Australian Government
Australian Institute of Health and Welfare

AIHW

Indigenous health checks and follow-ups

Web Report

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About

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

- In 2020–21, 237,000 Indigenous Australians had one of these health checks (27% of the projected population).
- The proportion of Indigenous health check patients who had an Indigenous-specific follow-up service within 12 months of their check increased from 12% to 47% between 2010–11 and 2019–20.

COVID-19

The report presents data on Indigenous-specific health checks and follow-up services for a time period up until the end of June 2021 (i.e. overlapping with the COVID-19 period). It also includes data on telehealth MBS items that were introduced in 2020 as part of the response to COVID-19.

Key findings

- In 2020–21, 5% of Indigenous-specific health check patients had a health check via phone or video-conference
- 47% of Indigenous Australians who had a health check in 2019–20 had an Indigenous-specific follow-up within 12 months
- 553,000 Indigenous Australians received at least 1 health check in the 5-year period to 30 June 2021
- In 2020–21, 27% of Indigenous Australians had an Indigenous health check – up from 10% in 2010–11
- Males aged 15–34 had the lowest rates of Indigenous-specific health checks of any male or female age group, at 18%

- Females had health checks at higher rates than males in every year between 2010–11 and 2020–21

Summary

Aboriginal and Torres Strait Islander people can receive an annual health check, designed specifically for Indigenous Australians and funded through Medicare (Department of Health 2021). This Indigenous-specific health check was introduced in recognition that Indigenous Australians, as a group, experience some particular health risks.

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

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

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

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

This report presents information on the use of:

- health checks provided under the Indigenous-specific Medicare Benefits Schedule (MBS) items 715, 228, 93470 and 93479; and
- follow-up services provided under Indigenous-specific MBS items 10987, 81300–81360, 93546–93558, 93571–93573 and 93579–93591;

as well as telehealth:

- health checks provided under the Indigenous-specific Medicare Benefits Schedule (MBS) items 92004, 92016, 92011 and 92023; and
- follow-up services provided under Indigenous-specific MBS items 93200, 93202, 93048, 93061, 93592 and 93593.

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

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

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

This report differs from the previous edition, due to: new 2020–21 data; the introduction of new MBS items for Indigenous-specific health checks and follow-ups delivered in Residential Aged Care Facilities (RACF); new Greater Capital City Statistical Areas (GCCSA) level analysis; and refinement of the analysis of time between consecutive health checks (see Data sources and notes).

Key findings

The health check rate dropped for a second year in a row

27.2% of Indigenous Australians (about 237,000 people) had an Indigenous-specific health check in 2020–21, compared with 28.0% in 2019–20 (239,000 people) and the peak rate of 28.8% in 2018–19 (241,000 people).

Older age groups had the highest rates

In 2020–21, Indigenous Australians aged 65 and over had the highest rate of Indigenous-specific health checks, at 40% of the population. The age group with the lowest rate of health checks was 15–24 year-olds, at 22%.

More females than males had health checks

In 2020–21, Indigenous females had higher rates of health checks than males, overall (29% and 25%, respectively), and had substantially higher rates than males among people aged 15–34.

Health check rates differ vastly between areas

In 2020–21, the area with the highest rate of health checks was *Townsville* (SA3), at 54% of the Indigenous population. At the low end, less than 5% of the Indigenous population had a health check in some areas, such as *Pittwater* (SA3) in Sydney and *Boroondara* (SA3) in Melbourne.

Over half the Indigenous population had a health check in 5 years

Over the 5-year period from 1 July 2016 to 30 June 2021, about 553,000 Indigenous Australians received at least one health check. This is equivalent to over half (63%) of the projected Indigenous population at 30 June 2021.

People in more remote areas wait the longest between health checks

In 2020–21, the average Indigenous-specific health check patient living in *Very Remote* areas had their previous health check 27 months earlier, compared with 22 months earlier among patients living in *Major Cities*.

Follow-up services fell for the first time

Fewer Indigenous Australians received Indigenous-specific follow-up services in 2020–21 than in 2019–20 (154,000 people in 2020–21 compared with 164,000 people in 2019–20). The number of patients had increased in all previous years.

Most follow-up care was delivered by an Aboriginal Health Practitioner or Practice Nurse

In 2020–21, the vast majority of Indigenous-specific follow-up services were delivered by an Aboriginal Health Practitioner or Practice Nurse (290,500 out of the total 358,000 services, or 81%), as opposed to an Allied Health professional (67,500 services).

More older people and females received follow-up care after a health check

Among the patients who received an Indigenous health check in 2019–20, 47% received an Indigenous-specific follow-up service in the 12 months following their health check (112,000 out of 239,000 patients). Patients aged 65 and over had the highest rate of follow-up, at 56%, and females had a higher rate of follow-up than males in every adult age group.

Follow-up rates among health check patients differ vastly between areas

Among the patients who received an Indigenous health check in 2019–20, those who lived in *Brisbane Inner – West* (SA3) had the highest rate of follow-up care in the 12 months following their health check, at 76%. Some areas had follow-up rates below 10%, such as *Limestone Coast* (SA3) and *Wellington* (SA3).

The annual follow-up rate among health check patients stopped increasing

Looking at the Indigenous health check patients from 2010–11 to 2019–20, the proportion who received an Indigenous-specific follow-up service in the 12 months following their health check increased in every year until 2019–20, when the rate of follow-up dropped very slightly (46.8% for 2018–19's patients compared with 46.7% for 2019–20).

References

Department of Health (2020) *Coronavirus (COVID-19) – Telehealth items guide*, Department of Health, Australian Government, accessed 22 February 2022.

Department of Health (2021) *Annual health checks for Aboriginal and Torres Strait Islander people*, Department of Health, Australian Government, accessed 3 June 2022.

Number of health checks

In 2020–21, there were about 244,000 Indigenous-specific health checks provided to about 237,000 Aboriginal and Torres Strait Islander people (Figure 1). The minimum time allowed between checks is 9 months, and so people can receive more than 1 health check in a year. Data from the Indigenous primary health care national Key Performance Indicators (nKPIs) data collection suggest that GPs at Aboriginal Community Controlled Health Organisations conduct nearly half of all Indigenous-specific health checks despite only making up about 1.8% of fulltime-equivalent general practitioners (GPs) (AIHW 2021).

Between 2010–11 and 2018–19, the number of Indigenous Australians receiving a health check more than tripled – from about 71,000 to 241,000 patients. For the first time in 9 years, the number of health check patients decreased during the COVID-19 pandemic (AIHW 2021). The number of people who received a health check first dropped slightly in 2019–20 (by about 2,200 patients or 1% since 2018–19), and then dropped again in 2020–21 by a similar number (about 2,200 patients or 1% since 2019–20) (Figure 1).

Telehealth MBS items were introduced in 2020, in response to COVID-19 and associated restrictions (Department of Health 2020). 12,000 Indigenous-specific health checks were conducted via telehealth in 2020–21, equating to 5% of all health checks in the financial year. The number of patients who received a health check via telehealth in 2020–21 was greater than in 2019–20 (12,000 compared with 10,000), but it is important to note that telehealth items were only available for 3–4 months in 2019–20 (Figure 1).

Figure 1: Number of Indigenous-specific health check patients and services by sex and telehealth status, 2010–11 to 2020–21

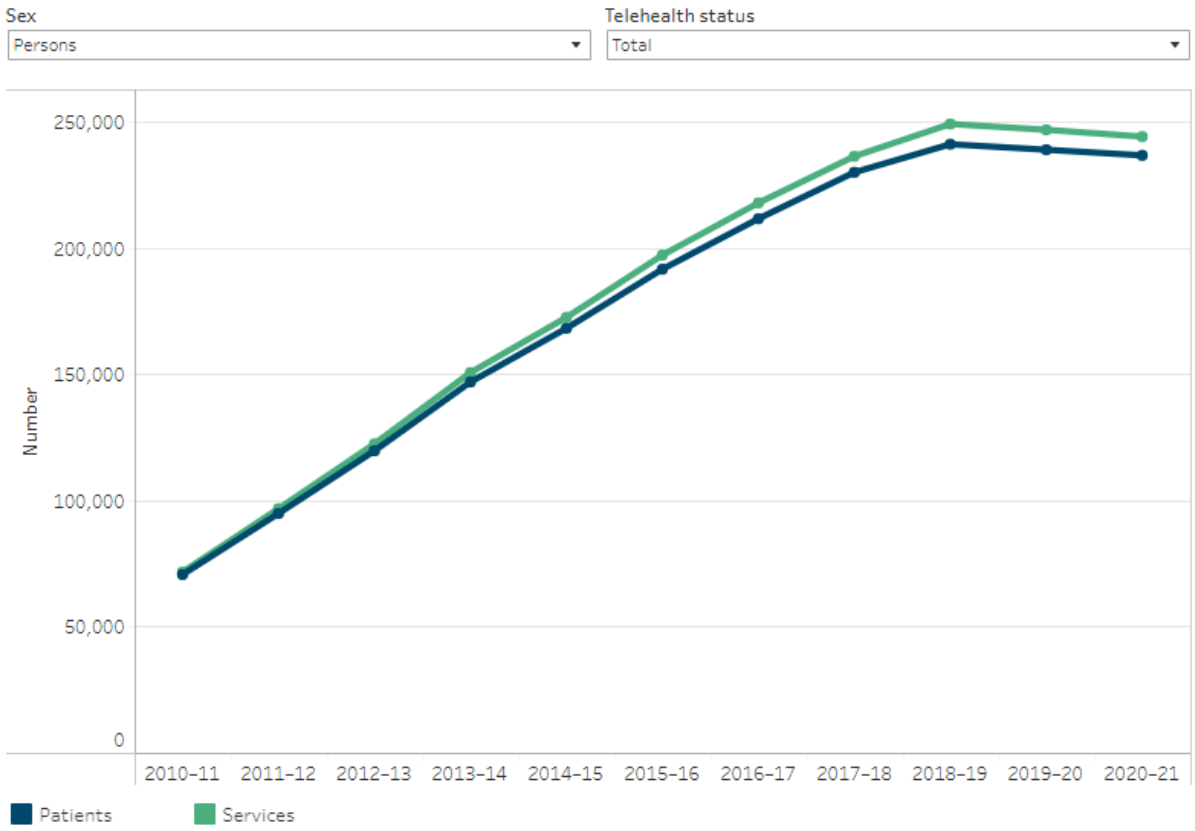


Figure 1: Number of Indigenous-specific health check patients and services by sex and telehealth status, 2010–11 to 2020–21

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. Telehealth items were introduced in March 2020, in response to COVID-19 and associated restrictions.
3. See 'Data sources and notes' for additional information.
4. Refer to table 'HC01' in data tables

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

References

Australian Institute of Health and Welfare (AIHW) 2021, *Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023*, AIHW, Australian Government, accessed 22 February 2022.

Department of Health (2020) *Coronavirus (COVID-19) – Telehealth items guide*, Department of Health, Australian Government, accessed 22 February 2022.

Rate of health checks

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

- national rates in 2020–21, and differences by age and sex
- trends in the annual rate of checks, from 2010–11 to 2020–21
- differences by geographic area in 2020–21
- patterns of use over a 5-year period from 1 July 2016 to 30 June 2021
- time between health checks for patients in 2020–21.

Rates have been calculated using ABS Indigenous population estimates and projections based on the 2016 Census. For certain geographic breakdowns, Indigenous population estimates have been derived by disaggregating available ABS data (see Box 1). See also the note on 2021 Census-based population data in Box 1.

Box 1: Population data used in rate calculations

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

2016 Census-based populations:

ERP estimates for Indigenous Australians based on the 2016 Census are available for 30 June 2016 (ABS 2018a). The ABS also produces projections of the Indigenous population for post-Census years based on assumptions about fertility, mortality and migration. These span the period 30 June 2017 to 30 June 2031 and are available for Australia, States and Territories, Indigenous Regions and combined Remoteness Areas (ABS 2019). A similar method was used by the ABS to backcast estimates spanning the period 2006 to 2015 (ABS 2019). The ABS makes no attempt to predict future changes in Indigenous identification when modelling these projections, though increased identification has had large impacts in the past (ABS 2018b).

In this report, annual rates of health checks are based on averages of the ABS' Series B projections. For example, population denominators for 2020–21 are the average of 30 June 2020 and 30 June 2021 projections. For Statistical Areas Level 3 (SA3), Greater Capital City Statistical Areas (GCCSA), Primary Health Networks (PHN) and expanded Remoteness Areas (RA), projections have been approximated by the AIHW using Iterative Proportional Fitting, supported by 2016 Census counts. This technique produces estimates that match the ABS' published outputs when summed back up to larger areas. Uncertainty in these estimates would be difficult to quantify, since there are many sources of error, but generally, estimates for areas with larger populations would be more reliable.

ERP estimates for the Indigenous Australian population based on the 2021 Census were not available at the time of release, but the 2021 PES indicates that the population identifying as being of Aboriginal and/or Torres Strait Islander origin should have been

around 983,000 people on Census night (10 August 2021) (ABS 2022). This is compared with a projected 879,000 people on 30 June 2021, based on the 2016 Census, 2016 PES and natural growth assumptions. Based on that difference, this means many of the percentages presented in this report could be overestimated, though it would vary across age groups and geographic areas. Future iterations of this web report will use 2021 Census-based population denominators, when available.

See Data sources and notes for additional information.

Comparability with rates published elsewhere

Implementation Plan goals

The Australian Government's new national health policy to improve health and wellbeing among Indigenous Australians is the National Aboriginal and Torres Strait Islander Health Plan 2021–2031. For the earlier health plan, national goals were set for increasing the use of Indigenous-specific health checks (see national goals for health checks). Information about the national goals can be found in the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023.

Rates in this section differ from rates used to assess progress towards the Implementation Plan goals due to different data specifications. Rates in this report are calculated using numbers of patients (while the national goals are based on number of services, which are higher than the number of patients), and presented according to the date the service was provided (while the national goals are based on the date the claim for the service was processed). Population denominators for rates presented in this report are projections based on the 2016 Census, while the national goals use projections based on the 2011 Census. Age of patients is also calculated differently for the national goals. Health check items for residents of Aged Care facilities are also included in this report. See Data sources and notes for additional information.

Other publications

Rates may be published elsewhere based on slightly different data. See Data sources and notes for additional information.

References

Australian Bureau of Statistics (ABS) (2018a) *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016*, ABS, Australian Government, accessed 22 February 2022.

ABS (2018b) *Census of Population and Housing: Understanding the Increase in Aboriginal and Torres Strait Islander Counts*, ABS, Australian Government, accessed 22 February 2022.

ABS (2019) *Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2006 – 2031*, ABS, Australian Government, accessed 22 February 2022.

ABS (2022) *2021 Census overcount and undercount*, ABS, Australian Government, accessed 28 June 2022.

National rates by age and sex

In 2020–21, 27% of Aboriginal and Torres Strait Islander people (237,000 out of 871,000 people) had an Indigenous-specific health check. Around 5% of health checks (12,000 of 244,000 services) were conducted at least partly via phone or video-conference in 2020–21 (Figure 2).

In 2020–21, the rates of Indigenous-specific health checks were:

- highest among those aged 65 and over, for both males and females – 41% of Indigenous females (10,200 females) and 38% of Indigenous males (7,800 males) in this age group received a health check
- lowest among those aged 5–14 for females (23% or 20,900 females) and among those aged 15–24 and 25–34 for males (18% or 15,400 males aged 15–24 and 12,600 aged 25–34) (Figure 2).

The rate of Indigenous-specific health checks was higher for females than for males – 29% compared with 25%, respectively (128,000 females and 109,000 males). Across age groups, the difference between males and females in the rate of checks was largest for those aged 25–34 (28% of Indigenous females, compared with 18% of Indigenous males). Among total health check recipients of each sex, females engaged with telehealth services slightly more so than males (5.2% of female patients compared with 4.7% of male patients – or around 6,700 females and 5,200 males) (Figure 2).

Rates of Indigenous-specific health checks delivered via telehealth differed only marginally between age groups in 2020–21. Just under 2% of the Indigenous population aged 65 and over received a health check via telehealth (900 patients), compared with 1% of the population aged 15–24 (1,700 patients) (Figure 2).

Figure 2: Indigenous-specific health check rates, by sex, age and telehealth status, 2020–21

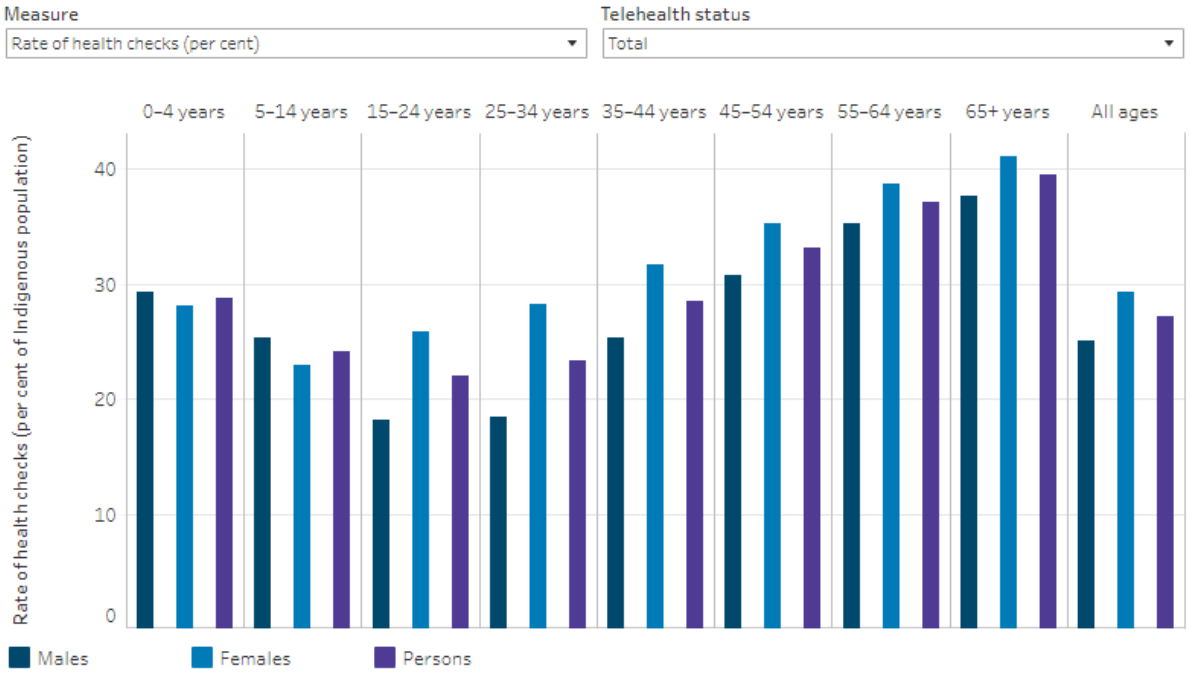


Figure 2: Indigenous-specific health check rates, by sex, age and telehealth status, 2020–21

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. Telehealth items were introduced in March 2020, in response to COVID-19 and associated restrictions.
3. See 'Data sources and notes' for additional information.
4. Refer to table 'HC02' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data; Populations based on Australian Bureau of Statistics (ABS) data.
https://www.aihw.gov.au

Trends in annual rate of health checks

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

Between 2010–11 and 2018–19, the proportion of Indigenous Australians who had an Indigenous-specific health check grew each year – from 9.9% in 2010–11 to 28.8% in 2018–19 (71,000 patients in 2010–11 and 241,000 in 2018–19). In 2019–20, that proportion dropped for the first time, with only 28.0% of Indigenous Australians receiving a health check (239,000 patients). The proportion dropped further in 2020–21, reaching only 27.2% of the projected Indigenous population (237,000 out of 871,000 people) (Figure 3).

Figure 3: Rate of Indigenous-specific health checks by sex, 2010–11 to 2020–21

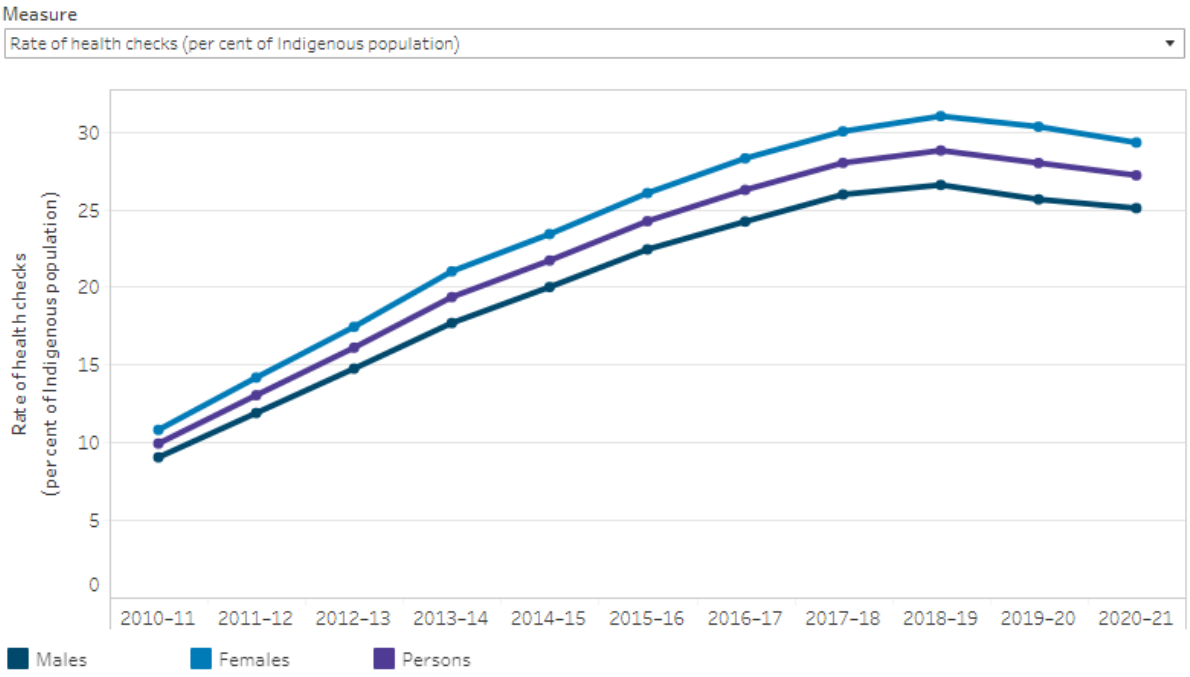


Figure 3: Rate of Indigenous-specific health checks by sex, 2010–11 to 2020–21

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. 'Change in rate' calculated as the rate of health checks in the reference year minus the rate of health checks in the previous year.
3. See 'Data sources and notes' for additional information.
4. Derived from table 'HC01' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data; Populations based on Australian Bureau of Statistics (ABS) data.
https://www.aihw.gov.au

Over the course of the decade, a higher proportion of Indigenous females received an Indigenous-specific health check each year, compared with Indigenous males (Figure 3). In both sexes, however, the rate of increase had been slowing – even before 2019–20:

- In 2011–12, the health check rate was 3.1 percentage points higher than in 2010–11.

- By 2017–18, the health check rate was only 1.7 percentage points higher than the previous year.
- In 2018–19, the health check rate was 0.8 percentage points higher than in 2017–18.
- In 2019–20, the health check rate dropped 0.8 percentage points, compared with 2018–19.
- In 2020–21, the health check rate again dropped 0.8 percentage points since the previous year (Figure 3).

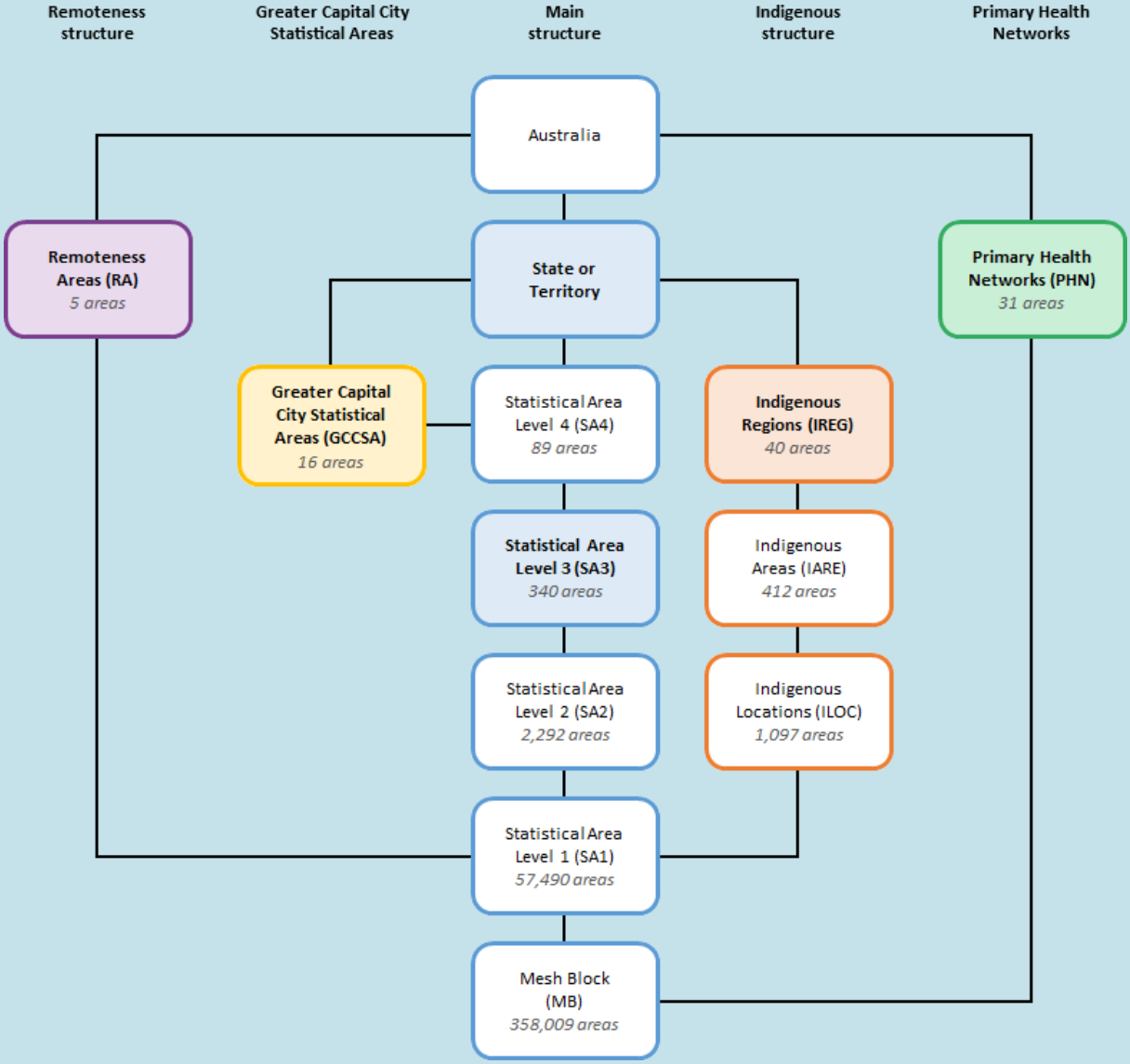
Geographic variation

This section looks at the variation in rates of Indigenous-specific health checks across Australia. See Box 2 for information about the reporting of geographic data.

Box 2: Notes on geographic reporting

Geographic region types

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



Notes:

- The Main structure, Greater Capital City Statistical Areas (GCCSA), Indigenous structure, and Remoteness structure refer to the Australian Bureau of Statistics' hierarchy of areas included in the 2016 Australian Statistical Geography Standard (ASGS).
- Remoteness Areas divide Australia into 5 classes of remoteness based on a measure of relative access to services in 2016. Access to services was measured using the

Accessibility and Remoteness Index of Australia (ARIA+), produced by the Hugo Centre for Population and Migration Studies at the University of Adelaide.

- Primary Health Networks (PHNs) were established in 2015 by the Australian Government. Some PHNs cross state/territory borders – most notably, the Victorian PHN, Murray, covers Albury (NSW). For more information, see the Department of Health's website.

Postcode data

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

Metropolitan classification

To distinguish different geographic regions based on their level of urban development, certain bar charts in Figure 4 and Figure 16 depict areas as:

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

Rates by geographic region

Figure 4 shows the rate of Indigenous-specific health checks in 2020–21, by 6 different geographic classifications – state/territory, Greater Capital City Statistical Areas (GCCSA), remoteness area, Primary Health Network (PHN), Indigenous Regions (IREG) and Statistical Areas Level 3 (SA3). See Box 2 for information about the reporting of geographic data.

In 2020–21:

- Across states and territories, Queensland had the highest rate of Indigenous-specific health checks (with 34% of the Aboriginal and Torres Strait Islander population receiving an Indigenous health check), followed by the Northern Territory (32%). Victoria had the lowest rate (14%) (Figure 4).
- Among the capital cities, *Greater Darwin* and *Greater Brisbane* had the highest rates of Indigenous-specific health checks (36% and 35%, respectively), while *Greater Melbourne* had the lowest rate (9%). Queensland, Tasmania and the Northern Territory had somewhat higher rates of health checks in their capital city areas, relative to their 'rest of state' areas. The other states had health check rates that

were higher in the 'rest of state' areas compared with their capital cities – particularly, in Victoria and New South Wales (Figure 4).

- Across PHNs, the rate of Indigenous-specific health checks ranged from 5% (in *Northern Sydney*) to 36% (in both *Western New South Wales* and *Brisbane North*) (Figure 4).

Figure 4: Indigenous-specific health check rates by geography and telehealth status, 2020–21

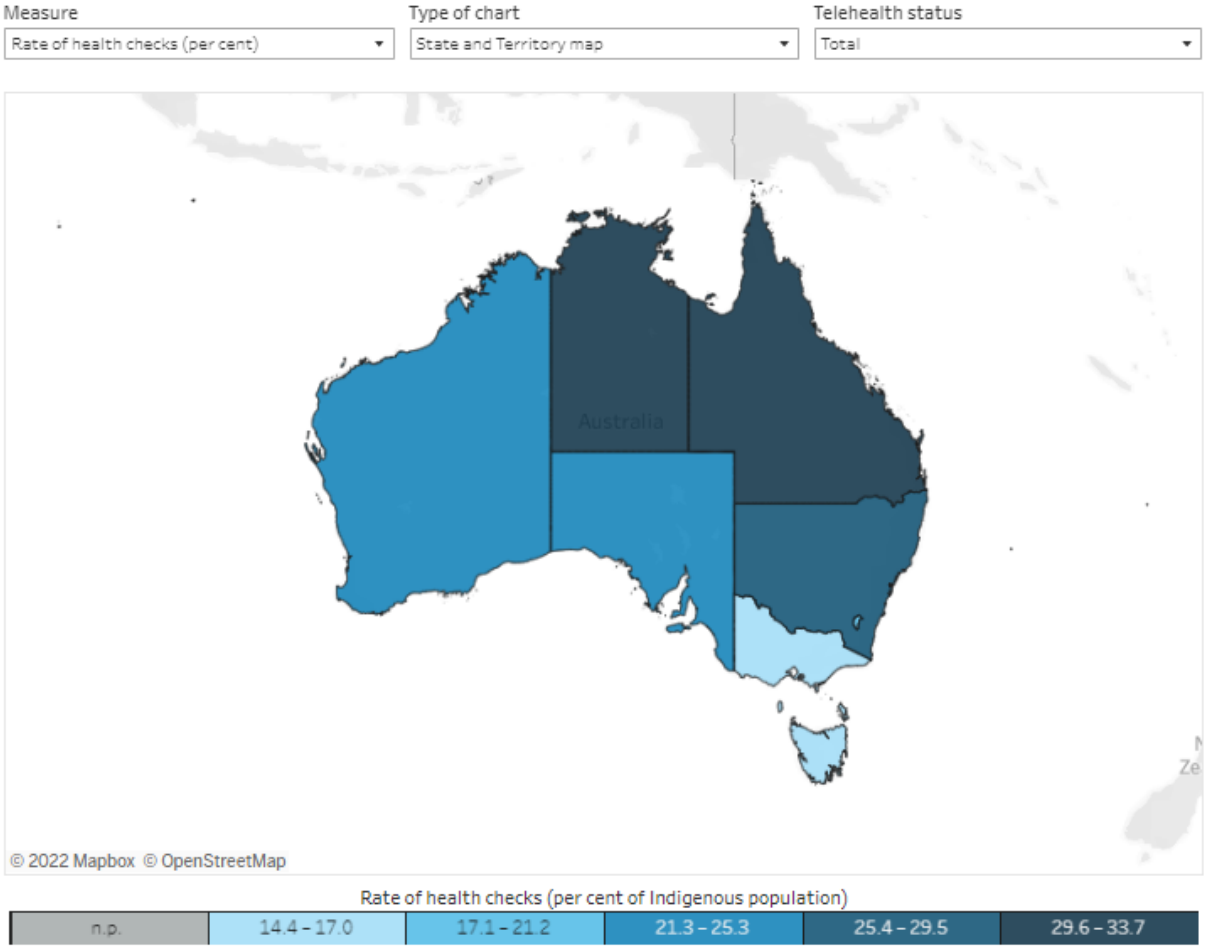


Figure 4: Indigenous-specific health check rates by geography and telehealth status, 2020–21
n.p. not published because of small numbers, confidentiality or other concerns about the quality of the data.
Notes
1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. Telehealth items were introduced in March 2020, in response to COVID-19 and associated restrictions.
3. See 'Data sources and notes' for additional information.
4. Refer to tables 'HC03' to 'HC08' in data tables.
Source: AIHW analysis of Medicare Benefits Schedule data; AIHW analysis of Australian Bureau of Statistics (ABS) population data.
https://www.aihw.gov.au

Across the 5 remoteness areas, the rate of Indigenous-specific health checks in 2020–21 was generally higher in more remote areas – increasing from 24% in *Major cities* to 33% in *Outer regional* and *Remote* areas. *Very remote* areas were the exception to this general pattern, with a rate of 25% (Figure 4). This may be partly due to the use of mailing

address to derive these rates – in particular, where a person lives in a *Very remote* area, but has mail delivered to a PO Box in a less remote location, the health check will be counted in the less remote location. Another explanatory factor would be the availability of GPs in more remote areas (RACGP 2020).

Across Indigenous Regions, the rate of Indigenous-specific health checks was highest in *Alice Springs* (52%) and lowest in *Melbourne* (10%) (Figure 4). Note that the rate in *Alice Springs* is likely to be inflated, since many residents of Central Australia use PO Boxes located in Alice Springs for receiving mail. This means some of the health checks counted in *Alice Springs* probably belong to residents of *Apatula* (IREG).

Across SA3s, the rate of Indigenous-specific health checks in 2020–21 ranged from 2% in *Pittwater* (NSW) to 54% in *Townsville* (Qld) (Figure 4; analysis relates to 329 areas for which rates could be reported).

On average, the rate of Indigenous-specific health checks was higher in SA3s with larger Indigenous populations. For example, the rate of health checks, when averaged across the SA3s in 2020–21, was:

- 14% in SA3s with fewer than 1,000 Indigenous Australians (113 SA3s)
- 24% in SA3s with between 1,000 and 4,999 Indigenous Australians (174 SA3s)
- 32% in SA3s with 5,000 or more Indigenous Australians (42 SA3s).

In 2020–21, about 7 in 10 SA3s (71%, or 235 areas) had a rate below the national average (that is, a rate lower than 27.2%). This is because SA3s with larger populations – which tended to have higher rates of health checks – contribute more to the national rate than the smaller SA3s.

Rates by State or Territory and age group

Breaking down the rates of Indigenous-specific health checks by state/territory and age groups reveals some noteworthy differences between the jurisdictions (Figure 5).

Indigenous Australians aged 55 and over have the highest rates of health checks in all jurisdictions except the Northern Territory, where young children (aged 0–4) have the highest rate. Tasmania has a higher overall rate of Indigenous health checks than Victoria, predominantly due to differences in the oldest age groups (25–54 and '55 and over') (Figure 5).

Figure 5: Indigenous-specific health check rates by State or Territory, age group and telehealth status, 2020–21

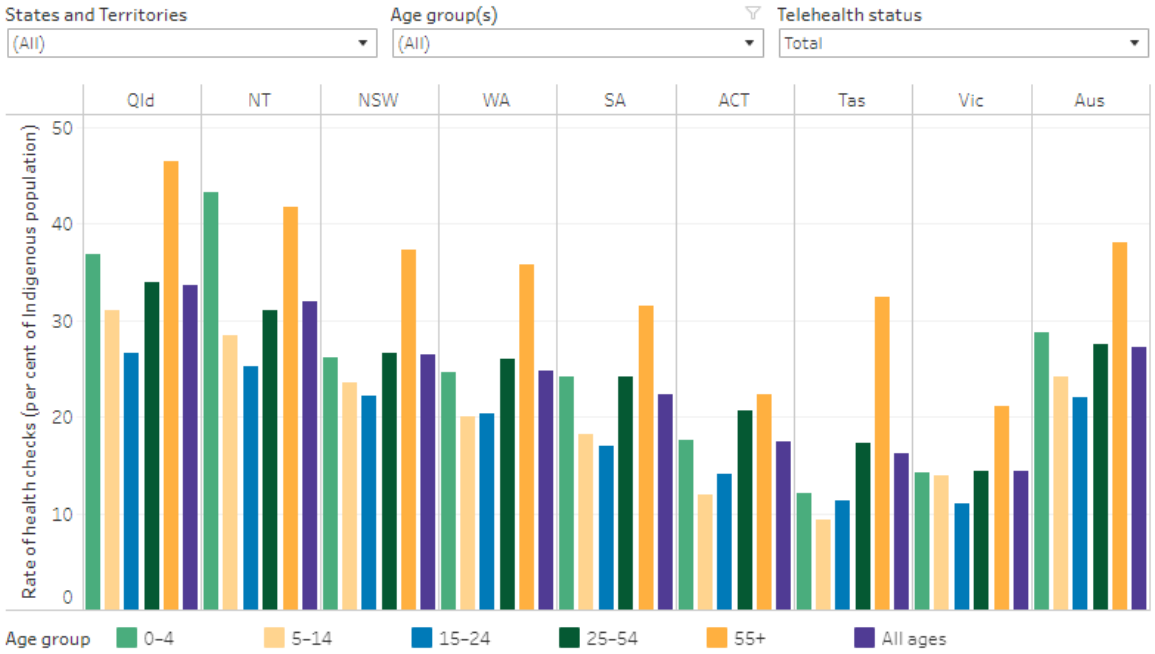


Figure 5: Indigenous-specific health check rates by State or Territory, age group and telehealth status, 2020–21

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. Telehealth items were introduced in March 2020, in response to COVID-19 and associated restrictions.
3. Patients and populations from Other Territories are included in New South Wales, to avoid small number problems.
4. See 'Data sources and notes' for additional information.
5. Refer to tables 'HC03' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data; Populations based on Australian Bureau of Statistics (ABS) data.

https://www.aihw.gov.au

Variation in telehealth use

As a proportion of all patients who received an Indigenous-specific health check in 2020–21, around 5% had a health check completed at least partly via telehealth (12,000 out of 237,000 patients). There was considerable variation between areas though, with relatively high proportions of telehealth use in *Greater Adelaide* (16%), *Greater Melbourne* (14%), *Greater Sydney* (11%) and the *Rest of Victoria* (10%), contrasting with very low proportions in *Greater Perth* (1.2%), the *Rest of Western Australia* (1.5%), the Australian Capital Territory (1.7%) and *Greater Darwin* (1.9%) (Figure 6).

Figure 6: Proportion of Indigenous-specific health check patients who received a health check via telehealth, by Greater Capital City Statistical Areas, 2020–21

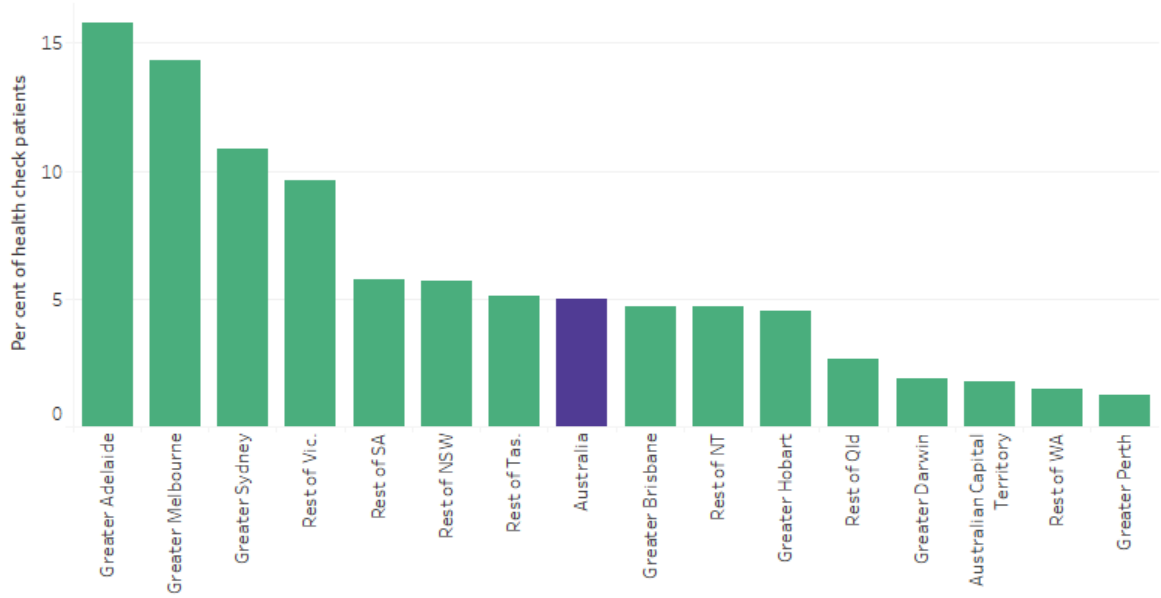


Figure 6: Proportion of Indigenous-specific health check patients who received a health check via telehealth, by Greater Capital City Statistical Areas, 2020–21

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. Telehealth items were introduced in March 2020, in response to COVID-19 and associated restrictions.
3. Percentages calculated as the *number of patients who had at least 1 Indigenous-specific health check delivered via telehealth* as a proportion of the *total number of patients who had an Indigenous-specific health check*.
4. See 'Data sources and notes' for additional information.
5. Derived from table 'HC04' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

References

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

Patterns over a 5-year period

Over the 5-year period from 1 July 2016 to 30 June 2021, about 553,000 Aboriginal and Torres Strait Islander people received at least one Indigenous-specific health check. This is equivalent to over half (63%) of the Indigenous population at 30 June 2021, acknowledging that a small proportion of those patients may have either died or moved overseas during the 5-year period.

The 553,000 Indigenous-specific health check patients included around:

- 222,000 people who received 1 health check during the 5-year period (equivalent to 25% of the Indigenous population)
- 145,000 people who received 2 health checks (16%)
- 97,000 people who received 3 health checks (11%)
- 59,000 people who received 4 health checks (7%)
- 30,000 people who received 5 or more health checks (3%) (Figure 7).

Indigenous females were more likely than Indigenous males to have received at least one Indigenous-specific health check during the 5-year period – equivalent to 66% of the Indigenous female population (289,000 females) compared with 60% of the Indigenous male population (264,000 males).

Figure 7: Indigenous-specific health check patients, by number of checks, July 2016 to June 2021

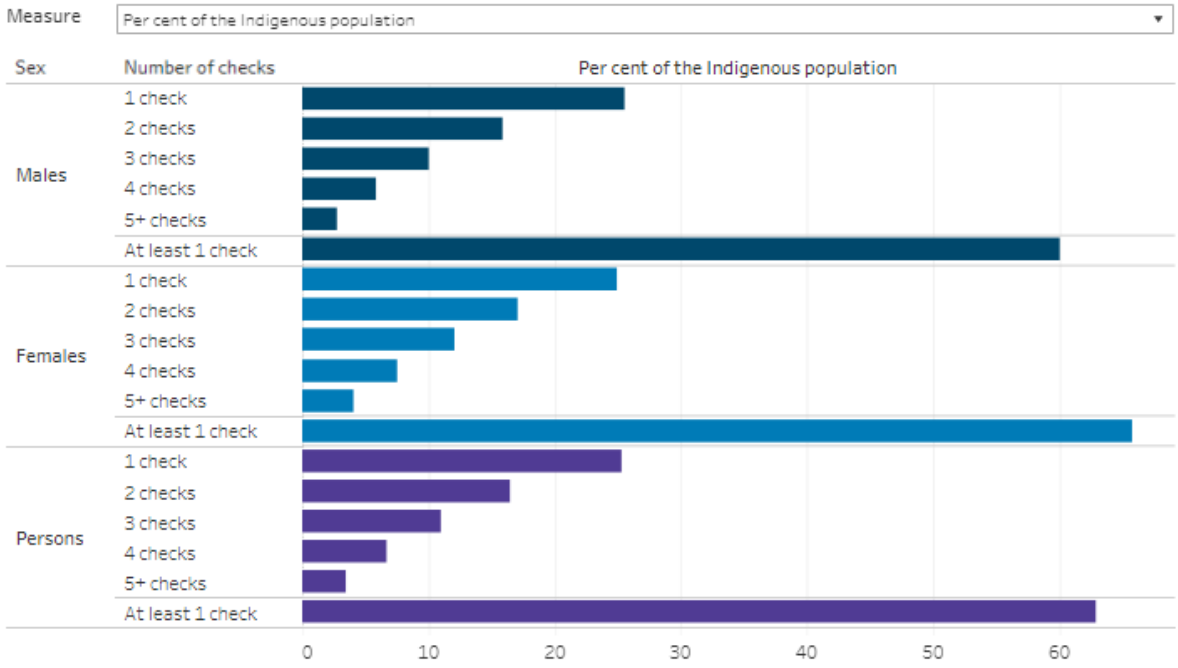


Figure 7: Indigenous-specific health check patients, by number of checks, 2016–17 to 2020–21 combined

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. Denominator used for percentage was the projected Indigenous population at 30 June 2021.
3. See 'Data sources and notes' for additional information.
4. Refer to table 'HC09' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data; Australian Bureau of Statistics (ABS) population data.

Over the 5-year period from 1 July 2016 to 30 June 2021, across states and territories, the proportion of the Indigenous population who received:

- at least one Indigenous-specific health check was highest in the Northern Territory (equivalent to 78%), followed by Queensland (76%); the proportion was lowest in Tasmania (34%).
- 5 or more Indigenous-specific health checks was highest in Queensland (5.9%), and lowest in Tasmania (1.0%) (Figure 8).

Figure 8: Indigenous-specific health check patients, by state and territory, and number of checks, July 2016 to June 2021

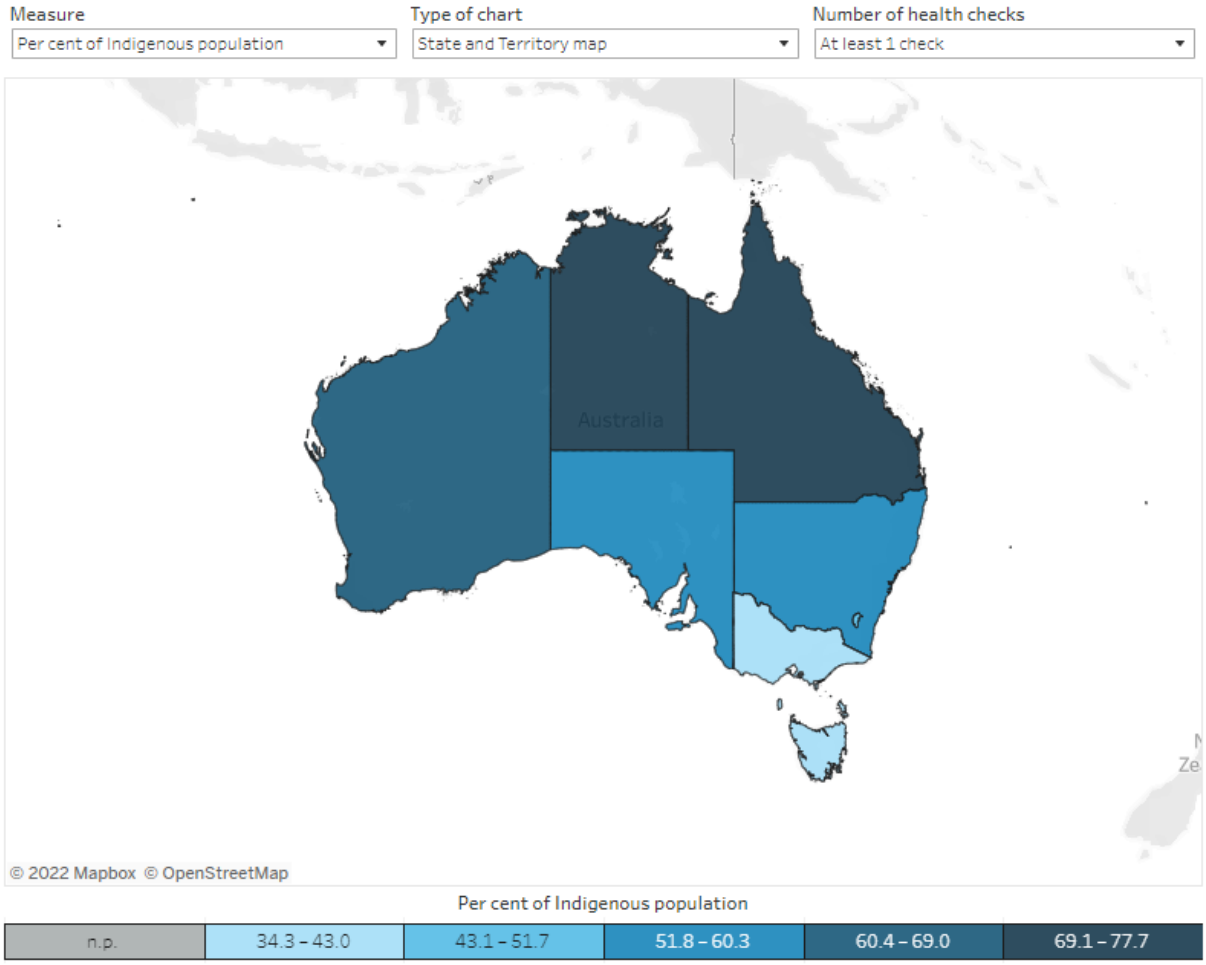


Figure 8: Indigenous-specific health check patients, by state and territory, and number of checks, 2016–17 to 2020–21 combined
n.p. not published because of small numbers, confidentiality or other concerns about the quality of the data.
Notes
1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. Denominator used for percentage was the projected Indigenous population at 30 June 2021.
3. See 'Data sources and notes' for additional information.
4. Refer to table 'HC10' in data tables.
Source: AIHW analysis of Medicare Benefits Schedule data; Australian Bureau of Statistics (ABS) population data.
https://www.aihw.gov.au

Time between health checks

This section looks at the length of time between consecutive health checks for different groups of Aboriginal and Torres Strait Islander people. Most of the analysis refers to people who had at least one Indigenous-specific health check in 2020–21, and describes the length of time between their most recent health check in that period and their previous most recent health check, if any, back to November 1999 (when Indigenous-specific health checks were first introduced for people aged 55 and over). The trend over time, looking at Indigenous health check patients over 10 years, is shown at the end.

Proportions in this section use the group of patients (or sub-group) who had at least one Indigenous-specific health check in the reference year (e.g. 2020–21) as the denominator, and not the total estimated Indigenous population. Therefore, the proportions are specific to the health check patients assessed in the reference year, and do not reflect the time between health checks for the entire Aboriginal and Torres Strait Islander population.

People without a previous health check on record (in other words, those with only one recorded MBS-billed Indigenous-specific health check in the relevant period) are included in the reporting of proportions, but do not factor into the reporting of mean and median months between consecutive health checks.

For additional information about the analysis, see Data and notes.

Overall, around 237,000 people had at least one Indigenous-specific health check in 2020–21 (Figure 9). Of these:

- 49,100 people (21%) had their previous health check less than 12 months earlier.
- 40,900 people (17%) had their previous health check 12 to 14 months earlier.
- Another 51,600 people (22%) had their previous health check 15 to 23 months earlier.
- 39,300 people (17%) had no previous Indigenous-specific health checks on record.
  - Note that this includes children under 5 years old, 44% (12,400) of whom had no prior Indigenous-specific health checks (Figure 10).

On average, people with at least one Indigenous-specific health check in 2020–21 and at least one earlier health check on record had their 2 most recent health checks 23.4 months apart. The median time between health checks was 16.0 months, for comparison (Figure 9).

Differences by sex

Females had slightly less time between their most recent health checks, on average, than males (22.9 months compared with 24.1 months, respectively). Additionally, more males (18%) had no prior history of health checks than females (15%) (Figure 9).

Figure 9: Indigenous-specific health check patients, by time between their 2 most recent health checks, by sex, 2020–21

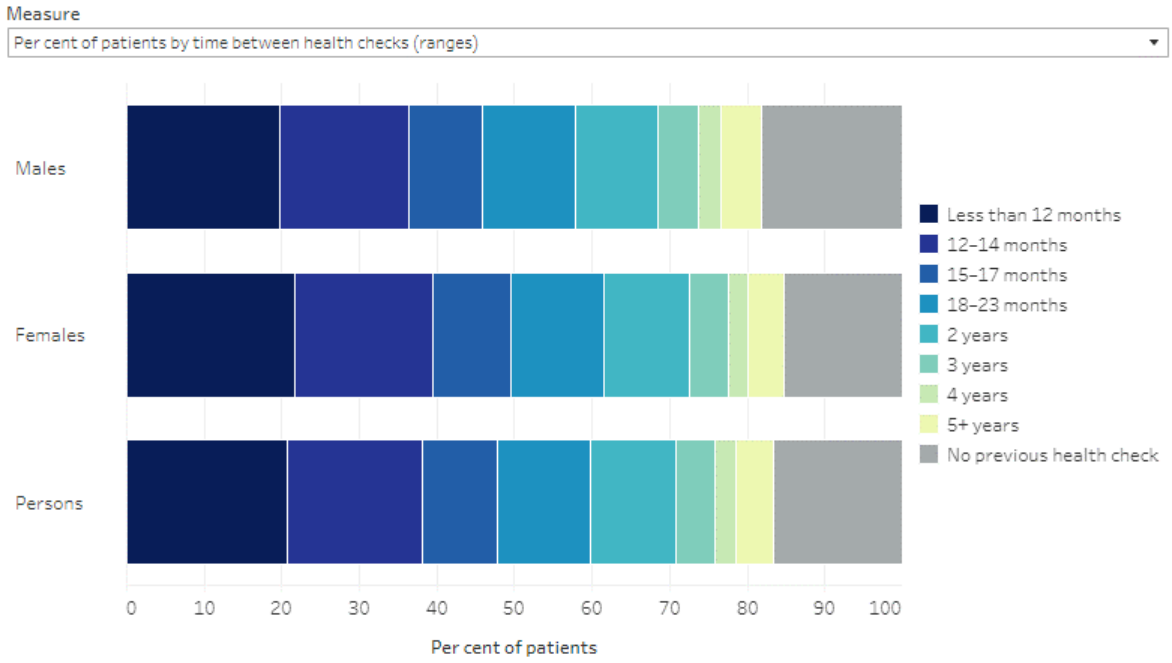


Figure 9: Indigenous-specific health check patients, by time between their 2 most recent health checks, by sex, 2020–21

Notes
1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. Analysis includes only patients who had at least one Indigenous-specific health check in 2020–21 (the reference period).
3. The time between health checks refers to the number of calendar months that elapsed between a patient's most recent health check in the reference period and their most recent previous health check, on record, back to November 1999.
4. Patients who only had one Indigenous-specific health check on record are shown as having 'no previous health check'.
5. Percentages refer to the proportion of patients in each grouping.
6. See 'Data sources and notes' for additional information.
7. Refer to table 'HC11' in data tables.
Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Differences by age

Looking at broad age groups, young children (0–4 years) were the most distinct group, since nearly half of those counted (44%) had only 1 Indigenous-specific health check on record, compared with 10–16% in other age groups (Figure 10). This is of course partly because some infants will be too young to have received a second health check.

Among those aged 5 and over:

- Indigenous youth (15–24 years) were the age group with the longest period between health checks (26.8 months on average), and highest proportion of patients without a previous health check on record (16%).
- Indigenous people aged 55 years and over had the shortest average period between their 2 most recent health checks (19.5 months), and lowest proportion of patients without a previous health check on record (10%) (Figure 10).

Figure 10: Indigenous-specific health check patients, by time between their 2 most recent health checks, by age group, 2020–21

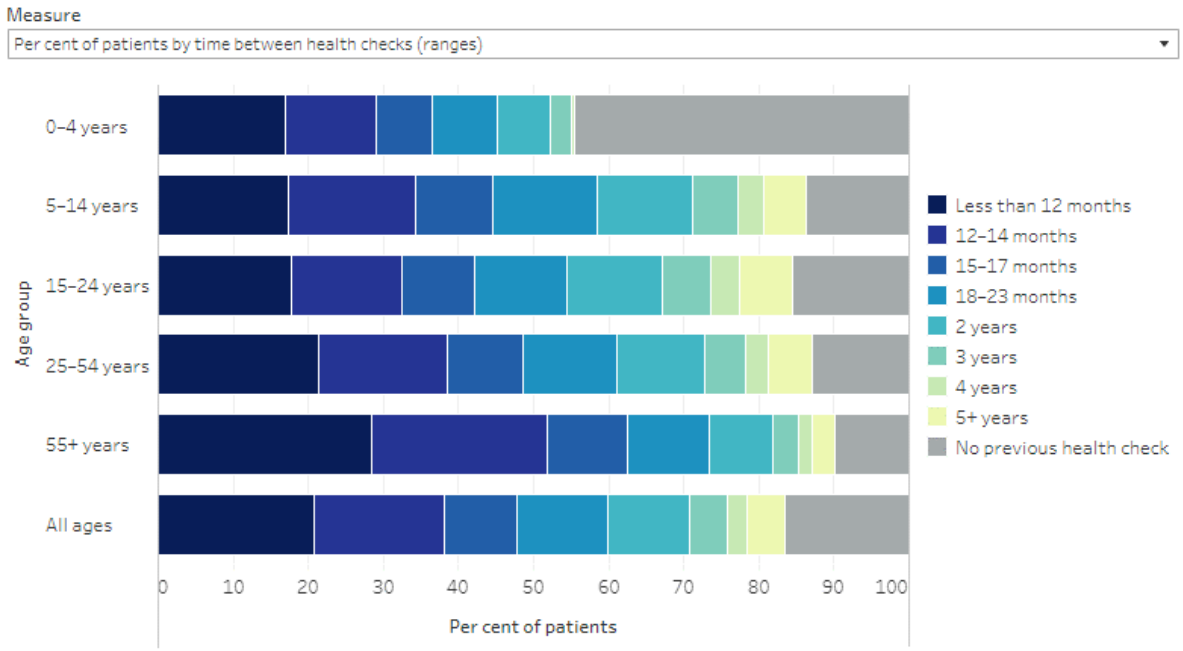


Figure 10: Indigenous-specific health check patients, by time between their 2 most recent health checks, by age group, 2020–21

Notes
1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. Analysis includes only patients who had at least one Indigenous-specific health check in 2020–21 (the reference period).
3. The time between health checks refers to the number of calendar months that elapsed between a patient's most recent health check in the reference period and their most recent previous health check, on record, back to November 1999.
4. Patients who only had one Indigenous-specific health check on record are shown as having 'no previous health check'.
5. Percentages refer to the proportion of patients in each grouping.
6. Age calculated at the date of service of each patient's most recent health check in the reference period.
7. See 'Data sources and notes' for additional information.
8. Refer to table 'HC12' in data tables.
Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Geographic variation

Looking at the states and territories:

- The Northern Territory had the lowest proportion of patients without a previous health check on record (10%), but also one of the longest average periods between health checks (25.6 months) (Figure 11).
- Queensland had a relatively low proportion of patients without a previous health check on record (14%), and the tied shortest average period between health checks (21.8 months).
- Tasmania had the highest proportion of patients without a previous health check on record (29%), but tied with Queensland for the shortest average period between health checks (21.8 months).

Among remoteness areas:

- Indigenous-specific health check patients living in the 3 non-remote area classifications had similar average time periods between health checks (22.4–23.0 months), however, the proportion of patients in *Major cities* without a previous health check on record was much higher than in *Outer regional* areas (21% and 13%, respectively).
- Patients living in *Remote* and *Very remote* areas had the longest average periods between health checks (24.9 months and 27.0 months, respectively), but relatively few patients had no previous health check on record (10% in both *Remote* areas and in *Very remote* areas).

Figure 11: Indigenous-specific health check patients, by time between their 2 most recent health checks, by geography, 2020–21

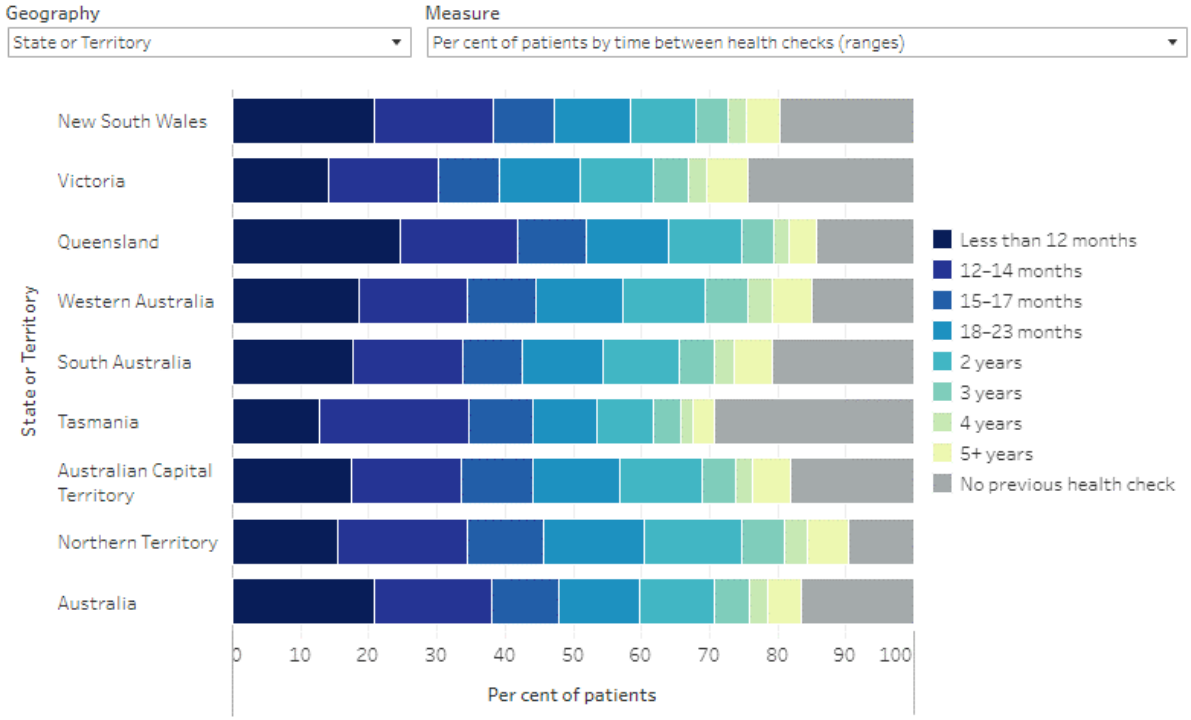


Figure 11: Indigenous-specific health check patients, by time between their 2 most recent health checks, by geography, 2020–21

Notes
1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. Analysis includes only patients who had at least one Indigenous-specific health check in 2020–21 (the reference period).
3. The time between health checks refers to the number of calendar months that elapsed between a patient's most recent health check in the reference period and their most recent previous health check, on record, back to November 1999.
4. Patients who only had one Indigenous-specific health check on record are shown as having 'no previous health check'.
5. Percentages refer to the proportion of patients in each grouping.
6. Geography determined at the date of service of each patient's most recent health check in the reference period.
7. See 'Data sources and notes' for additional information.
8. Refer to tables 'HC13' and 'HC14' in data tables.
Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Trends over time

The largest change over the decade spanning 2011–12 to 2020–21 was in how many patients each year had at least one earlier health check on record. After 9 years, just over 83% of patients in 2020–21 (197,000 out of 237,000 people) had received at least one earlier health check, up from 50% of patients (47,600 out of 94,800 people) in 2011–12 (Figure 12).

Between 2014–15 and 2019–20, the mean number of months between consecutive health checks ranged from 22.2 to 22.8 months. Among 2020–21's patients, there was a slight increase in the average time between health checks (23.4 months, compared with 22.8 among 2019–20's patients). This was mainly due to there being fewer people whose 2 most recent health checks were less than 15 months apart in 2020–21, compared with 2019–20, likely resulting from concerns or restrictions related to COVID-19 (Figure 12).

Figure 12: Indigenous-specific health check patients, by time between their 2 most recent health checks, by year, 2011–12 to 2020–21

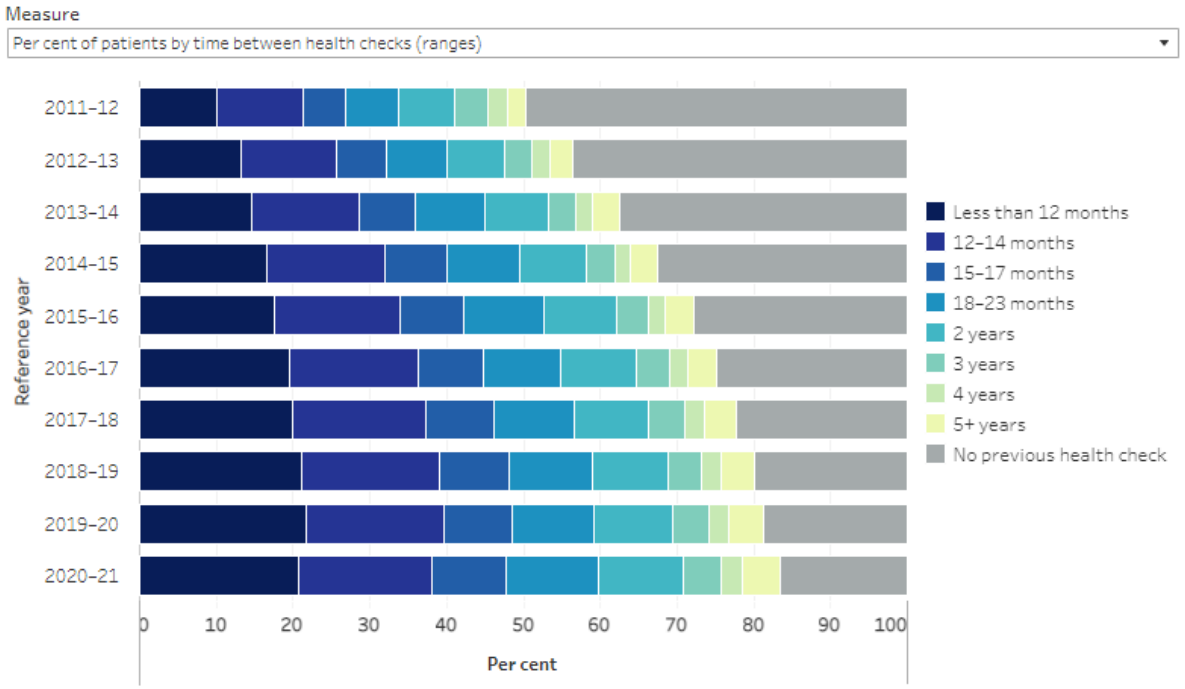


Figure 12: Indigenous-specific health check patients, by time between their 2 most recent health checks, by year, 2011–12 to 2020–21

Notes
1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. Analysis includes only patients who had at least one Indigenous-specific health check between 2011–12 and 2020–21 (one or more of the reference years).
3. The time between health checks refers to the number of calendar months that elapsed between a patient's most recent health check in the reference year and their most recent previous health check, on record, back to November 1999.
4. Patients who only had one Indigenous-specific health check on record are shown as having 'no previous health check'.
5. Percentages refer to the proportion of patients in each grouping.
6. See 'Data sources and notes' for additional information.
7. Refer to tables 'HC15' in data tables.
Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Number of follow-ups

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

Based on needs identified during a health check, Aboriginal and Torres Strait Islander people can access Indigenous-specific follow-up services – from allied health workers, practice nurses, or Aboriginal and Torres Strait Islander Health practitioners – through MBS items 10987, 81300–81360, 93546–93558, 93571–93573, 93579–93591 and telehealth items 93048, 93061, 93200, 93202, 93592 and 93593 (see also Box 3).

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

In 2020–21, there were about 358,000 Indigenous-specific follow-up services provided to 154,000 Indigenous Australians – equivalent to 18% of the projected population. This was an increase from around 18,400 follow-ups provided to 9,900 patients (or 1.4% of the population) in 2010–11 (Figure 13).

The number of Indigenous-specific follow-up services dropped for the first time in 2020–21, the first full year of the COVID-19 pandemic. There were around 388,000 follow-up services in 2019–20, but only 358,000 in 2020–21, amounting to a decrease of 8% (Figure 13).

Note: Some records from a small number of service providers have been excluded due to data quality concerns.

Figure 13: Number of Indigenous-specific follow-up services and patients by sex and telehealth status, 2010–11 to 2020–21

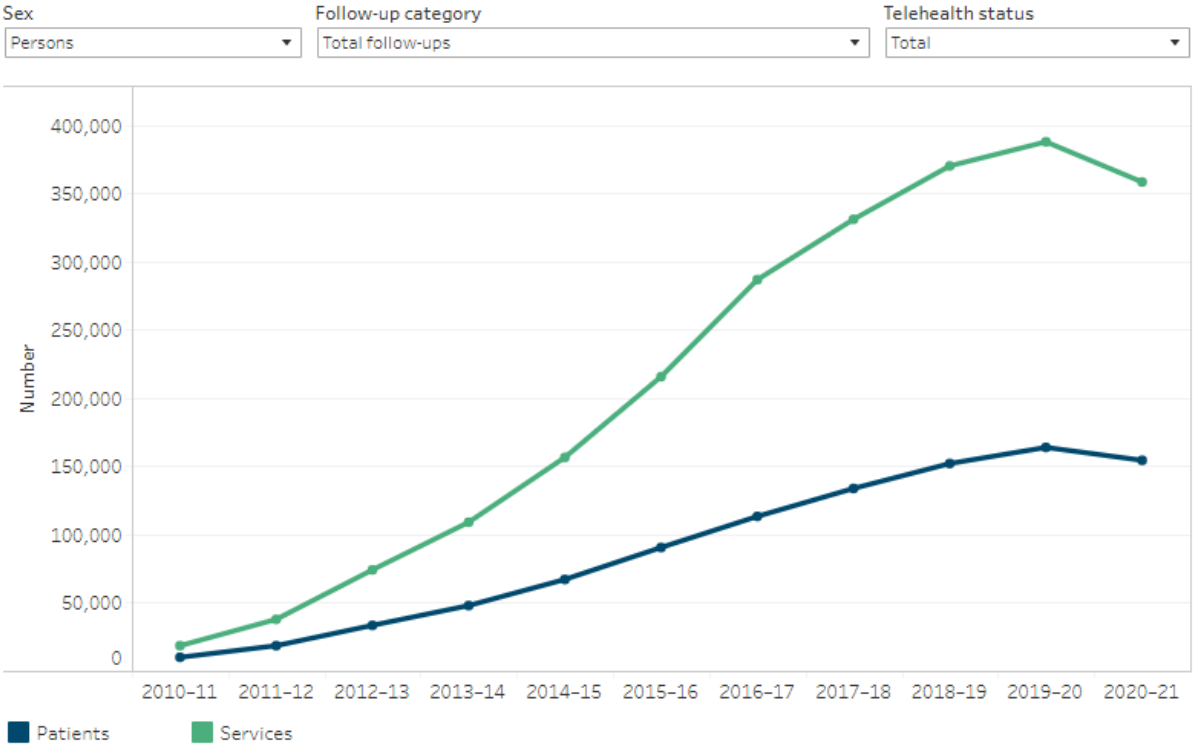


Figure 13: Number of Indigenous-specific follow-up services and patients by sex and telehealth status, 2010–11 to 2020–21

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. Telehealth items were introduced in March 2020, in response to COVID-19 and associated restrictions.
3. Some records from a small number of service providers have been excluded due to data quality concerns.
4. See 'Data sources and notes' for additional information.
5. Refer to table 'FS01' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

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

Based on health needs identified during an Indigenous-specific health check (MBS items 715, 228, 92004, 92011, 92016, 92023, 93470 and 93479), people can access a range of Indigenous-specific follow-up services – these are described below. The MBS item number indicates the type of provider, but not always the type of service received, as some provider types – such as Indigenous health practitioners – can provide a mix of services.

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

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

- examinations/interventions indicated as necessary by the health check;
- education regarding medication compliance and associated monitoring;
- checks on clinical progress and service access;
- education, monitoring and counselling activities and lifestyle advice;
- taking medical history; and
- prevention advice for chronic conditions, and associated follow up.

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

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

Allied health follow-up services (MBS items 81300–81360, 93048, 93061, 93546–93558, 93571–93573, 93579–93593)

Indigenous Australians who have received an Indigenous-specific health check can access up to 10 follow-up allied health services per calendar year, provided by either:

- an Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker, following referral by the GP (MBS items 81300, 93048, 93061, 93546, 93579, 93592 and 93593); or
- an allied health worker, following referral by the GP (MBS items 81305–81360, 93048, 93061, 93547–93558, 93571–93573, 93580–93593).

Most item numbers relate to 1 eligible allied health professional only (see Table 2 in Data sources and notes). For items 81305–81360, 93547–93558, 93571–93573 and 93580–93591, this provides an indication of the type of services received (for example, item 81335 relates to a physiotherapy service provided by a physiotherapist); however item 81300 could include a range of allied health service types.

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

Further, MBS items 93546–93558, 93571–93573, 93579–93591, 93592 and 93593 are Allied Health items, which were added in December 2020 for Indigenous Australians in Residential Aged Care Facilities. MBS items 93592 and 93593 are telehealth items and may be delivered by any of the allied health professionals eligible to claim items 81300–81360.

References

Bailie J, Schierhout GH, Kelaher MA, Laycock AF, Percival NA, O'Donoghue LR, McNeair TL, Chakraborty A, Beacham BD and Bailie RS (2014) 'Follow-up of Indigenous-specific health assessments – a socioecological analysis', *Medical Journal of Australia*, 200(11):653–657, doi:10.5694/mja13.00256.

Dutton T, Stevens W and Newman J (2016), 'Health assessments for Indigenous Australians at Orange Aboriginal Medical Service: health problems identified and

subsequent follow up', *Australian Journal of Primary Health*, 22(3):233–238, doi:10.1071/PY14120.

Type of follow-ups

In 2020–21, of Indigenous-specific follow-up services, there were:

- 291,000 services provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to 139,000 Indigenous Australians
- 67,500 allied health services provided to 32,400 Indigenous Australians.

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

- physiotherapists (about 17,500 services)
- podiatrists (12,400 services)
- Aboriginal health workers or Aboriginal and Torres Strait Islander health practitioners (about 11,600 services) (Table 1).

Telehealth items were claimed for 7% of allied health follow-ups in 2020–21 (4,800 of 67,500 services), compared with only 3% of follow-ups (9,200 of 291,000 services) with a practice nurse or an Aboriginal and Torres Strait Islander health practitioner (Table 1).

Table 1: Number of Indigenous-specific follow-up services and patients, by type of follow-up, 2020–21

Category	Practitioner type	Telehealth status	Number of follow-up patients	Number of follow-up services
Aboriginal Health Practitioner or Practice Nurse	Aboriginal Health Practitioner or Practice Nurse	Face-to-face	135,243	281,325
		Telehealth	7,439	9,207
		Total	138,904	290,532
Allied health	Aboriginal Health Worker or A..	Face-to-face	9,346	11,583
	Audiologist	Face-to-face	1,189	1,291
	Chiropractor	Face-to-face	1,487	4,048
	Diabetes Educator	Face-to-face	1,257	1,809
	Dietitian	Face-to-face	2,815	3,971
	Exercise Physiologist	Face-to-face	1,766	3,081
	Mental Health Worker	Face-to-face	86	155
	Occupational Therapist	Face-to-face	1,456	2,451
	Osteopath	Face-to-face	190	491
	Physiotherapist	Face-to-face	7,516	17,537
	Podiatrist	Face-to-face	7,042	12,436
	Psychologist	Face-to-face	498	922
	Speech Pathologist	Face-to-face	1,434	2,998
	Total Allied health	Face-to-face	30,584	62,773
		Telehealth	3,424	4,767
		Total	32,373	67,540
Total follow-ups	Total follow-ups	Face-to-face	149,901	344,098
		Telehealth	10,483	13,974
		Total	154,228	358,072

Table 1: Number of Indigenous-specific follow-up services and patients, by type of follow-up, 2020–21

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. The number of patients by type will not add to the total number of patients, as patients can receive more than one type of follow-up service.
3. Telehealth items were introduced in March 2020, in response to COVID-19 and associated restrictions.
4. Some records from a small number of service providers have been excluded due to data quality concerns.
5. See 'Data sources and notes' for additional information.
6. Refer to table 'FS02' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Follow-up rates

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

- national rates, and differences by age and sex – focusing on people who had a health check in 2019–20
- patient counts by number of follow-ups received – from 2010–11 to 2019–20
- differences by geographic area – for people who had a health check in 2019–20
- trends in the national rate of follow-up – from 2010–11 to 2019–20.

Note that because of the 12-month follow-up window and lag-time in processing some claims, this measure is not available at the time of release for everyone who received an Indigenous-specific health check in 2020–21.

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

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

One outcome of an Indigenous-specific health check (MBS items 715, 228, 92004, 92011, 92016, 92023, 93470 and 93479) can be referral for Indigenous-specific follow-up services under Indigenous-specific MBS items 10987, 81300–81360, 93200, 93202, 93048, 93061, 93546–93558, 93571–93573, 93579–93591, 93592 and 93593. This report looks at the proportion of Indigenous Australians who received one of these follow-up services in the 12 months following their health check.

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

Calculating rates

Rates were calculated using the total number of people who had an Indigenous-specific health check as the denominator, while the numerator was people who received an Indigenous-specific follow-up in the 12 months following their health check. For example, for 2019–20 data:

- The denominator was people who received an Indigenous-specific health check between 1 July 2019 and 30 June 2020.
- The numerator was people who received an Indigenous-specific health check between 1 July 2019 and 30 June 2020 **and** subsequently received a follow-up service within 12 months of the health check (which could occur anytime between 1 July 2019 and 30 June 2021, depending on the date of the health check). For individuals with more than one health check in 2019–20, a follow-up service could follow both health checks or only one health check and they would be counted the same way.
- The rate was calculated as the numerator divided by the denominator and multiplied by 100.

Limitations

Key limitations of the analysis include:

- No information is available from the MBS data set on the outcomes of a health check, and so it is not known how many people actually require follow-up care. Not all Indigenous Australians who have a health check will need follow-up services. Consequently, variation in follow-up rates (for example, by age group or geographic regions), may partly reflect differences in health status, need for follow-up care and whether people are willing or able to attend prescribed follow-up services.
- The data relate only to MBS-rebated Indigenous-specific follow-up items provided by an Aboriginal and Torres Strait Islander health practitioner, practice nurse, or allied health professional (see also Box 3). Indigenous Australians may receive other MBS-rebated services after a health check that are also available to non-Indigenous patients (such as chronic disease management items) or may receive follow-up services that are not rebated through the MBS.

National rates by age and sex

In 2019–20, 239,000 Aboriginal and Torres Strait Islander people received an Indigenous-specific health check – of these people, 47% (112,000) received an Indigenous-specific follow-up service in the 12 months following their health check.

Among people who had a health check in 2019–20:

- The follow-up rate was slightly higher among Indigenous females (48%) than among Indigenous males (45%). The differences were greatest among those aged 15–34, but negligible below the age of 15.
- For both males and females, the follow-up rate was highest among those aged 65 and over (54% and 57%, respectively).
- For males, the follow-up rate was lowest among those aged 15–24 (38%).
- For females, the follow-up rate was lowest among those aged 5–14 (41%) (
- Figure 14).

The variation in follow-up rates may partly reflect differences in the need for follow-up care among different age groups (see also Box 4). For example, in general, older people have higher health care needs than younger people, and so are likely to have a greater need for follow-up services. However, follow-up rates do not differ greatly between age groups. To some extent, this could be due to older people being more likely to have follow-up activities that are not covered by the included MBS items.

Figure 14: Indigenous-specific health check patients who received an Indigenous-specific follow-up service in the 12 months following the health check, by year of health check, sex and age, 2010–11 to 2019–20

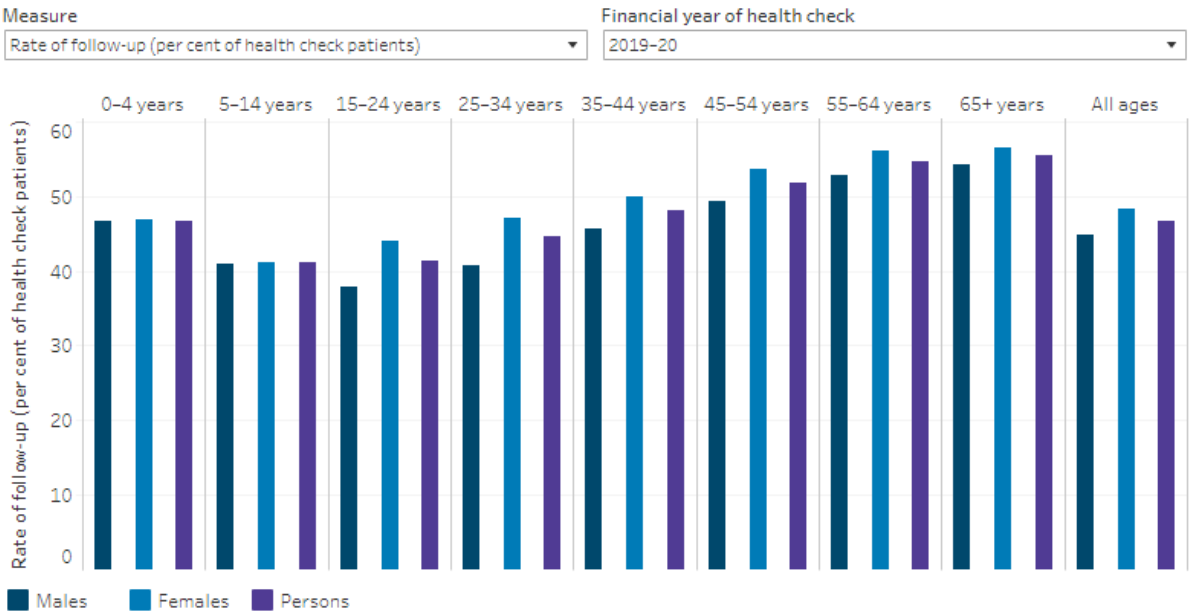


Figure 14: Indigenous-specific health check patients who received an Indigenous-specific follow-up service in the 12 months following the health check, by year of health check, sex and age, 2010–11 to 2019–20

Notes

1. Analysis is based on date of service, for services processed before 30/04/2022.
2. Data are presented according to the financial year in which the health check was provided.
3. The number of follow-up patients refers to the number of people who received a follow-up within 12 months of a health check. The follow-up rate is calculated by dividing the number of follow-up patients by the number of health check patients.
4. Some records from a small number of service providers have been excluded due to data quality concerns.
5. See 'Data sources and notes' for additional information.
6. Refer to table 'FS03' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Number and type of follow-ups

Among the 239,000 Aboriginal and Torres Strait Islander people who had an Indigenous-specific health check in 2019–20:

- 20% (or 48,000 people) had 1 Indigenous-specific follow-up within 12 months of the health check.
- 10% (or 23,000 people) had 2 follow-ups.
- 5% (or 13,000 people) had 3 follow-ups.
- 3% (or 8,000 people) had 4 follow-ups.
- 8% (or 19,000 people) had 5 or more follow-ups (Figure 15).

Indigenous Australians who had an Indigenous-specific health check in 2019–20 were more likely to receive follow-up care from a practice nurse or Aboriginal and Torres Strait Islander health practitioner than from an allied health service provider:

- 43% (or 103,000 people) had at least one follow-up service from a practice nurse of Indigenous health practitioner.
- 11% (or 26,000 people) had at least one allied health follow-up service.

Figure 15: Indigenous-specific health check patients, by number of follow-ups received in the 12 months following the health check, by year of health check and type of follow-up, 2010–11 to 2019–20

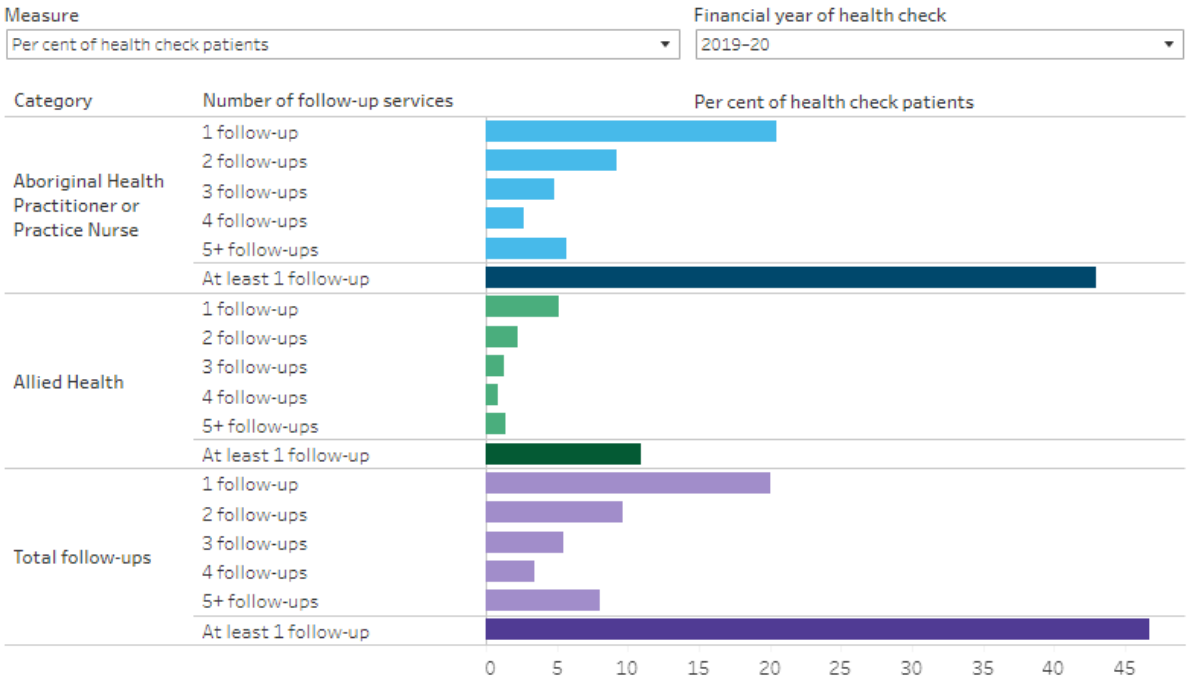


Figure 15: Indigenous-specific health check patients, by number of follow-ups received in the 12 months following the health check, by year and type of follow-up, 2010–11 to 2019–20

Notes

1. Analysis is based on date of service, for services processed before 30/04/2022.
2. Data are presented according to the financial year in which the health check was provided.
3. The number of follow-up patients refers to the number of people who received a follow-up within 12 months of a health check. The per cent of health check patients is calculated by dividing the number of follow-up patients by the number of health check patients.
4. Some records from a small number of service providers have been excluded due to data quality concerns.
5. See 'Data sources and notes' for additional information.
6. Refer to table 'FS04' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Geographic variation

Figure 16 shows the number and proportion of Aboriginal and Torres Strait Islander people who received an Indigenous-specific follow-up within 12 months of a health check, by 6 different geographic classifications – state/territory, Greater Capital City Statistical Areas (GCCSA), remoteness area, Primary Health Network (PHN), Indigenous Region (IREG) and Statistical Areas Level 3 (SA3s). See Box 2 for more information about the geographic classifications.

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

Among Aboriginal and Torres Strait Islander people who had an Indigenous-specific health check in 2019–20:

- Across states and territories, the follow-up rate varied from 17% in the Australian Capital Territory to 60% in the Northern Territory.
- Across GCCSAs, the follow-up rate varied from 17% in the Australian Capital Territory to 64% in *Greater Brisbane*.
- Across remoteness areas, the follow-up rate ranged between 44% and 46% in non-remote areas, and between 51% and 53% in remote areas.
- Across PHNs, the follow-up rate varied from 17% in the Australian Capital Territory to 65% in *Brisbane North*.
- Across IREGs, the follow-up rate ranged between 17% in the Australian Capital Territory and 73% in *Alice Springs*.
- Across 304 SA3s for which follow-up rates could be reported, the follow-up rate ranged from 8% to 76%. Of these SA3s, 66% (200 areas) had a rate below the national average (that is, less than 46.6%) (Figure 16).

Figure 16: Indigenous-specific health check patients in 2019–20 who received an Indigenous-specific follow-up service in the 12 months following the health check, by geographic area

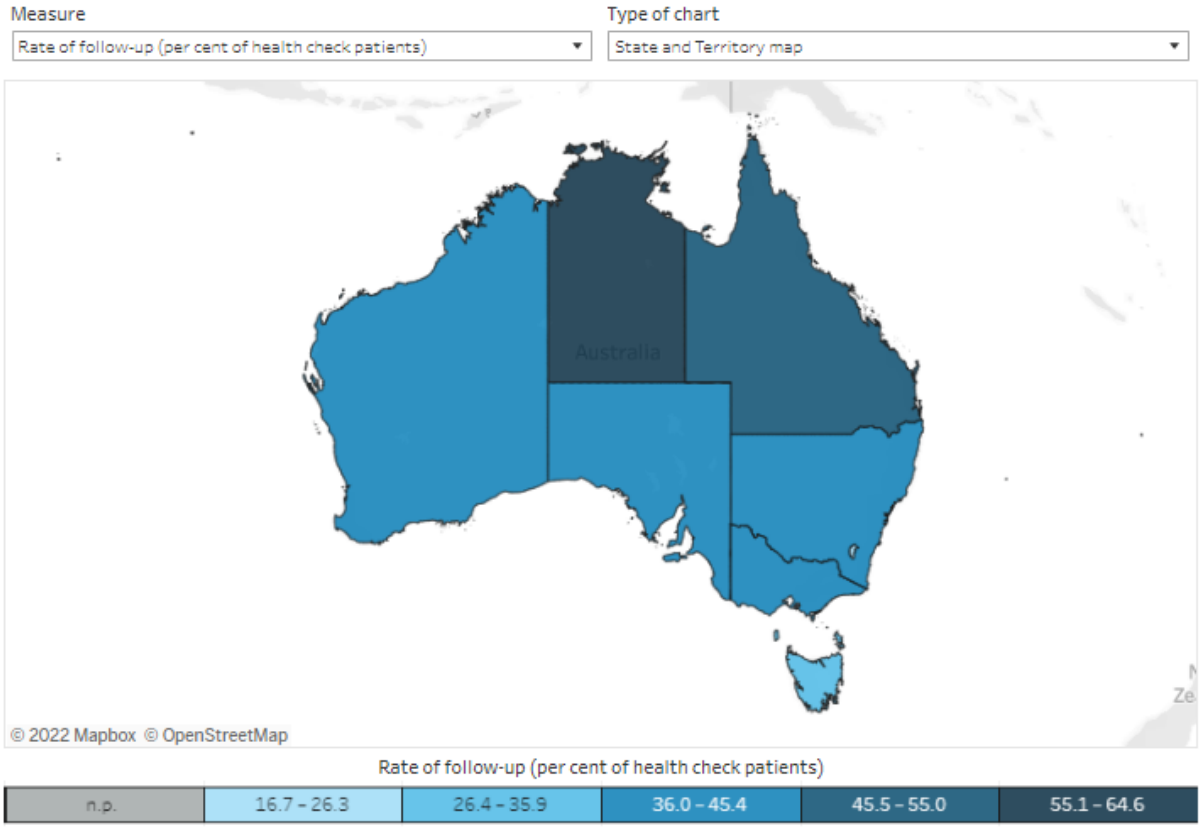


Figure 16: Indigenous-specific health check patients in 2019–20 who received an Indigenous-specific follow-up service in the 12 months following the health check, by geographic area

n.p. not published because of small numbers, confidentiality or other concerns about the quality of the data.

Notes

1. Analysis is based on date of service, for services processed before 30/04/2021.
2. Data are presented according to the financial year in which the health check was provided.
3. The number of follow-up patients refers to the number of people who received a follow-up within 12 months of a health check. The follow-up rate is calculated by dividing the number of follow-up patients by the number of health check patients.
4. Some records from a small number of service providers have been excluded due to data quality concerns.
5. See 'Data sources and notes' for additional information.
6. Refer to tables 'FS05' to 'FS10' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

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

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

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

References

Bailie J, Schierhout GH, Kelaher MA, Laycock AF, Percival NA, O'Donoghue LR, McNeair TL, Chakraborty A, Beacham BD and Bailie RS (2014) 'Follow-up of Indigenous-specific health assessments – a socioecological analysis', *Medical Journal of Australia*, 200(11):653–657, doi:10.5694/mja13.00256.

Department of Health (2018) *Report from the Aboriginal and Torres Strait Islander Health Reference Group*, Department of Health, Australian Government.

Trends in follow-up rate

Between 2010–11 and 2019–20, the proportion of Indigenous-specific health check patients who had an Indigenous-specific follow-up within 12 months increased from 12% to 47%. The follow-up rate decreased slightly in 2019–20, compared with the rate in 2018–19 (by only 0.2 percentage points) – this was during the COVID-19 pandemic (Figure 17).

Young Indigenous children (aged 0–4) saw the largest uptick (percentage point wise) in follow-up service rates among reported age groups over the period, increasing from 8% of health check patients in 2010–11 to 47% in 2019–20 (Figure 17).

Figure 17: Indigenous-specific health check patients who received an Indigenous-specific follow-up service in the 12 months following the health check, by sex, age and year of health check, 2010–11 to 2019–20

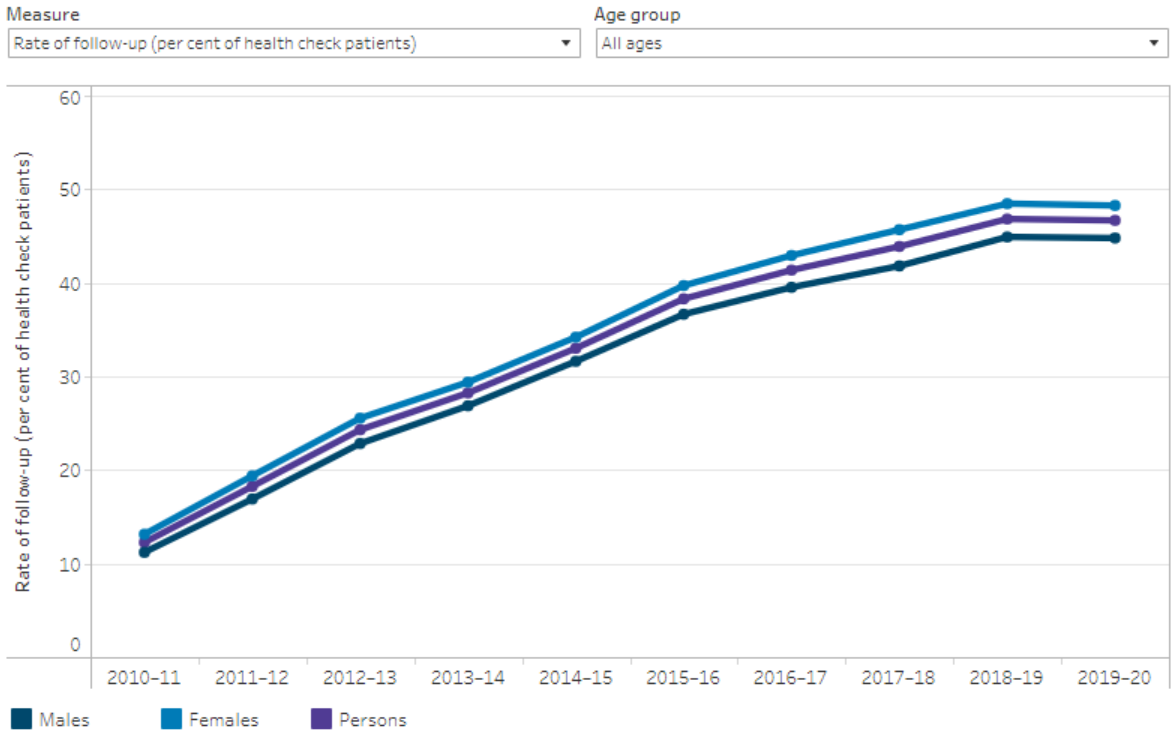


Figure 17: Indigenous-specific health check patients who received an Indigenous-specific follow-up service in the 12 months following the health check, by sex, age and year of health check, 2010–11 to 2019–20

Notes

1. Analysis is based on date of service, for services processed on or before 30/04/2022.
2. Data are presented according to the financial year in which the health check was provided.
3. The number of follow-up patients refers to the number of people who received a follow-up within 12 months of a health check. The follow-up rate is calculated by dividing the number of follow-up patients by the number of health check patients.
4. Some records from a small number of service providers have been excluded due to data quality concerns.
5. See 'Data sources and notes' for additional information.
6. Refer to table 'FS03' in data tables.

Source: AIHW analysis of Medicare Benefits Schedule data.

https://www.aihw.gov.au

Data sources and notes

This page provides:

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

Medicare Benefits Schedule (MBS) data

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

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

In this report, data are presented for:

- Indigenous-specific health checks – listed as items 715, 228, 92004, 92011, 92016, 92023, 93470 and 93479 on the MBS.
- Indigenous-specific health check follow-up services – listed as items 10987, 81300–81360, 93048, 93061, 93200, 93202, 93546–93558, 93571–93573, 93579–93591, 93592 and 93593 on the MBS.

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

MBS Indigenous-specific health checks

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

- MBS item 715 (available from 1 May 2010)
- MBS item 228 (available from 1 July 2018)
- MBS items 93470 and 93479 in Residential Aged Care Facilities (available from 10 October 2020 to 30 June 2022)
- Video-conference MBS items 92004 and 92011 (available from 30 March 2020)

- Telephone MBS items 92016 and 92023 (available from 30 March 2020 to 30 June 2021)

MBS items 715, 92004, 92016 and 93470 relate to health checks provided by a vocationally registered general practitioner (GP), while items 228, 92011, 92023 and 93479 relate to health checks provided by non-vocationally registered GPs. In all cases, suitably qualified health professionals can assist under the supervision of the practitioner. The requirements of an Indigenous-specific health check, which are set out in the relevant sections of the MBS, include an assessment of the patient's health, including their physical, psychological and social wellbeing. The check also assesses what preventive health care, education and other help should be offered to the patient to improve their health and wellbeing.

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

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

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

MBS Indigenous-specific follow-up services

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

- MBS item 10987: Follow-up services provided by a practice nurse or registered Aboriginal and Torres Strait Islander health practitioner on behalf of a GP after a health check to a maximum of 10/calendar year (increased from 5/calendar year in 2009).
- MBS items 81300–81360: Allied health follow-up services after a health check to a maximum of 10/calendar year. There are 13 separate items, 1 for each eligible allied health profession shown in Table 2. The professionals need to meet specific

eligibility requirements, be in private practice and register with Medicare Australia in order to claim the follow-up items.

- MBS items 93546–93558: Allied health follow-up services (initial/long attendances) delivered in Residential Aged Care Facilities after a health check. There are 13 separate items, 1 for each eligible allied health profession shown in Table 2 (available from 10 December 2020 to 30 June 2022).
- MBS items 93571–93573: Allied health follow-up services (additional physical therapies) delivered in Residential Aged Care Facilities after a health check. There are 3 separate items: 1 for exercise physiologists; 1 for occupational therapists; 1 for physiotherapists (available from 10 December 2020 to 30 June 2022).
- MBS items 93579–93591: Allied health follow-up services (subsequent/standard attendances) delivered in Residential Aged Care Facilities after a health check. There are 13 separate items, 1 for each eligible allied health profession shown in Table 2 (available from 10 December 2020 to 30 June 2022).
- Telehealth MBS items 93200 and 93202: Video-conference or telephone follow-up services provided by a practice nurse or registered Aboriginal and Torres Strait Islander health practitioner on behalf of a GP after a health check to a maximum of 10/calendar year (available from 20 April 2020).
- Telehealth MBS items 93048 and 93061: Allied health follow-up services after a health check to a maximum of 10/calendar year, delivered via video-conference or telephone (available from 30 March 2020).
- Telehealth MBS items 93592 and 93593: Allied health follow-up services delivered in Residential Aged Care Facilities after a health check, delivered via video-conference or telephone (available from 10 December 2020 to 30 June 2022).

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

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

Eligible allied health professionals	Non-RACF items	RACF items
Aboriginal health worker/Aboriginal and Torres Strait Islander health practitioner	81300	93546, 93579
Diabetes Educator	81305	93547, 93580
Audiologist	81310	93548, 93581
Exercise physiologist	81315	93549, 93582, 93571
Dietitian	81320	93550, 93583
Mental health worker	81325	93551, 93584
Occupational therapist	81330	93552, 93585, 93572

Eligible allied health professionals	Non-RACF items	RACF items
Physiotherapist	81335	93553, 93586, 93573
Podiatrist	81340	93554, 93587
Chiropractor	81345	93555, 93588
Osteopath	81350	93556, 93589
Psychologist	81355	93557, 93590
Speech pathologist	81360	93558, 93591
Any eligible allied health professional (telehealth)	93048, 93061	93592, 93593

Population data

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

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

Remoteness, GCCSA, PHN and SA3 estimates

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

Technical notes about the analysis

Counting services and people

This report presents data using 2 different counting units:

- services – that is, the number of health checks (or follow-ups, as applicable) provided in the specified period

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

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

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

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

- For *annual rates of health checks* and for *health check patients who received a follow-up service in the 12 months following the health check*: where patients had more than 1 health check in a financial year, age was calculated from the date of the first health check for odd-numbered Patient Identifier Numbers (PINs) and from the last health check for even-numbered PINs in that financial year.
  - This tactic was used to reduce bias in the derivation of age, and was used to select from multiple patient postcodes as well. Upward bias on age is introduced when age is calculated at the date of the last health check in a financial year for patients with more than 1 health check, because birthdays are likely to have passed by the time of the second health check. A PIN's final digit is effectively random, so this tactic splits the patient records into 2 groups, with upward bias on half and downward bias on the other half. Age could otherwise have been calculated at the 31st of December to reduce bias, but then a separate tactic would need to be used for managing multiple postcodes.
- For *numbers of health checks between July 2016 and June 2021*: where patients had more than 1 health check over the period, age was calculated from the date of the last health check in the reference period.
  - This tactic was used to better align with the population structure at the end of the reference period.

Note: Since patients are assigned to only one age group in a given year, it is safe to combine data from multiple age groups if required. Similarly, combining data from multiple regions is generally safe, however rounding errors may compound to give slightly inaccurate sums. Patient counts for face-to-face services and telehealth services should not be summed, since this could lead to double-counting of patients who had at least one of each type of service. Also, conflicting patient counts may occur when an individual's age group and/or location was assigned differently for telehealth and face-to-face records.

Dates and reference periods

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

The data in this report relate to services provided between 1 July 2010 and 30 June 2021, which were processed on or before 30 April 2022. Data are reported by date of service as this more accurately reflects when the service was provided. Due to lags between date of service and date of processing, there will be a small proportion of services provided during the reference period that are not captured in these data. For example, if a service was provided on 29 June 2021, but not processed until 1 May 2022, it will not be included in the data.

Data in this report are presented for financial years (1 July to 30 June). These are written with the second year abbreviated – for example, 2020–21 refers to the period from 1 July 2020 to 30 June 2021.

Location

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

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

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

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

For this report, postcodes were re-assigned to 6 different geographies (based on the 2016 Australian Statistical Geography Standard) – Statistical Areas Level 3 (SA3s), Indigenous Regions (IREGs), Primary Health Networks (PHNs), remoteness areas, Greater Capital City Statistical Areas (GCCSA) and state and territories. Where postcodes fell across the boundaries of multiple areas (for example, multiple SA3s), data were

apportioned based on the population distribution of Indigenous Australians, according to AIHW analysis of ABS population estimates at 30 June 2016. Records with invalid postcode information could not be assigned to sub-national areas.

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

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

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

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

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

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

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

- the following SA3s: Adelaide City (SA), Alice Springs (NT), Bald Hills - Everton Park (Qld), Barkly (NT), Beaudesert (Qld), Beenleigh (Qld), Botany (NSW), Burnside (SA), Cairns - North (Qld), Canberra East (ACT), Canning (WA), Central Highlands (Tas.), Chermside (Qld), Daly - Tiwi - West Arnhem (NT), Darwin City (NT), Darwin Suburbs (NT), East Arnhem (NT), Gold Coast - North (Qld), Gold Coast Hinterland (Qld), Goldfields (Qld), Hawkesbury (NSW), Jimboomba (Qld), Katherine (NT), Loddon - Elmore (Vic), Melbourne City (Vic), Mudgeeraba - Tallebudgera (Qld), Nathan (Qld), Noosa Hinterland (Qld), Nundah (Qld), Palmerston (NT), Parramatta (NSW), Perth City (WA), Richmond - Windsor (NSW), Rouse Hill - McGraths Hill (NSW), Southport (Qld), Strathpine (Qld), Sunnybank (Qld), Swan (WA), Sydney Inner City (NSW), The Gap - Enoggera (Qld), and The Hills District (Qld).
- the following IREGs: Alice Springs (NT), Apatula (NT), Tennant Creek (NT), Katherine (NT), Nhulunbuy (NT), Darwin (NT), Jabiru - Tiwi (NT).

- *Remote* and *Very remote* areas in the analysis by remoteness.

Time between Indigenous-specific health checks

To report the time interval between patients' consecutive Indigenous-specific health checks (based on date of service), 2 slightly different methods were used to convert the days to months:

For ranges of months (e.g. 'Less than 12 months', '12–14 months'), the number of fully elapsed calendar months were calculated – where a calendar month has fully elapsed when the day's date returns to or surpasses the same-numbered day in consecutive months.

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

For mean and median time intervals, days were converted to months based on the average number of days per month {days ÷ (365.25/12)}. This allowed for higher precision and accuracy compared with calculating means and medians from the number of fully elapsed months. Estimates were rounded downward to 0.1 of a month.

Comparisons with other reports

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

In addition, as described in 'Population data', this report primarily uses population estimates and projections, based on the 2016 Census, when calculating rates. The rates may also differ to those released in future updates of this report (or in other reports) when revised estimates based on the 2021 Census are available (see also Box 1).

The analysis of time between health checks has also been refined in this edition in 3 key ways:

- Earlier Indigenous-specific health check items from 1999–2010 were included in the analysis.
- The reference periods for all analyses were restricted to 1 financial year, rather than 2 financial years pooled.

- Mean and median numbers of months between health checks were calculated from the number of days (see 'Time between Indigenous-specific health checks' presented earlier).

Timeline of major developments in health check implementation

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

Table 3: Major developments in health check implementation

When?	What?	Why?
November 1999	55 years and over annual health check (MBS items 704 and 706) introduced	The first Indigenous-specific health check established as the Indigenous equivalent of health checks for non-Indigenous people aged 75 years and over
May 2004	15–54 years 2-yearly adult health check (MBS item 710) introduced	The extension of health checks to adults recognised that the conditions responsible for early deaths of Aboriginal and Torres Strait Islander people started before the age of 55.
May 2006	0–14 years annual child health check (MBS item 708) introduced	With this addition, Aboriginal and Torres Strait Islander people of all ages were eligible for preventive health checks.
November 2008	Follow-up health services (MBS items 10987 and 81300–81360) introduced	Allowed people who received an Indigenous health check to receive subsidised follow-up care with a Practice Nurse, registered Aboriginal Health Worker or a range of allied health professionals.
December 2008	National Partnership Agreement implemented	The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes included the Indigenous Chronic Disease Package. This package was funded by the Australian Government over 4 years from 2009–2013 and included a number of elements relevant to improving uptake of Indigenous-specific health measures.
July 2009	Medicare Local Closing the Gap workforce established	Part of the Indigenous Chronic Disease Package, this workforce comprised: • 86 full-time equivalent Indigenous outreach workers to support Aboriginal and Torres

When?	What?	Why?
		Strait Islander people access primary health-care services and follow-ups • 86 full-time equivalent Indigenous health project officers to lead Aboriginal and Torres Strait Islander health issues within Medicare Locals, and raise awareness of Closing the Gap initiatives relevant to mainstream primary care. This workforce assisted with the delivery of the Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care programs.
March 2010	Practice Incentive Program Indigenous Health Incentive introduced	Part of the Indigenous Chronic Disease Package, the Indigenous Health Incentive was included under the Practice Incentives Program.
May 2010	Health check items 704, 708 and 710 combined	The 3 separate item numbers were replaced by a single item: MBS item 715. The frequency of health checks was standardised to annual, so Aboriginal and Torres Strait Islander people aged 15–54 were able to have a health check every year, instead of every 2 years.
2010	Indigenous status required by Royal Australian College of General Practitioners Standards	Existing requirements were strengthened, so practices seeking accreditation had to demonstrate they were routinely recording Aboriginal and Torres Strait Islander status in their active patient records.
July 2011–12	Divisions of General Practice transitioned to Medicare Locals	Divisions of General Practice (n=112), as well as their national and jurisdiction level support structures (the Australian General Practice Network and 8 state-based organisations) were replaced with Medicare Locals (n=62), as part of the National Health Reform Agenda.
2013	National Aboriginal and Torres Strait Islander Health Plan 2013–2023	As part of efforts to close the gap, since 2011, the Australian Government worked with Aboriginal and Torres Strait Islander people to produce the National Aboriginal and Torres Strait Islander Health Plan, providing an opportunity to collaboratively set out a 10-year plan for the direction of Indigenous health policy

When?	What?	Why?
June 2014	Australian Medicare Local Alliance abolished	Australian Medicare Local Alliance (the national coordination body for Medicare Locals) was abolished. Regional coordination and support of the Closing the Gap workforce undertaken by the Alliance also ceased.
2015	Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023	The Implementation Plan outlines the actions to be taken by the Australian Government and other key stakeholders to give effect to the vision, principles, priorities and strategies of the Health Plan, including goals for increasing the use of Indigenous-specific health checks.
July 2015	Medicare locals replaced by Primary Health Networks	Medicare Locals (n=62) were replaced by Primary Health Networks (n=31). In 2015–16, funding for the Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care programs was provided through Primary Health Networks.
July 2016	Integrated Team Care Activity started	Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care program funding was combined into new Integrated Team Care Activity.
July 2018	MBS health check item, 228, introduced for non-VR Medical Practitioners	Allows eligible non-vocationally recognised medical practitioners (other than GPs and specialists) to claim MBS subsidies for Indigenous-specific health checks.
March 2020	COVID-19 temporary telehealth health check and follow-up items introduced	To help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers (available until 30 September 2020).
September 2020	COVID-19 temporary telehealth items extended until 31 March 2021	To help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers (previously available until 30 September 2020).
December 2020	COVID-19 temporary health check items, 93470 and 93479, and follow-up items, introduced for Residential Aged Care Facilities	To improve access to multidisciplinary care for residents of residential aged care facilities (RACF) during the COVID-19 pandemic (available until 30 June 2022).

When?	What?	Why?
March 2021	COVID-19 temporary telehealth items extended until 30 June 2021	To help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers (previously available until 31 March 2021).
April 2021	COVID-19 temporary video-conference (telehealth) items extended until 31 December 2021	To help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers (previously available until 30 June 2021).
July 2021	COVID-19 temporary telephone (telehealth) items were discontinued at the end of June	Video-conference services were the preferred approach for substituting a face-to-face consultation.
2021	Health check templates	The National Aboriginal Community Controlled Health Organisation (NACCHO) and Royal Australian College of General Practitioners (RACGP) released 5 Indigenous-specific health check templates for testing, designed for different age groups, and downloadable from the RACGP website.
2021	National Aboriginal and Torres Strait Islander Health Plan 2021–2031	The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 is the updated national policy to improve health and wellbeing outcomes for Aboriginal and Torres Strait Islander people over 10 years.
December 2021	Some COVID-19 temporary telehealth items became permanent	To help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers (previously available until 31 December 2021).
July 2022	COVID-19 temporary RACF items were discontinued at the end of June	—
2021–2023	Health check Smart Form development	The Department of Health commissioned CSIRO to develop Smart Forms for health checks, using Item 715 as a proof of concept. Smart Forms are intended to streamline the collection and sharing of clinical information to improve patient outcomes.

National goals for health checks

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

To maintain continuity, data for the Implementation Plan goals relating to Indigenous-specific health checks are based on: date of processing; age approximated from date of service and false date of birth (1 January of birth-year); calculated using the number of health checks; calculated using population projections based on the 2011 Census; and do not include MBS items for residents of Aged Care facilities at this time. Thus, the rates used for tracking progress against the Implementation Plan goals do not align with the rates shown in this report (which are based on date of service, based on actual age, relate to the number of people who received at least 1 health check, use population projections based on the 2016 Census, and include health checks in Aged Care facilities). Both rates are shown in Table 4, for comparison.

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

Table 4: 2023 Implementation Plan (IP) goals and national 2020–21 health check rates (per cent)

Age	2023 IP goal health check rate (%)	2020–21 health check rate (%) – counting health checks by date of processing	2020–21 health check rate (%) – counting patients by date of service
0–4	69	26	29
5–14	46	28	24
15–24	42	24	22
25–54	63	30	28
55 and over	74	45	38

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