicates that in local areas with a higher proportion of patients with three or more chronic conditions, opportunities may exist to optimise care for these patients.

The percentage of all GP consultations in which chronic conditions were **actively managed** differed, depending on where the GP practises:

- GP management of selected cardiovascular risk conditions ranged from 5% to 11% across local areas nationally
- GP management of depression or anxiety ranged from 4% to 9% across local areas nationally
- GP management of arthritis or chronic back pain ranged from 3% to 7% across local areas nationally.

Depending on where a GP practises, the approach they take to actively manage their patients' chronic conditions also differs:

- In managing selected cardiovascular risk conditions:
  - **Statins were prescribed** on 26% to 40% of GP management occasions across local areas nationally. Current guidelines recommend that most patients with these conditions should be treated with statins[10]
  - A **referral to another health professional** was provided on 4% to 11% of occasions across local areas.
- In managing depression or anxiety, diverse approaches taken may reflect the availability of allied health professionals and specialists:
  - A **psychotropic medication** (such as an antidepressant, antipsychotic or sedative) was prescribed on 38% to 74% of GP management occasions across local areas
  - **GP counselling** was provided on 25% to 51% of occasions across local areas
  - A **referral to another health professional** was provided on 11% to 21% of occasions across local areas.
- In managing arthritis or chronic back pain:
  - A **medication was prescribed** on 52% to 75% of GP management occasions across local areas
  - A **referral to another health professional** was provided on 11% to 22% of occasions across local areas
  - **Imaging was ordered** on 8% to 20% of occasions across local areas, despite current guidelines discouraging imaging for the management of chronic low back pain.[11]

The following pages summarise the findings for each of the selected chronic conditions found in this report.

GP care for patients with selected cardiovascular risk conditions

Among **all people who visit the GP** at least once in a year, the percentage of people who had a selected cardiovascular risk condition ranged from 17% to 19% in metropolitan areas, and from 16% to 21% in regional and rural communities.

The percentage of **all GP consultations** that were with patients who had a cardiovascular risk condition, irrespective of whether the condition was managed, was 22% in high-income and middle-income metropolitan areas. It ranged from 19% to 30% in lower-income metropolitan and all regional and rural areas.

GPs managed cardiovascular risk conditions in about one-third of all the consultations with these patients. The proportion of all GP consultations in which a cardiovascular risk condition was **actively managed** ranged from one in 20 (5%) consultations in South Eastern Melbourne and West Moreton-Oxley (Qld) to one in nine (11%) consultations in Hume (Vic/NSW).

GP actions in the management of cardiovascular risk conditions also varied across local areas. Depending on where a GP practises, the percentage of GP management occasions in which statins were prescribed ranged from 26% to 40% and a referral to another health professional from 4% to 11% across local areas.

(Figures 4 to 7, pages 20 to 23)

GP care for patients with depression and anxiety

Among **all people who visit the GP** at least once in a year, the percentage of people who had depression, anxiety or both of these conditions ranged from 16% to 18% in metropolitan areas and from 13% to 20% in regional and rural communities.

The percentage of **all GP consultations** that were with patients who had depression, anxiety or both of these conditions, irrespective of whether these conditions were managed, ranged from 18% to 21% in metropolitan, 20% to 23% in regional, and 15% to 18% in rural communities.

GPs managed depression or anxiety in about one-third of all the consultations with these patients. Across local areas, the proportion of all GP consultations in which depression or anxiety were **actively managed** ranged from one in 25 (4%) consultations in Sydney North Shore & Beaches to one in 11 (9%) consultations in Frankston-Mornington Peninsula (Vic) and Hume (Vic/NSW).

GP actions in the management of depression or anxiety also varied across local areas. Depending on where a GP practises, a psychotropic was prescribed on 38% to 74% of GP management occasions, GP counselling on 25% to 51% and a referral to another health professional was provided on 11% to 21% of occasions across local areas.

(Figures 8 to 11, pages 30 to 33)

GP care for patients with arthritis and chronic back pain

Among **all people who visit the GP** at least once in a year, the percentage of people who had arthritis, chronic back pain or both of these conditions ranged slightly from 16% to 18% in metropolitan, 20% to 21% in regional and 16% to 20% in rural areas.

The percentage of **all GP consultations** that were with patients who had arthritis, chronic back pain or both of these conditions, irrespective of whether these conditions were managed, ranged from 21% to 27% in metropolitan, 27% to 28% in regional and 19% to 29% in rural areas.

GPs managed arthritis or chronic back pain in about one-fifth of all the consultations with these patients. Across local areas, the proportion of all GP consultations in which arthritis or chronic back pain were **actively managed** ranged from one in 33 (3%) consultations in Sydney North Shore & Beaches to one in 14 (7%) consultations in Murrumbidgee (NSW) and Tasmania.

GP actions in the management of arthritis or chronic back pain also varied across local areas. Depending on where a GP practises, the percentage of GP management occasions where a medication was prescribed ranged from 52% to 75%, a referral to another health professional was provided from 11% to 22% and imaging was ordered from 8% to 20% across local areas.

(Figures 12 to 15, pages 40 to 43)

Introduction

About this report

The National Health Performance Authority (the Authority) bases its performance reports on indicators agreed by the Council of Australian Governments (COAG). This report provides information on the following equity and effectiveness indicators:

- Access to services by type of service compared to need
- GP-type service use.

The report also provides contextual information relevant to the following indicators:

- Specialist service utilisation
- Allied health-type service use
- Percentage of the population receiving primary mental health care.

This is the Authority's first report on primary health care that presents information at the local level on how often and in what way GPs manage their patients' health conditions, particularly chronic conditions.

Findings are broken down by 61 areas called Medicare Local catchments. The national network of Medicare Local organisations was established between 2011 and 2012 to work with GPs and other health professionals to improve the responsiveness, coordination and integration of local health services. These organisations are due to be replaced in 2015.

The report's findings can be considered in the context of four broad themes:

1. How frequently selected chronic conditions are found among **people who visit a GP** in a year
2. How often **GPs see patients** with one chronic condition or two or more chronic conditions (multimorbidity)
3. How often GPs **actively manage** patients for that chronic condition. In other words, how often a GP took steps to mitigate or monitor that condition, as opposed to another unrelated health problem
4. What **actions GPs took** to manage that condition (such as prescribing a medication or providing a referral or counselling)

(See Measuring GP activity in this report, pages 6 and 7).

Findings are presented around these themes for people who have a selected cardiovascular risk condition; depression and anxiety; and the musculoskeletal conditions, arthritis and chronic back pain. These conditions were selected because they are some of the most common among people in the community and are frequently seen in general practice **(see page 4)**.

In addition, the likelihood that people with these conditions experience complications or need to be hospitalised is reduced if these conditions are detected and managed early. Health outcomes are also improved with appropriate and ongoing GP care.[6]

The report offers insights into the extent to which GPs care for patients who have one or multiple chronic conditions, as many of these conditions require similar multidisciplinary approaches to prevention, treatment and management.[1]

While there is evidence that many aspects of care are well managed in Australia, there are gaps in the consistent delivery of appropriate care according to recommended guidelines. For example, studies have shown:

- Only 41% of patients in Australia with selected cardiovascular risk conditions were taking statins despite current guidelines recommending almost all people at risk of cardiovascular disease, and who require treatment, take a statin[8,11]
- Only 45% of patients with depression or anxiety were offered a treatment that could be beneficial[9]
- Only 18% of patients with low back pain received an analgesic, and 45% received a referral for imaging despite guidelines recommending the use of analgesics and discouraging imaging to manage low back pain[10,12].

Since people with chronic conditions consume a large amount of health and hospital services, improvements in their health and care are likely to increase the productivity and performance of Australia's health system.

In this context, optimal management of people with chronic conditions are of mutual interest to primary health care networks and Local Hospital Networks.

The aim of this report is to deepen understanding of local populations and how GP care differs across local areas, and to help clinicians and health service managers target improvements in services relative to the health needs of people in their communities.

What we know about GP care for people with chronic conditions

The number of people in Australia with a chronic condition is increasing, as is the number and percentage who have multiple chronic conditions.[4]

Common chronic conditions among people in Australia include selected cardiovascular risk conditions such as hyperlipidaemia (12%), type 2 diabetes (6%) and ischaemic heart disease (5%).[13,14]

One in six Australians have a diagnosed mental health condition including depression (10%) and anxiety (6%).[13,14] Almost one in seven have a musculoskeletal condition including arthritis (12%) and chronic back pain (4%).[14] Overall, one in two Australians are estimated to have at least one chronic condition and one in four have two or more chronic conditions (multimorbidity).[15]

Across local communities, there may be opportunities to improve prevention, treatment and management of chronic conditions. The Authority has reported marked differences in local rates of potentially avoidable hospitalisations and premature deaths from chronic conditions.[2,3]

For example:

- In 2011–12, the rate of potentially avoidable hospitalisations for chronic conditions varied across local areas from 643 per 100,000 population in Northern Sydney to 2,237 per 100,000 population in Central and North West Queensland
- The rate of potentially avoidable admissions for chronic conditions varied across similar metropolitan and regional communities
- Potentially avoidable hospitalisations for cardiovascular conditions were particularly high.[3]

In Australia, the economic burden of chronic conditions is also significant. In 2008–09, the direct health care costs of three of the four most expensive groups of conditions (cardiovascular diseases, mental disorders and musculoskeletal conditions) was estimated to be $20 billion, or more than one-quarter (27%) of all health expenditure.[4]

What we don't know

In Australia, there is limited information available at the local level on the reasons why people visit the GP and the health care they receive, which is intended to prevent, treat and manage chronic conditions.

There is also limited information on how GPs differ in the care they provide and the impact this has on rates of hospitalisations, morbidity and mortality.

This report is intended to start filling this gap in local-level information.

About the data

Data for this report were sourced from a continuous, national cross-sectional study of general practice activity called the Bettering the Evaluation and Care of Health (BEACH) program, which is conducted by the Family Medicine Research Centre (FMRC), the University of Sydney. Analysis of data was provided by FMRC.

The BEACH program comprises ever-changing, random samples of approximately 1,000 participating GPs per year, each of whom records information about encounters with 100 consecutive consenting patients. In this report, these encounters are called GP consultations.

The information in this report is about GP activity and the care GPs provide to their patients. The data does not include information on people who do not visit a GP or people with undiagnosed conditions. All of the data in this report are mapped to the geographic catchments where services were provided, rather than where people live.

Information on the management of chronic conditions by GPs and the actions GPs take (such as referral, prescription, counselling) are reported for the period from April 2009 to March 2013, and include 393,300 GP consultations.

The prevalence of conditions among patients are reported from a substudy within the BEACH program, the Supplementary and Nominal Data (SAND) for the period from July 2005 to June 2013, and include 25,855 patient consultations.

To report BEACH data at the local level, the Authority decided and FMRC applied methods and suppression rules to ensure the reliability, representativeness and confidentiality of the data.

To enable fairer comparisons, the Authority has allocated each local area to one of seven peer groups, based on socioeconomic status, remoteness, and distance to hospitals: three in metropolitan areas, two in regional areas, and two in rural areas. More information on these peer groups is available in the **Appendix, page 46**.

About the patients

Patients identified as having **one or more selected chronic conditions** include those patients, of any age, diagnosed with one or more of the following 18 commonly managed conditions, in order based on prevalence at GP consultation:

- Hypertension
- Osteoarthritis
- Hyperlipidaemia
- Depression
- Gastro-oesophageal reflux disease
- Anxiety
- Asthma
- Chronic back pain
- Ischaemic heart disease
- Type 2 diabetes
- Cancer (malignant neoplasm)
- Sleep disorder
- Chronic obstructive pulmonary disease
- Cerebrovascular disease/cerebrovascular accident
- Congestive heart failure
- Peripheral vascular disease
- Rheumatoid arthritis
- Type 1 diabetes.

The BEACH data were used to identify patients, of any age, with **selected cardiovascular risk conditions** based on clinical guidelines[11] to support the management of:

- Ischaemic heart disease – including acute myocardial infarction (AMI)
- Cerebrovascular disease and stroke
- Heart failure
- Type 2 diabetes among people 60 years of age and older
- Hyperlipidaemia.

Patients identified as having **depression, anxiety or both of these conditions** include patients, of any age, who have diagnosed depression, anxiety or both conditions, which is considered by the GP to be chronic.

Patients identified as having **arthritis or chronic back pain** include those patients, of any age, who have diagnosed osteoarthritis, rheumatoid arthritis and/or chronic back pain. Osteoarthritis and rheumatoid arthritis account for 86% of all arthritis problems managed in BEACH data.

About the measures

Patients with a chronic condition, included in this report, are those patients who visit the GP at least once in a year who are recorded by the GP as having a selected cardiovascular risk condition; depression, anxiety or both of these conditions; arthritis or chronic back pain or one or more of 18 selected chronic conditions per 100 people who visit the GP at least once in a year. Information is presented as a percentage.

This measure was weighted to the age and sex distribution of people who visited the GP at least once in a year, using Medicare Benefits Schedule data.

GP consultations with patients who have a chronic condition, is measured as the number of GP consultations that involved patients who have a specific chronic condition or one or more common chronic conditions per 100 GP consultations.

Information is presented as the percentage of GP consultations that occur with patients who have a condition, irrespective of whether the patient had that condition managed.

That is, people with a selected cardiovascular risk condition who, for example, had other problems managed but not the cardiovascular risk condition, are included in this measure. Therefore, this measure shows the percentage of consultations in which GPs have the opportunity to 'check up' on patients who have this condition, irrespective of the reason they visited.

GP management of chronic conditions is measured as the number of GP consultations in which the chronic condition or multiple chronic conditions are actively managed by the GP per 100 GP consultations. Information is presented as the percentage of GP consultations in which a specific chronic condition is actively managed, or for multimorbidity, when two or more chronic conditions of any kind are managed.

For example, people with a cardiovascular risk condition who had other problems managed, but not their cardiovascular risk condition are excluded in this measure.

GP actions in the management of chronic conditions is measured as the number of times a referral, prescription or GP counselling is provided to manage a specific chronic condition per 100 GP management occasions for the specific chronic condition. Information is presented as a percentage.

For more information on the methods used in the report see *Healthy Communities: GP care for patients with chronic conditions in 2009–2013, Technical Supplement* at **www.myhealthycommunities.gov.au**

Measuring GP activity in this report

There are many people living in Australia with one or more chronic conditions, such as selected cardiovascular risk conditions, depression, anxiety, arthritis and chronic back pain.

Patients

Percentage of all people who visit a GP at least once in a year who have a chronic condition

Consultations

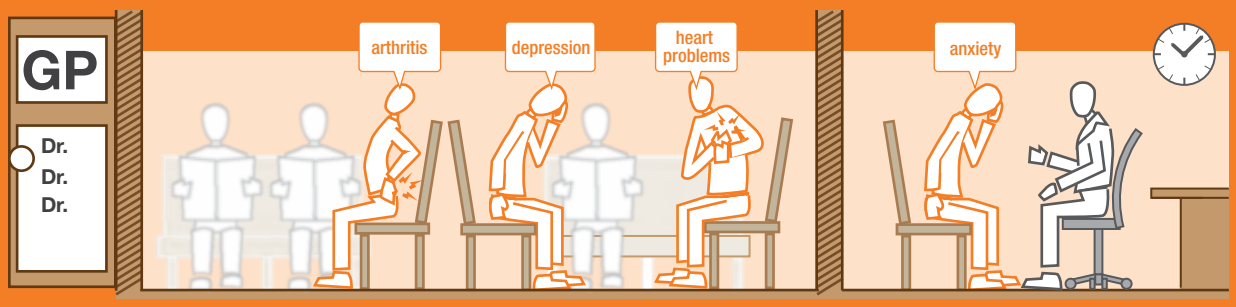
Percentage of all GP consultations with patients who have chronic conditions

Management

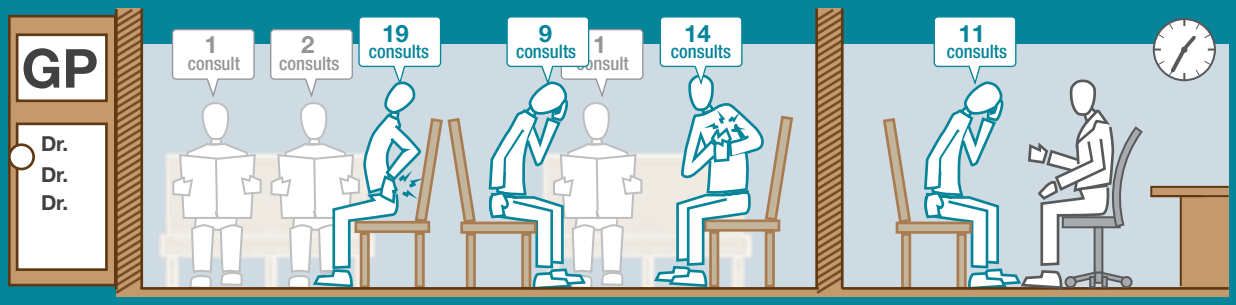
Percentage of all GP consultations in which chronic conditions are actively managed

Actions

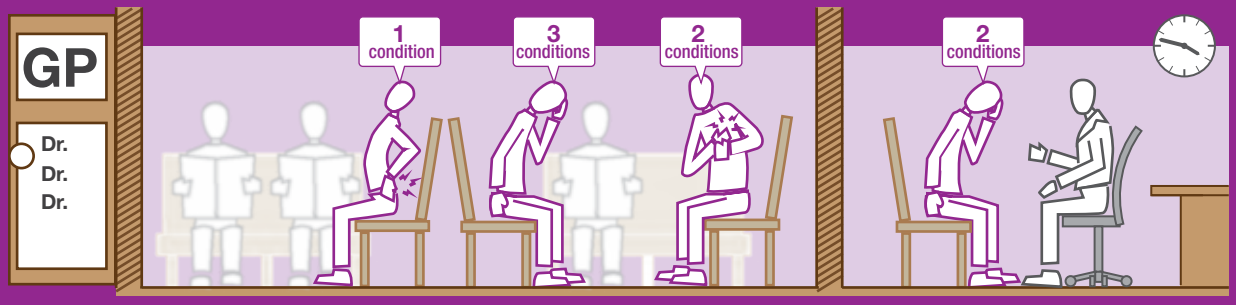
Percentage of GP management occasions in which patients with chronic conditions receive a prescription, referral or counselling



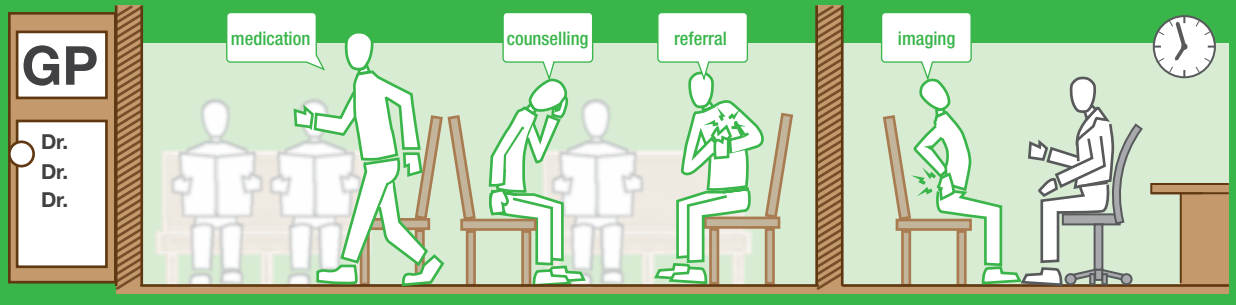
Most people with a chronic condition visit a GP each year



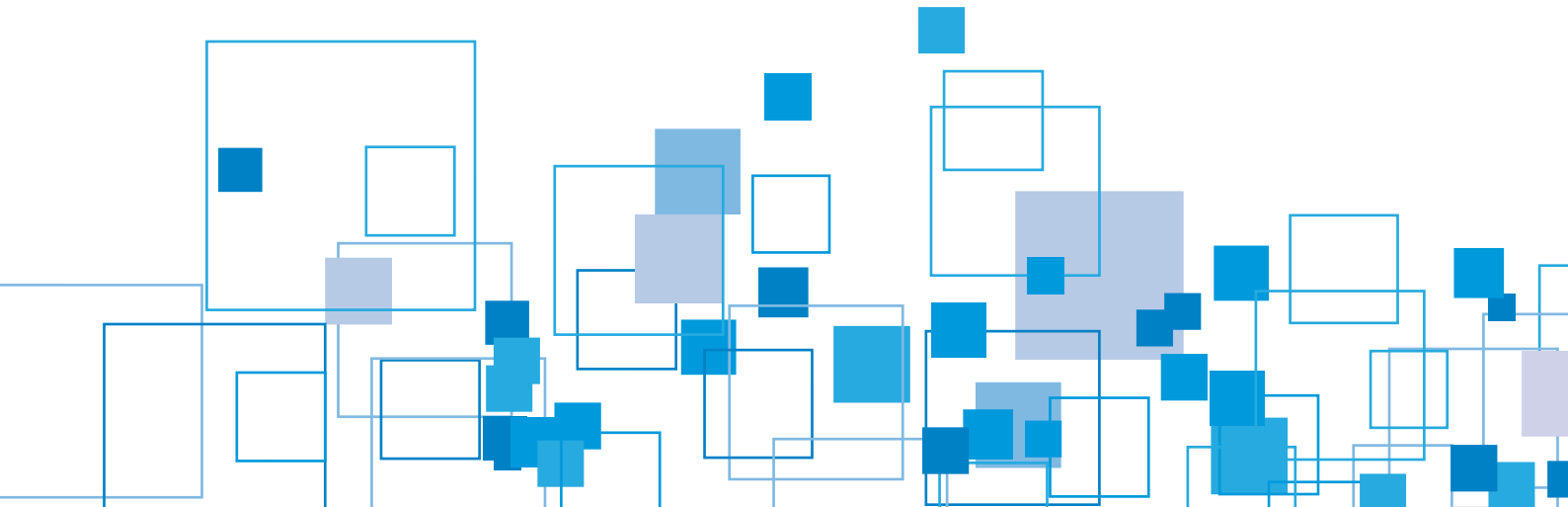
Patients *with* chronic conditions tend to have more GP consultations than patients *without*



GPs may *actively manage* one or more chronic conditions during a single consultation



GPs may take clinical actions such as prescribing medications to manage these conditions



GP care for patients with chronic conditions and multimorbidity

GP care for patients with chronic conditions in 2009–2013

Key findings: GP care for patients with chronic conditions and multimorbidity

The number of people in Australia with chronic conditions is increasing, as is the number and percentage who have multiple chronic conditions (multimorbidity).[4]

GPs provide care for acute and episodic health conditions and help patients manage chronic conditions. Patients with two, or three or more chronic conditions, often have complex health needs that require ongoing management and coordination of more specialised care with other parts of the health care system.

Among **all people who visit the GP** at least once in a year, the percentage of people who had one or more chronic conditions ranged from 44% to 56% across local areas. The percentage was slightly higher in regional areas, particularly in lower-income regional areas than in metropolitan areas **(Figure 1, page 12)**.

In comparison, the percentage of **all GP consultations** that involved patients who had one or more chronic conditions was only slightly higher (51% to 60%) across metropolitan and rural areas, and higher still (60% to 66%) across regional areas **(Figure 2, page 12)**.

Across local areas, the percentage of GP consultations in which one or more chronic conditions were **actively managed** ranged from 34% of all GP consultations in Sydney North Shore & Beaches, to 50% of consultations in Hume (Vic/NSW).

- Among metropolitan communities (**Metro 1, 2 and 3** peer groups), the highest percentage of GP consultations in which one or more chronic conditions were **actively managed** was Southern Adelaide-Fleurieu-Kangaroo Island
- Among regional communities (**Regional 1 and 2**) the highest percentage of GP consultations in which one or more chronic conditions were **actively managed** was Hume (Vic/NSW)
- Among rural communities (**Rural 1 and 2**) the highest percentage of GP consultations in which one or more chronic conditions were **actively managed** was Townsville-Mackay (Qld)

(Figure 3b, page 13).

The findings also indicate that irrespective of variation in how often GPs saw patients with **three or more** chronic conditions (19% to 30% of consultations across peer groups), they **actively managed** three or more chronic conditions at about the same frequency (2% to 3% of consultations). This may indicate that in local areas with a higher proportion of patients with three or more chronic conditions, opportunities may exist to optimise care for these patients **(Figures 2, 3a and 3b, pages 12 and 13)**.

Figure 1: Percentage of people who visit the GP at least once in a year who had one, two or three or more common chronic conditions*, by *Medicare Local catchment peer group*, 2005–2013†

Peer groups	Number of chronic conditions		
	One only	Two only	Three or more
Metro 1	21%	11%	16%
Metro 2	20%	11%	18%
Metro 3	19%	11%	19%
Regional 1	20%	12%	19%
Regional 2	20%	13%	23%
Rural 1	20%	10%	20%
Rural 2	19%	10%	15%

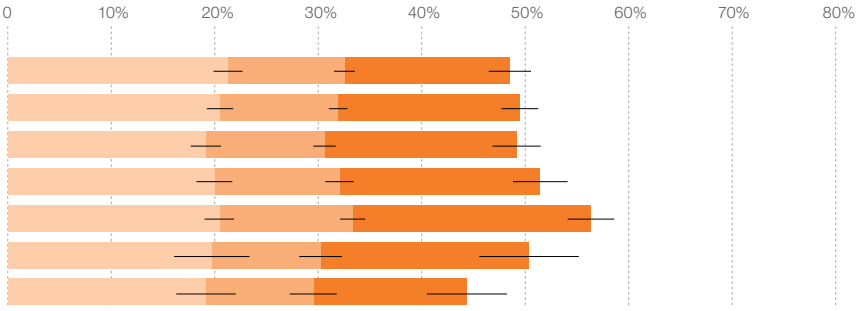


Figure 2: Percentage of GP consultations with patients who had one, two or three or more common chronic conditions*, by *Medicare Local catchment peer group*, 2005–2013

Peer groups	Number of chronic conditions		
	One only	Two only	Three or more
Metro 1	21%	12%	21%
Metro 2	20%	13%	23%
Metro 3	18%	14%	28%
Regional 1	19%	14%	27%
Regional 2	20%	15%	30%
Rural 1	18%	13%	29%
Rural 2	20%	12%	19%

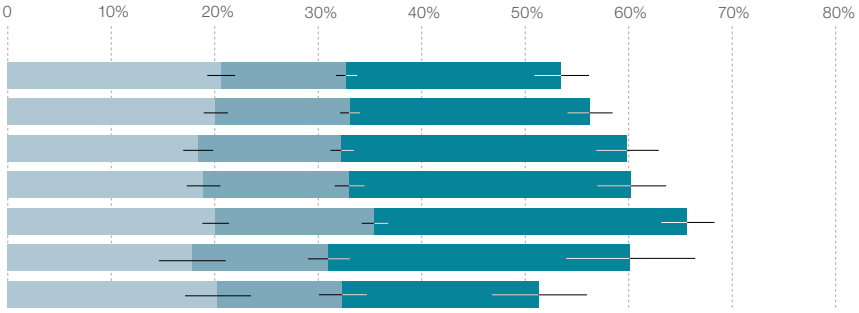
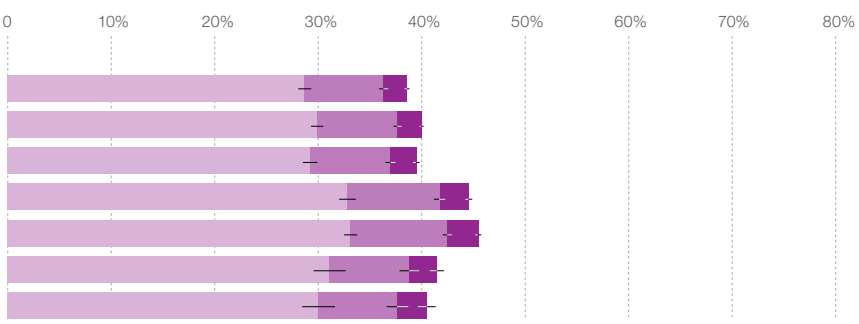


Figure 3a: Percentage of GP consultations in which one, two or three or more chronic conditions‡ were managed, by *Medicare Local catchment peer group*, 2009–2013

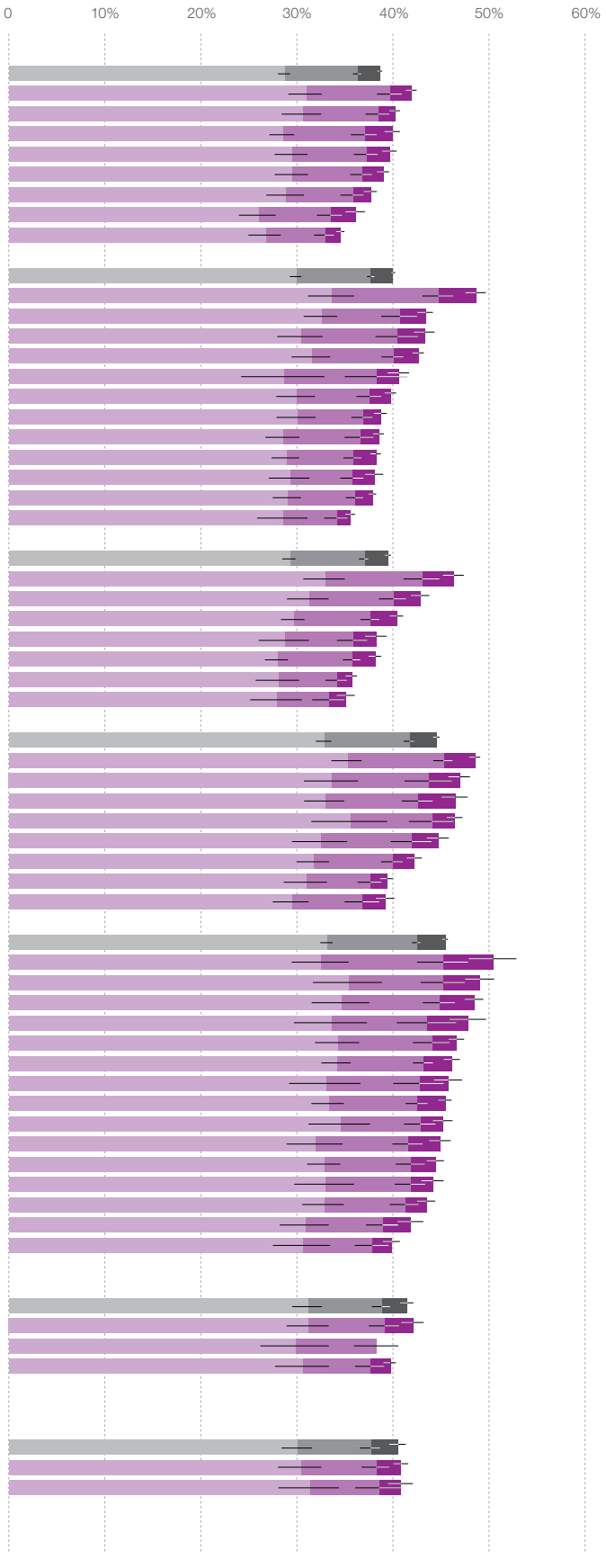
Peer groups	Number of chronic conditions		
	One only	Two only	Three or more
Metro 1	29%	8%	2%
Metro 2	30%	8%	2%
Metro 3	29%	8%	3%
Regional 1	33%	9%	3%
Regional 2	33%	9%	3%
Rural 1	31%	8%	3%
Rural 2	30%	8%	3%



95% Confidence interval.
* Results comprise patients who are recorded by the GP as having been diagnosed with one or more of 18 common chronic conditions.
† Data were weighted to the attending patient population using Department of Human Services, Medicare Benefits statistics, 12 months ending June 2013.
‡ Results comprise all chronic conditions managed. See O'Halloran J, et al. Defining chronic conditions for primary care with ICPC-2. Fam Pract 2004;21(4).
NP Not available for publication.
Notes: Data are reported as whole numbers. However, for graphical display and ordering they are plotted unrounded. Data are collected from a national survey of GPs. Characteristics of participating GPs may differ from non-participating GPs in a Medicare Local catchment which may affect the generalisability of results. For data limitations and exclusions see this report's Technical Supplement.
Source: Customised analysis of BEACH dataset (April 2009–March 2013) and BEACH SAND substudy dataset (July 2005–June 2013) prepared for the National Health Performance Authority by the Family Medicine Research Centre, the University of Sydney.

Figure 3b: Percentage of GP consultations in which one, two or three or more chronic conditions‡ were managed, by *Medicare Local catchment*, 2009–2013

Medicare Local catchments grouped by peer group	Number of chronic conditions: One only	Two only	Three or more
Metro 1	**29%**	**8%**	**2%**
Northern Sydney	31%	9%	2%
Australian Capital Territory	30%	8%	2%
Inner West Sydney	28%	9%	3%
Inner NW Melbourne	29%	8%	2%
Inner East Melbourne	29%	7%	2%
Bayside (Vic)	29%	7%	2%
Eastern Sydney	26%	8%	3%
Sydney Nth Shore & Beaches	27%	6%	2%
Metro 2	**30%**	**8%**	**2%**
Sthn Adelaide-Fleurieu-Kang. Is.	34%	11%	4%
Fremantle (WA)	32%	8%	3%
Eastern Melbourne	30%	10%	3%
Perth Central & East Metro	31%	8%	3%
South Western Melbourne	29%	10%	2%
Central Adelaide & Hills	30%	8%	2%
Gold Coast (Qld)	30%	7%	2%
Perth North Metro	28%	8%	2%
Greater Metro South Brisbane	29%	7%	2%
South Eastern Sydney	29%	7%	2%
Metro North Brisbane	29%	7%	2%
Bentley-Armadale (WA)	28%	6%	1%
Metro 3	**29%**	**8%**	**3%**
Northern Adelaide	33%	10%	3%
Northern Melbourne	31%	9%	3%
South Western Sydney	30%	8%	3%
Macedon Ranges & NW Melbourne	29%	7%	2%
Western Sydney	28%	8%	2%
West Moreton-Oxley (Qld)	28%	6%	2%
South Eastern Melbourne	28%	5%	2%
Regional 1	**33%**	**9%**	**3%**
Hunter (NSW)	35%	10%	3%
Frankston-Mornington Peninsula (Vic)	34%	10%	3%
Illawarra-Shoalhaven (NSW)	33%	10%	4%
Perth South Coastal	35%	9%	2%
Central Coast NSW	32%	10%	3%
Sunshine Coast (Qld)	32%	8%	2%
Nepean-Blue Mountains (NSW)	31%	7%	2%
Barwon (Vic)	29%	7%	2%
Regional 2	**33%**	**9%**	**3%**
Hume (Vic/NSW)	32%	13%	5%
Loddon-Mallee-Murray (Vic/NSW)	35%	10%	4%
Wide Bay (Qld)	35%	10%	4%
Murrumbidgee (NSW)	33%	10%	4%
Gippsland (Vic)	34%	10%	3%
Tasmania	34%	9%	3%
Goulburn Valley (Vic)	33%	10%	3%
North Coast NSW	33%	9%	3%
Great South Coast (Vic)	34%	8%	2%
Southern NSW	32%	10%	3%
Darling Downs-SW Qld	33%	9%	3%
Grampians (Vic)	33%	9%	2%
South West WA	33%	8%	2%
Western NSW	31%	8%	3%
New England (NSW)	30%	7%	2%
Country South SA	NP	NP	NP
Rural 1	**31%**	**8%**	**3%**
Townsville-Mackay (Qld)	31%	8%	3%
Central Qld	30%	9%	NP
Country North SA	31%	7%	2%
Far West NSW	NP	NP	NP
Lower Murray (Vic/NSW)	NP	NP	NP
Rural 2	**30%**	**8%**	**3%**
Far North Qld	30%	8%	3%
Northern Territory	31%	7%	2%
Central & NW Qld	NP	NP	NP
Goldfields-Midwest (WA)	NP	NP	NP
Kimberley-Pilbara (WA)	NP	NP	NP



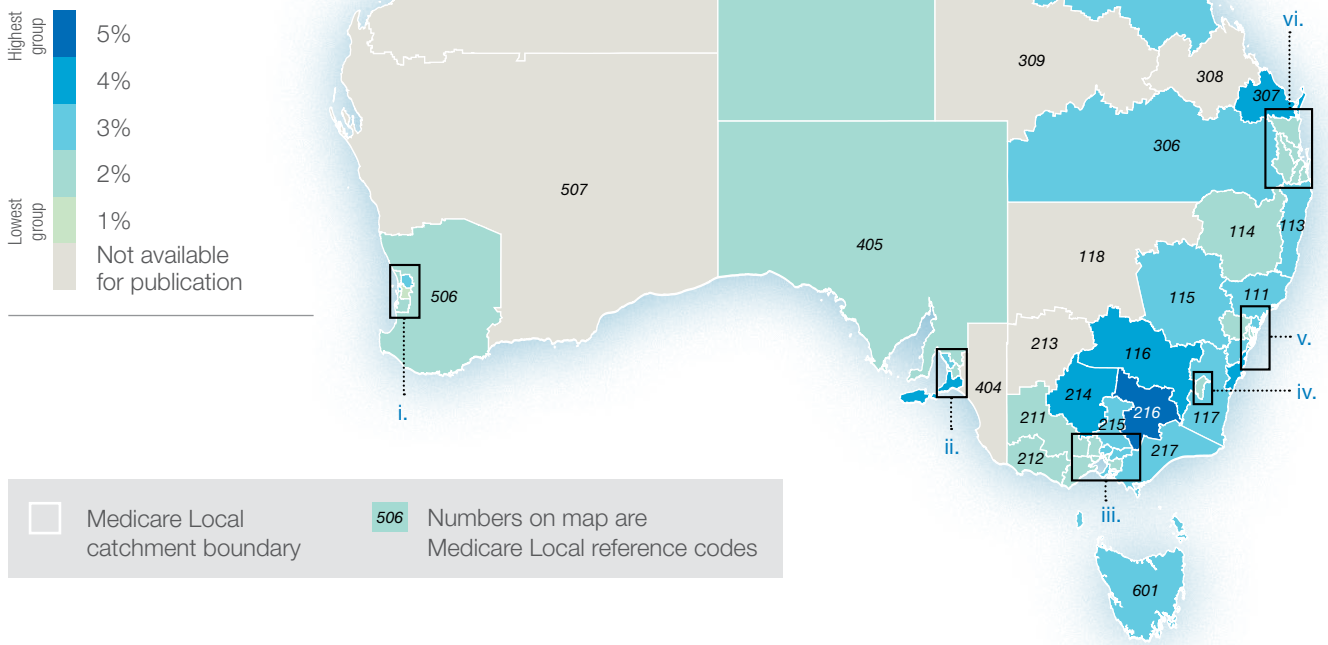
GP management of three or more chronic conditions

Years of data: 2009–2013

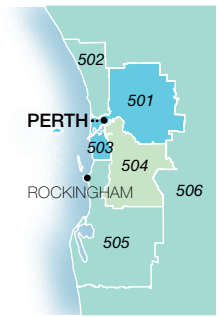
During 2009–2013, the percentage of GP consultations in which three or more chronic conditions[1] were managed varied across Medicare Local catchments and across peer groups, ranging from 5% in Hume (Vic/NSW) to 1% in Bentley-Armadale (WA).

Percentage of GP consultations in which three or more chronic conditions were managed, 2009–2013

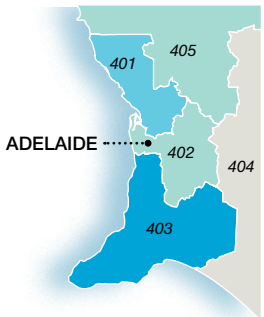
Results for Medicare Local catchments were ranked from highest to lowest then split into five groups.[2]



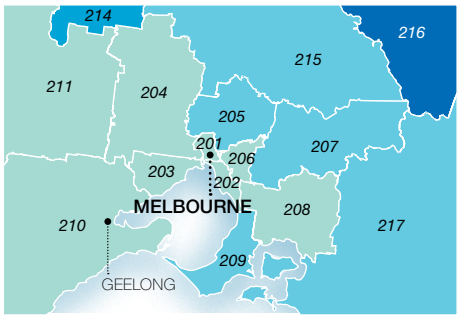
i. Perth and surrounding areas



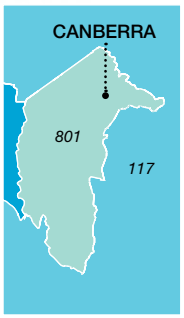
ii. Adelaide and surrounding areas



iii. Melbourne and surrounding areas



iv. Canberra and surrounding areas

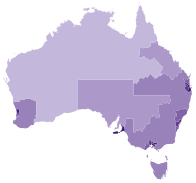


1. Results comprise all chronic conditions managed in general practice defined in O'Halloran J, et al. Defining chronic conditions for primary care with ICPC-2. Fam Pract 2004;21(4):381–6.
2. Each Medicare Local catchment has been assigned to a group that represents one percentage point.
3. For more information on peer groups and the calculation of peer group results refer to this report's Technical Supplement.

Notes: Data are reported as whole numbers. However, for graphical display and ordering they are plotted unrounded. Data are collected from a national survey of GPs. Characteristics of participating GPs may differ from non-participating GPs in a Medicare Local catchment which may affect the generalisability of results. For data limitations and exclusions see this report's Technical Supplement.

Source: Customised analysis of BEACH data prepared for the National Health Performance Authority by the Family Medicine Research Centre, the University of Sydney, 2009–2013. **Data can be downloaded from www.myhealthycommunities.gov.au**

Fair comparisons

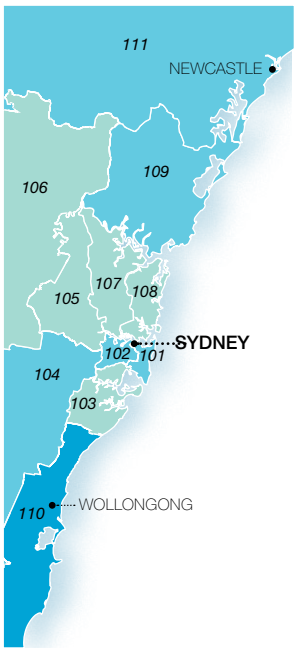


To compare Medicare Locals more fairly, each Medicare Local catchment has been grouped into one of seven peer groups[3], based on remoteness and socioeconomic status. This allows:

- Medicare Local catchments to be compared within the same metropolitan, regional or rural peer group
- Medicare Local catchments to be compared with the average for their peer group.

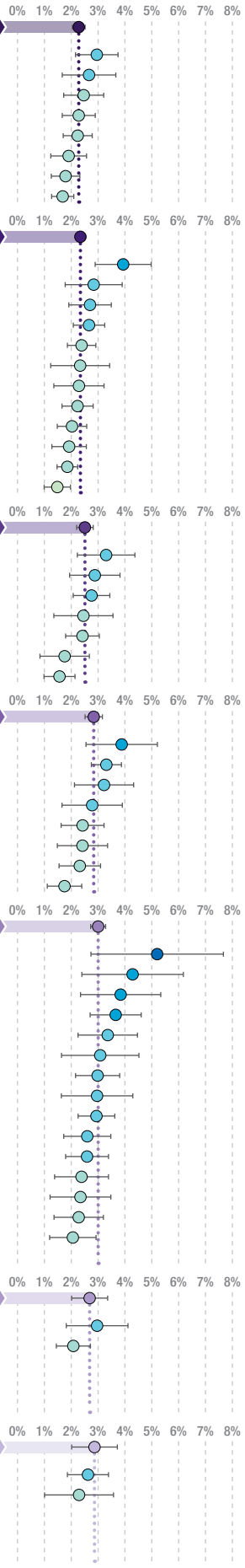
It also allows variation to be seen across peer groups that may be associated with remoteness and socioeconomic status.

v. Sydney and surrounding areas

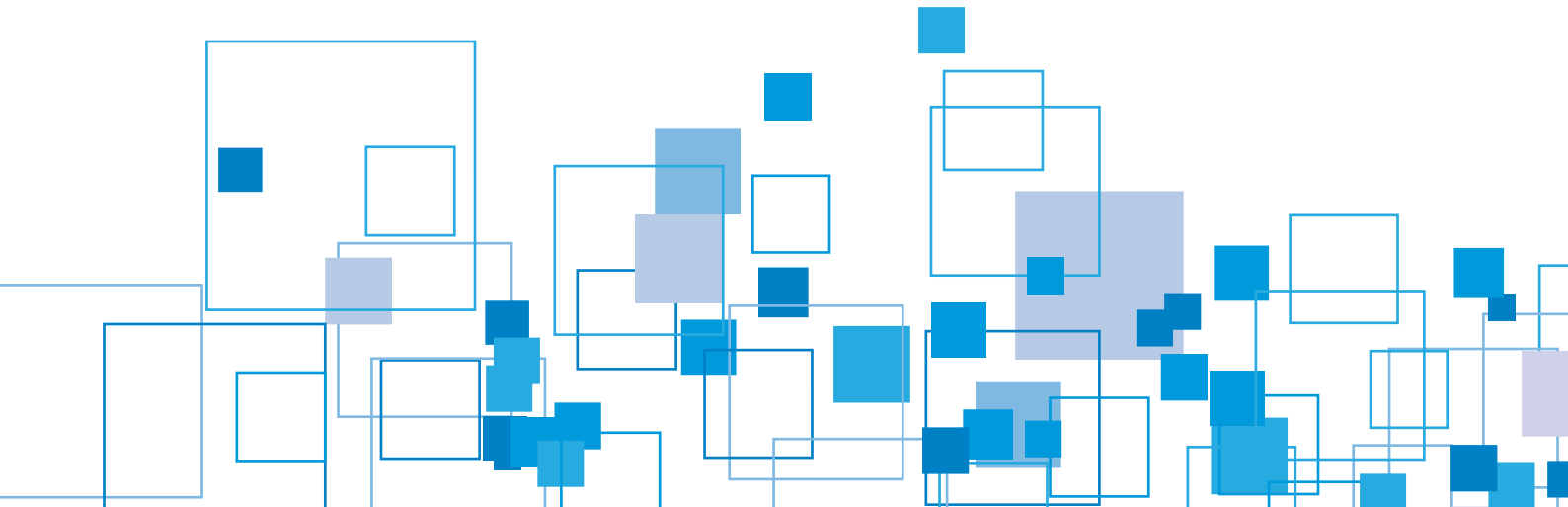


vi. Brisbane and surrounding areas

Peer groups	Map Ref.	
Metro 1		**2%**
Inner West Sydney	102	3%
Eastern Sydney	101	3%
Inner NW Melbourne	201	2%
Inner East Melbourne	206	2%
Northern Sydney	107	2%
Bayside	202	2%
Australian Capital Territory	801	2%
Sydney North Shore & Beaches	108	2%
Metro 2		**2%**
Sthn Adelaide-Fleurieu-Kang. Is.	403	4%
Eastern Melbourne	207	3%
Fremantle	503	3%
Perth Central & East Metro	501	3%
Greater Metro South Brisbane	302	2%
South Western Melbourne	203	2%
South Eastern Sydney	103	2%
Central Adelaide & Hills	402	2%
Perth North Metro	502	2%
Gold Coast	303	2%
Metro North Brisbane	301	2%
Bentley-Armadale	504	1%
Metro 3		**3%**
Northern Adelaide	401	3%
Northern Melbourne	205	3%
South Western Sydney	104	3%
Macedon Ranges & NW Melb	204	2%
Western Sydney	105	2%
South Eastern Melbourne	208	2%
West Moreton-Oxley	305	2%
Regional 1		**3%**
Illawarra-Shoalhaven	110	4%
Hunter	111	3%
Frankston-Mornington Peninsula	209	3%
Central Coast NSW	109	3%
Perth South Coastal	505	2%
Barwon	210	2%
Sunshine Coast	304	2%
Nepean-Blue Mountains	106	2%
Regional 2		**3%**
Hume	216	5%
Murrumbidgee	116	4%
Loddon-Mallee-Murray	214	4%
Wide Bay	307	4%
Southern NSW	117	3%
Goulburn Valley	215	3%
Tasmania	601	3%
Western NSW	115	3%
North Coast NSW	113	3%
Darling Downs-SW Qld	306	3%
Gippsland	217	3%
Great South Coast	212	2%
Grampians	211	2%
South West WA	506	2%
New England	114	2%
Country South SA	404	NP
Rural 1		**3%**
Townsville-Mackay	310	3%
Country North SA	405	2%
Far West NSW	118	NP
Lower Murray	213	NP
Central Qld	308	NP
Rural 2		**3%**
Far North Qld	311	3%
Northern Territory	701	2%
Central & NW Qld	309	NP
Goldfields-Midwest	507	NP
Kimberley-Pilbara	508	NP



NP Not available for publication.
More information can be found at **www.myhealthycommunities.gov.au** and in this report's Technical Supplement.



GP care for patients with selected cardiovascular risk conditions

GP care for patients with chronic conditions in 2009–2013

Key findings: GP care for patients with selected cardiovascular risk conditions

In Australia, many of the most common chronic conditions are cardiovascular risk conditions, including hyperlipidaemia (12%), type 2 diabetes (6%) and ischaemic heart disease (5%).[13,14]

Among **all people who visit the GP** at least once in a year, the percentage of people who had one or more selected cardiovascular risk conditions ranged from 17% to 19% in metropolitan communities to 16% to 21% in regional and rural communities **(Figure 4, page 20)**.

The percentage of **all GP consultations** that involved patients who had a selected cardiovascular risk condition, irrespective of whether the condition was managed, was 22% in high and middle-income metropolitan areas compared to 19% to 30% in lower-income metropolitan, as well as all regional and rural areas **(Figure 5, page 20)**.

GPs managed cardiovascular risk conditions in about one-third of all consultations with these patients. Across local areas, the proportion of all GP consultations in which cardiovascular risk conditions were **actively managed** ranged from one in nine (11%) consultations in Hume (Vic/NSW) to one in 20 (5%) consultations in South Eastern Melbourne and West Moreton-Oxley (Qld) **(Figure 6b, page 21)**.

GP actions to manage selected cardiovascular risk conditions also varied across local areas, which illustrates the diverse approaches to managing these conditions and may reflect the availability of allied health professionals and specialists.

Depending on where a GP practises, the percentage of GP management occasions in which **statins were prescribed** ranged from 26% in South Eastern Melbourne and Sunshine Coast (Qld) to 40% in Central Queensland and Eastern Sydney.

Across local areas, a **referral to another health professional** was provided for one in 25 (4%) GP management occasions for a cardiovascular risk condition in Bayside (Vic), Northern Melbourne, and Central Queensland compared to one in nine (11%) occasions in Nepean-Blue Mountains (NSW) **(Figure 7, page 22 and 23)**.

There were also some differences between similar local areas that are within the same peer group, after accounting for geographic and socioeconomic characteristics.

Selected cardiovascular risk conditions comprise ischaemic heart disease, including acute myocardial infarction (AMI), cerebrovascular disease, heart failure, stroke and hyperlipidaemia, and type 2 diabetes for people 60 years and over. These conditions were selected based on recommended guidelines for the management of these conditions.[11]

Figure 4: Percentage of people who visit the GP at least once in a year who had a selected cardiovascular risk condition*, by *Medicare Local catchment peer group*, 2005–2013†

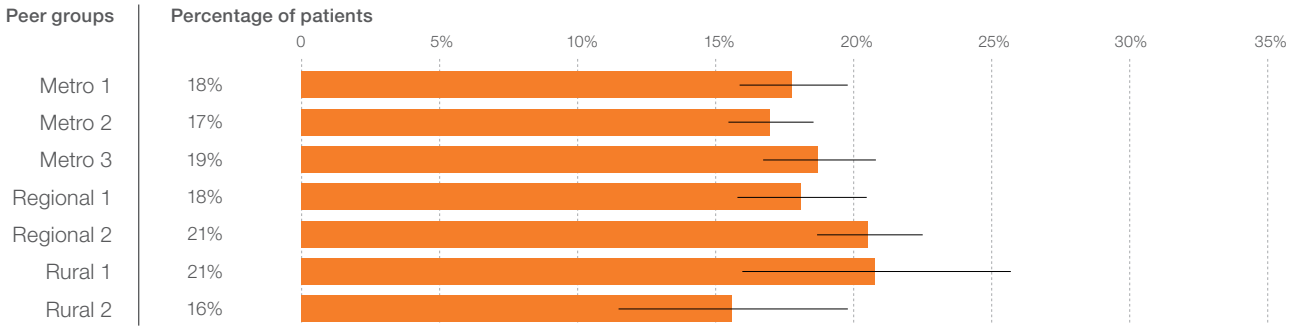


Figure 5: Percentage of GP consultations with patients who had a selected cardiovascular risk condition*, by *Medicare Local catchment peer group*, 2005–2013

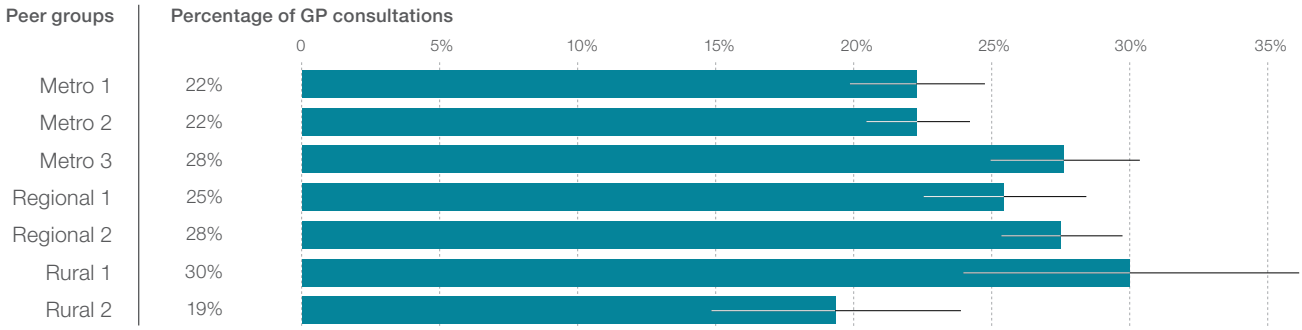
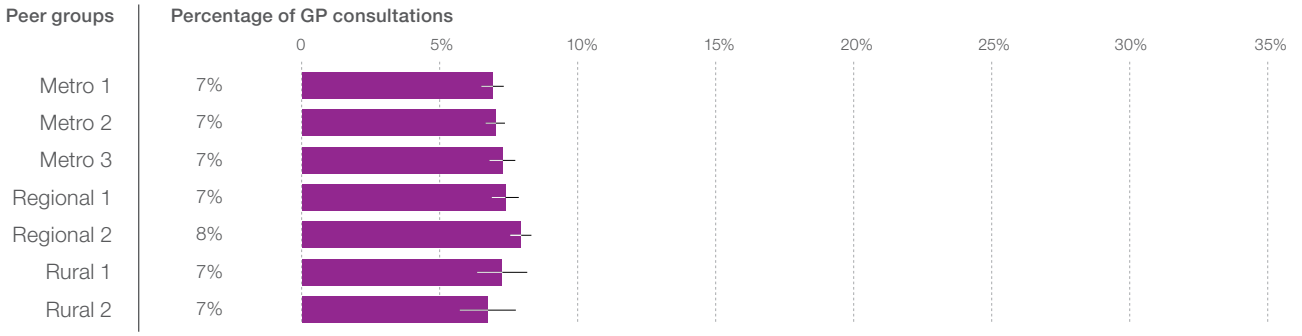


Figure 6a: Percentage of GP consultations in which a selected cardiovascular risk condition* was managed, by *Medicare Local catchment peer group*, 2009–2013



95% Confidence interval.

* Selected cardiovascular risk conditions comprise ischaemic heart disease including acute myocardial infarction (AMI), cerebrovascular disease, heart failure, stroke and hyperlipidaemia, and type 2 diabetes for people 60 years and over. These conditions were selected based on recommended guidelines for the management of these conditions.

† Customised analysis of BEACH SAND substudy data (2005–2013) weighted to the attending population using Department of Human Services, Medicare Benefits statistics, 12 months ending June 2013.

\# Interpret with caution.

NP Not available for publication.

Notes: Data are reported as whole numbers. However, for graphical display and ordering they are plotted unrounded. Data are collected from a national survey of GPs. Characteristics of participating GPs may differ from non-participating GPs in a Medicare Local catchment which may affect the generalisability of results. For data limitations and exclusions see this report's Technical Supplement.

Source: Customised analysis of BEACH dataset (April 2009–March 2013) and BEACH SAND substudy dataset (July 2005–June 2013) prepared for the National Health Performance Authority by the Family Medicine Research Centre, the University of Sydney.

Data can be downloaded from www.myhealthycommunities.gov.au

Figure 6b: Percentage of GP consultations in which a selected cardiovascular risk condition* was managed, by Medicare Local catchment, 2009–2013

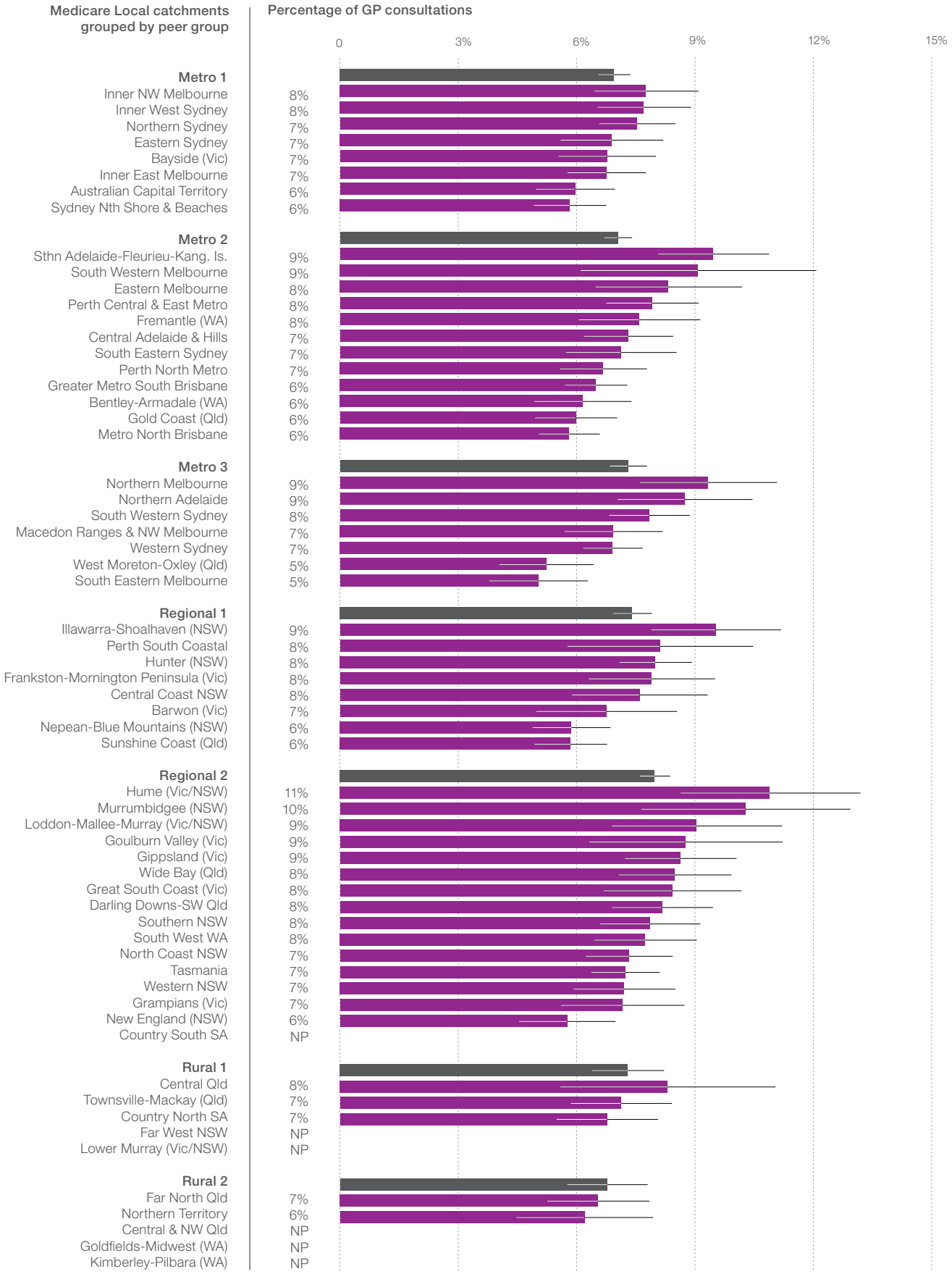
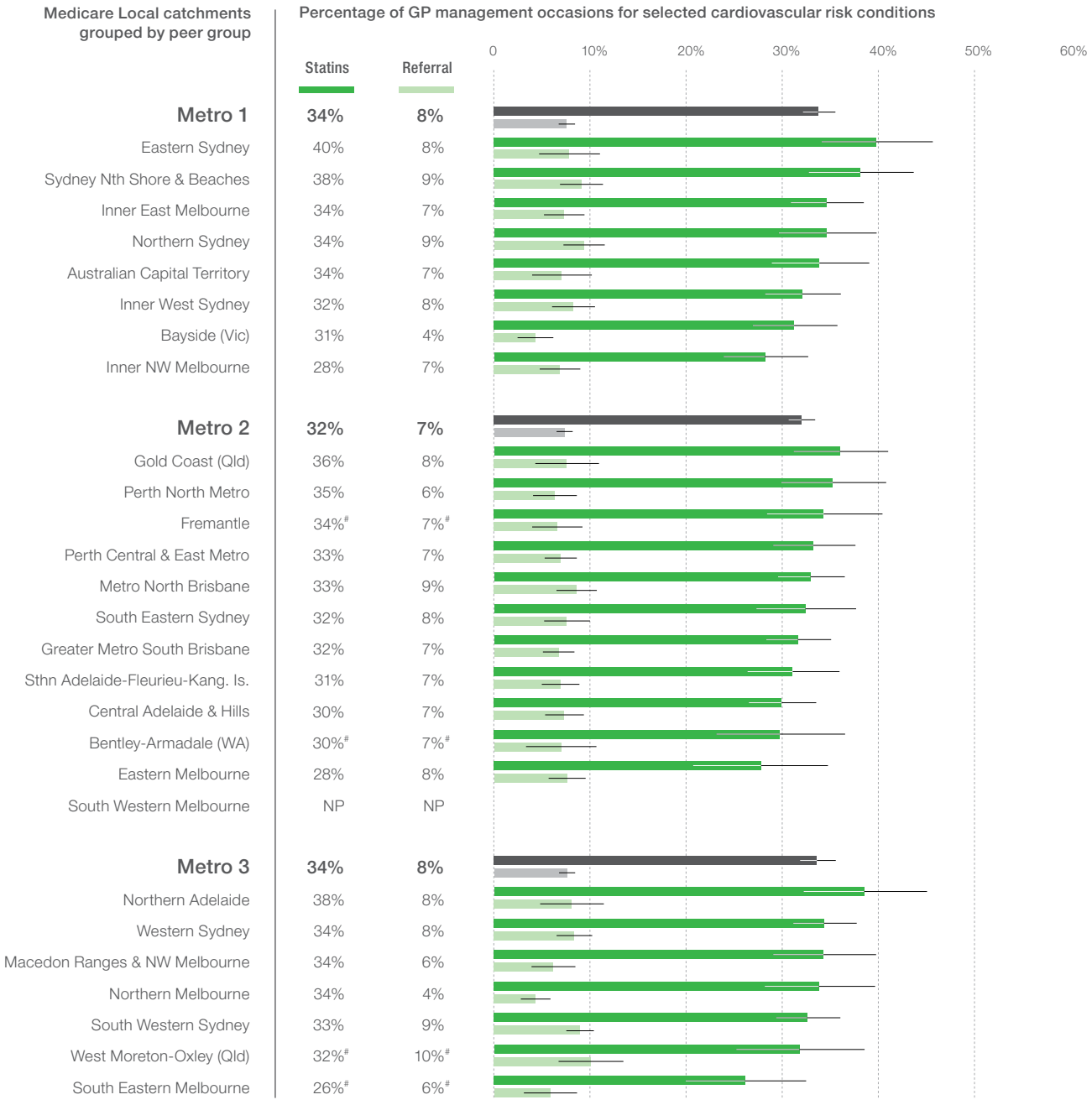


Figure 7: Percentage of GP management occasions in which statins were prescribed or a referral to a health professional was provided in the management of a selected cardiovascular risk condition*, by *Medicare Local catchment*, 2009–2013



95% Confidence interval.

* Selected cardiovascular risk conditions comprise ischaemic heart disease including acute myocardial infarction (AMI), cerebrovascular disease, heart failure, stroke and hyperlipidaemia, and type 2 diabetes for people 60 years and over. These conditions were selected based on recommended guidelines for the management of these conditions.

\# Interpret with caution.

NP Not available for publication.

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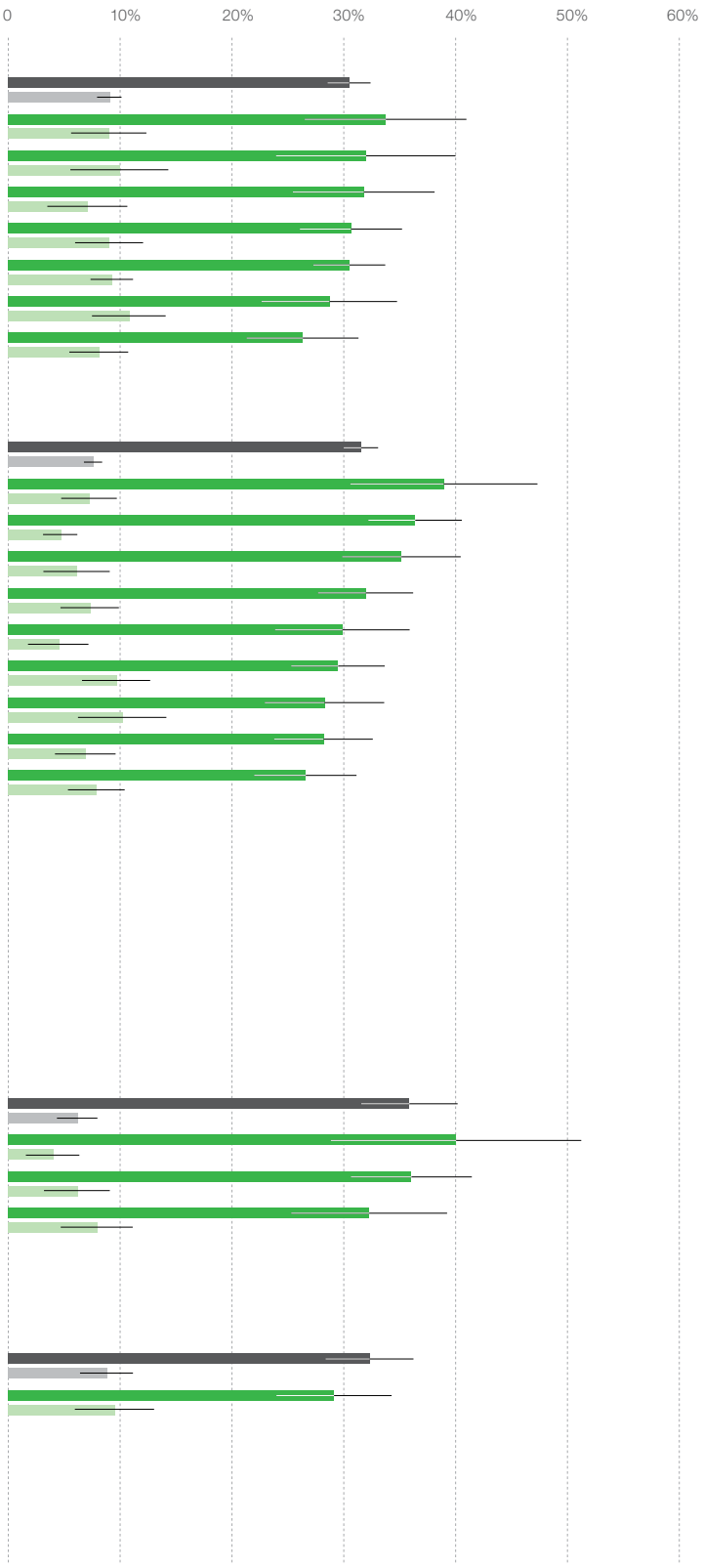
Source: Customised analysis of BEACH data prepared for the National Health Performance Authority by the Family Medicine Research Centre, the University of Sydney, 2009–2013.

Data can be downloaded from www.myhealthycommunities.gov.au

Medicare Local catchments grouped by peer group	Statins	Referral
Regional 1	**30%**	**9%**
Central Coast NSW	34%	9%
Frankston-Mornington Peninsula (Vic)	32%#	10%#
Barwon (Vic)	32%#	7%#
Illawarra-Shoalhaven (NSW)	31%	9%
Hunter (NSW)	30%	9%
Nepean-Blue Mountains (NSW)	29%#	11%#
Sunshine Coast (Qld)	26%	8%
Perth South Coastal	NP	NP
Regional 2	**31%**	**8%**
Hume (Vic/NSW)	39%#	7%#
Tasmania	36%	5%
Southern NSW	35%	6%
South West WA	32%	7%
Wide Bay (Qld)	30%#	5%#
North Coast NSW	29%	10%
Western NSW	28%	10%
Gippsland (Vic)	28%	7%
Darling Downs-SW Qld	27%	8%
Country South SA	NP	NP
Goulburn Valley (Vic)	NP	NP
Grampians (Vic)	NP	NP
Great South Coast	NP	NP
Loddon-Mallee-Murray (Vic/NSW)	NP	NP
Murrumbidgee (NSW)	NP	NP
New England (NSW)	NP	NP
Rural 1	**36%**	**6%**
Central Qld	40%#	4%#
Townsville-Mackay (Qld)	36%	6%
Country North SA	32%#	8%#
Far West NSW	NP	NP
Lower Murray (Vic/NSW)	NP	NP
Rural 2	**32%**	**9%**
Far North Qld	29%	10%
Central & NW Qld	NP	NP
Goldfields-Midwest (WA)	NP	NP
Kimberley-Pilbara (WA)	NP	NP
Northern Territory	NP	NP

Percentage of GP management occasions of a selected cardiovascular risk conditions



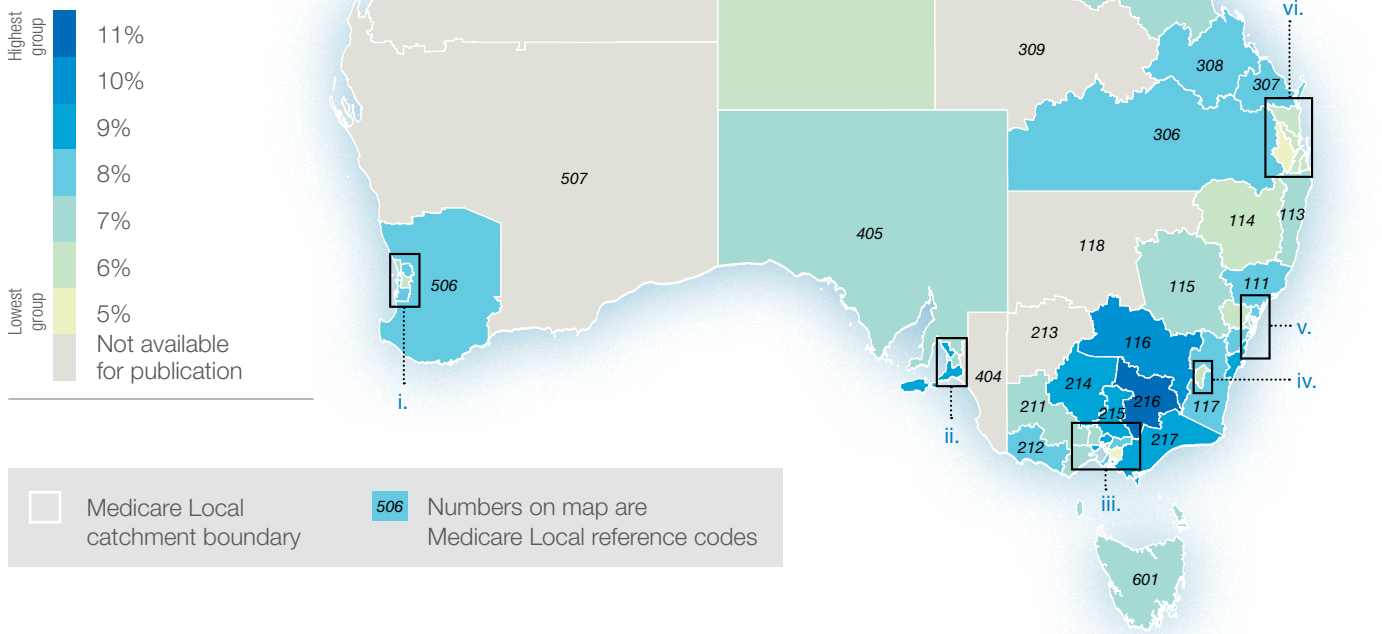
GP management of selected cardiovascular risk conditions

Years of data: 2009–2013

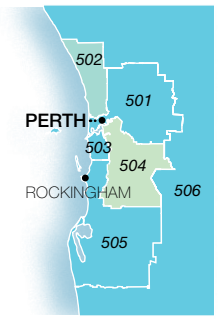
During 2009–2013, the percentage of GP consultations in which a selected cardiovascular risk condition[1] was managed varied across Medicare Local catchments and across peer groups, ranging from 11% in Hume (Vic/NSW) to 5% in South Eastern Melbourne and West Moreton-Oxley (Qld).

Percentage of GP consultations in which a selected cardiovascular risk condition was managed, 2009–2013

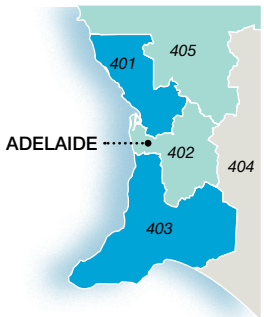
Results for Medicare Local catchments were ranked from highest to lowest then split into seven groups.[2]



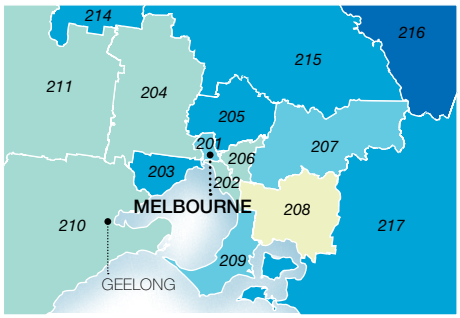
i. Perth and surrounding areas



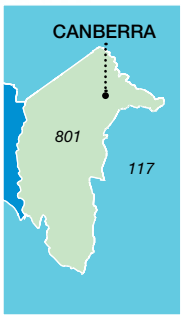
ii. Adelaide and surrounding areas



iii. Melbourne and surrounding areas



iv. Canberra and surrounding areas

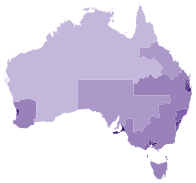


1. Selected cardiovascular risk conditions comprise ischaemic heart disease including acute myocardial infarction (AMI), cerebrovascular disease, heart failure, stroke and hyperlipidaemia, and type 2 diabetes for people 60 years and over. These conditions were selected based on recommended guidelines for the management of these conditions.
2. Each Medicare Local catchment has been assigned to a group that represents one percentage point.
3. For more information on peer groups and the calculation of peer group results refer to this report's Technical Supplement.

Notes: Data are reported as whole numbers. However, for graphical display and ordering they are plotted unrounded. Data are collected from a national survey of GPs. Characteristics of participating GPs may differ from non-participating GPs in a Medicare Local catchment which may affect the generalisability of results. For data limitations and exclusions see this report's Technical Supplement.

Source: Customised analysis of BEACH data prepared for the National Health Performance Authority by the Family Medicine Research Centre, the University of Sydney, 2009–2013. **Data can be downloaded from www.myhealthycommunities.gov.au**

Fair comparisons

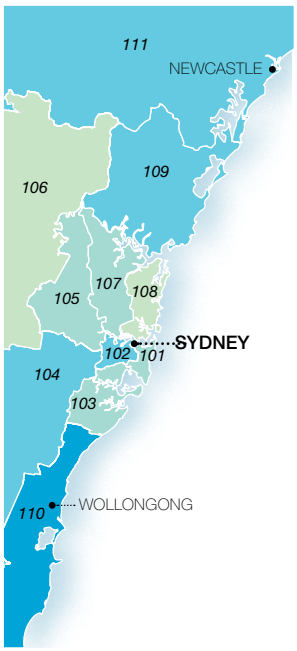


To compare Medicare Locals more fairly, each Medicare Local catchment has been grouped into one of seven peer groups[3], based on remoteness and socioeconomic status. This allows:

- Medicare Local catchments to be compared within the same metropolitan, regional or rural peer group
- Medicare Local catchments to be compared with the average for their peer group.

It also allows variation to be seen across peer groups that may be associated with remoteness and socioeconomic status.

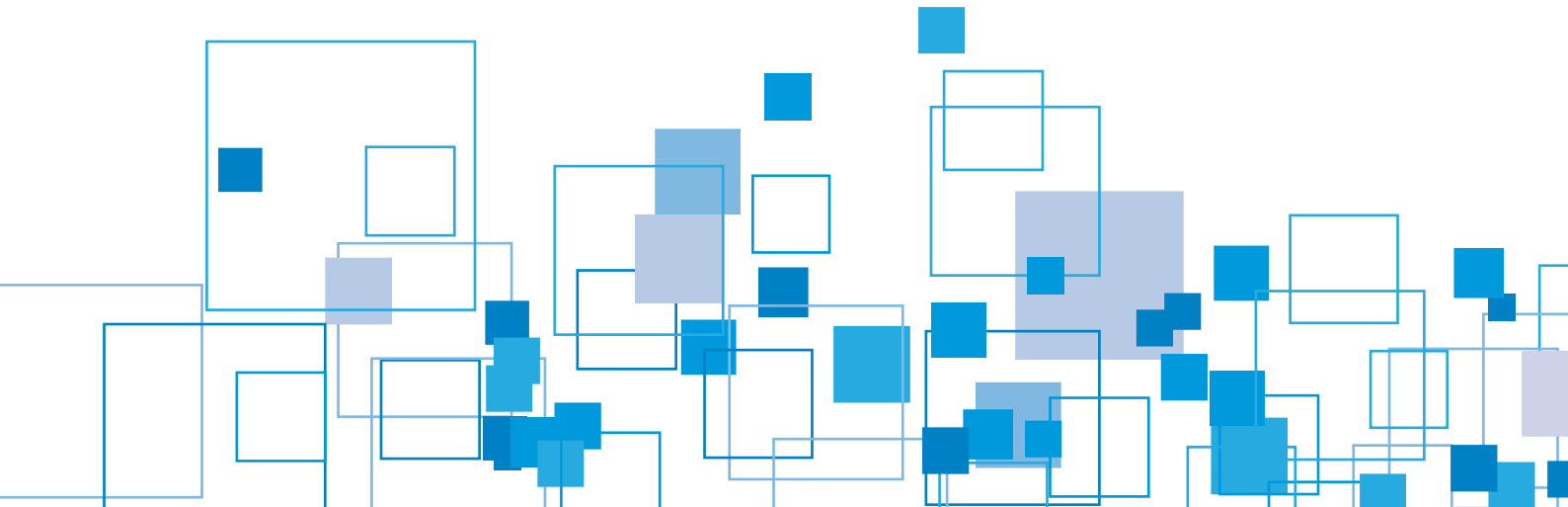
v. Sydney and surrounding areas



vi. Brisbane and surrounding areas

Peer groups	Map Ref.	
Metro 1		**7%**
Inner NW Melbourne	201	8%
Inner West Sydney	102	8%
Northern Sydney	107	7%
Eastern Sydney	101	7%
Bayside	202	7%
Inner East Melbourne	206	7%
Australian Capital Territory	801	6%
Sydney North Shore & Beaches	108	6%
Metro 2		**7%**
Sthn Adelaide-Fleurieu-Kang. Is.	403	9%
South Western Melbourne	203	9%
Eastern Melbourne	207	8%
Perth Central & East Metro	501	8%
Fremantle	503	8%
Central Adelaide & Hills	402	7%
South Eastern Sydney	103	7%
Perth North Metro	502	7%
Greater Metro South Brisbane	302	6%
Bentley-Armadale	504	6%
Gold Coast	303	6%
Metro North Brisbane	301	6%
Metro 3		**7%**
Northern Melbourne	205	9%
Northern Adelaide	401	9%
South Western Sydney	104	8%
Macedon Ranges & NW Melb	204	7%
Western Sydney	105	7%
West Moreton-Oxley	305	5%
South Eastern Melbourne	208	5%
Regional 1		**7%**
Illawarra-Shoalhaven	110	9%
Perth South Coastal	505	8%
Hunter	111	8%
Frankston-Mornington Peninsula	209	8%
Central Coast NSW	109	8%
Barwon	210	7%
Nepean-Blue Mountains	106	6%
Sunshine Coast	304	6%
Regional 2		**8%**
Hume	216	11%
Murrumbidgee	116	10%
Loddon-Mallee-Murray	214	9%
Goulburn Valley	215	9%
Gippsland	217	9%
Wide Bay	307	8%
Great South Coast	212	8%
Darling Downs-SW Qld	306	8%
Southern NSW	117	8%
South West WA	506	8%
North Coast NSW	113	7%
Tasmania	601	7%
Western NSW	115	7%
Grampians	211	7%
New England	114	6%
Country South SA	404	NP
Rural 1		**7%**
Central Qld	308	8%
Townsville-Mackay	310	7%
Country North SA	405	7%
Far West NSW	118	NP
Lower Murray	213	NP
Rural 2		**7%**
Far North Qld	311	7%
Northern Territory	701	6%
Central & NW Qld	309	NP
Goldfields-Midwest	507	NP
Kimberley-Pilbara	508	NP

NP Not available for publication.
More information can be found at **www.myhealthycommunities.gov.au** and in this report's Technical Supplement.



GP care for patients with depression and anxiety

GP care for patients with chronic conditions in 2009–2013

Key findings: GP care for patients with depression and anxiety

One in six Australians had a diagnosed mental health condition including depression (10%) and anxiety (6%) in 2008–09.[14]

Among **all people who visit the GP** at least once in a year, the percentage of people who had depression, anxiety or both of these conditions ranged from 16% to 18% in metropolitan communities to 13% to 20% in regional and rural communities **(Figure 8, page 30)**.

The percentage of **all GP consultations** that involved patients who had depression, anxiety or both these conditions, irrespective of whether the condition was managed, ranged slightly from 18% to 21% in metropolitan, 20% to 23% in regional and 15% to 18% in rural communities **(Figure 9, page 30)**.

GPs manage depression or anxiety in about one-third of all consultations with these patients. Across local areas, the proportion of al GP consultations in which depression or anxiety was **actively managed** ranged from one in 25 (4%) consultations in Sydney North Shore & Beaches compared to one in 11 (9%) consultations in Frankston-Mornington Peninsula (Vic) and Hume (Vic/NSW) **(Figure 10b, page 31)**.

GP actions in the management of depression or anxiety also varied across local areas, which illustrates the diverse approaches to managing these conditions and may reflect the availability of allied health professionals and specialists **(Figure 11, pages 32 and 33)**.

Depending on where a GP practises, a **psychotropic medication** (such as an antidepressant, antipsychotic or sedative) was prescribed on 38% of GP management occasions for depression or anxiety in Northern Sydney compared to 74% in Hume (Vic/NSW).

Across local areas, **GP counselling** was provided on 25% of GP management occasions for depression or anxiety in Southern NSW compared to 51% in Southern Adelaide-Fleurieu-Kangaroo Island.

Across local areas, a **referral to another health professional** was provided on 11% of GP management occasions for depression or anxiety in Southern Adelaide-Fleurieu-Kangaroo Island and Central Adelaide & Hills compared to 21% in Eastern Sydney **(Figure 11, pages 32 and 33)**.

There were also notable differences between similar local areas that are within the same peer group, after accounting for geographic and socioeconomic characteristics.

Figure 8: Percentage of people who visit the GP at least once in a year who had depression, anxiety or both of these conditions*, by *Medicare Local catchment peer group*, 2005–2013†

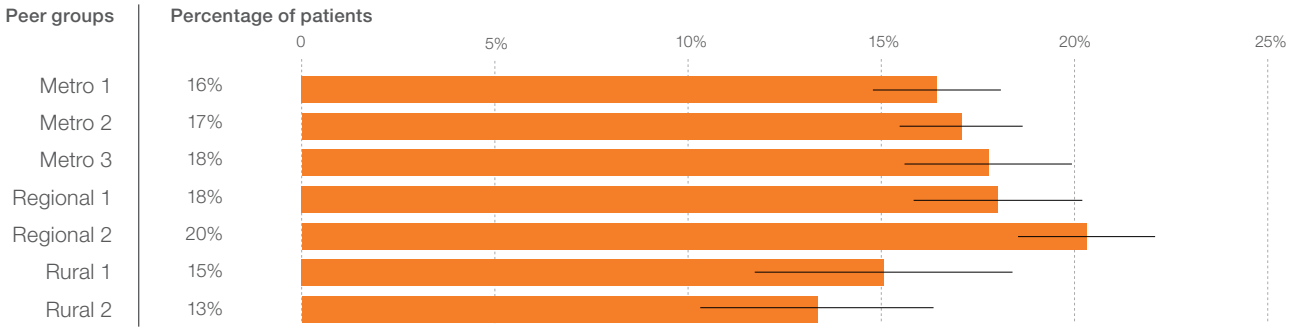


Figure 9: Percentage of GP consultations with patients who had depression, anxiety or both of these conditions*, by *Medicare Local catchment peer group*, 2005–2013

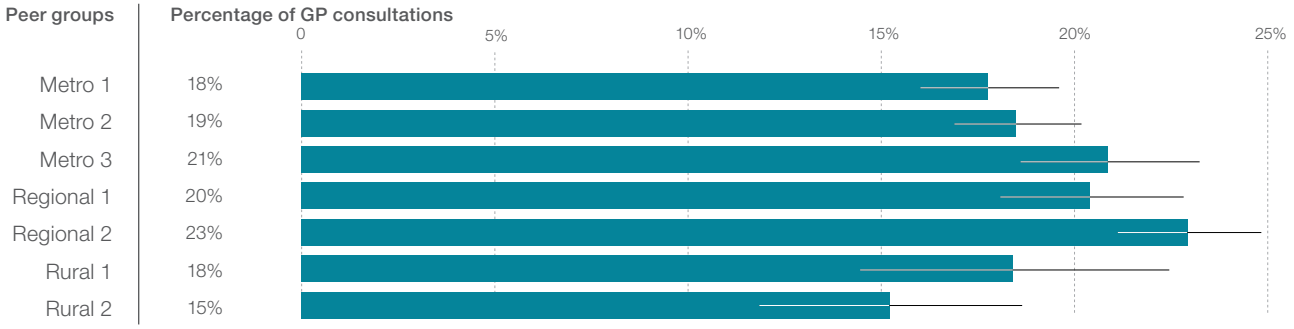
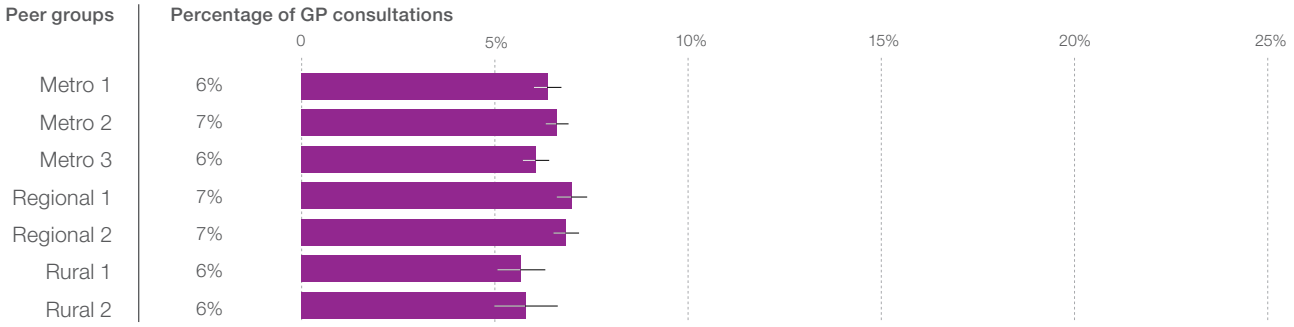


Figure 10a: Percentage of GP consultations in which depression or anxiety* was managed, by *Medicare Local catchment peer group*, 2009–2013



95% Confidence interval.
* Results comprise patients who are recorded by the GP as having been diagnosed with depression, anxiety or both of these conditions.
† Customised analysis of BEACH SAND substudy data (July 2005–June 2013) prepared for the National Health Performance Authority weighted to the attending patient population using Department of Human Services, Medicare Benefits statistics, 12 months ending June 2013.
\# Interpret with caution.
NP Not available for publication.
Notes: Data are reported as whole numbers. However, for graphical display and ordering they are plotted unrounded. Data are collected from a national survey of GPs. Characteristics of participating GPs may differ from non-participating GPs in a Medicare Local catchment which may affect the generalisability of results. For data limitations and exclusions see this report's Technical Supplement.
Source: Customised analysis of BEACH dataset (April 2009–March 2013) and BEACH SAND substudy dataset (July 2005–June 2013) prepared for the National Health Performance Authority by the Family Medicine Research Centre, the University of Sydney.
Data can be downloaded from www.myhealthycommunities.gov.au

Figure 10b: Percentage of GP consultations in which depression or anxiety* was managed, by *Medicare Local catchment*, 2009–2013

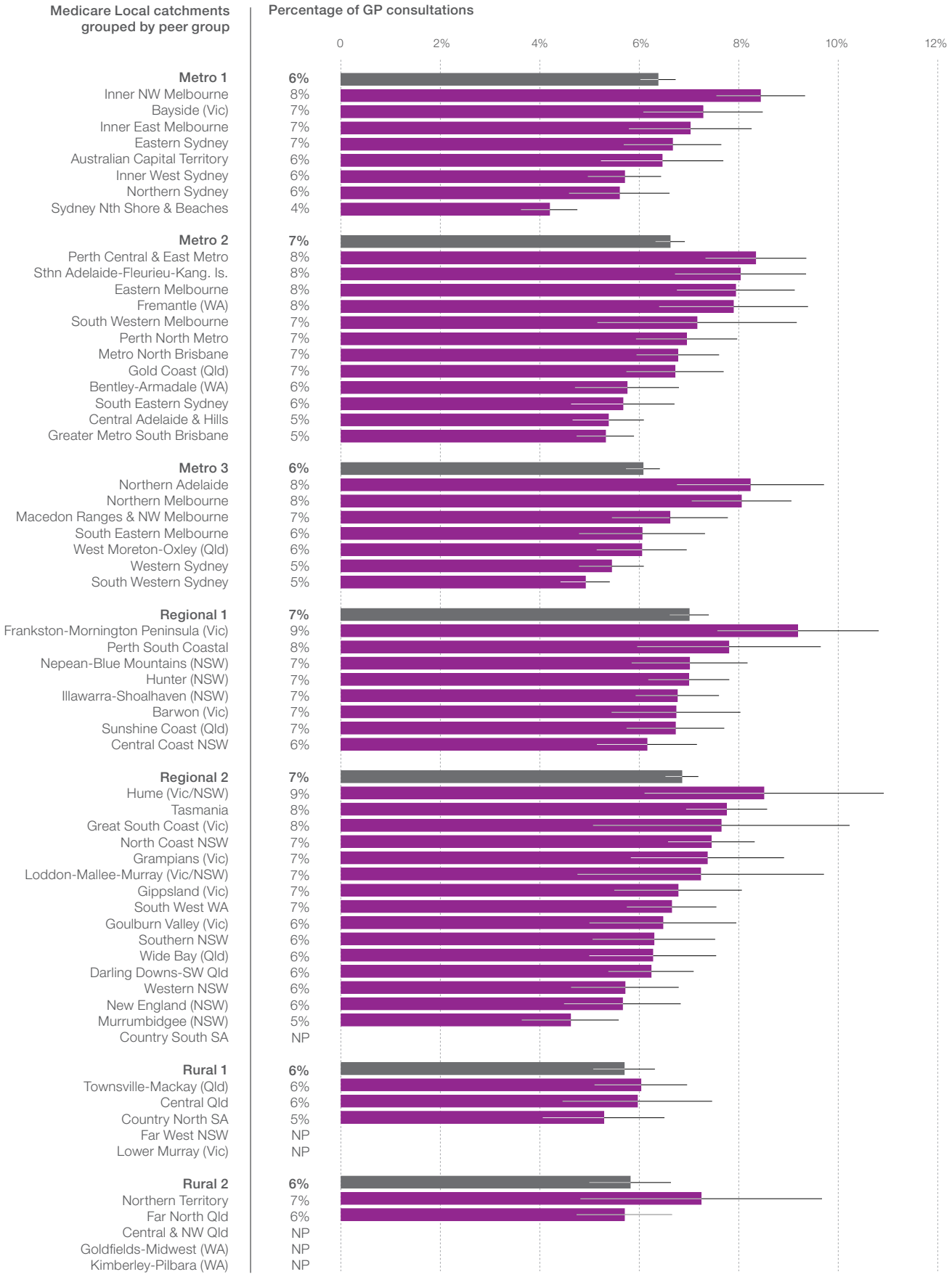
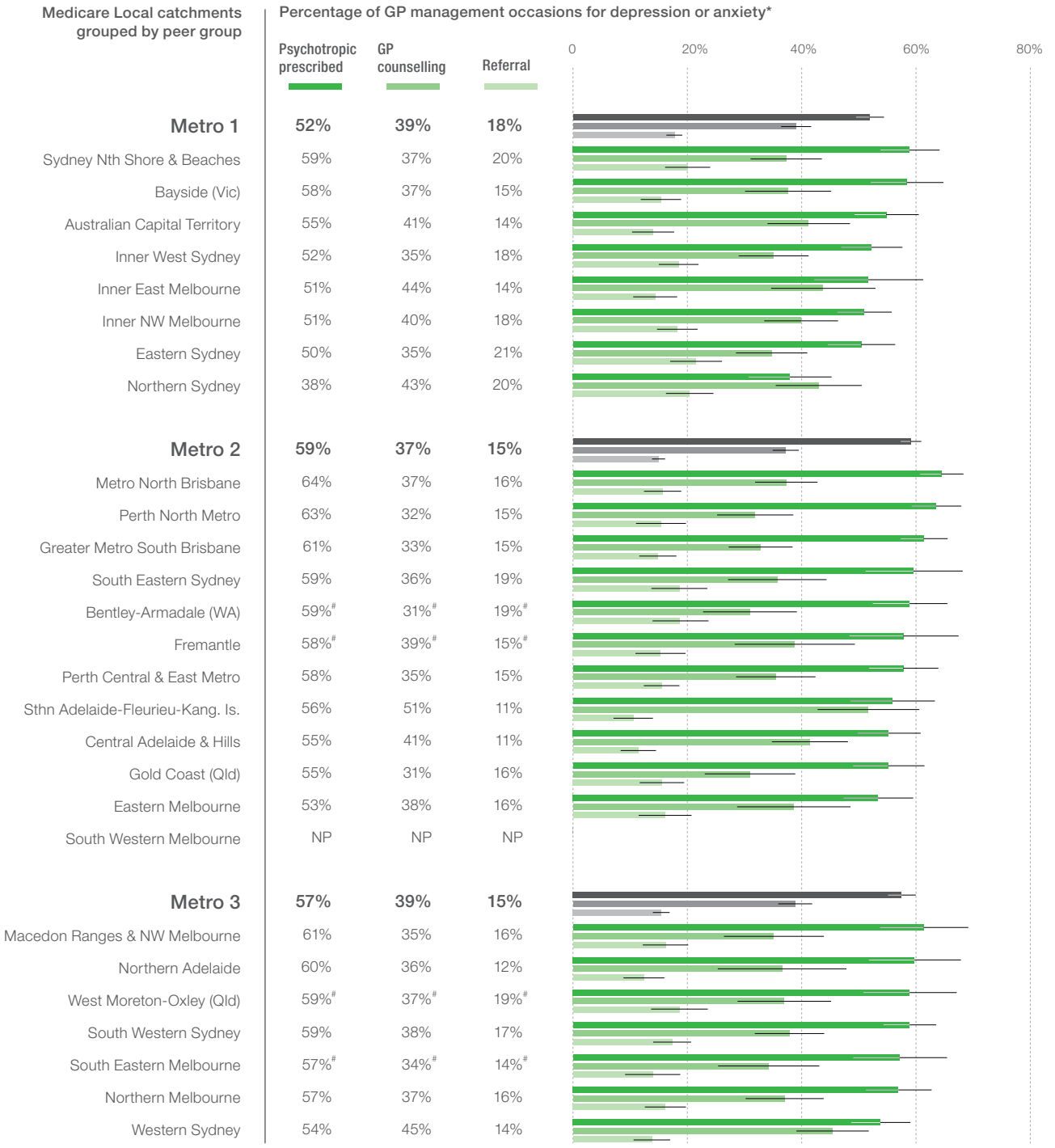


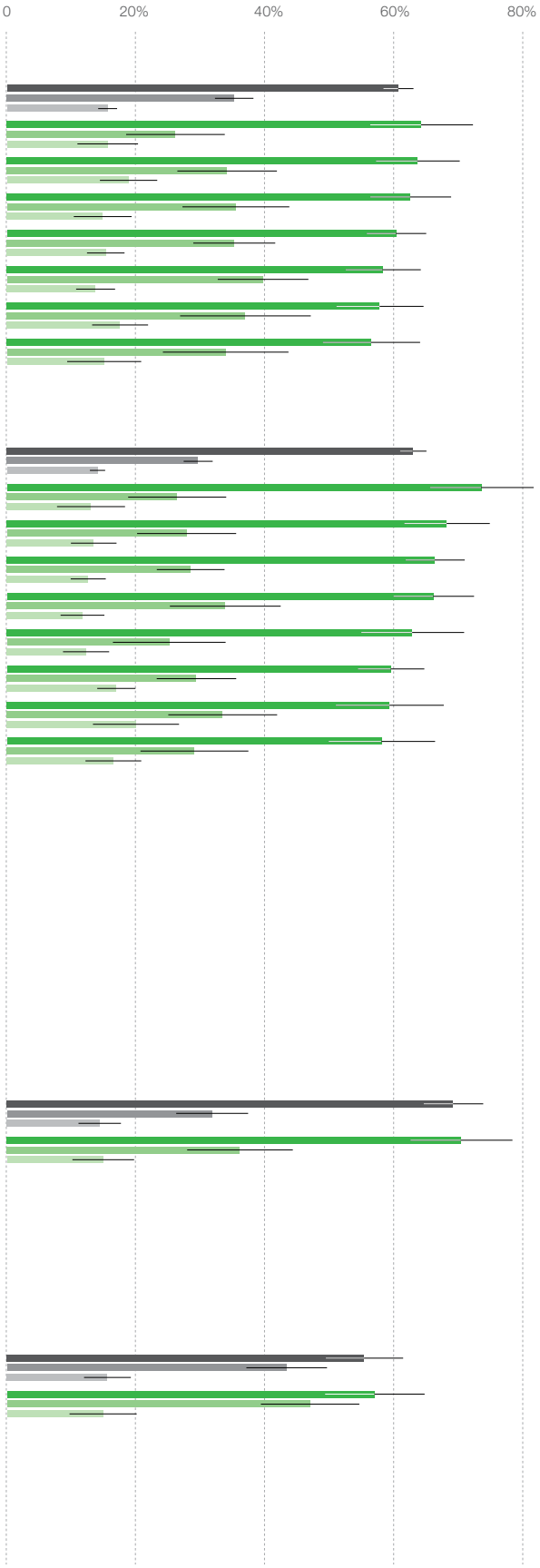
Figure 11: Percentage of GP management occasions in which psychotropics were prescribed, GP counselling, or a referral to a health professional was provided in the management of depression or anxiety, by *Medicare Local catchment*, 2009–2013



95% Confidence interval.
* Due to the opportunity to have zero, one, two or three management options percentages do not add to 100.
\# Interpret with caution.
NP Not available for publication.
Notes: Data are reported as whole numbers. However, for graphical display and ordering they are plotted unrounded. Data are collected from a national survey of GPs. Characteristics of participating GPs may differ from non-participating GPs in a Medicare Local catchment which may affect the generalisability of results. For data limitations and exclusions see this report's Technical Supplement.
Source: Customised analysis of BEACH dataset (April 2009–March 2013) and BEACH SAND substudy dataset (July 2005–June 2013) prepared for the National Health Performance Authority by the Family Medicine Research Centre, the University of Sydney.
Data can be downloaded from www.myhealthycommunities.gov.au

Medicare Local catchments grouped by peer group	Psychotropic prescribed	GP counselling	Referral
Regional 1	**61%**	**35%**	**16%**
Frankston-Mornington Peninsula (Vic)	64%#	26%#	16%#
Illawarra-Shoalhaven (NSW)	64%	34%	19%
Central Coast NSW	63%#	35%#	15%#
Hunter (NSW)	60%	35%	15%
Sunshine Coast (Qld)	58%	40%	14%
Nepean-Blue Mountains (NSW)	58%	37%	18%
Barwon (Vic)	57%#	34%#	15%#
Perth South Coastal	NP	NP	NP
Regional 2	**63%**	**30%**	**14%**
Hume (Vic/NSW)	74%#	26%#	13%#
South West WA	68%	28%	13%
Tasmania	66%	28%	13%
Darling Downs-SW Qld	66%#	34%#	12%#
Southern NSW	63%#	25%#	12%#
North Coast NSW	60%	29%	17%
Western NSW	59%#	33%#	20%#
Gippsland (Vic)	58%#	29%#	16%#
Country South SA	NP	NP	NP
Goulburn Valley (Vic)	NP	NP	NP
Grampians (Vic)	NP	NP	NP
Great South Coast	NP	NP	NP
Loddon-Mallee-Murray (Vic/NSW)	NP	NP	NP
Murrumbidgee (NSW)	NP	NP	NP
New England (NSW)	NP	NP	NP
Wide Bay (Qld)	NP	NP	NP
Rural 1	**69%**	**32%**	**14%**
Townsville-Mackay (Qld)	70%#	36%#	15%#
Central Qld	NP	NP	NP
Country North SA	NP	NP	NP
Far West NSW	NP	NP	NP
Lower Murray (Vic/NSW)	NP	NP	NP
Rural 2	**55%**	**43%**	**16%**
Far North Qld	57%#	47%#	15%#
Central & NW Qld	NP	NP	NP
Goldfields-Midwest (WA)	NP	NP	NP
Kimberley-Pilbara (WA)	NP	NP	NP
Northern Territory	NP	NP	NP

Percentage of GP management occasions for depression or anxiety*



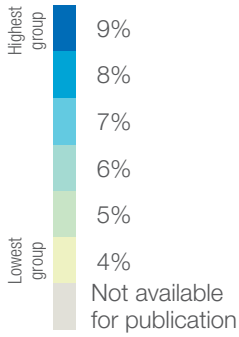
GP management of depression or anxiety

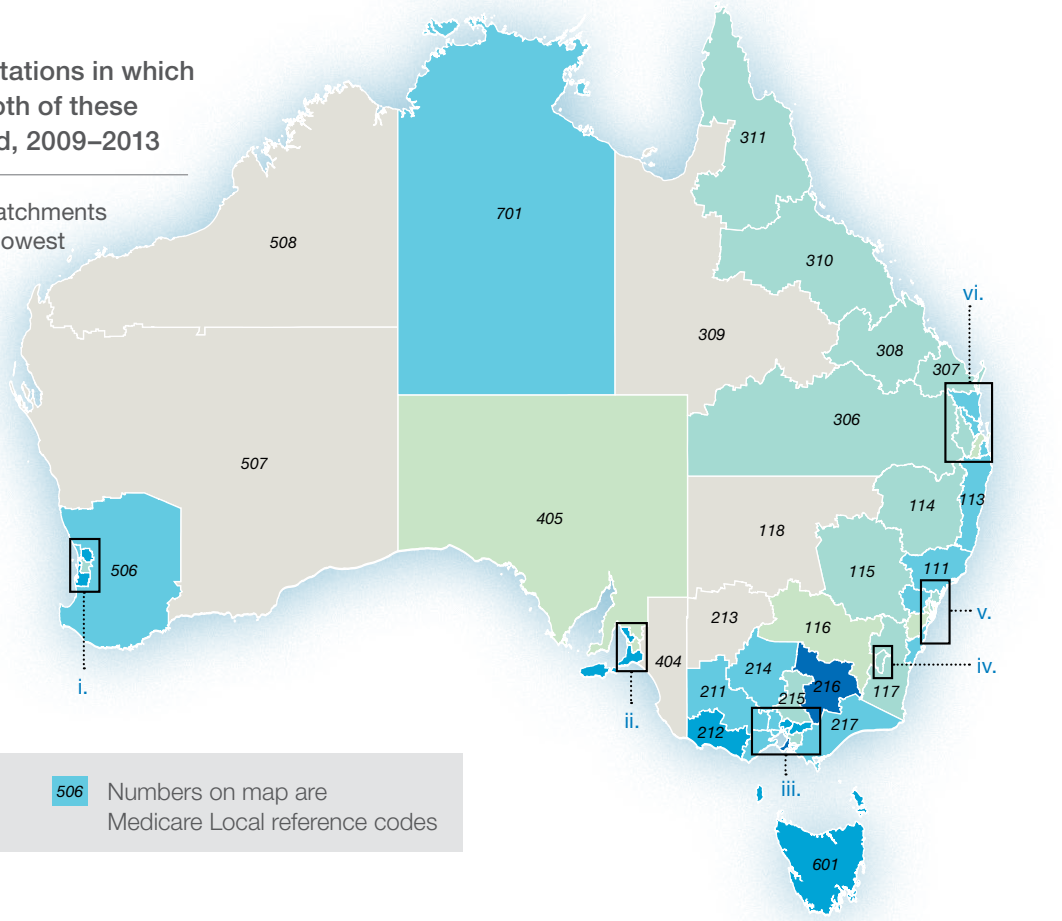
Years of data: 2009–2013

During 2009–2013, the percentage of GP consultations in which depression or anxiety was managed varied across Medicare Local catchments and across peer groups, ranging from 9% in Frankston-Mornington Peninsula (Vic) and Hume (Vic/NSW) to 4% in Sydney North Shore & Beaches.

Percentage of GP consultations in which depression, anxiety or both of these conditions were managed, 2009–2013

Results for Medicare Local catchments were ranked from highest to lowest then split into six groups.[2]

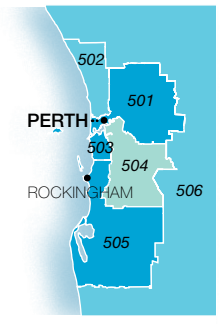




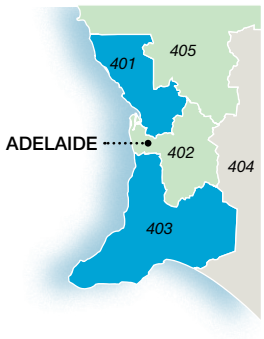
Medicare Local catchment boundary

506 Numbers on map are Medicare Local reference codes

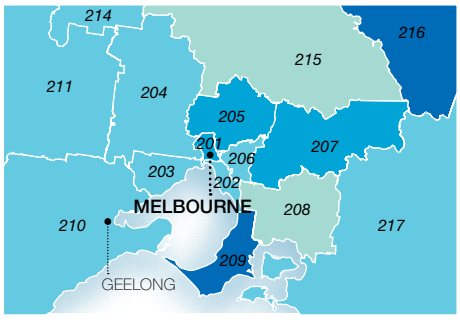
i. Perth and surrounding areas



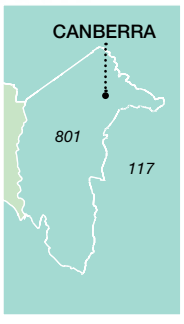
ii. Adelaide and surrounding areas



iii. Melbourne and surrounding areas



iv. Canberra and surrounding areas



1. Results comprise patients of any age with diagnosed depression and/or anxiety.
2. Each Medicare Local catchment has been assigned to a group that represents one percentage point.
3. For more information on peer groups and the calculation of peer group results refer to this report's Technical Supplement.

Notes: Data are reported as whole numbers. However, for graphical display and ordering they are plotted unrounded.
Data are collected from a national survey of GPs. Characteristics of participating GPs may differ from non-participating GPs in a Medicare Local catchment which may affect the generalisability of results. For data limitations and exclusions see this report's Technical Supplement.

Source: Customised analysis of BEACH data prepared for the National Health Performance Authority by the Family Medicine Research Centre, the University of Sydney, 2009–2013.

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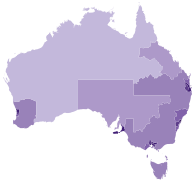
Fair comparisons

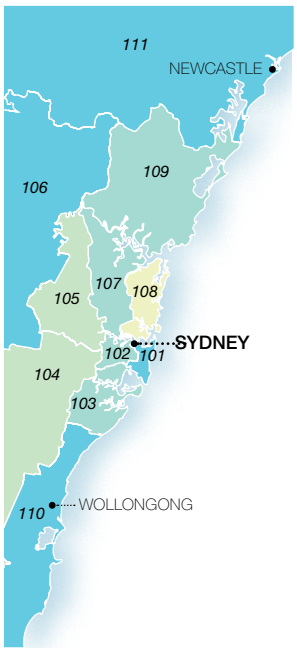


To compare Medicare Locals more fairly, each Medicare Local catchment has been grouped into one of seven peer groups[3], based on remoteness and socioeconomic status. This allows:

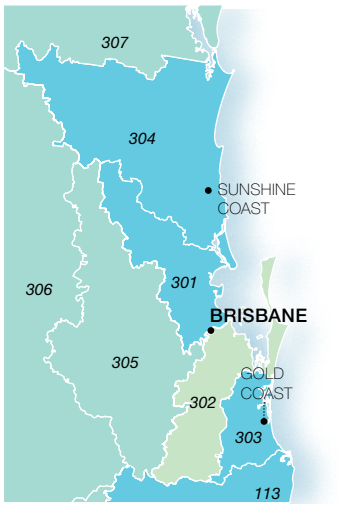
- Medicare Local catchments to be compared within the same metropolitan, regional or rural peer group
- Medicare Local catchments to be compared with the average for their peer group.

It also allows variation to be seen across peer groups that may be associated with remoteness and socioeconomic status.

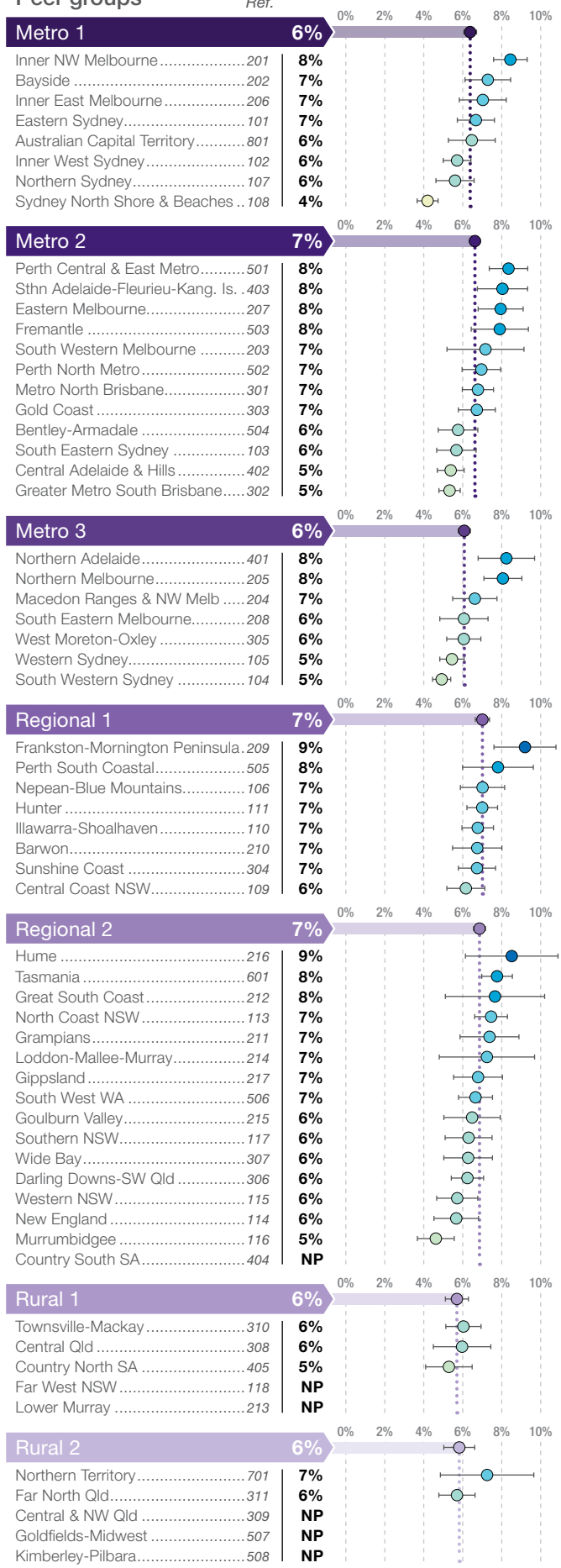
v. Sydney and surrounding areas



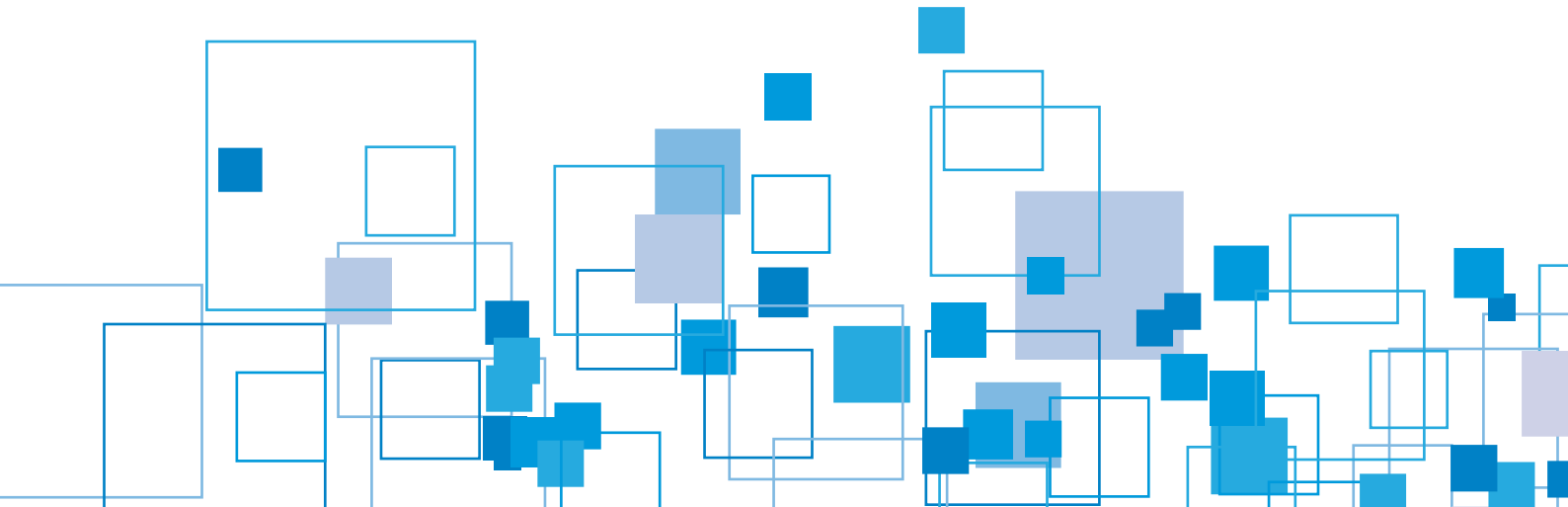
vi. Brisbane and surrounding areas



Peer groups	Map Ref.	
Metro 1		**6%**
Inner NW Melbourne	201	8%
Bayside	202	7%
Inner East Melbourne	206	7%
Eastern Sydney	101	7%
Australian Capital Territory	801	6%
Inner West Sydney	102	6%
Northern Sydney	107	6%
Sydney North Shore & Beaches	108	4%
Metro 2		**7%**
Perth Central & East Metro	501	8%
Sthn Adelaide-Fleurieu-Kang. Is.	403	8%
Eastern Melbourne	207	8%
Fremantle	503	8%
South Western Melbourne	203	7%
Perth North Metro	502	7%
Metro North Brisbane	301	7%
Gold Coast	303	7%
Bentley-Armadale	504	6%
South Eastern Sydney	103	6%
Central Adelaide & Hills	402	5%
Greater Metro South Brisbane	302	5%
Metro 3		**6%**
Northern Adelaide	401	8%
Northern Melbourne	205	8%
Macedon Ranges & NW Melb	204	7%
South Eastern Melbourne	208	6%
West Moreton-Oxley	305	6%
Western Sydney	105	5%
South Western Sydney	104	5%
Regional 1		**7%**
Frankston-Mornington Peninsula	209	9%
Perth South Coastal	505	8%
Nepean-Blue Mountains	106	7%
Hunter	111	7%
Illawarra-Shoalhaven	110	7%
Barwon	210	7%
Sunshine Coast	304	7%
Central Coast NSW	109	6%
Regional 2		**7%**
Hume	216	9%
Tasmania	601	8%
Great South Coast	212	8%
North Coast NSW	113	7%
Grampians	211	7%
Loddon-Mallee-Murray	214	7%
Gippsland	217	7%
South West WA	506	7%
Goulburn Valley	215	6%
Southern NSW	117	6%
Wide Bay	307	6%
Darling Downs-SW Qld	306	6%
Western NSW	115	6%
New England	114	6%
Murrumbidgee	116	5%
Country South SA	404	NP
Rural 1		**6%**
Townsville-Mackay	310	6%
Central Qld	308	6%
Country North SA	405	5%
Far West NSW	118	NP
Lower Murray	213	NP
Rural 2		**6%**
Northern Territory	701	7%
Far North Qld	311	6%
Central & NW Qld	309	NP
Goldfields-Midwest	507	NP
Kimberley-Pilbara	508	NP



NP Not available for publication.
More information can be found at **www.myhealthycommunities.gov.au** and in this report's Technical Supplement.



GP care for patients with arthritis and chronic back pain

GP care for patients with chronic conditions in 2009–2013

Key findings: GP care for patients with arthritis and chronic back pain

In Australia, almost one in seven people have a musculoskeletal condition including arthritis (12%) and chronic back pain (4%).[14]

Among **all people who visit the GP** at least once in a year, the percentage of people who had arthritis or chronic back pain ranged from 16% to 18% in metropolitan, 20% to 21% in regional and 16% to 20% in rural areas **(Figure 12, page 40)**.

The percentage of **all GP consultations** that involved patients who had arthritis, chronic back pain or both of these conditions, irrespective of whether the condition was managed, ranged from 21% to 27% in metropolitan, 27% to 28% in regional and from 19% to 29% in rural areas **(Figure 13, page 40)**.

GPs manage arthritis or chronic back pain in about one-fifth of all consultations with these patients. Across local areas, the proportion of all GP consultations in which arthritis or chronic back pain were **actively managed** ranged from one in 33 (3%) GP consultations in Sydney North Shore & Beaches compared to one in 14 (7%) consultations in Murrumbidgee (NSW) and Tasmania **(Figure 14b, page 41)**.

GP actions in the management of arthritis or chronic back pain also varied across local areas, which illustrates the diverse approaches to managing these conditions and may reflect the availability of allied health professionals and specialists.

Depending on where a GP practises, a **medication was prescribed** on 52% of GP management occasions for arthritis or chronic back pain in Northern Sydney compared to 75% in Nepean-Blue Mountains.

Across local areas, a **referral to another health professional** was provided on 11% of GP management occasions for arthritis or chronic back pain in Northern Melbourne, West Moreton-Oxley (Qld), Far North Queensland and Tasmania compared to 22% in Darling-Downs South West Queensland and Northern Sydney.

Across local areas, **imaging was ordered** on 8% of GP management occasions for arthritis or chronic back pain in North Coast NSW, Macedon Ranges & North Western Melbourne and Northern Adelaide compared to 20% in Central Coast NSW **(Figure 15, pages 42 and 43)**.

Figure 12: Percentage of people who visit the GP at least once in a year who had arthritis or chronic back pain*, by *Medicare Local catchment peer group*, 2005–2013†

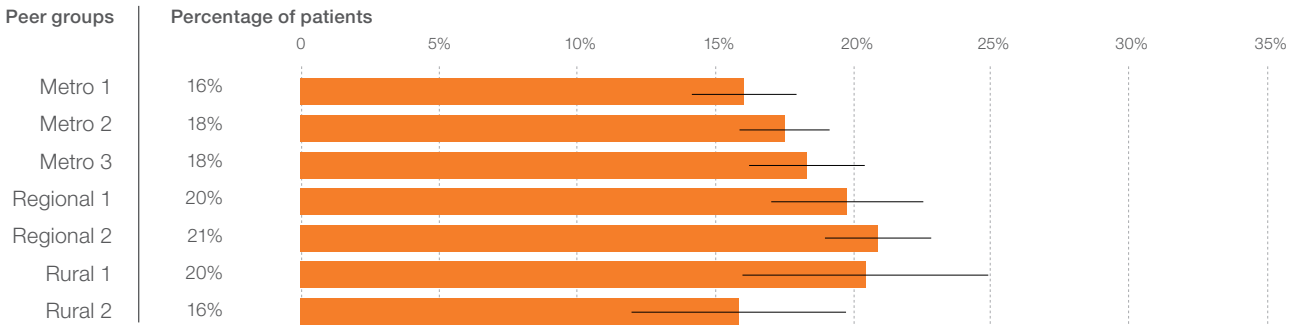


Figure 13: Percentage of GP consultations with patients who had arthritis or chronic back pain*, by *Medicare Local catchment peer group*, 2005–2013

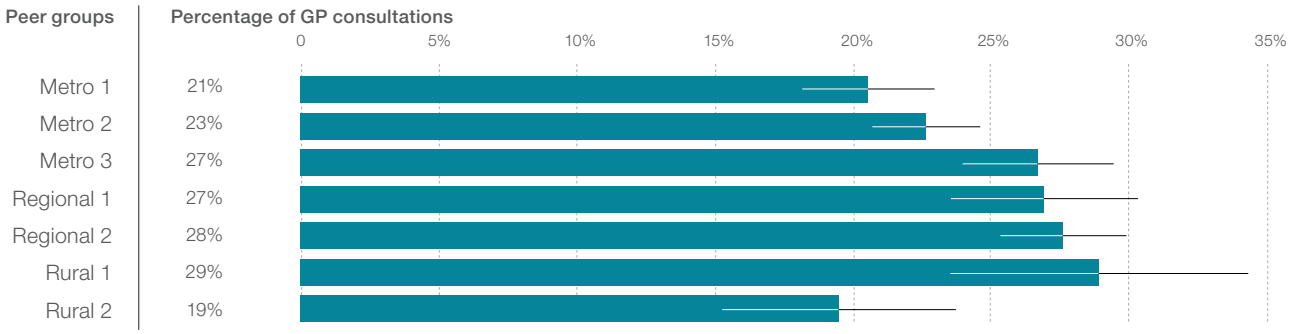
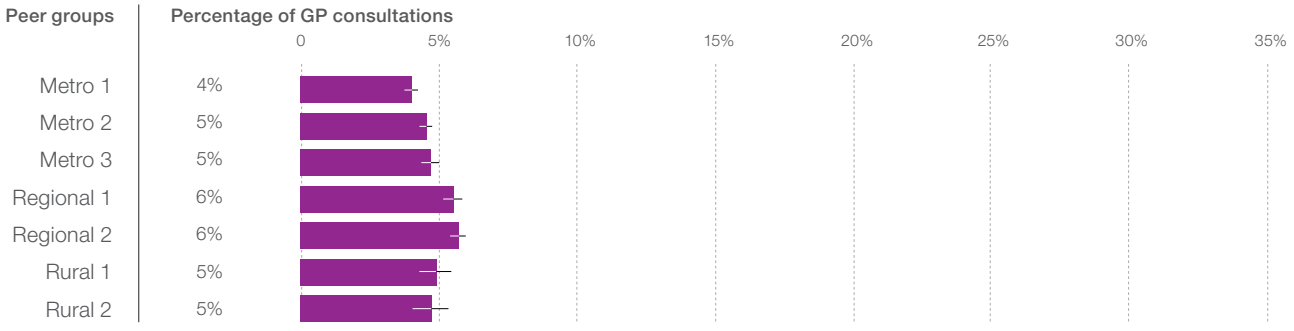


Figure 14a: Percentage of GP consultations in which arthritis or chronic back pain* was managed, by *Medicare Local catchment peer group*, 2009–2013



95% Confidence interval.

* Results comprise patients who are recorded by the GP as having been with arthritis (defined as osteoarthritis or rheumatoid arthritis) or chronic back pain

† Customised analysis of BEACH SAND substudy data (July 2005–June 2013) prepared for the National Health Performance Authority weighted to the attending patient population using Department of Human Services, Medicare Benefits statistics, 12 months ending June 2013.

\# Interpret with caution.

NP Not available for publication.

Notes: Data are reported as whole numbers. However, for graphical display and ordering they are plotted unrounded. Data are collected from a national survey of GPs. Characteristics of participating GPs may differ from non-participating GPs in a Medicare Local catchment which may affect the generalisability of results. For data limitations and exclusions see this report's Technical Supplement.

Source: Customised analysis of BEACH dataset (April 2009–March 2013) and BEACH SAND substudy dataset (July 2005–June 2013) prepared for the National Health Performance Authority by the Family Medicine Research Centre, the University of Sydney.

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Figure 14b: Percentage of GP consultations in which arthritis or chronic back pain* was managed, by *Medicare Local catchment*, 2009–2013

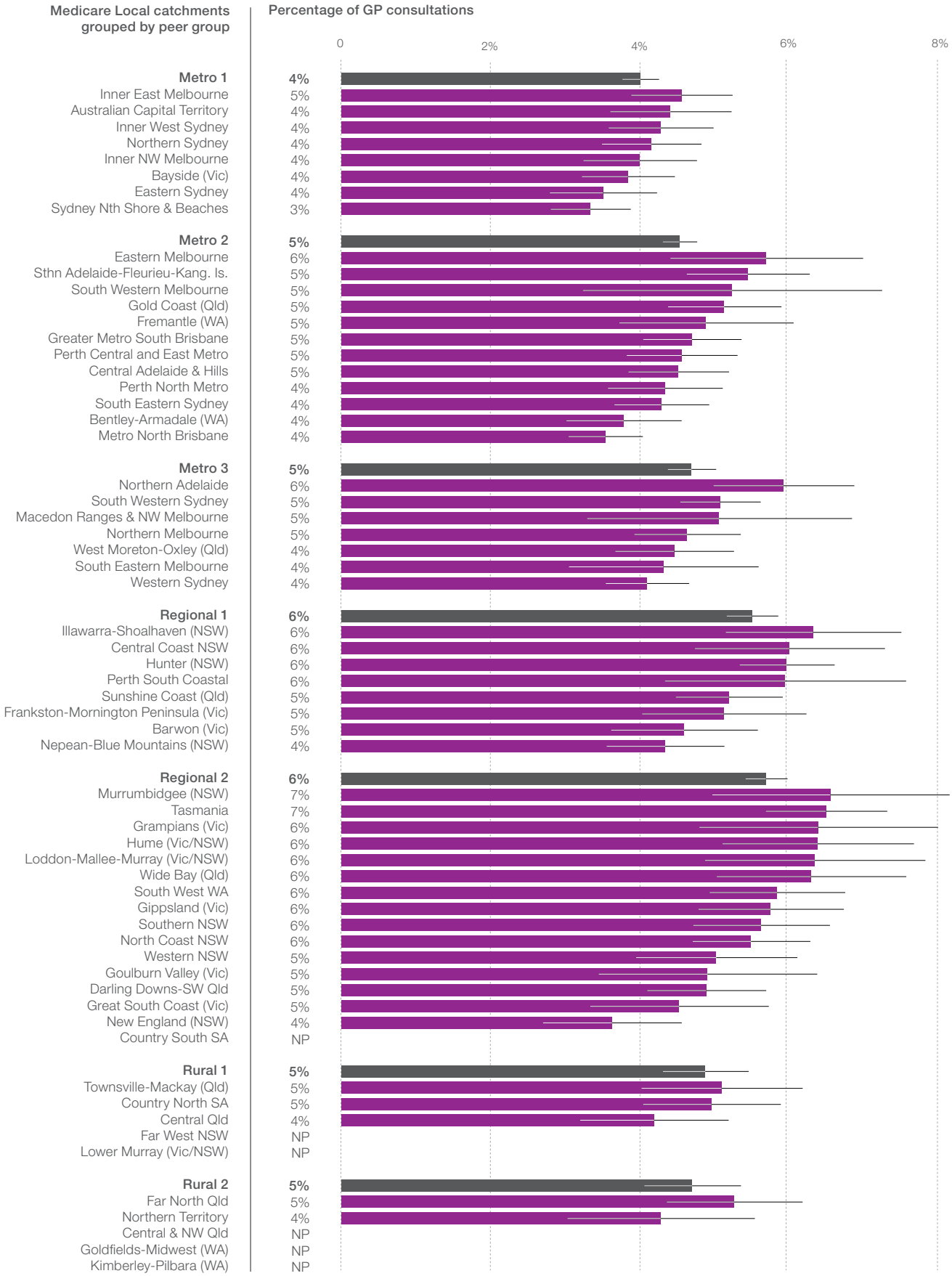
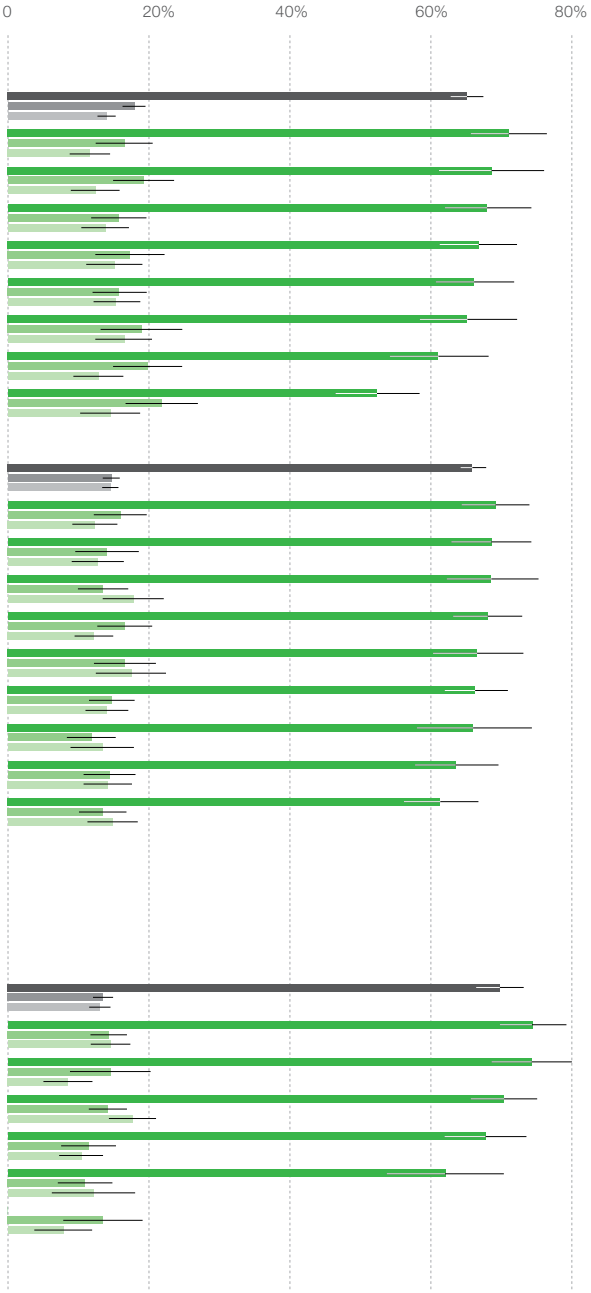


Figure 15: Percentage of GP management occasions in which medications were prescribed, a referral to a health professional or imaging was provided in the management of arthritis or chronic back pain, by *Medicare Local catchment*, 2009–2013

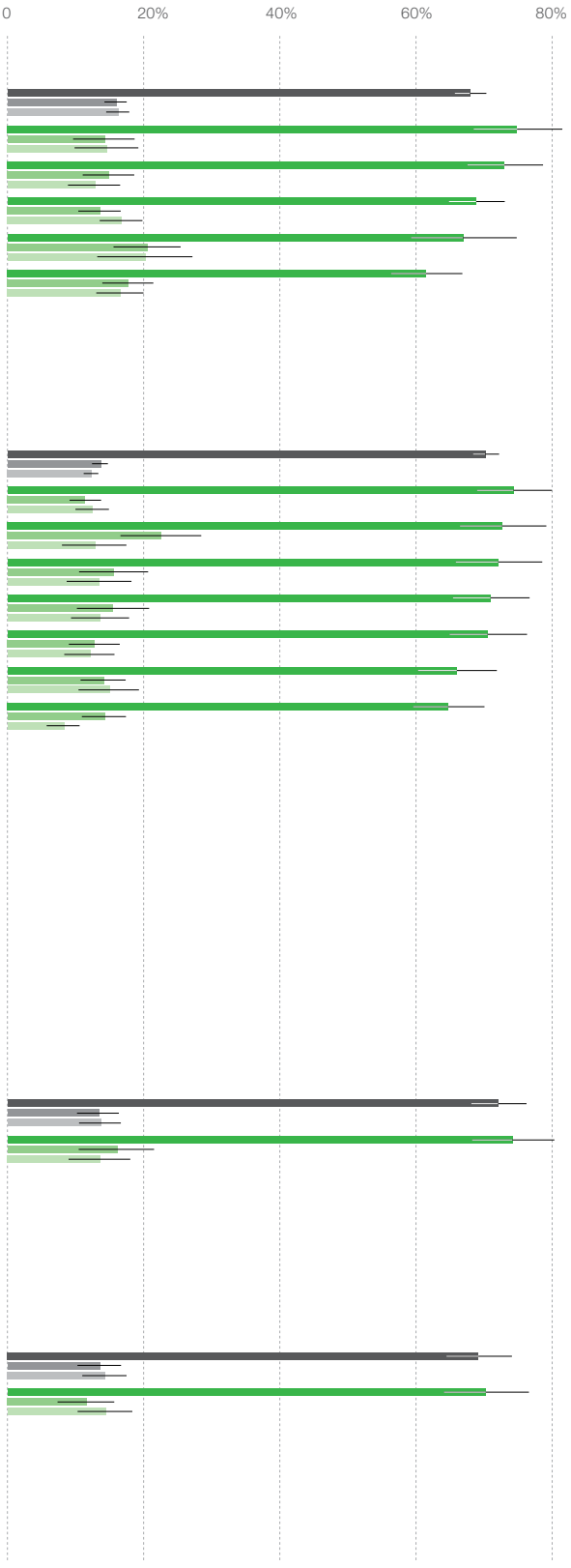
Medicare Local catchments grouped by peer group	Medications prescribed	Referral	Imaging
Metro 1	**65%**	**18%**	**14%**
Bayside (Vic)	71%#	16%#	11%#
Inner NW Melbourne	69%	19%	12%
Inner West Sydney	68%	16%	14%
Sydney Nth Shore & Beaches	67%#	17%#	15%#
Inner East Melbourne	66%	16%	15%
Australian Capital Territory	65%#	19%#	16%#
Eastern Sydney	61%#	20%#	13%#
Northern Sydney	52%#	22%#	14%#
Metro 2	**66%**	**15%**	**14%**
Sthn Adelaide-Fleurieu-Kang. Is.	69%	16%	12%
Perth North Metro	69%#	14%#	13%#
Gold Coast (Qld)	69%#	13%#	18%#
Greater Metro South Brisbane	68%	16%	12%
South Eastern Sydney	66%#	16%#	17%#
Metro North Brisbane	66%	15%	14%
Eastern Melbourne	66%#	12%#	13%#
Perth Central & East Metro	63%	14%	14%
Central Adelaide & Hills	61%	13%	15%
Bentley-Armadale (WA)	NP	NP	NP
Fremantle	NP	NP	NP
South Western Melbourne	NP	NP	NP
Metro 3	**70%**	**13%**	**13%**
South Western Sydney	74%	14%	14%
Northern Adelaide	74%#	14%#	8%#
Western Sydney	70%	14%	18%
Northern Melbourne	68%#	11%#	10%#
West Moreton-Oxley (Qld)	62%#	11%#	12%#
Macedon Ranges & NW Melbourne	NP	13%#	8%#
South Eastern Melbourne	NP	NP	NP



95% Confidence interval.
* Due to the opportunity to have zero, one, two or three management options percentages do not add to 100.
\# Interpret with caution.
NP Not available for publication.
Notes: Data are reported as whole numbers. However, for graphical display and ordering they are plotted unrounded. Data are collected from a national survey of GPs. Characteristics of participating GPs may differ from non-participating GPs in a Medicare Local catchment which may affect the generalisability of results. For data limitations and exclusions see this report's Technical Supplement.
Source: Customised analysis of BEACH data prepared for the National Health Performance Authority by the Family Medicine Research Centre, the University of Sydney, 2009–2013.
Data can be downloaded from www.myhealthycommunities.gov.au

Medicare Local catchments grouped by peer group	Medications prescribed	Referral	Imaging
Regional 1	**68%**	**16%**	**16%**
Nepean-Blue Mountains (NSW)	75%#	14%#	15%#
Illawarra-Shoalhaven (NSW)	73%	15%	13%
Hunter (NSW)	69%	13%	17%
Central Coast NSW	67%#	20%#	20%#
Sunshine Coast (Qld)	61%	18%	16%
Frankston-Mornington Peninsula (Vic)	NP	NP	NP
Barwon (Vic)	NP	NP	NP
Perth South Coastal	NP	NP	NP
Regional 2	**70%**	**14%**	**12%**
Tasmania	74%	11%	12%
Darling Downs-SW Qld	73%#	22%#	13%#
Southern NSW	72%#	15%#	13%#
Western NSW	71%#	15%#	13%#
Gippsland (Vic)	70%#	13%#	12%#
South West WA	66%#	14%#	15%#
North Coast NSW	65%	14%	8%
Country South SA	NP	NP	NP
Goulburn Valley (Vic)	NP	NP	NP
Grampians (Vic)	NP	NP	NP
Great South Coast	NP	NP	NP
Hume (Vic/NSW)	NP	NP	NP
Loddon-Mallee-Murray (Vic/NSW)	NP	NP	NP
Murrumbidgee (NSW)	NP	NP	NP
New England (NSW)	NP	NP	NP
Wide Bay (Qld)	NP	NP	NP
Rural 1	**72%**	**13%**	**14%**
Townsville-Mackay (Qld)	74%#	16%#	13%#
Central Qld	NP	NP	NP
Country North SA	NP	NP	NP
Far West NSW	NP	NP	NP
Lower Murray (Vic/NSW)	NP	NP	NP
Rural 2	**69%**	**13%**	**14%**
Far North Qld	70%#	11%#	14%#
Central & NW Qld	NP	NP	NP
Goldfields-Midwest (WA)	NP	NP	NP
Kimberley-Pilbara (WA)	NP	NP	NP
Northern Territory	NP	NP	NP

Percentage of GP management occasions for arthritis or chronic back pain*



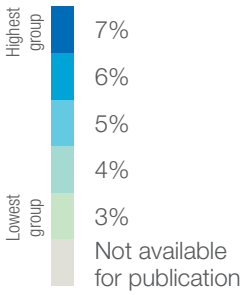
GP management of arthritis or chronic back pain

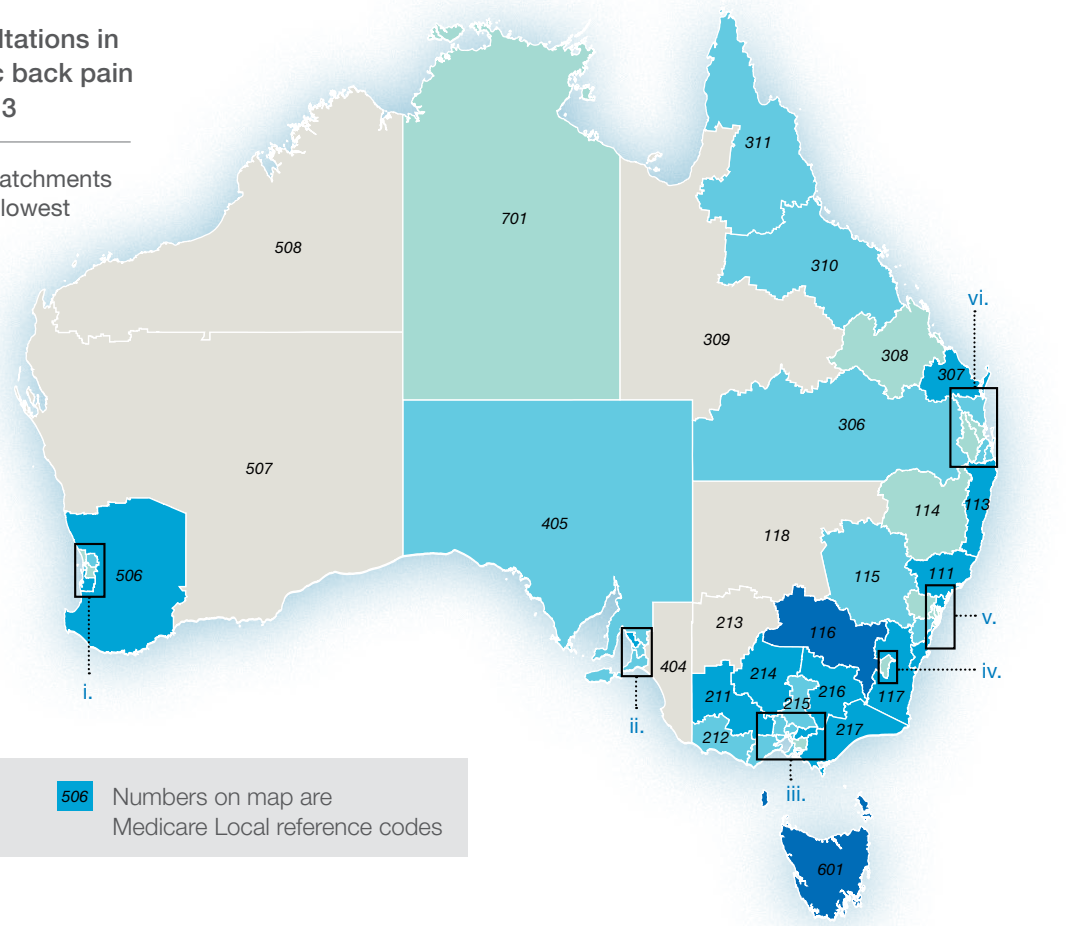
Years of data: 2009–2013

During 2009–2013, the percentage of GP consultations in which arthritis or chronic back pain[1] was managed varied across Medicare Local catchments and across peer groups, ranging from 7% in Murrumbidgee (NSW) and Tasmania to 3% in Sydney North Shore & Beaches.

Percentage of GP consultations in which arthritis or chronic back pain was managed, 2009–2013

Results for Medicare Local catchments were ranked from highest to lowest then split into five groups.[2]

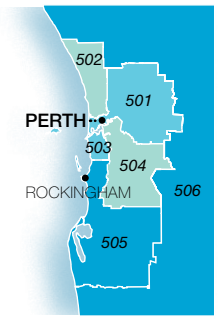




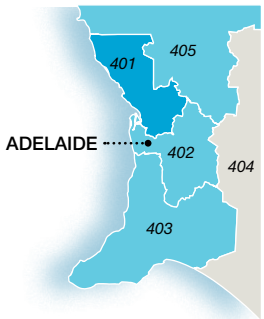
Medicare Local catchment boundary

506 Numbers on map are Medicare Local reference codes

i. Perth and surrounding areas

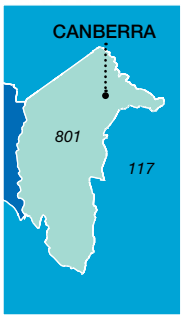


ii. Adelaide and surrounding areas



iii. Melbourne and surrounding areas

iv. Canberra and surrounding areas

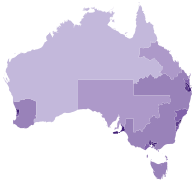


1. Results comprise management of osteoarthritis and rheumatoid arthritis which account for 85.6% of all arthritis managed by GPs during consultations for chronic back pain.
2. Each Medicare Local catchment has been assigned to a group that represents one percentage point.
3. For more information on peer groups and the calculation of peer group results refer to this report's Technical Supplement.

Notes: Data are reported as whole numbers. However, for graphical display and ordering they are plotted unrounded.
Data are collected from a national survey of GPs. Characteristics of participating GPs may differ from non-participating GPs in a Medicare Local catchment which may affect the generalisability of results. For data limitations and exclusions see this report's Technical Supplement.

Source: Customised analysis of BEACH data prepared for the National Health Performance Authority by the Family Medicine Research Centre, the University of Sydney, 2009–2013. **Data can be downloaded from www.myhealthycommunities.gov.au**

Fair comparisons

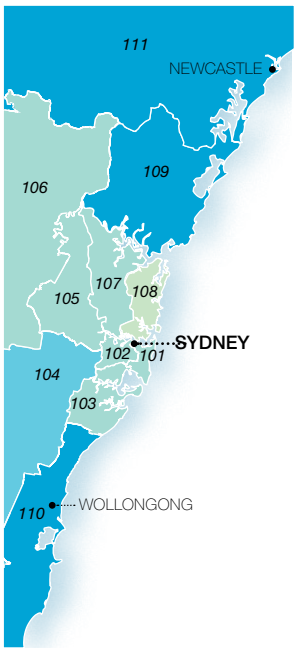


To compare Medicare Locals more fairly, each Medicare Local catchment has been grouped into one of seven peer groups[3], based on remoteness and socioeconomic status. This allows:

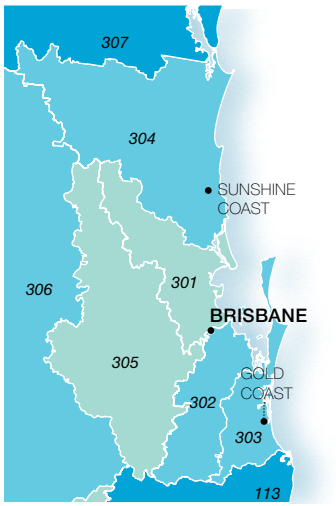
- Medicare Local catchments to be compared within the same metropolitan, regional or rural peer group
- Medicare Local catchments to be compared with the average for their peer group.

It also allows variation to be seen across peer groups that may be associated with remoteness and socioeconomic status.

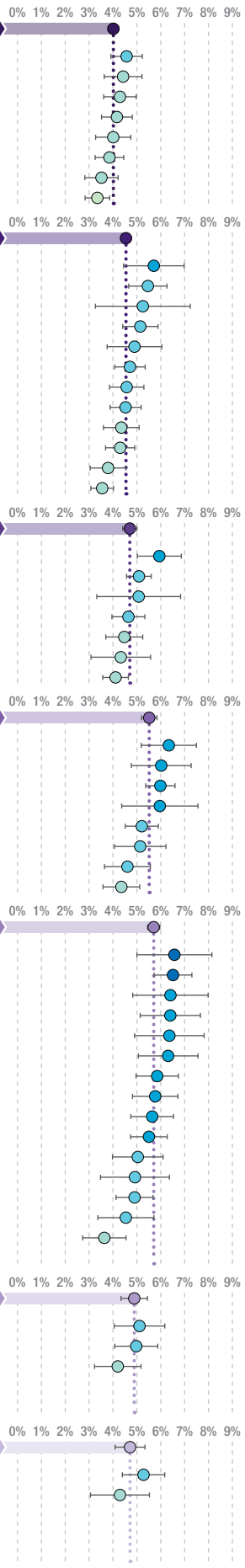
v. Sydney and surrounding areas



vi. Brisbane and surrounding areas



Peer groups	Map Ref.	
Metro 1		**4%**
Inner East Melbourne	206	5%
Australian Capital Territory	801	4%
Inner West Sydney	102	4%
Northern Sydney	107	4%
Inner NW Melbourne	201	4%
Bayside	202	4%
Eastern Sydney	101	4%
Sydney North Shore & Beaches	108	3%
Metro 2		**5%**
Eastern Melbourne	207	6%
Sthn Adelaide-Fleurieu-Kang. Is.	403	5%
South Western Melbourne	203	5%
Gold Coast	303	5%
Fremantle	503	5%
Greater Metro South Brisbane	302	5%
Perth Central & East Metro	501	5%
Central Adelaide & Hills	402	5%
Perth North Metro	502	4%
South Eastern Sydney	103	4%
Bentley-Armadale	504	4%
Metro North Brisbane	301	4%
Metro 3		**5%**
Northern Adelaide	401	6%
South Western Sydney	104	5%
Macedon Ranges & NW Melb	204	5%
Northern Melbourne	205	5%
West Moreton-Oxley	305	4%
South Eastern Melbourne	208	4%
Western Sydney	105	4%
Regional 1		**6%**
Illawarra-Shoalhaven	110	6%
Central Coast NSW	109	6%
Hunter	111	6%
Perth South Coastal	505	6%
Sunshine Coast	304	5%
Frankston-Mornington Peninsula	209	5%
Barwon	210	5%
Nepean-Blue Mountains	106	4%
Regional 2		**6%**
Murrumbidgee	116	7%
Tasmania	601	7%
Grampians	211	6%
Hume	216	6%
Loddon-Mallee-Murray	214	6%
Wide Bay	307	6%
South West WA	506	6%
Gippsland	217	6%
Southern NSW	117	6%
North Coast NSW	113	6%
Western NSW	115	5%
Goulburn Valley	215	5%
Darling Downs-SW Qld	306	5%
Great South Coast	212	5%
New England	114	4%
Country South SA	404	NP
Rural 1		**5%**
Townsville-Mackay	310	5%
Country North SA	405	5%
Central Qld	308	4%
Far West NSW	118	NP
Lower Murray	213	NP
Rural 2		**5%**
Far North Qld	311	5%
Northern Territory	701	4%
Central & NW Qld	309	NP
Goldfields-Midwest	507	NP
Kimberley-Pilbara	508	NP



NP Not available for publication.
More information can be found at **www.myhealthycommunities.gov.au** and in this report's Technical Supplement.

Appendix

About the peer groups

To enable fairer comparisons, the Authority allocated each Medicare Local catchment to one of seven peer groups, based on socioeconomic status, remoteness and distance to hospitals.

- **Metro 1:** High urban density, higher socioeconomic status
- **Metro 2:** Medium urban density, medium socioeconomic status
- **Metro 3:** Low urban density, lower socioeconomic status
- **Regional 1:** Outer urban areas, middle socioeconomic status
- **Regional 2:** Mostly non-metro urban and regional areas, middle socioeconomic status
- **Rural 1:** Distance from metro cities, with diverse socioeconomic status
- **Rural 2:** Mostly large remote areas, middle or lower socioeconomic status.

To find more information about peer groups, see *Healthy Communities: GP care for patients with chronic conditions in 2009–2013, Technical Supplement* at **www.myhealthycommunities.gov.au**

Glossary

Actively managed	Involves the care and monitoring of a patient's health condition by a GP.
Acute health condition	A medical condition that comes on suddenly and lasts for a limited time.
Acute myocardial infarction (AMI)	Occurs when there is restricted or totally obstructed blood flow, causing death of muscle in an area of the heart. Commonly referred to as a heart attack.
Allied health professional	A health professional who is not a doctor, nurse or dentist; the term includes physiotherapists, psychologists and dieticians.
Anxiety disorder	Clinically significant anxiety that is not restricted to any particular situation, including anxiety neurosis and panic disorder, with or without physical symptoms.
Arthritis	A chronic disease of the joints. Common forms include osteoarthritis and rheumatoid arthritis.
Asthma	A chronic lung disease that inflames and narrows the airways. Asthma causes recurring periods of wheezing, a feeling of constriction in the chest, shortness of breath and coughing.
Cancer	General term covering a variety of malignancies, whereby gene damage causes cells to multiply, invade and spread without control.
Cardiovascular	Relating to the heart, blood vessels and circulation.
Cerebrovascular accident (CVA)	Commonly known as a stroke, whereby a cerebral haemorrhage causes brain damage or, blockage of cerebral vessels which restricts or stops blood flow to the brain resulting in death of brain cells.
Chronic back pain	Refers to pain in the spine of three months or more and outlasting the usual healing process.
Chronic condition	A medical condition characterised by a combination of the following characteristics: duration that has lasted or is expected to last six months or more, a pattern of recurrence or deterioration, a poor prognosis, and consequences that impact on an individual's quality of life.
Chronic obstructive pulmonary disease (COPD)	A group of diseases that affect the lungs and airways. It is defined by limited airflow as a result of breakdown of lung tissue and obstruction of the small airways.

Clinical treatments	Clinical treatments performed may include general and specific advice, counselling (e.g. for weight loss, smoking, medication) or education, family planning and administrative processes (e.g. providing a medical certificate).
Common chronic condition	For the purposes of this report, a chronic medical condition that occurs frequently among people in the community and in general practice patients.
Congestive heart failure	A clinical syndrome due to heart disease, characterized by breathlessness and abnormal sodium and water retention, often resulting in oedema (swelling).
Consultation	A face-to-face professional interchange between a patient and a health professional to discuss a health concern.
Depression	A mood disorder with prolonged feelings of sadness and hopelessness, which is often accompanied by low self-esteem, a loss of interest in activities, and suicidal thoughts or self-blame.
Diabetes type 1	One of the two major types of diabetes mellitus: an autoimmune disease that results in the destruction of cells in the pancreas, leading to loss of the ability to secrete insulin. It has an abrupt onset, and insulin injections are required to sustain life; peak age of onset is 12 years. Also called insulin-dependent, juvenile, juvenile-onset, and Type I d. mellitus.
Diabetes type 2	One of the two major types of diabetes mellitus, with a peak age of onset between 50 and 60 years and a gradual development with few early symptoms. Dietary control with or without oral hypoglycaemic drugs is usually effective. Insulin injections are not usually needed. Diagnosis is based on pathology tests indicating glucose resistance. Called also adult-onset, maturity-onset, non–insulin-dependent, and Type II d. mellitus.
Gastro-oesophageal reflux disease (GORD)	A common condition in which the liquid contents of the stomach reflux back up into the oesophagus (food pipe).
General practitioner (GP)	A medical practitioner who provides primary comprehensive and continuing care to patients and their families within the community (RACGP).
GP management occasion	A consultation in which a GP takes clinical action, such as prescribing medication, to manage the patient's chronic condition
Hyperlipidaemia	The presence of abnormally high levels of lipids (fats) such as cholesterol and triglycerides in the blood.

Hypertension	Occurs when the blood is persistently pumping at a higher pressure than normal through the arteries. This can contribute to a number of conditions or diseases including heart attack, kidney disease or stroke.
Imaging	Production of diagnostic images; for example CT (computed tomography), MRI (magnetic resonance imaging), X-rays, ultrasound and nuclear medicine scans.
Insomnia	Insomnia means difficulty with either falling or staying asleep. It is one of a number of sleep disorders.
Ischaemic heart disease (IHD)	A disease characterised by reduced blood supply to the heart. Also called coronary heart disease. It is the most common form of cardiovascular disease. May take the form of a heart attack (see also acute myocardial infarction) and/or angina (a chronic condition when a temporary loss of blood supply to the heart causes periodic chest pain).
Morbidity	Any departure, subjective or objective, from a state of physiological wellbeing. In this sense, sickness, illness and morbid conditions are synonymous.
Multimorbidity	Refers to when two or more chronic medical conditions occur in one person.
Not available for publication (NP)	This applies when data are not able to be published for reasons related to reliability, validity and/or confidentiality. Methods used to determine whether a statistic is published are included in the report's Technical Supplement.
Obesity	A person whose body mass index (BMI) was greater than or equal to 30.
Oesteoarthritis	A chronic and common form of arthritis, affecting mostly the spine, hips, knees and hands. It can first appear from the age of about 30 and is more common and severe with increasing age.
Peripheral vascular disease (PVD)	Peripheral vascular disease is the reduced circulation of blood to a body part other than the brain or heart. It is caused by narrowed or blocked arteries.
Prescription drugs	Pharmaceutical medicines only available on the prescription of a registered medical practitioner and only available from pharmacies.

Primary Health Networks	The Australian Government announced in the 2014–15 Budget that new Primary Health Networks (PHNs) will begin operations from 1 July 2015. Primary Health Networks will play a critical role in connecting health services across local communities so that patients, particularly those needing coordinated care, have the best access to a range of health care providers, including practitioners, community health services and hospitals. PHNs will work directly with GPs, other primary care providers, secondary care providers and hospitals.
Psychotropics	Psychotropic medicines act on the central nervous system to affect perception, mood, consciousness, cognition and/or behaviour. Examples include antidepressants, antipsychotics and sedatives.
Referral	The process by which the responsibility for part, or all, of the care of a patients is temporarily transferred to another health care provider.
Rheumatoid arthritis	A chronic, multisystem disease whose most prominent feature is joint inflammation and resulting damage, most often affecting the hand joints in symmetrical fashion. Can occur in all age groups but most commonly appears between ages 20 and 40.
Selected cardiovascular risk condition	For the purposes of this report, data were used to identify patients, of any age, with cardiovascular risk conditions based on clinical guidelines to support the prevention or management of: ischaemic heart disease - including acute myocardial infarction (AMI), cerebrovascular disease and stroke, and heart failure.
Statins	Drugs used to lower plasma lipoproteins and cholesterol.
Stroke	See CVA.

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- Dr Evan Ackermann
  - Chair, National Standing Committee for Quality Care, Royal Australian College of General Practitioners (RACGP)
- Mr David Butt
  - Chief Executive Officer, National Mental Health Commission
- Professor Mark Harris
  - Centre for Primary Health Care and Equity, University of New South Wales and Centre for Obesity Management and Prevention Research Excellence in Primary Health Care (COMPaRE-PHC)
- Ms Rebecca Lee
  - Project Officer, Health Equity and Secondary Prevention, Heart Foundation
- A/Prof Graeme Miller
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- Mr Luke Slawomirski
  - Program Manager, Implementation Support, Australian Commission on Safety and Quality in Health Care
- Ms Donna Stephenson
  - Policy Director, Consumers Health Forum of Australia
- Dr Lynn Weekes AM
  - Chief Executive Officer, NPS MedicineWise.

The National Health Performance Authority also received technical advice from the Family Medicine Research Centre, the University of Sydney. This technical Advisory Committee comprised:

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About the Authority

The National Health Performance Authority has been set up as an independent agency under the *National Health Reform Act 2011*. It commenced full operations in 2012.

Under the terms of the Act, the Authority monitors and reports on the performance of Local Hospital Networks, public and private hospitals, primary health care organisations and other bodies that provide health care services.

The Authority's reports give all Australians access to timely and impartial information that allows them to compare fairly their local health care organisations against other similar organisations and against national standards.

The reports let people see, often for the first time, how their local health care organisations measure up against comparable organisations across Australia.

The Authority's activities are also guided by a document known as the Performance and Accountability Framework agreed by the Council of Australian Governments. The framework contains a set of indicators that form the basis for the Authority's performance reports.

The Authority's role will include reporting on the performance of health care organisations against these indicators in order to identify both high-performing Local Hospital Networks, Medicare Locals and hospitals (so effective practices can be shared), and Local Hospital Networks and Medicare Local catchments that perform poorly (so that steps can be taken to address problems).

The Authority releases reports on a quarterly basis, and also publishes performance data on the MyHospitals website (**www.myhospitals.gov.au**), the MyHealthyCommunities website (**www.myhealthycommunities.gov.au**) and on **www.nhpa.gov.au**

The Authority consists of a Chairman, a Deputy Chairman and five other members, appointed for up to five years. Members of the Authority are:

- Ms Patricia Faulkner AO (Chairman)
- Mr John Walsh AM (Deputy Chairman)
- Dr David Filby PSM
- Professor Michael Reid
- Professor Paul Torzillo AM
- Professor Claire Jackson
- Professor Bryant Stokes AM RFD (on leave).

The conclusions in this report are those of the Authority. No official endorsement from any Minister, department of health or health care organisation is intended or should be inferred.

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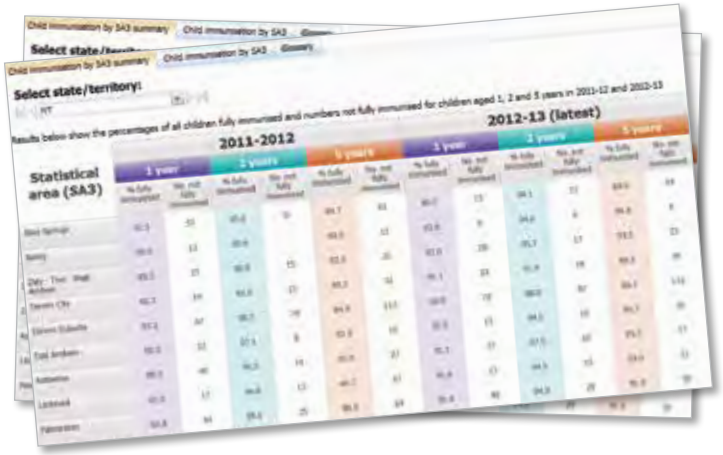

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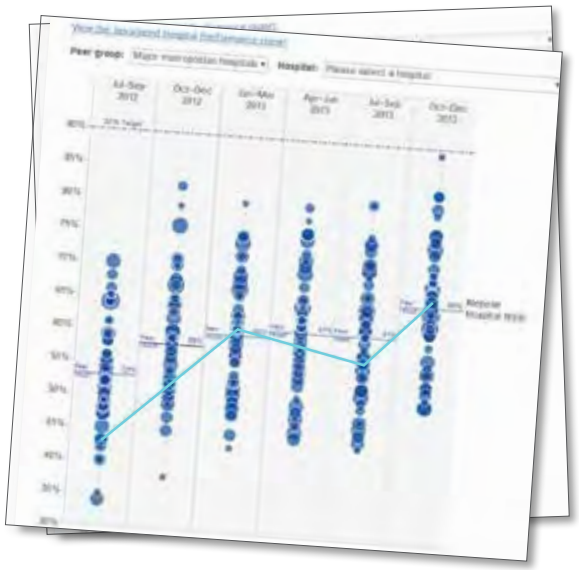

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