Australian Government
Australian Institute of Health and Welfare

AIHW

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

Web report

Cat. no: IHW 227

Report release: 30 January 2024

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

About

Information on organisations funded by the Australian Government under its Indigenous Australians' Health Programme (IAHP) to deliver culturally appropriate primary health care services to Aboriginal and Torres Strait Islander (First Nations) people is available through 2 data collections – the Online Services Report (OSR) and the national Key Performance Indicators (nKPI) collections.

This report is updated periodically to include the latest data from these collections. For more information see Notes.

For more information on this topic, including analysis of the impact of COVID-19 on organisations reporting to these collections, see Related material.

Around 9,300 full-time equivalent staff were employed in 2022–23, an increase from around 8,000 in 2018–19	Around 507,000 clients were cared for in 2022–23, an increase from 498,000 in 2018–19
Around 3.71 million episodes of care were provided in 2022–23, a decrease from 3.74 million in 2018–19	At June 2023, 77% of First Nations babies born in the last year had their birthweight recorded, up from 69% in June 2017

Summary

First Nations-specific primary health care organisations (referred to as organisations in this report) play a critical role in improving the health of First Nations people through prevention, early intervention, health education, and the timely identification and management of health issues. For information on the terms used in this report see Glossary.

The Online Services Collection (OSR) contains contextual information about the organisations, including clients, client contacts, episodes of care, staffing levels and vacancies.

Organisations

In 2022–23, **213** organisations provided First Nations-specific primary health care, compared with 210 in 2018–19

Learn more >

In 2022–23, **69%** (or148) of organisations were Aboriginal Community Controlled Organisations (ACCHOs), compared with 65% (137) in 2018–19

Learn more >

In 2022–23, **47%** (or 100) of organisations were in *Remote* or *Very remote* areas, compared with 50% (105) in 2018–19

Learn more >

Employed FTE staff

Around **9,300** full-time equivalent staff were employed in 2022–23, an increase of 14% from 8,000 in 2018–19

Learn more >

In 2022–23, **51%** (or around 4,800) of employed full-time equivalent staff were First Nations people, compared with 52% (4,100) in 2018–19

Learn more >

In 2022–23, **35%** (or around 3,300) of employed full-time equivalent staff were in *Remote* or *Very remote* areas, compared with 43% (3,400) in 2018–19

Learn more >

Vacant FTE positions

At 30 June 2023, there were around **1,000** vacant full-time equivalent positions, an increase of 62% from 390 at 30 June 2019

Learn more >

At 30 June 2023, **12%** (or around 120) of vacant full-time equivalent positions were for Aboriginal and Torres Strait Islander health workers and practitioners, compared with 20% (78) at 30 June 2019

Learn more >

At 30 June 2023, **52%** (or around 540) of vacant full-time equivalent positions were in *Remote* or *Very remote* areas, compared with 59% (230) at 30 June 2019

Learn more >

Clients

Around **507,000** clients were cared for in 2022–23, an increase from 498,000 in 2018–19

Learn more >

In 2022–23, **82%** (or around 443,00) of clients were First Nations people, compared with 79% in 2018–19

Learn more >

In 2022–23, **34%** (or around 171,000) of clients were in *Remote* or *Very remote* areas, compared with 37% in 2018–19

Learn more >

Client contacts

Around **5.7 million** client contacts were made in 2022–23, a decrease from 6.1 million from 2018–19

Learn more >

An average of **11.2** contacts per client were made in 2022–23, compared with 12.2 in 2018–19

Learn more >

In 2022–23, **35%** (or around 2.0 million) of client contacts were made in *Remote* or *Very remote* areas, compared with 40% in 2018–19

Learn more >

Episodes of care

Around **3.71 million** episodes of care were provided in 2022–23, a decrease from 3.74 million in 2018–19

Learn more >

An average of **7.3** episodes of care per client were provided in 2022–23, compared with 7.6 in 2018–19

Learn more >

In 2022–23, **35%** (or around 1.3 million) episodes of care were provided in *Remote* or *Very remote* areas, compared with 38% in 2018–19

Learn more >

Maternal and child health organisations

A small number of organisations reporting to the collections receive funding only to provide specific maternal and child health programs or services (such as those based within a hospital or broader health organisation).

Because these organisations (referred to as maternal and child health organisations) are significantly different from other organisations reporting to the OSR collection, both in terms of what they are funded for and what they report, their data are generally excluded from the OSR data presented in this report (unless otherwise noted). See also Interpreting OSR data.

Because the maternal and child health indicators included in the nKPI collection apply directly to the maternal and child health organisations, and the aims of the programs or services these organisations are funded to deliver are considered similar to the aims of maternal and child health care delivered within other reporting organisations, data from maternal and child health organisations are included in the nKPI data presented in this report. See also Interpreting nKPI data.

Most organisations also provide a set of process-of-care and health-status indicators for First Nations people to the national Key Performance Indicators (nKPI) collection. These indicators focus on maternal and child health, preventative health, and chronic disease management.

Key: √ = improved; × = not improved; ≈ = little or no change

Maternal and child health indicators

First antenatal visit

At June 2023, **60%** (or around 2,600) of female First Nations regular clients who gave birth in the last year had their first antenatal visit before 14 weeks

Trend = X

(June 2021 to June 2023)

Learn more >

Birthweight recorded

At June 2023, **77%** (or around 5,900) of First Nations babies born in the last year had their birthweight recorded

Trend = √

(June 2017 to June 2023)

Learn more >

Birthweight result

At June 2023, **86%** (or around 5,000) of First Nations babies born in the last year had a healthy birthweight

Trend = ≈

(June 2017 to June 2023)

Learn more >

Smoking during pregnancy

At June 2023, **58%** (or around 2,900) of female First Nations regular clients who gave birth in the last year had never smoked or were an ex-smoker

Trend = √

(June 2017 to June 2023)

Learn more >

Health check

At June 2023, **35%** (or around 36,300) of First Nations regular clients aged 0–14 had an Aboriginal and Torres Strait Islander Peoples Health Assessment in the last year

Trend = X

(December 2020 to June 2023)

Learn more >

Preventative health indicators

Smoking status recorded

At June 2023, **71%** (or around 212,000) of First Nations regular clients aged 11 and over had their smoking status recorded in the last year

Trend = X

(June 2021 to June 2023)

Learn more >

Smoking status result

At June 2023, **53%** (or around 109,000) of First Nations regular clients aged 11 and over had never smoked or were an ex-smoker

Trend = ≈

(June 2017 to June 2023)

Learn more >

Alcohol consumption recorded

At June 2023, **55%** (or around 150,000) of First Nations regular clients aged 15 and over had their alcohol consumption status recorded in the last 2 years

Trend = X

(June 2017 to June 2023)

Learn more >

Health check

At June 2023, **45%** (or around 121,000) of First Nations regular clients aged 15 and over had an Aboriginal and Torres Strait Islander Health Assessment in the last 2 years

Trend = X

(December 2020 to June 2023)

Learn more >

CVD risk assessment

At June 2023, **48%** (or around 59,300) of First Nations regular clients aged 35–74 had risk factors recorded to enable CVD assessment

Trend = ≈

(June 2017 to June 2023)

Learn more >

CVD risk assessment result

At June 2023, **58%** (or around 6,600) of First Nations regular clients aged 35–74 had a low absolute cardiovascular risk in the last 2 years

Trend = ≈

(June 2017 to June 2023)

Learn more >

Cervical screening

At June 2023, **42%** (or around 45,300) of female of First Nations regular clients had a cervical screening test in the last 5 years

Trend = √

(December 2020 to June 2023)

Learn more >

Immunised against influenza

At June 2023, **20%** (or around 76,000) of First Nations regular clients aged 6 months and over were immunised against influenza

Trend = X

(December 2020 to June 2023)

Learn more >

BMI

At June 2023, **25%** (or around 37,300) of First Nations regular clients aged 18 and over whose BMI was recorded in the previous 2 years were of 'normal' weight

Trend = X

(December 2021 to June 2023)

Learn more >

Chronic disease management indicators

Chronic Disease Management Plan

At June 2023, **51%** (or around 25,500) of First Nations regular clients with type 2 diabetes had a Chronic Disease Management Plan in the last 2 years

Trend = X

(December 2020 to June 2023)

Learn more >

Blood pressure result recorded

At June 2023, **63%** (or around 32,100) of First Nations regular clients with type 2 diabetes had their blood pressure result recorded in the last 6 months

Trend = X

(June 2017 to June 2023)

Learn more >

Blood pressure result

At June 2023, **66%** (or around 21,100) of First Nations regular clients with type 2 diabetes had a blood pressure result within recommended guidelines in the last 6 months

Trend = ≈

(June 2021 to June 2023)

Learn more >

HbA1c result recorded

At June 2023, **50%** (or around 25,400) of First Nations regular clients with type 2 diabetes had their HbA1c result recorded in the last 6 months

Trend = X

(June 2017 to June 2023)

Learn more >

HbA1c result

At June 2023, **41%** (or around 10,500) of First Nations regular clients with type 2 diabetes had an HbA1c result within recommended guidelines in the last 6 months

Trend = ≈

(June 2017 to June 2023)

Learn more >

Kidney function test type – type 2 diabetes

At June 2023, **45%** (or around 22,300) of First Nations regular clients aged 18 and over with type 2 diabetes had both an eGFR and an ACR test recorded in the last year

Trend = √

(June 2022 to June 2023)

Learn more >

Kidney function test result – type 2 diabetes

At June 2023, **39%** (or around 8,500) of First Nations regular clients aged 18 and over with type 2 diabetes had a risk category of 'normal' recorded in the last year

Trend = √

(June 2022 to June 2023)

Learn more >

Kidney function test type – CVD

At June 2023, **39%** (or around 7,700) of First Nations regular clients aged 18 and over with CVD had both an eGFR and an ACR test recorded in the last year

Trend = √

(June 2022 to June 2023)

Learn more >

Kidney function test result – CVD

At June 2023, **41%** (or around 3,100) of First Nations regular clients aged 18 and over with CVD had a risk category of 'normal' recorded in the last year

Trend = √

(June 2022 to June 2023)

Learn more >

Interpreting results over time

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

- general changes in the organisations that report each period, such as changes in the number or type of organisations in-scope to report
- changes in data quality or data being excluded, for example, as a result of issues identified in organisations' clinical information systems or changes in their reporting practices
- changes to indicator specifications, for example, as a result of revisions to relevant clinical or best practice guidelines
- the impact of the COVID-19 pandemic.

For more information on interpreting changes over time see Technical notes. For more information on changes to indicator specifications see Interpreting nKPI data. For more information on the impact of COVID-19 on First Nations-specific primary health care organisations (using selected OSR items and nKPI process-of-care indicators) see Related materials.

Introduction

Information on organisations funded by the Australian Government under its Indigenous Australians' Health Programme (IAHP) to provide primary health care services to First Nations people is available through 2 data collections, the Online Services Report (OSR) and the national Key Performance Indicators (nKPI):

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

This report presents the latest results from these collections.

Purpose of the OSR and nKPI collections

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

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

Table 1a: Number of organisations reporting 2022–23 (OSR)/June 2023 (nKPI)[(a)]

IAHP funding type	Reporting to OSR	Reporting to nKPI	Reporting to both collections
Primary health care	213	212	194
Maternal and child health[(b)]	19	21	16
Total	232	233	210

Table 1b: Number of organisations reporting 2021–22 (OSR)/June 2022 (nKPI)[(a)]

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

Table 1c: Number of organisations reporting 2020–21 (OSR)/June 2021 (nKPI)[(a)]

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

Table 1d: Number of organisations reporting 2019–20 (OSR)/June 2020 (nKPI)[(a)]

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

Table 1e: Number of organisations reporting 2018–19 (OSR)/June 2019 (nKPI)[a]

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

a. Refers to the June collection period for the nKPI and the financial year collection period for the OSR.

b. Organisations that received funding only to provide maternal and child health programs or services. OSR data presented in this report exclude these organisations unless otherwise noted. For more information see Interpreting OSR data and Interpreting nKPI data. For selected OSR data from these organisations see Data.

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

Notes

1. Not all funded organisations report to the collections each period. Organisations may receive an exemption from providing data for a particular period, or may be in-scope to report but do not report for some reason (for example, because reporting was made voluntary for a period).
2. For information, including on interpreting changes over time, see Technical notes.

Source: OSR and nKPI data collections.

All organisations receiving IAHP funding share a commitment to providing holistic, comprehensive and culturally appropriate health care, and can be split into 2 main types:

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

The 2 types of organisations can have very different profiles (Table 2), varying in governance structure, size, workforce composition, additional sources of funding, the services they offer, and the needs of their clients. Caution should therefore be used

when comparing data by organisation type. For more information on interpreting data, see Technical notes and Glossary.

Table 2: Selected results from the OSR collection by organisation type, 2022–23

Measure	ACCHO	Non-ACCHO	Total
Clients (mean)	2,958	1,063	2,379
Clients (median)	2,273	654	1,667
First Nations clients (mean)	2,423	848	1,943
First Nations clients (median)	1,683	534	1,233
Client contacts (mean)	35,170	7,497	26,725
Client contacts (median)	25,073	5,019	15,984
Episodes of care (mean)	22,192	6,566	17,424
Episodes of care (median)	16,180	4,773	11,797
Employed health full time equivalent (FTE) staff (mean)	32	6	24
Employed health full time equivalent (FTE) staff (median)	22	4	12
Total number of organisations	148	65	213

Source: OSR data collection.

Clients

A person is counted as a client once only within an organisation, regardless of how many times they are seen. A client, however, may attend more than one organisation. The extent to which this occurs is not known and is not adjusted for.

OSR

Organisations reporting to the OSR collection may see a mix of First Nations and non-Indigenous clients. Data for both First Nations and non-Indigenous clients are included in the OSR collection. Not all clients included in the OSR collection are regular clients.

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

nKPI

Organisations reporting to the nKPI collection may see a mix of First Nations and non-Indigenous clients. Some of these are considered regular clients of the organisation.

For the purposes of the nKPI collection, with the exception of 2 indicators on birthweight, indicators include only First Nations regular clients. This is defined as a First Nations person who attended a particular primary health care organisation at least 3 times in the previous 2 years. The 2 indicators related to birthweight are for babies that have attended the organisation more than once in the previous 12 months.

Indicators that are collected by sex and age only include records where age and sex were recorded.

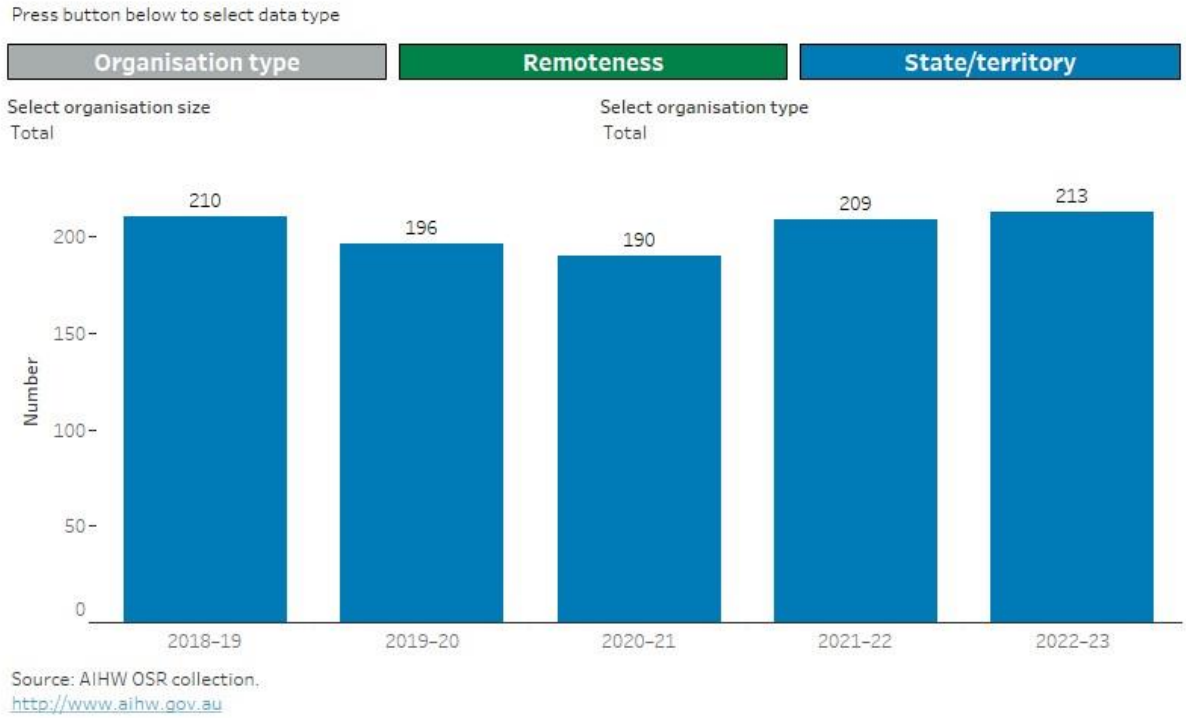
A count of the overall number of First Nations regular clients (without a sex or age recorded, with a sex recorded but not an age, with an age recorded but not a sex, and with both a sex and age recorded) is also collected.

OSR – organisations

In 2022–23, 213 organisations reported to the Online Services Reporting (OSR) collection (Figure 1). Of these:

- 69% (or 148) were Aboriginal Community Controlled Health Organisations (ACCHOs) and 31% (65) were organisations other than ACCHOs (non-ACCHOs)
- 34% (or 73) were in *Very remote* areas, 21% (44) in *Inner regional* areas, 20% (43) in *Outer regional* areas, 13% (27) in *Remote* areas and 12% (26) in *Major cities.*

Figure 1: First Nations-specific primary health care organisations by reporting period



Notes

1. 'Total' includes all organisations who reported in each reporting period.
2. For organisation size, 'Total submitted' includes only organisations that provided valid client numbers in each reporting period.
3. For more information, including on interpreting changes over time, see Technical notes.

For more information on OSR organisations (including on the number of service delivery sites) see Data.

OSR – staff (FTE)

At 30 June 2023, organisations employed around 9,300 full-time equivalent (FTE) staff (Figure 1). During 2022–23, they also had around 270 visiting FTE staff not paid for by the organisations themselves.

Full-time equivalent staff

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

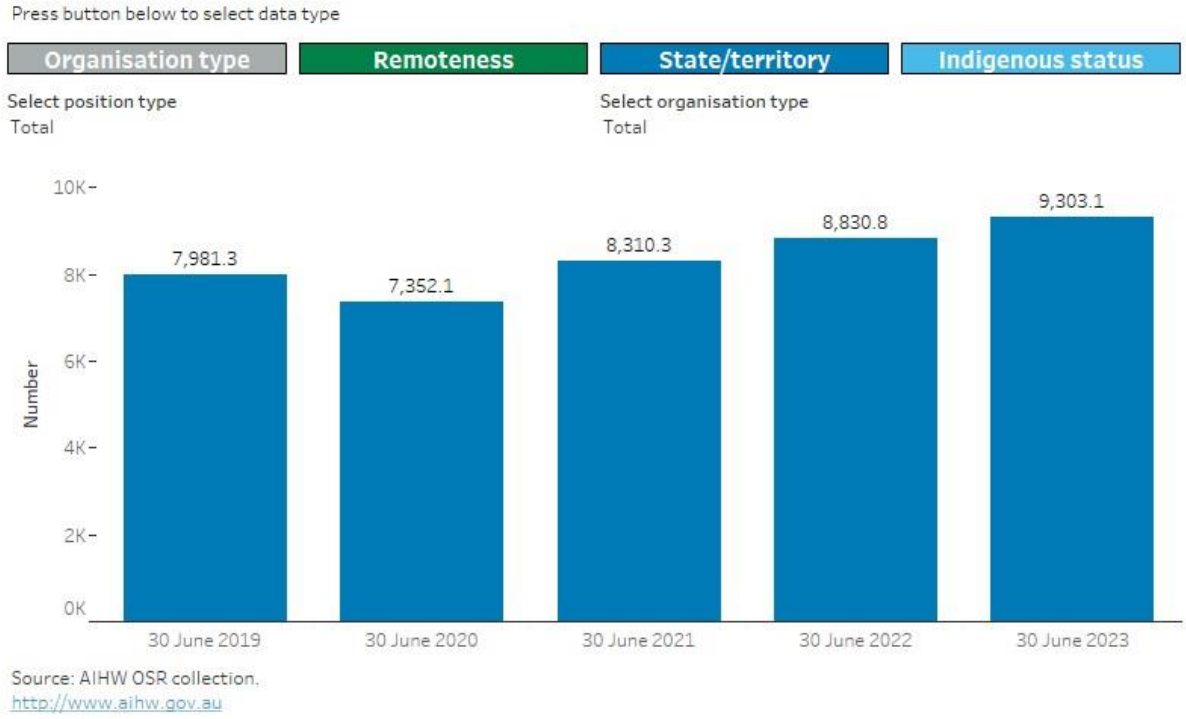
In the OSR total FTE staff consists of:

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

Of the employed FTE staff:

- 93% (or around 8,700 FTE) were in Aboriginal Community Controlled Health Organisations (ACCHOs)
- 23% (or around 2,100 FTE) were in *Major cities*, 23% (2,100) in *Inner regional* areas, 19% (1,800) in *Outer regional* areas, 19% (1,700) in *Remote* areas and 17% (1,500) in *Very remote* areas
- 51% (or around 4,800 FTE) were First Nations people
- 54% (or around 5,100 FTE) were health staff.

Figure 1: Employed FTE staff by reporting period and position type



Notes

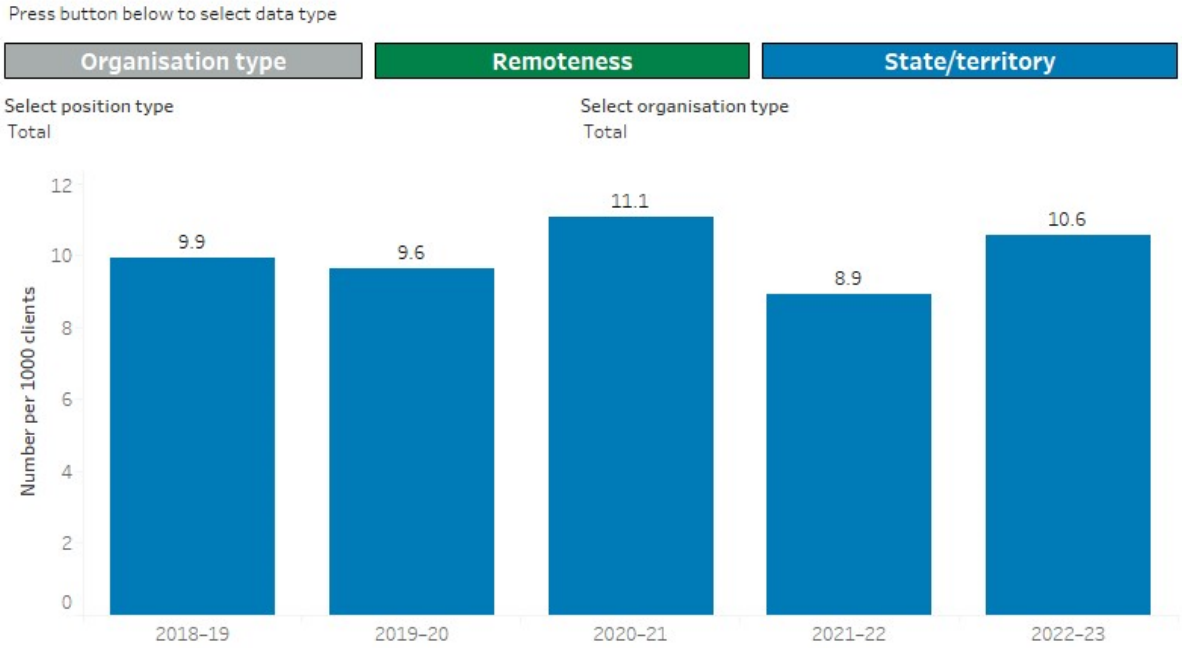
1. 'Other health' positions include sexual health workers, traditional healers, environmental health workers, trainee positions and 'other' health workers.

2. For more information, including on interpreting changes over time, see Technical notes.

Compared with non-ACCHOS, ACCHOs employed a higher proportion of First Nations staff (52% compared with 40%).

There were around 10.6 total (employed and visiting) health FTE staff per 1,000 clients (Figure 2). ACCHOs had a higher number of total health staff per 1,000 clients than non-ACCHOs (11.6 compared with 6.9).

Figure 2: Total health FTE staff per 1,000 clients by reporting period and position type



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

Notes

1. Includes employed and visiting FTE staff. Employed staff FTE are as at 30 June each period. Visiting staff FTE and number of clients are for a 12 month period from 1 July to 30 June each period.
2. For more information, including on interpreting changes over time, see Technical notes.

For more information on FTE staff see Data.

OSR – vacancies (FTE)

At 30 June 2023, organisations had over 1,000 vacant full-time equivalent (FTE) positions (Figure 1).

Full-time equivalent vacant positions

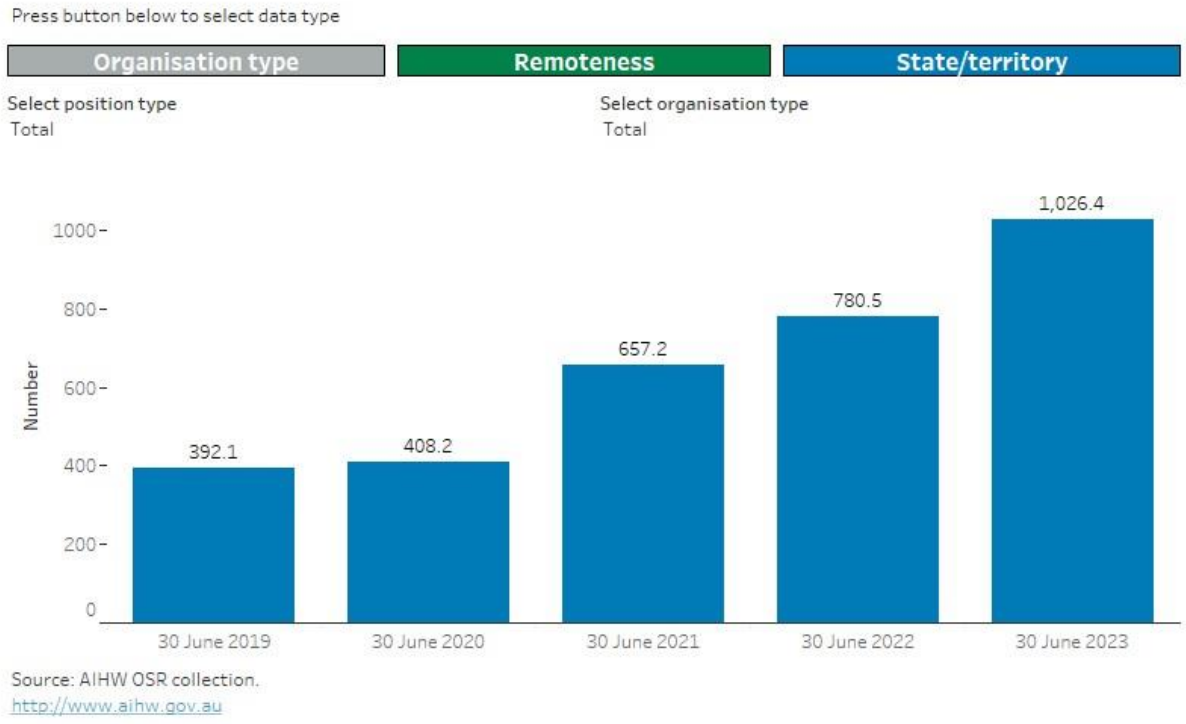
Full-time equivalent (FTE) is a standard measure of the size of a workforce that takes into account both the number of workers and the hours that each works. For example, if a workforce comprises 2 people working full-time 40 hours a week and 2 working half-time, this is the same as 3 working full-time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

In the OSR, full-time equivalent vacant positions are how many vacant positions an organisation had at 30 June.

Of the vacant full-time equivalent (FTE) positions:

- 86% (or around 880 FTE) were at Aboriginal Community Controlled Health Organisations (ACCHOs)
- 32% (or around 330 FTE) were in *Remote* areas, 21% (210) in *Major cities*, 20% (210) in *Very remote* areas, 14% (145) in *Outer regional* areas and 13% (135) in *Inner regional* areas
- 72% (or around 730 FTE) were for health positions.

Figure 1: Vacant FTE positions by reporting period and position type

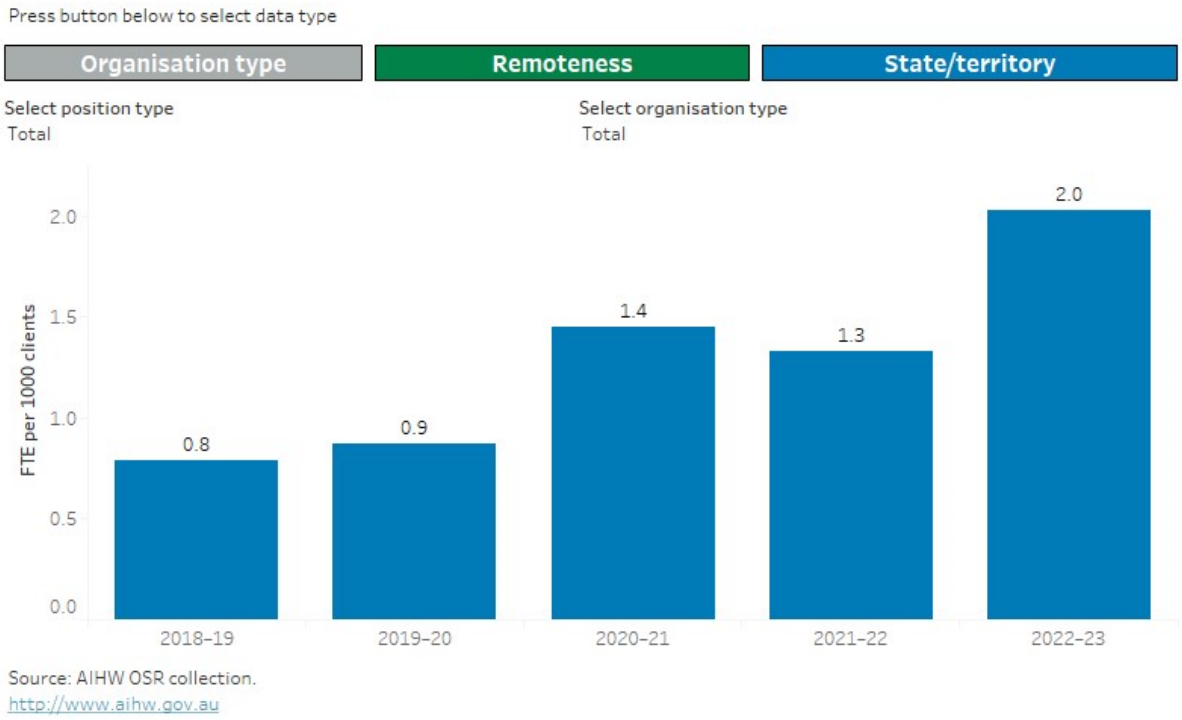


Note: For more information, including on interpreting changes over time, see Technical notes.

There has been an increase in the number of vacant FTE positions reported in the most recent OSR collection periods (that is, in the number of vacant FTE as at 30 June 2021, 30 June 2022 and 30 June 2023 compared with those reported for previous periods). While it is difficult to be definitive about the reasons for this, as many of the organisations with increased vacancies also had an increase in employed FTE, it is likely that at least some of these vacancies relate to the delivery of new services rather than an increase in delivery of existing services. Some of this change, especially in 2021 and 2022, may have been a result (direct or indirect) of the COVID-19 pandemic. However, not all comments organisations provided for variations in these numbers (reported for organisations with a 20% or more increase or decrease) clearly linked the increase in vacancies to COVID-19. These increases may also be the result of other unrelated factors, for example, general changes in funding, direction, structure or size resulting in more or different services being delivered. For more information on the impact of COVID-19 see Related material.

There were around 2.0 vacant FTE positions per 1,000 clients (Figure 2).

Figure 2: Vacant FTE positions per 1,000 clients by reporting period and position type



Notes:

1. Vacant FTE are as at 30 June each period. Visiting staff FTE and number of clients are for a 12 month period from 1 July to 30 June each period.
2. For more information, including on interpreting changes over time, see Technical notes.

For more information on vacant FTE positions see Data.

OSR – clients

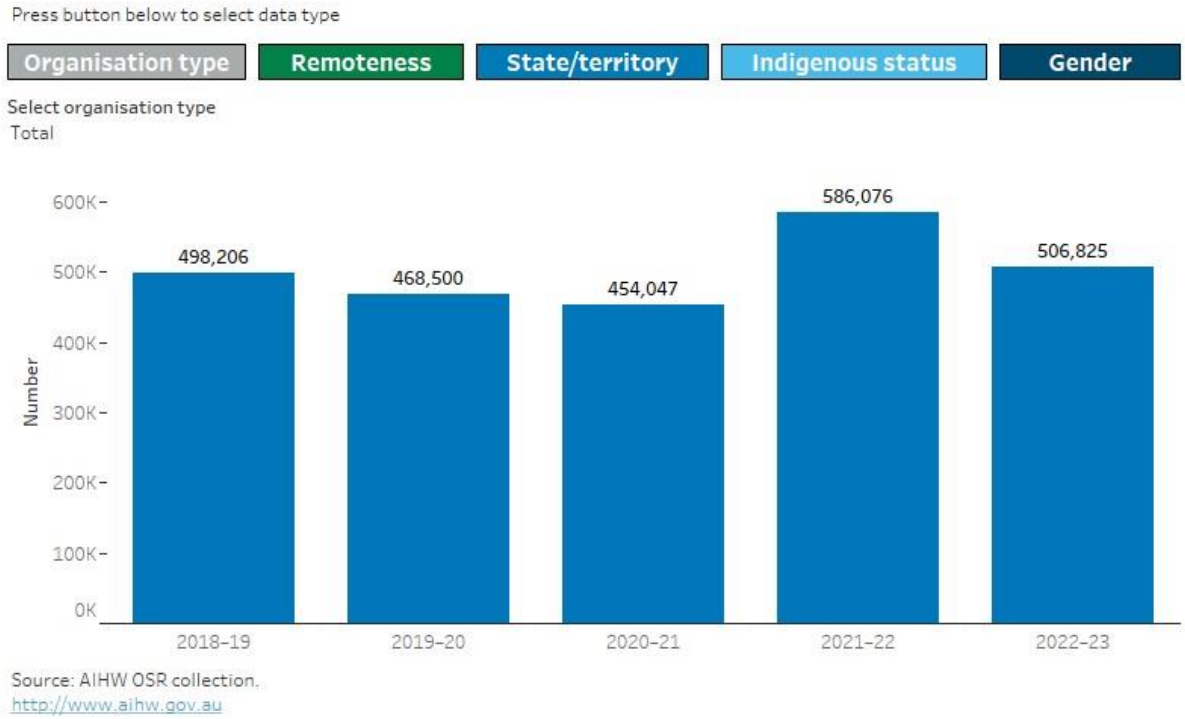
In 2022–23, organisations saw around 507,000 clients (Figure 1). The number of clients decreased by 16% between 2021–2022 and 2022–23. This was mostly a result of the large (50%) decrease in the number of non-Indigenous clients and likely reflects the jump in non-Indigenous clients seeking COVID-related services in 2021–22 followed by a return to a more 'normal' service provision the following year. For more information on the impact of COVID-19 see Related material.

Clients

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

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

Figure 1: Client numbers by reporting period



Note: For more information, including on interpreting changes over time, see Technical notes.

Of clients:

- 86% (or around 438,000) were seen by Aboriginal Community Controlled Health Organisations (ACCHOs)
- 24% (or around 123,000) were seen in *Major cities*, 21% (107,000) in *Inner regional* areas, 21% (106,000) in *Outer regional* areas, 17% (88,500) in *Remote* and 16% (82,500) in *Very remote* areas
- 54% (or around 273,000) were female
- 82% (or around 414,000) were First Nations people
- 56% (or around 286,000) were aged under 35.

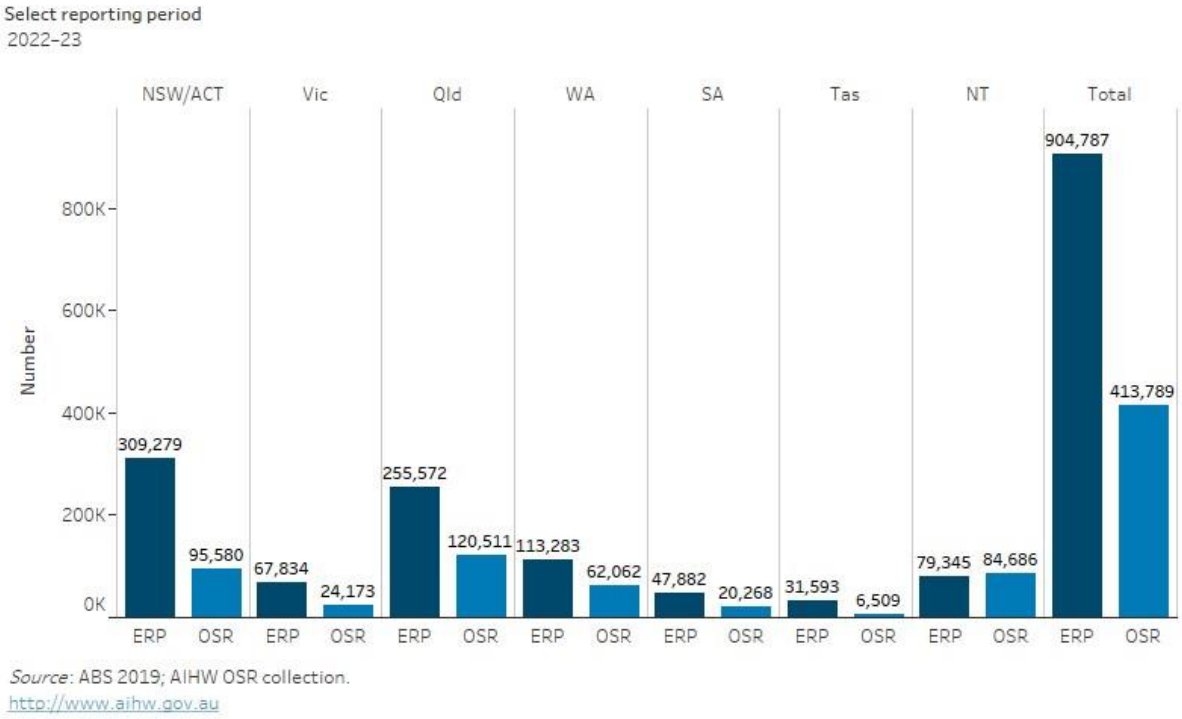
ACCHOs and non-ACCHOs both generally saw:

- a higher proportion of female than male clients (around 54% in both types of organisation were female)
- a higher proportion of First Nations clients (82% in ACCHOs and 80% in non-ACCHOs) than non-Indigenous clients (around 17% in both).

The age profile of clients attending ACCHOs was generally younger than those attending non-ACCHOs, with 57% of clients of ACCHOs being aged under 35 compared with 52% in non-ACCHOs.

In 2022–23, around 46% (414,000) of the estimated resident First Nations population (905,000) were First Nations clients of organisations reporting to the OSR collection (Figure 2).

Figure 2: First Nations clients compared with estimated resident First Nations population by state/territory and reporting period



Source: ABS 2019; AIHW OSR collection.
http://www.aihw.gov.au

Notes

1. In some cases clients may be counted at more than one organisation. The number of First Nations clients being greater than the First Nations ERP is most common in *Remote* and *Very remote* areas.

2. ERP is at 31 December of the relevant reporting period. Population projections for the period 2018–19 to 2022–23 are based on the 2016 Census of Population and Housing. The ERP may vary from that used for the nKPI collection because of differences in reporting periods.

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

4. For more information, including on interpreting changes over time, see Technical notes.

For more information on clients see Data.

Reference

ABS (Australian Bureau of Statistics) (2019) *Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2006 to 2031* [Series B projections], ABS cat. No. 3238.0, ABS, Australian Government, accessed 12 October 2023.

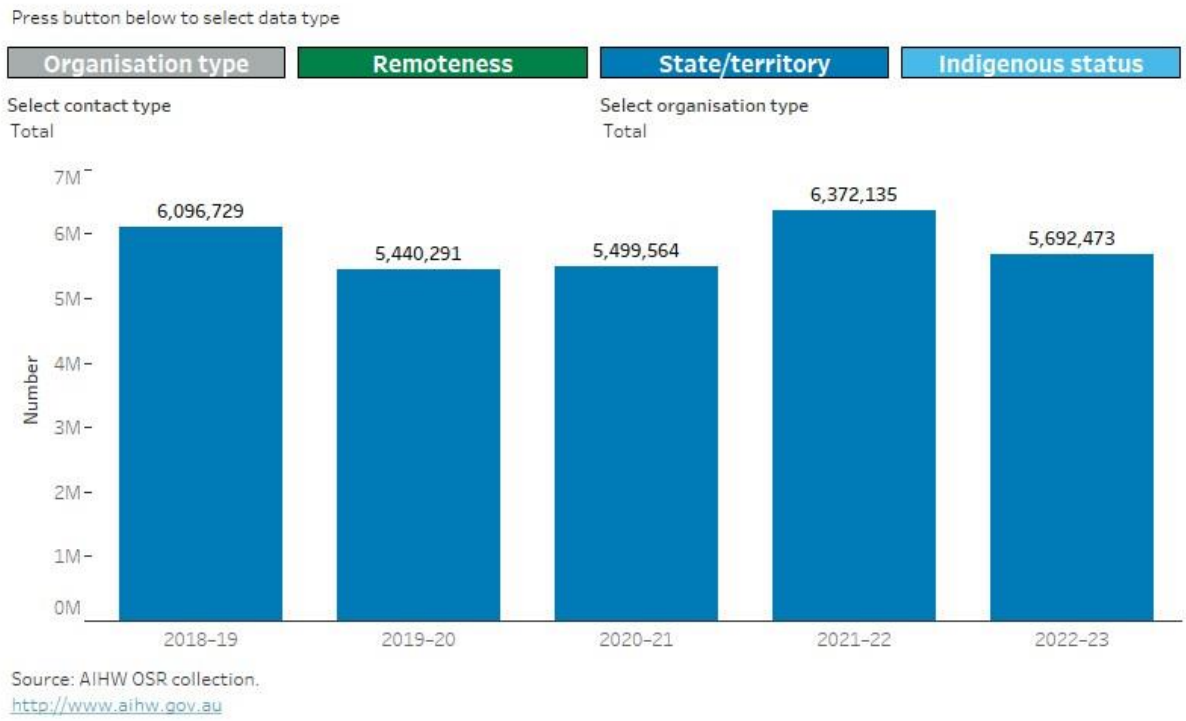
OSR – client contacts

In 2022–23, organisations had around 5.7 million client contacts (Figure 1). The number of client contacts decreased by 12% between 2021–22 and 2022–23. This was mostly a result of the large (37%) decrease in episodes of care for non-Indigenous clients and likely reflects the jump in non-Indigenous clients seeking COVID-related services in 2021–22 followed by a return to a more 'normal' service provision the following year.

Client contact

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

Figure 1: Client contacts by reporting period and contact type



Note: For more information, including on interpreting changes over time, see Technical notes.

Of client contacts:

- 91% (or around 5.2 million) were provided by Aboriginal Community Controlled Health Organisations (ACCHOs)
- 23% (or around 1.3 million) were provided in *Inner regional* areas, 22% (1.2 million) in *Major cities*, 21% (1.2 million) in *Outer regional* areas, 18% (1.0 million) in *Remote* areas and 17% in *Very remote* areas

- 87% (5.0 million) were with First Nations clients
- 32% (or around 1.8 million) were made by a general practitioner (GP)
- 30% (or around 1.7 million) were made by nurses
- 11% (or around 625,000) were made by Aboriginal and Torres Strait Islander health workers and practitioners.

There were an average of 11.2 contacts per client.

For more information on client contacts see Data.

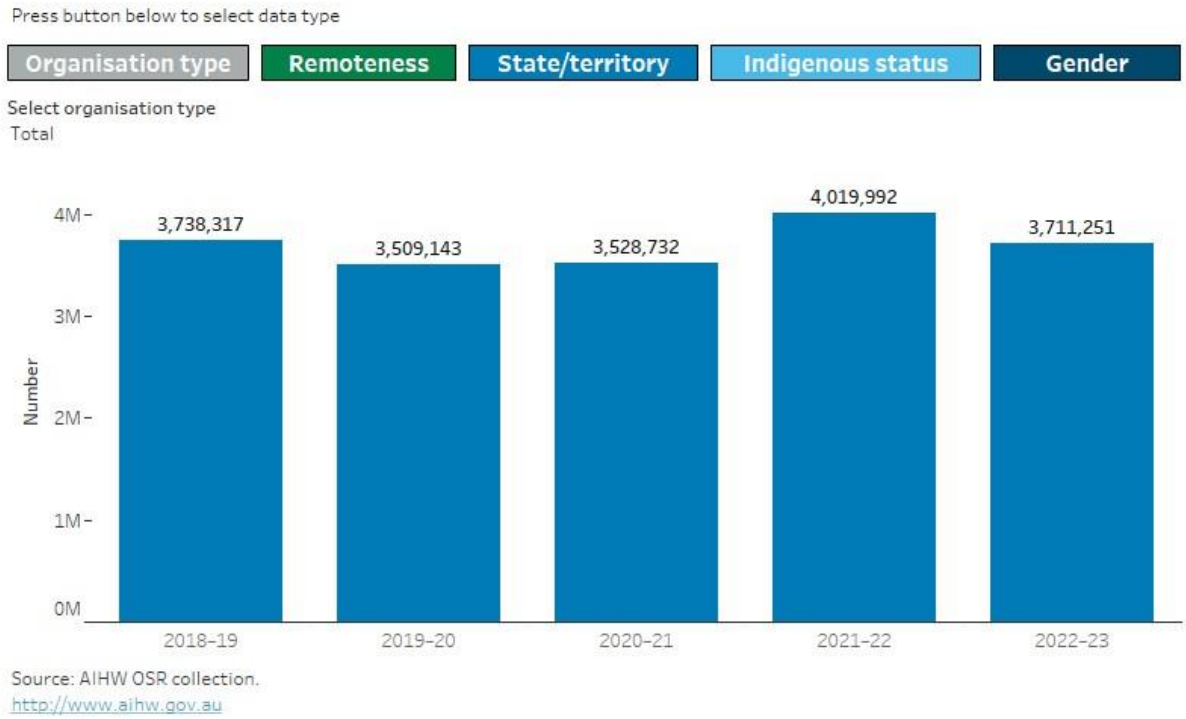
OSR – episodes of care

In 2022–23, organisations provided around 3.7 million episodes of care (Figure 1). The number of episodes of care decreased by 8% between 2021–22 and 2022–23. This was mostly a result of the large (24%) decrease in episodes of care for non-Indigenous clients and likely reflects the jump in non-Indigenous clients seeking COVID-related services in 2021–22 followed by a return to a more 'normal' service provision the following year.

Episode of care

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

Figure 1: Episodes of care by reporting period



Note: For more information, including on interpreting changes over time, see Technical notes.

Of episodes of care:

- 88% (or around 3.3 million) were provided by Aboriginal Community Controlled Health Organisations (ACCHOs)
- 23% (or around 853,000) were provided in *Inner regional* areas, 23% (844,000) in *Major cities*, 19% (711,000) in *Outer regional* areas, 18% (665,000) in *Very remote* areas and 17% (638,000) in *Remote* areas
- 59% (or around 2.2 million) were with female clients
- 86% (or around 3.2 million) were with First Nations clients.

There were an average of 7.3 episodes of care per client.

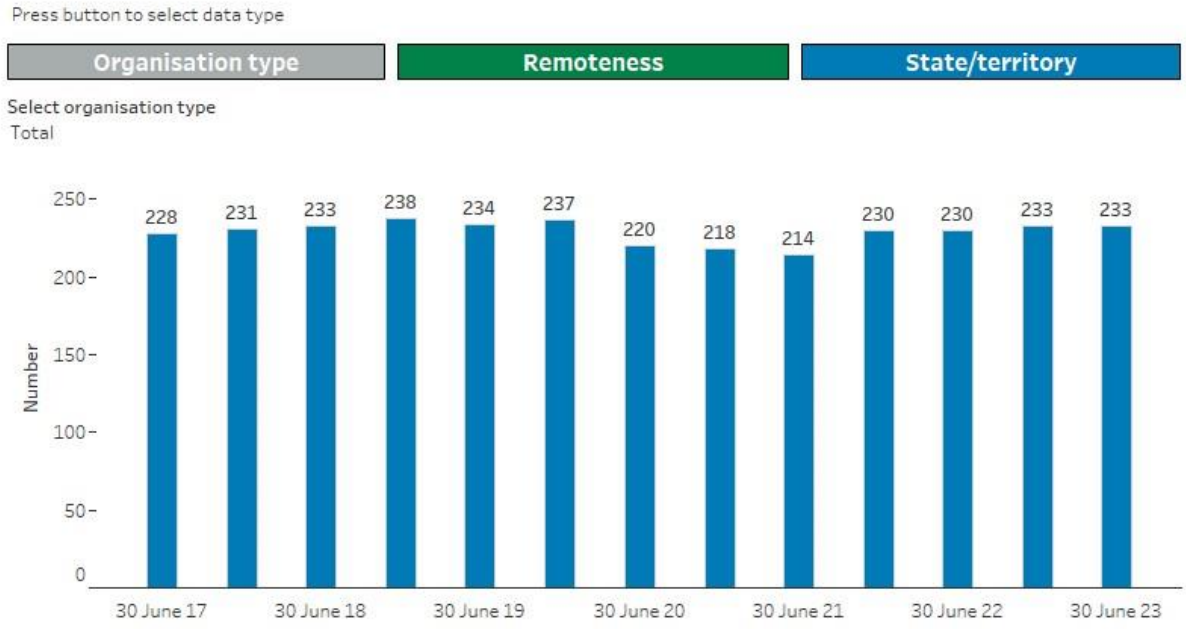
For more information on episodes of care see Data.

nKPI – organisations

At June 2023, 233 organisations reported to the national Key Performance Indicators (nKPI) collection (Figure 1). Of these:

- 33% (or 77) were in *Very remote* areas, 21% (49) were in *Inner regional* areas, 20% (47) in *Outer regional* areas, 14% (32) in *Remote* areas and 12% (28) in *Major cities*
- 66% (or 153) were Aboriginal Community Controlled Health Organisations (ACCHOs), of which:
  - 25% (or 39) were in *Outer regional* areas, 25% (38) in *Inner regional* areas, 22% (34) in *Very remote* areas, 16% (24) in *Remote* areas and 12% (18) in *Major cities*
- 34% (or 80) were organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs), of which:
  - 54% (or 43) were in *Very remote* areas, 14% (11) in *Inner regional* areas, 13% (10) in *Major cities*, 10% (8) in *Outer regional* areas and 10% (8) in *Remote* areas.

Figure 1: First Nations-specific primary health care organisations by reporting period



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

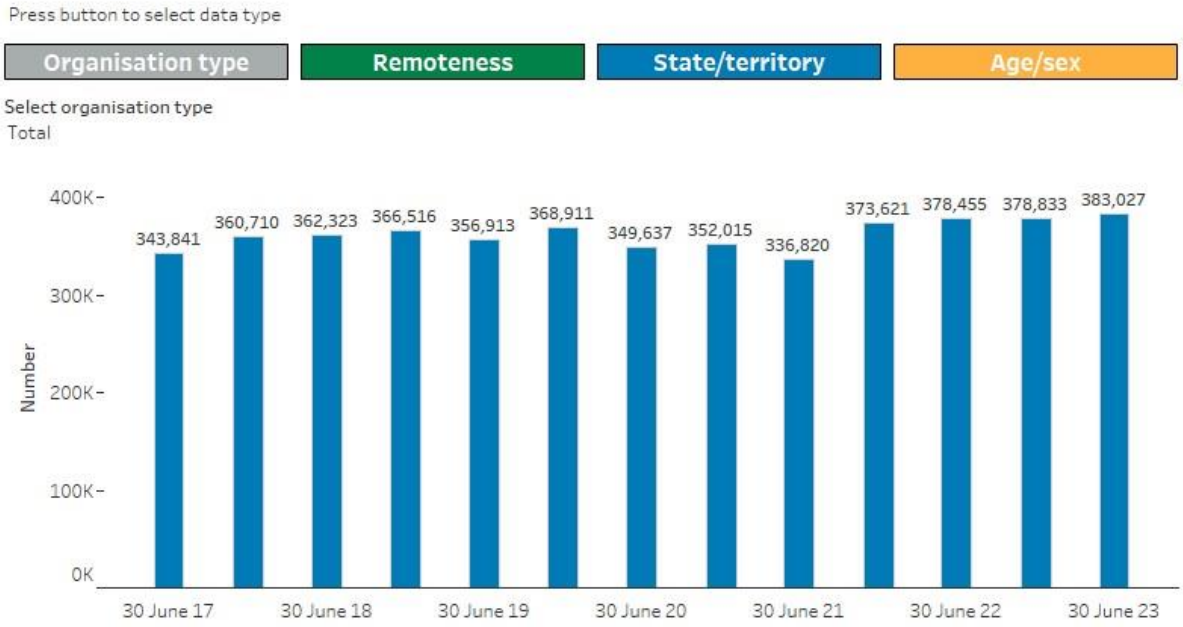
Note: For more information, including on interpreting changes over time, see Technical notes.

For more information on organisations see Data.

nKPI – clients

There were over 383,000 First Nations regular clients at June 2023 (that is, First Nations clients who had visited the organisation 3 or more times in the 2 years up to 30 June 2023) (Figure 1). This is based on estimates provided by the organisations and may differ from the number of First Nations regular clients reported as indicator denominators (for more information see Data).

Figure 1: First Nations regular clients by reporting period



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

Notes

1. Data for 'Age/sex' are based on the number of First Nations regular clients collected as part of PI03 and PI09 and does not include ages 5–14 prior to December 2020. All other data are based on the number of First Nations regular clients with age and sex recorded and include all ages for all periods.
2. For more information, including on interpreting changes over time, see Technical notes.

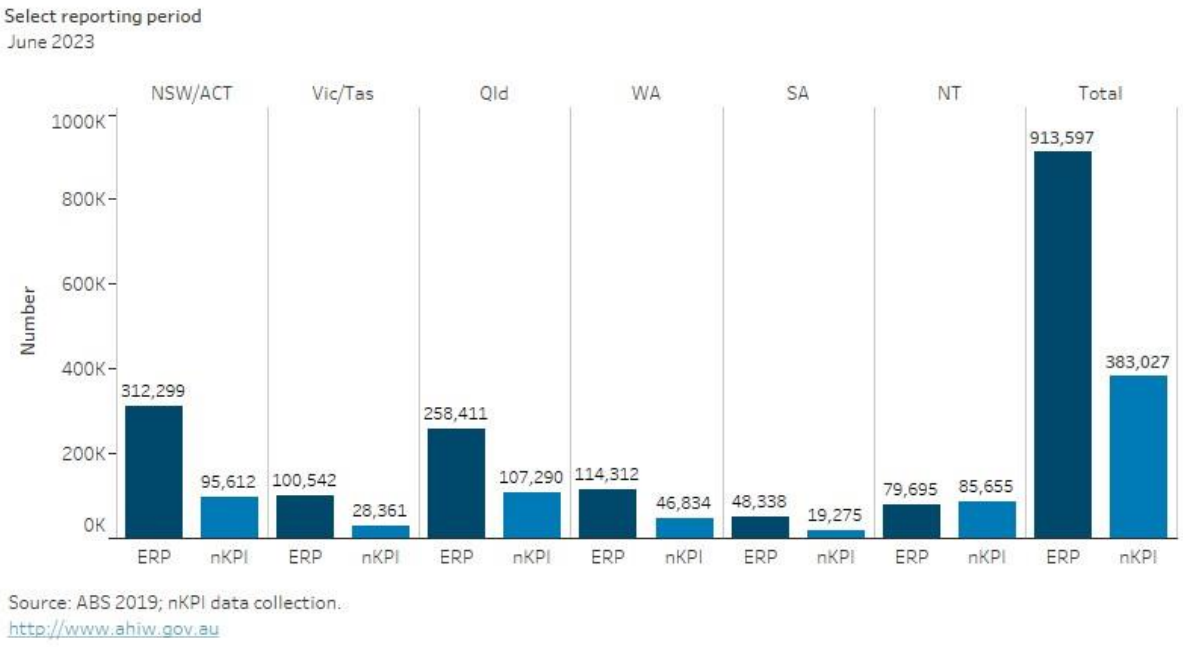
Of clients:

- 24% (or around 90,700) were seen in *Major cities*, 21% (81,100) in *Inner regional* areas, 20% (75,400) in *Very remote* areas, 19% (73,500) in *Outer regional* areas and 16% (62,400) in *Remote* areas
- 84% (or around 323,000) were seen in Aboriginal Community Controlled Health Organisations (ACCHOs), of which:

  - 26% (or around 84,000) were seen in *Major cities*, 23% (74,600) in *Inner regional* areas, 22% (70,300) in *Outer regional* areas, 17% (53,800) in *Remote* areas and 13% (40,400) in *Very remote* areas
- 16% (or around 59,900) were seen in organisations other than Aboriginal Community Controlled Health Organisations (non-ACCHOs), of which:
  - 58% (or around 35,000) were seen in *Very remote* areas, 14% (8,500) in *Remote* areas, 11% (6,700) in *Major cities*,11% (6,500) in *Inner regional* areas and 5% (3,300) in *Outer regional* areas
- 54% (or around 202,600) were female
- 61% (or around 126,100) were aged under 35.

At June 2023, 42% of the estimated resident First Nations population (around 914,000) were First Nations regular clients of organisations reporting to the nKPI collection (around 383,000) (Figure 2).

Figure 2: First Nations regular clients compared with the estimated resident First Nations population, by state/territory and reporting period



Source: ABS 2019; nKPI data collection.
http://www.ahiw.gov.au

Notes

1. In some cases clients may be counted at more than one organisation. The number of First Nations clients being greater than the First nations ERP is most common in *Remote* and *Very remote* areas.

2. ERP is at 30 June of the relevant reporting period. Population projections for the period June 2017 to June 2023 are based on the 2016 Census of Population and Housing. The ERP may vary from that used for the OSR collection because of differences in reporting periods.

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

4. nKPI data are based on data provided on the number of First Nations regular clients with age and sex recorded.

5. ABS and nKPI data include all ages.

6. For more information, including on interpreting changes over time, see Technical notes.

For more information on clients see Data.

Reference

ABS (Australian Bureau of Statistics) (2019) *Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2006 to 2031* [Series B projections], ABS cat. no. 3238.0, ABS, Australian Government, accessed 1 November 2023.

nKPI – maternal and child health indicators

Of the 5 maternal and child health measures presented in Table 1, 2 have improved, one showed no (or limited) change and 2 have not improved over time.

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

Table 1: Trends for selected maternal and child health indicators[a]

Measure	Trend	Period
PI13: First antenatal visit before 14 weeks[b]	×	June 2021 to June 2023
PI01: Birthweight recorded[c]	√	June 2017 to June 2023
PI02: Healthy (normal) birthweight[c]	≈	June 2017 to June 2023
PI11: Smoking during pregnancy – ex-smoker/never smoked[b]	√	June 2021 to June 2023
PI03: Health check – aged 0–14[b]	×	December 2020 to June 2023

a. Trend is calculated as a linear trend of proportions in comparable periods between the June 2017 and June 2023 collection periods, including the December collection periods. Comparable periods may vary between indicators, for example, if there is a break in series. Where there has been a break in series, only the trend following the break is presented in Table 1. For data over time for all available periods see Data. For trends before and after a break in series see the visualisations on each indicator pages.

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

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

Notes

1. Key: √ = improved; × = not improved; ≈ = little or no change.
2. Some of the indicators in the national Key Performance Indicators (nKPI) collection have, or can be split into, more than one part.

3. Reporting to the nKPI collection for June 2020, December 2020 and June 2021 was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19.

4. For more information, including on interpreting changes over time, see Technical notes.

Source: nKPI data collection.

For more information maternal and child health indicators see the page for each indicator and Data.

First antenatal visit (PI13)

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

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

It is reported here in 2 parts as the proportion of female First Nations regular clients who gave birth within the previous 12 months who had:

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

It is collected for age groups:

- less than 20
- 20–34
- 35 and over.

There have been changes to the specification of this indicator over time. For more information see Interpreting nKPI data.

Why antenatal care is important

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

Antenatal care provides an opportunity to find, treat, and provide advice on chronic or pre-existing conditions that might cause pregnancy-related complications, such as hypertension, diabetes, mental health problems, sexually transmitted infections, tobacco and alcohol misuse, inadequate nutrition, and unhealthy weight. Regular antenatal care, and especially that starting in the first trimester, is associated with less pregnancy-related complications and with positive maternal and child health outcomes.

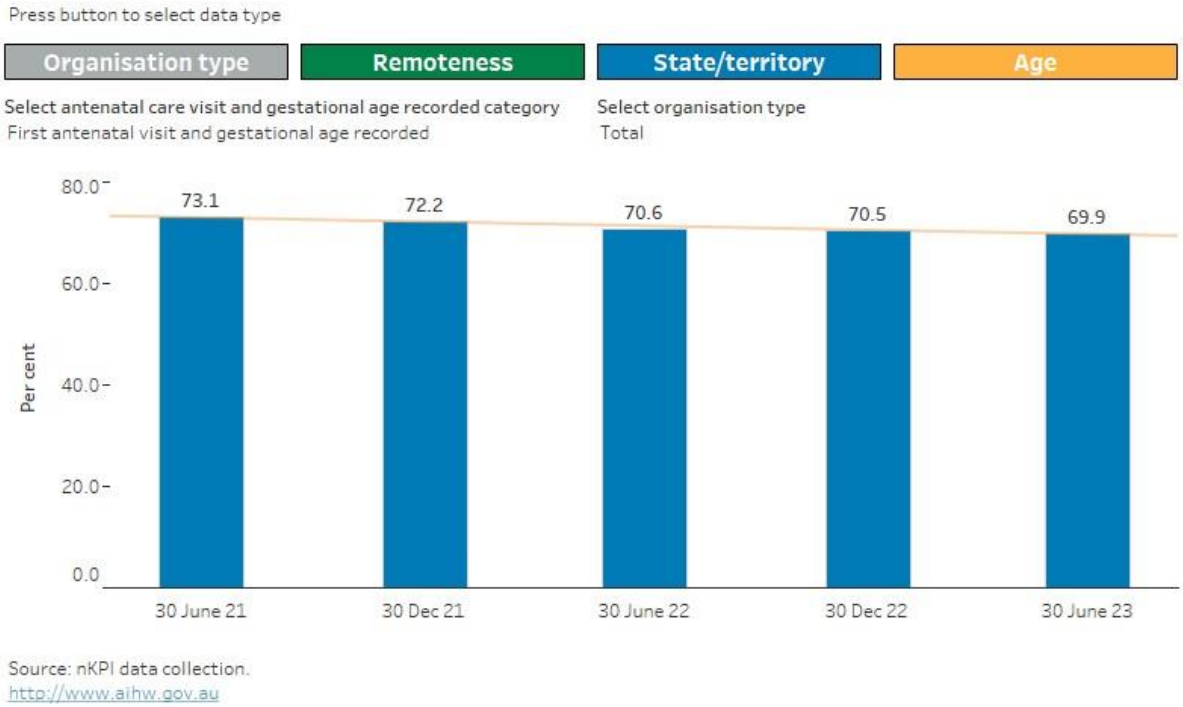
The targets in the National Agreement on Closing the Gap include several aimed at children, including a target to increase the proportion of First Nations babies with a healthy

birthweight to 91% by 2031 (with supporting indicators on the use of antenatal care by pregnant women).

Data from the National Perinatal Data Collection show that the proportion of First Nations mothers attending an antenatal visit in the first trimester has increased over time. First Nations mothers, however, are less likely than non-Indigenous mothers to have their first antenatal care visit in the first trimester (AIHW 2023).

At June 2023, 70% (or around 4,400) of female First Nations regular clients had an antenatal care visit and gestational age recorded at their first antenatal care visit, 30% (1,900) did not (Figure 1).

Figure 1: Whether first antenatal visit and gestational age were recorded by reporting period



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

Notes

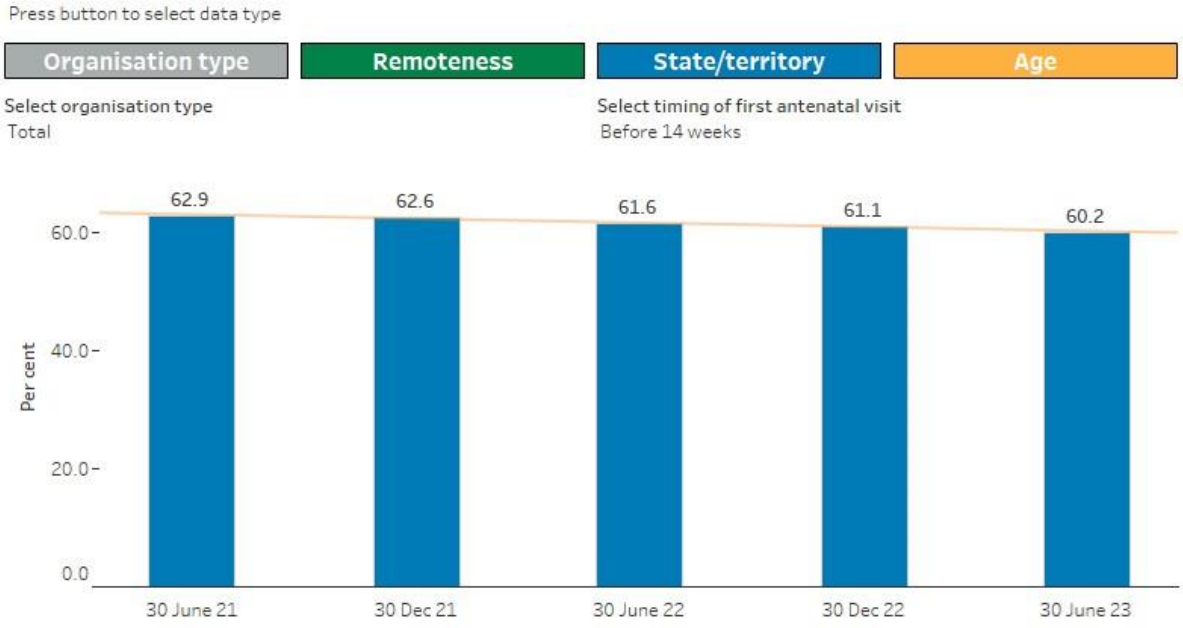
1. In June 2021, specifications changed for this indicator. Data on whether or not there was antenatal care visit or the gestational age was recorded at the first antenatal care visit can be compared with previous periods with caution. For more information see Interpreting nKPI data. Data prior to June 2021 are not presented here (for consistency with Figure 2) but can be found in Archived content.

2. For more information, including on interpreting changes over time, see Technical notes.

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

- 60% (or around 2,600) had their visit before 14 weeks (first trimester)
- 18% (or around 770) had their visit at 14–19 weeks
- 22% (or around 960) had their visit at 20 or more weeks (Figure 2).

Figure 2: Timing of first antenatal visit by reporting period and timing of visit



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

Notes

1. In June 2021, specifications changed for this indicator and data from that point on for the total and most visit timing categories (except '20 or more weeks') cannot be compared with previous periods. For more information see Interpreting nKPI data.

2. Proportions are calculated using the denominator of female Indigenous regular clients who had an antenatal care visit and gestational age recorded at their first antenatal care visit.

3. For more information, including on interpreting changes over time, see Technical notes.

For more information on first antenatal visit see Data.

Reference

AIHW (Australian Institute of Health and Welfare) (2023) *Aboriginal and Torres Strait Islander Health Performance Framework: antenatal care*, AIHW, Australian Government, accessed 11 December 2023.

Birthweight (PI01 and PI02)

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

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

There have been changes to the specifications of these indicators over time. For more information see Interpreting nKPI data.

Why birthweight is important

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

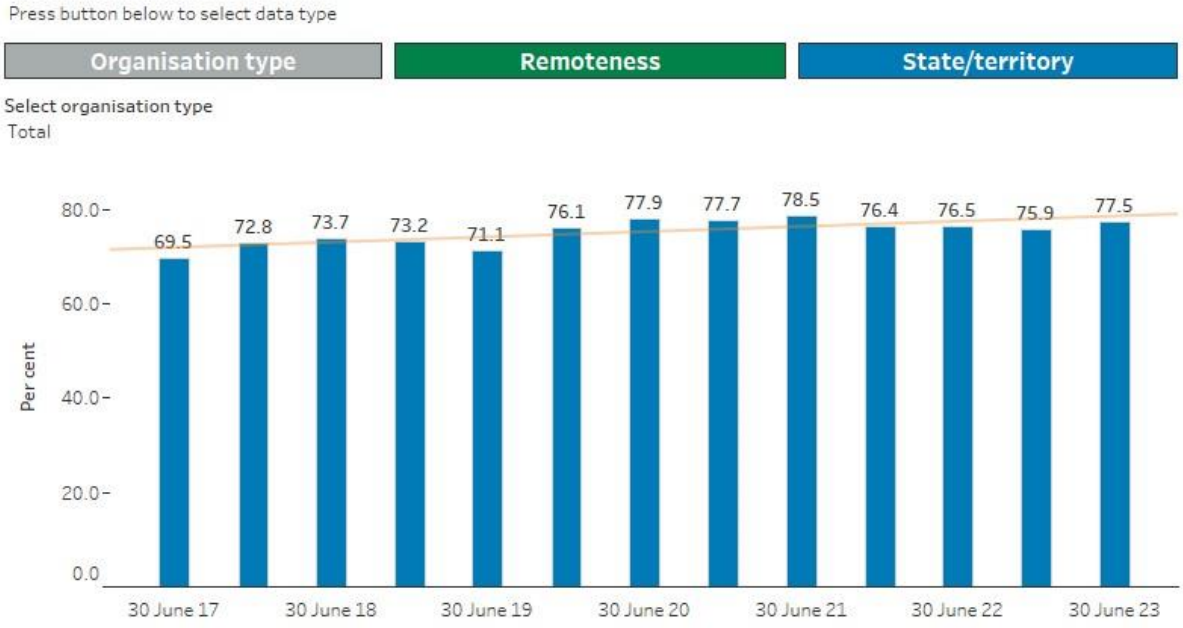
The targets in the National Agreement on Closing the Gap include several aimed at children, including a target to increase the proportion of First Nations babies with a healthy birthweight to 91% by 2031.

Data from the National Perinatal Data Collection show that the majority of First Nations babies have a normal birthweight, however, they are less likely to do so than non-Indigenous babies (AIHW 2023). There has been little change in this in recent years.

Birthweight recorded (PI01)

At June 2023, 77% (or around 5,900) of First Nations babies born within the previous 12 months had their birthweight recorded (Figure 1).

Figure 1: Birthweight recorded by reporting period



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

Notes

1. In June 2021, specifications changed for this indicator. For more information see Interpreting nKPI data.
2. For more information, including on interpreting changes over time, see Technical notes.

Birthweight result (PI02)

At June 2023, 86% (or around 5,000) of First Nations babies born within the previous year had a healthy (normal) birthweight (Figure 1).

Figure 2: Birthweight result by reporting period

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

Notes

1. In June 2021, specifications changed for this indicator. For more information see Interpreting nKPI data.
2. For more information, including on interpreting changes over time, see Technical notes.

For more information on birthweight recording and results see Data.

Reference

AIHW (Australian Institute of Health and Welfare) (2023) *Aboriginal and Torres Strait Islander Health Performance Framework: birthweight*, AIHW, Australian Government, accessed 11 December 2023.

Smoking during pregnancy (PI11)

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

- current smoker
- ex-smoker
- never smoked.

It is collected for age groups:

- less than 20
- 20–34
- 35 and over.

There have been changes to the specification of this indicator over time. For more information see Interpreting nKPI data.

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

Why not smoking during pregnancy is important

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

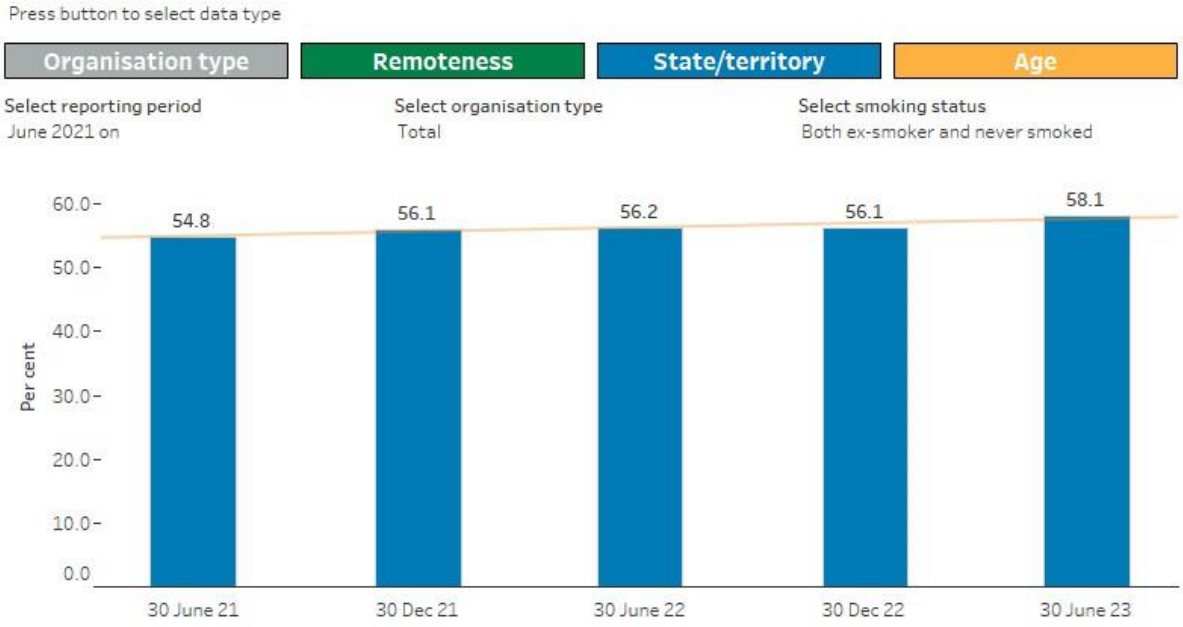
Tobacco smoking during pregnancy is the most common preventable risk factor for pregnancy complications, and is associated with poorer perinatal outcomes, including low birthweight, being small for gestational age, pre-term birth and perinatal death. Women who stop smoking during pregnancy can reduce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

The targets in the National Agreement on Closing the Gap include several aimed at children, including a target to increase the proportion of First Nations babies with a healthy birthweight to 91% by 2031 (with smoking during pregnancy as a supporting indicator).

Data from the National Perinatal Data Collection show that the proportion of First Nations mothers who smoke during pregnancy has decreased over time. First Nations mothers, however, are more likely to smoke during pregnancy than non-Indigenous mothers (AIHW 2023).

At June 2023, 42% (or around 2,100) of female First Nations regular clients who gave birth within the previous 12 months smoked at some point during pregnancy, 42% (2,100) had never smoked and 16% (770) were ex-smokers (Figure 1).

Figure 1: Smoking status during pregnancy by reporting period



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

Notes

1. In June 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. For more information see Interpreting nKPI data.

2. For more information, including on interpreting changes over time, see Technical notes.

For more information on smoking during pregnancy see Data.

Reference

AIHW (Australian Institute of Health and Welfare) (2023) *Aboriginal and Torres Strait Islander Health Performance Framework: health behaviours during pregnancy*, AIHW, Australian Government, accessed 11 December 2023.

Health check – aged 0–14 (PI03)

This indicator is the proportion of First Nations regular clients aged 0–14 who had an Aboriginal and Torres Strait Islander Peoples Health Assessment (health check) within the previous 12 months.

It is collected for males and females in age groups:

- 0–4
- 5–14.

There have been changes to the specification of this indicator over time. For more information see Interpreting nKPI data.

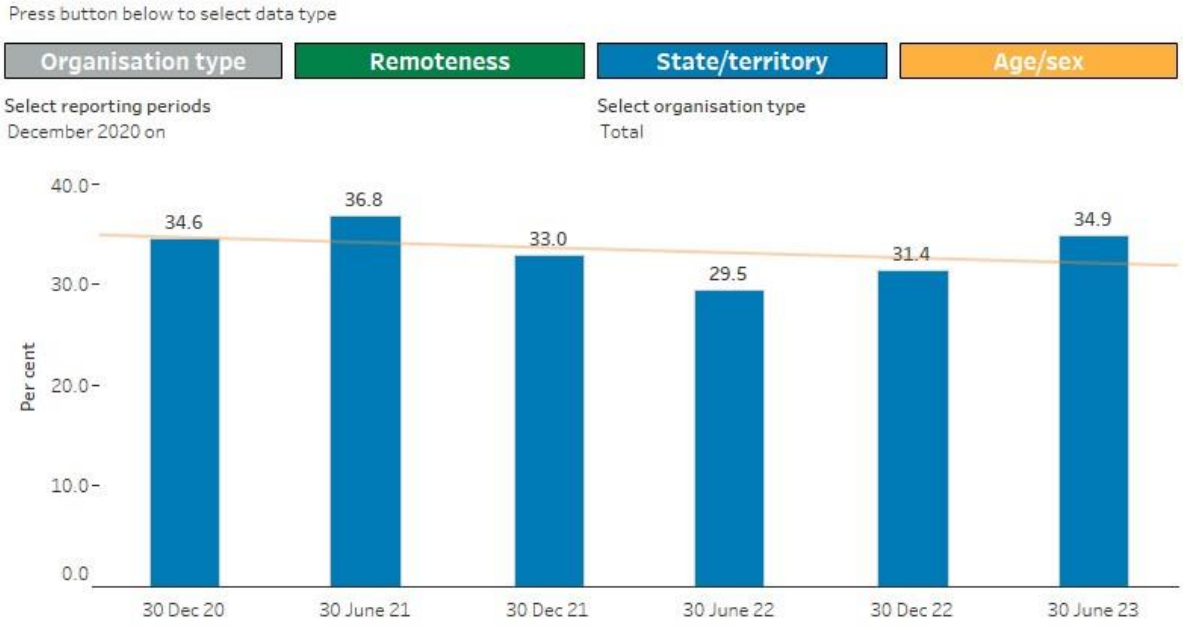
Ages 15 and over are also collected for PI03, with data presented under the Preventative health domain.

Why health checks are important

Through Medicare, First Nations people can receive an Aboriginal and Torres Strait Islander Peoples Health Assessment from their doctor, as well as referrals for follow-up services. The Aboriginal and Torres Strait Islander Peoples Health Assessment was introduced in recognition that First Nations people, as a group, experience some particular health risks. The aim of the health check is to encourage early detection and treatment of common conditions that cause ill health and early death.

At June 2023, 35% (or around 36,300) of First Nations regular clients aged 0–14 had a health check within the previous 12 months (Figure 1).

Figure 1: Health check aged 0–14 by reporting period



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

Notes

1. In December 2020, specifications changed for this indicator and data from that point on cannot be compared with previous periods. For more information see Interpreting nKPI data.

2. For more information, including on interpreting changes over time, see Technical notes.

For more information on health checks for ages 0–14 see Data.

nKPI – preventative health indicators

Of the 9 preventative health measures presented in Table 1, one has improved, 3 showed no (or limited) change and 5 have not improved over time.

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

Table 1: Trends for selected preventative health indicators[a]

Measure	Trend	Period
PI09: Smoking status recorded[b]	×	June 2021 to June 2023
PI10: ex-smoker/never smoked[b]	≈	June 2021 to June 2023
PI16: Alcohol consumption status recorded	×	June 2017 to June 2023
PI03: Health check – aged 15 and over[b]	×	December 2020 to June 2023
PI20: Risk factors to enable CVD assessment	≈	June 2017 to June 2023
PI21: low absolute cardiovascular risk	≈	June 2017 to June 2023
PI22: Cervical screening[c]	√	December 2020 to June 2023
PI14: Immunised against influenza[b]	×	December 2020 to June 2023
PI12: BMI – normal weight[b]	×	December 2021 to June 2023

a. Trend is calculated as a linear trend of proportions in comparable periods between the June 2017 and June 2023 collection periods, including the December collection periods. Comparable periods may vary between indicators, for example, if there is a break in series. Where there has been a break in series, only the trend following the break is presented in Table 1. For data over time for all available periods see Data. For trends before and after a break in series see the visualisations on each indicator pages.

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

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

Notes

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

Source: nKPI data collection.

For more information preventative health indicators see the page for each indicator and Data.

Smoking (PI09 and PI10)

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

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

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

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

There have been changes to the specifications of these indicators over time. For more information see Interpreting nKPI data.

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

Why not smoking is important

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

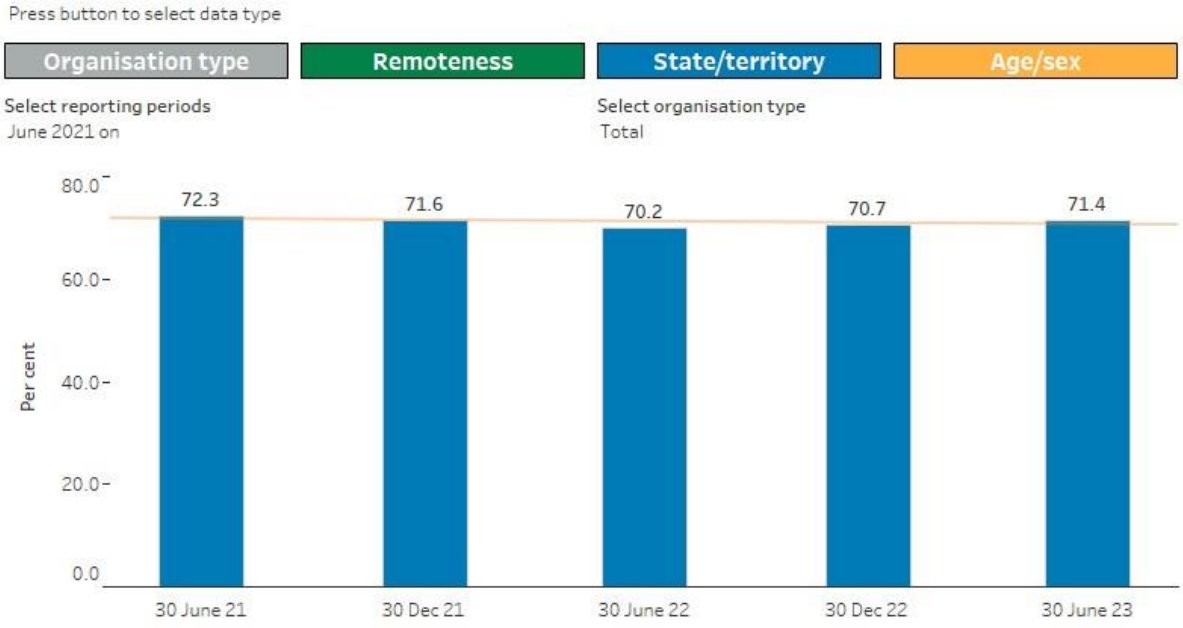
It is an important cause of preventable ill health and death in Australia and is a leading risk factor for the development of many chronic health conditions and premature death. Health conditions often affected by tobacco smoking include many types of cancer, respiratory disease and heart disease.

Data from the Australian Bureau of Statistics' 2018–19 National Aboriginal and Torres Strait Islander Health Survey show that the proportion of First Nations adults who smoke has decreased over time. First Nations adults, however, are more likely to smoke than non-Indigenous adults (AIHW 2023).

Smoking status recorded (PI09)

At June 2023, 71% (or around 212,000) of First Nations regular clients aged 11 and over had their smoking status recorded within the previous 24 months (Figure 1).

Figure 1: Smoking status recorded by reporting period



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

Notes

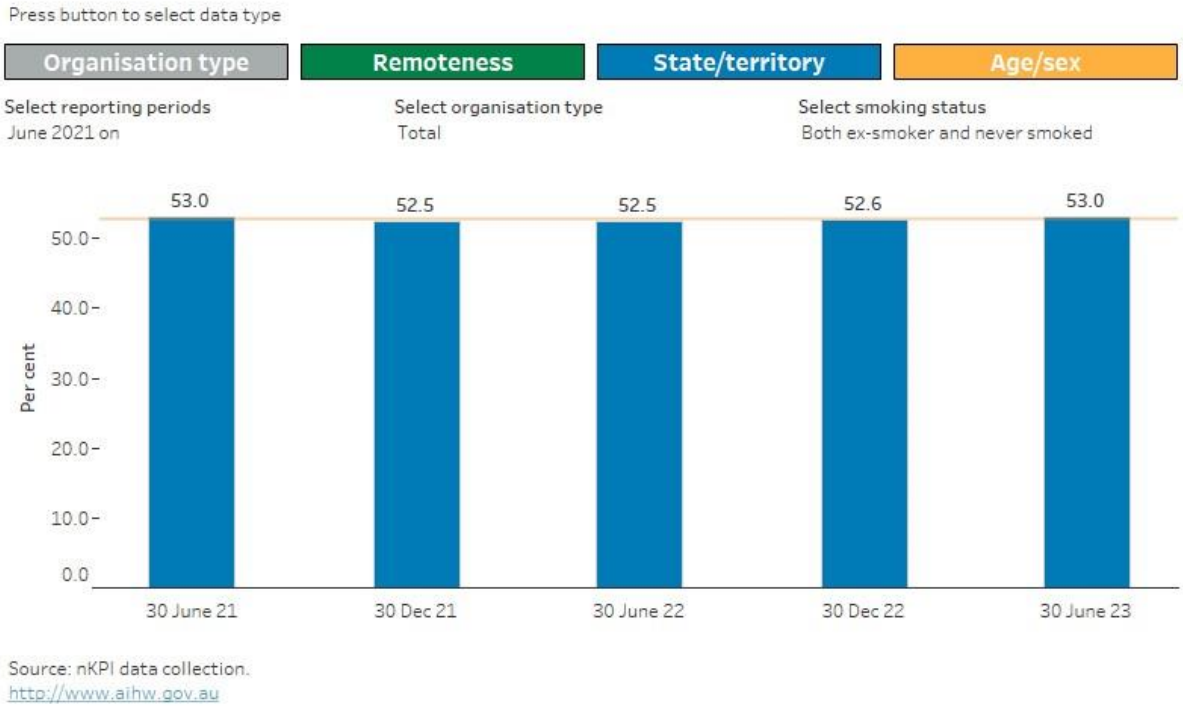
1. In June 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. For more information see Interpreting nKPI data.

2. For more information, including on interpreting changes over time, see Technical notes.

Smoking status result (PI10)

At June 2023, 47% (or around 100,000) of First Nations regular clients aged 11 and over were current smokers, 38% (80,300) had never smoked and 15% (31,900) were ex-smokers (Figure 2).

Figure 2: Smoking status result by reporting period



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

Notes

1. In June 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods for all ages or the total. For more information see Interpreting nKPI data.

2. For more information, including on interpreting changes over time, see Technical notes.

For more information on smoking status see Data.

Reference

AIHW (Australian Institute of Health and Welfare) (2023) *Aboriginal and Torres Strait Islander Health Performance Framework: tobacco use*, AIHW, Australian Government, accessed 11 December 2023.

Alcohol consumption (PI16)

This indicator is the proportion of First Nations regular clients aged 15 and over who had their alcohol consumption status recorded within the previous 24 months.

It is collected for males and females in age groups:

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

Why recording alcohol consumption is important

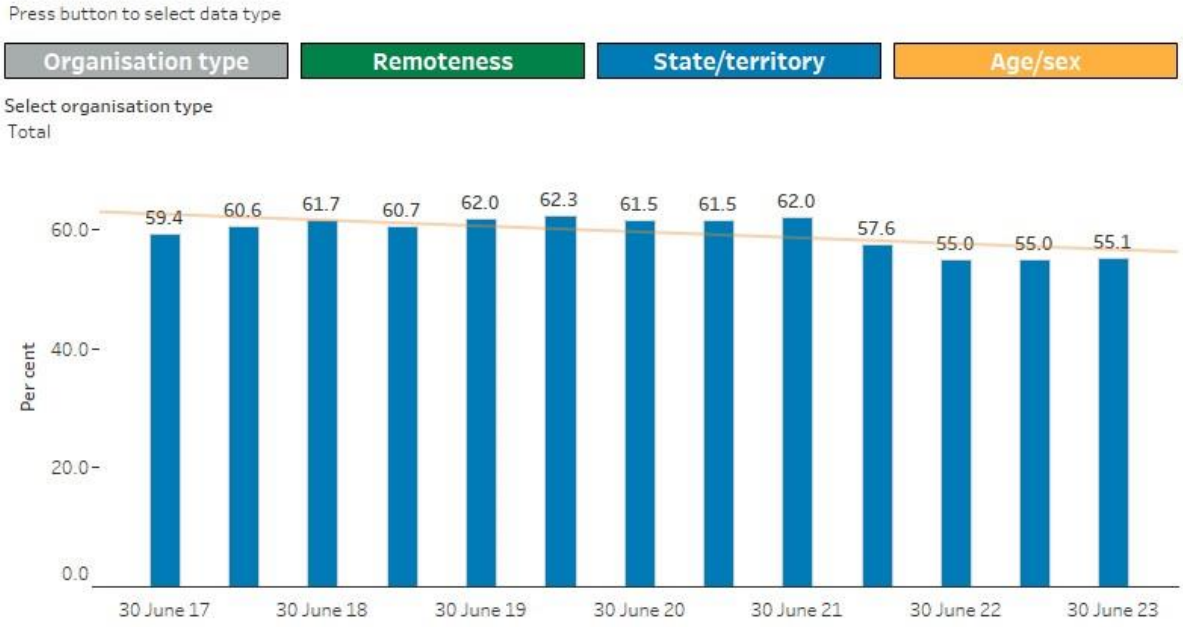
Alcohol consumption refers to the consumption of drinks containing ethanol, commonly referred to as alcohol. The quantity, frequency or regularity with which alcohol is drunk provides a measure of the level of alcohol consumption.

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

Data from the Australian Bureau of Statistics' 2018–19 National Aboriginal and Torres Strait Islander Health Survey show that the proportion of First Nations people aged 15 and over who did not drink alcohol in the last 12 months has increased in recent years, and they were also more likely than non-Indigenous Australians to have not drunk alcohol in the previous 12 months (AIHW 2023).

At June 2023, 55% (or around 150,000) of First Nations regular clients aged 15 and over had their alcohol consumption status recorded within the previous 24 months (Figure 1).

Figure 1: Alcohol consumption status recorded by reporting period



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

Note: For more information, including on interpreting changes over time, see Technical notes.

For more information on alcohol consumption see Data.

Reference

AIHW (Australian Institute of Health and Welfare) (2023) *Aboriginal and Torres Strait Islander Health Performance Framework: risky alcohol consumption*, AIHW, Australian Government, accessed 11 December 2023.

Health check – aged 15 and over (PI03)

This indicator is the proportion of First Nations regular clients aged 15 and over who had an Aboriginal and Torres Strait Islander Peoples Health Assessment (health check) completed within the previous 24 months.

It is collected for males and females in age groups:

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

There have been changes to the specifications of this indicator over time. For more information see Interpreting nKPI data.

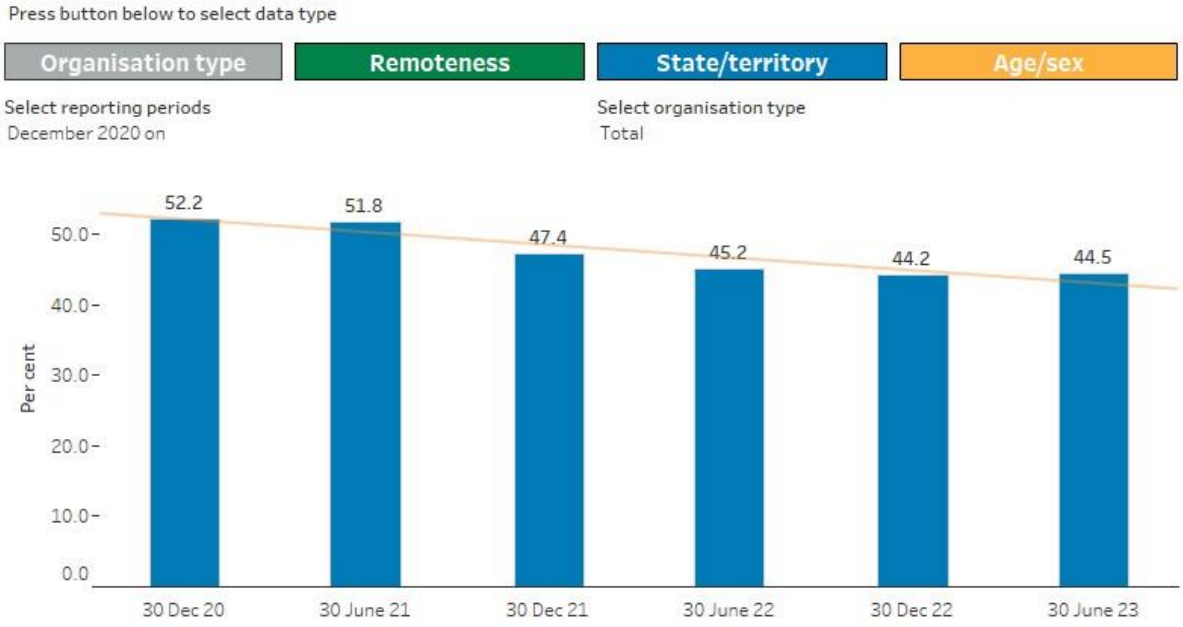
Ages 0–14 are also collected for PI03, with data presented under the Maternal and child health domain.

Why health checks are important

Through Medicare, First Nations people can receive an Aboriginal and Torres Strait Islander Peoples Health Assessment from their doctor, as well as referrals for follow-up services. The Aboriginal and Torres Strait Islander Peoples Health Assessment was introduced in recognition that First Nations people, as a group, experience some particular health risks. The aim of the health check is to encourage early detection and treatment of common conditions that cause ill health and early death – for example, diabetes and heart disease.

At June 2023, 45% (or around 121,000) of First Nations regular clients aged 15 and over had a health check completed within the previous 24 months (Figure 1).

Figure 1: Health check aged 15 and over by reporting period



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

Notes

1. In December 2020, specifications changed for this indicator and data from that point on cannot be compared with previous periods. For more information see Interpreting nKPI data.

2. For more information, including on interpreting changes over time, see Technical notes.

For more information on health checks for ages 15 and over see Data.

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

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

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

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

- 35–44
- 45–54
- 55–64
- 65–74.

Why CVD risk assessment is important

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

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

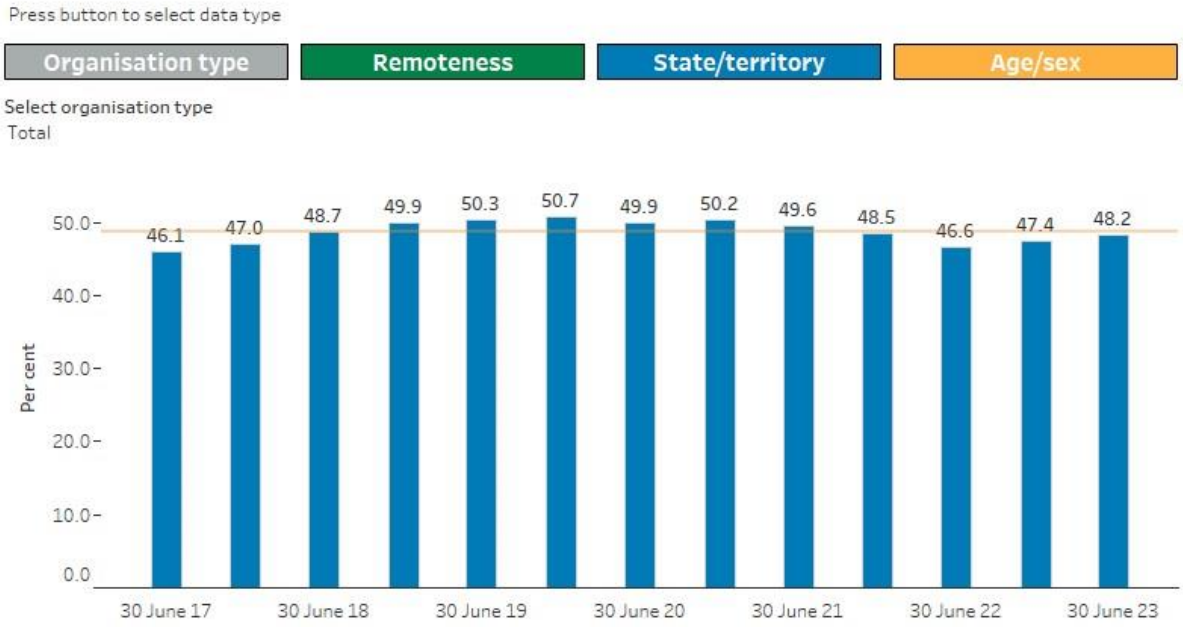
Absolute CVD risk assessment combines risk factors to calculate the probability that an individual will develop a cardiovascular event or other vascular disease within a specified time frame (usually 5 years) (RACGP 2018).

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

Cardiovascular disease risk assessment (PI20)

At June 2023, 48% (or around 59,300) of First Nations regular clients aged 35–74 with no known history of CVD had the necessary risk factors recorded within the previous 24 months to assess their absolute CVD risk (Figure 1).

Figure 1: CVD risk assessment by reporting period



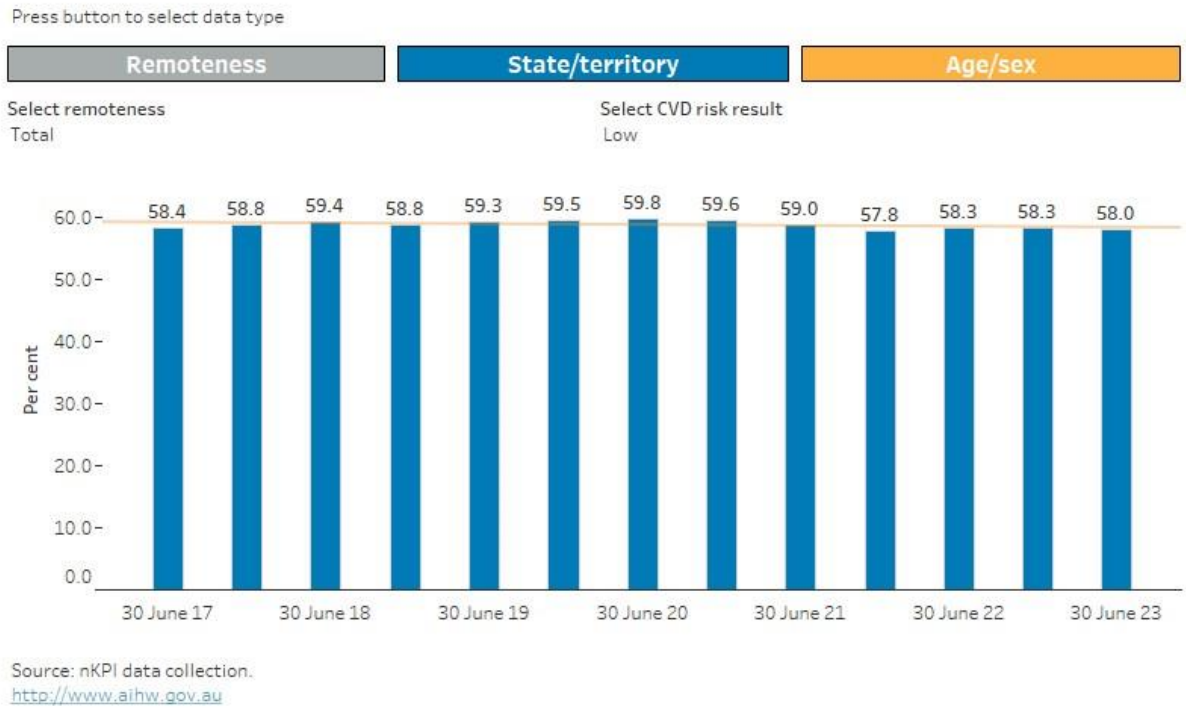
Source: nKPI data collection.
http://www.aihw.gov.au

Note: For more information, including on interpreting changes over time, see Technical notes.

Cardiovascular disease risk assessment result (PI21)

At June 2023, 58% (or around 6,600) of First Nations regular clients aged 35–74 with no known history of CVD who had an absolute CVD risk recorded within the previous 24 months had a low absolute CVD risk, 7% (850) moderate and 35% (4,000) high (Figure 2).

Figure 2: CVD risk assessment result by reporting period



Note: For more information, including on interpreting changes over time, see Technical notes.

For more information on cardiovascular disease risk assessment see Data.

References

Agostino J, Wong D, Paige E, Wade V, Connell C, Davey ME, Peiris DP, Fitzsimmons D, Burgess CP, Mahoney R, Lonsdale E, Fernando P, Malamoo L, Eades S, Brown A, Jennings G, Lovett RW and Banks E (2020) *Cardiovascular disease risk assessment for Aboriginal and Torres Strait Islander adults aged under 35 years: a consensus statement*. *Medical Journal of Australia*, 212(9):422–427, doi:10.5694/mja2.50529, accessed 1 November 2023.

AIHW (Australian Institute of Health and Welfare) (2021) *Cardiovascular disease*, Cat. no. CVD 83, AIHW, Australian Government, accessed 1 November 2023.

RACGP (The Royal Australian College of General Practitioners) (2018) *Guidelines for preventive activities in general practice. 9th edition, updated*, RACGP, accessed 1 November 2023.

Cervical screening (PI22)

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

It is collected for females in age groups:

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

There have been changes to the specification of this indicator over time. For more information see Interpreting nKPI data.

Why cervical screening is important

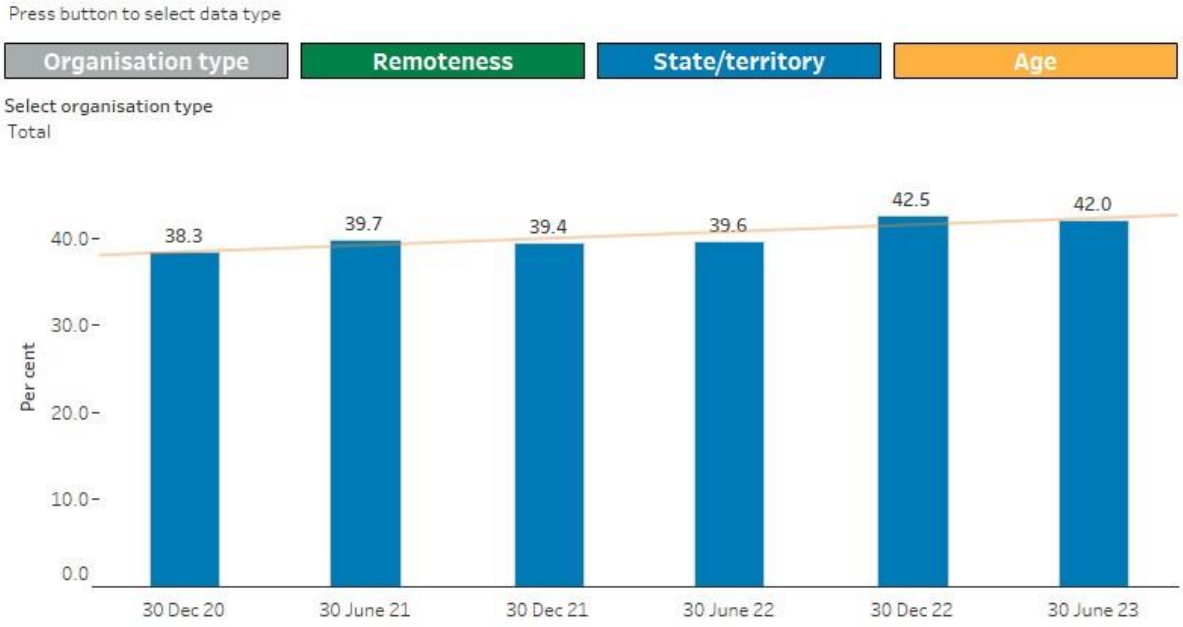
Cervical screening aims to detect and treat precancerous abnormalities that might otherwise progress to cervical cancer. First Nations women generally experience a high burden from cervical cancer compared with non-Indigenous women (AIHW 2021).

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

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

At June 2023, 42% (or around 45,300) of female First Nations regular clients aged 25–74 who have not had a hysterectomy had a cervical screening test within the previous 5 years (Figure 1).

Figure 1: Cervical screening within the previous 5 years by reporting period



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

Note: For more information, including on interpreting changes over time, see Technical notes.

For more information on cervical screening see Data.

Reference

AIHW (Australian Institute of Health and Welfare) (2023) National Cervical Screening Program monitoring report 2023, Cancer series 141. Cat. no. CAN 157, AIHW, Australian Government, accessed 2 January 2024.

Immunised against influenza (PI14)

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

It is collected for males and females in age groups:

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

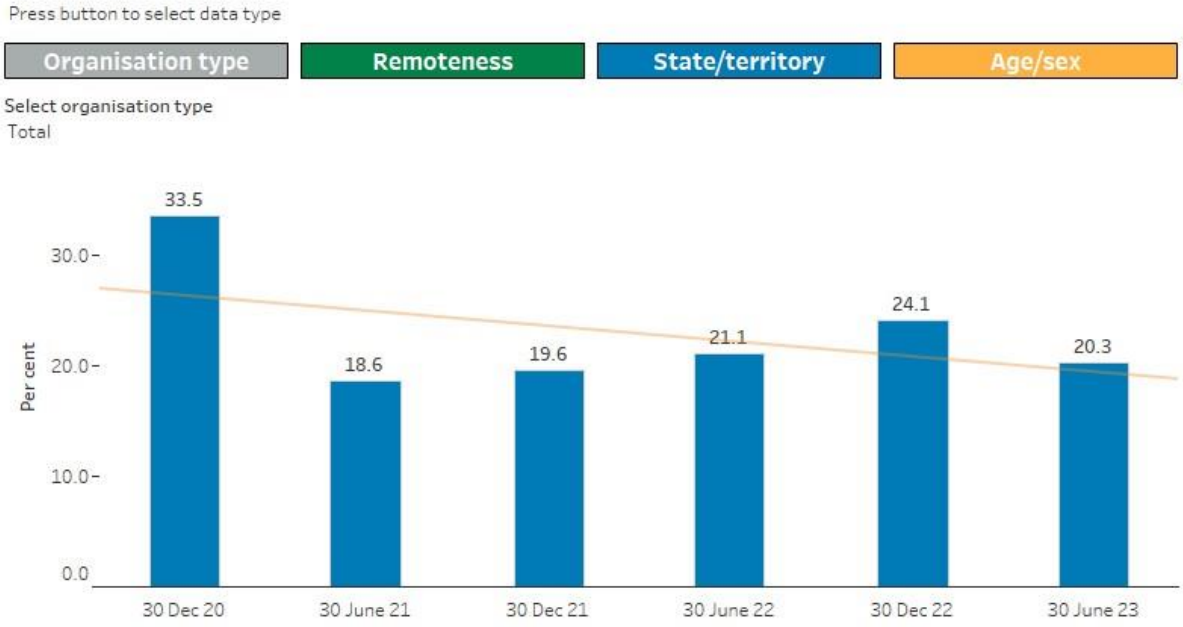
There have been changes to the specification of this indicator over time. For more information see Interpreting nKPI data.

Why immunisation against influenza is important

Influenza (the flu) is a contagious respiratory disease that causes seasonal epidemics in Australia. Anyone can be infected with influenza but some people, such as First Nations people, have a higher chance of serious illness and complications, such as pneumonia. Some people with influenza die as a result of their infection. Annual influenza vaccination substantially reduces the risk of hospitalisation and death from influenza and pneumonia for First Nations people (AIHW 2023).

At June 2023, 20% (or around 76,000) of First Nations regular clients aged 6 months and over received an influenza immunisation within the previous 12 months (Figure 1).

Figure 1: Immunised against influenza by reporting period



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

Notes

1. In December 2020, specifications changed for this indicator and data from that point on cannot be compared with previous periods. For more information see Interpreting nKPI data.

2. For more information, including on interpreting changes over time, see Technical notes.

For more information on influenza immunisation see Data.

Reference

AIHW (Australian Institute of Health and Welfare) (2023) *Aboriginal and Torres Strait Islander Health Performance Framework: immunisation*, AIHW, Australian Government, accessed 1 November 2023.

Body Mass Index (BMI) (PI12)

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

It is reported here in 2 parts as the proportion of First Nations regular clients aged 18 and over who, within the previous 24 months, had:

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

It is collected for males and females in age groups:

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

There have been changes to the specification of this indicator over time. For more information see Interpreting nKPI data.

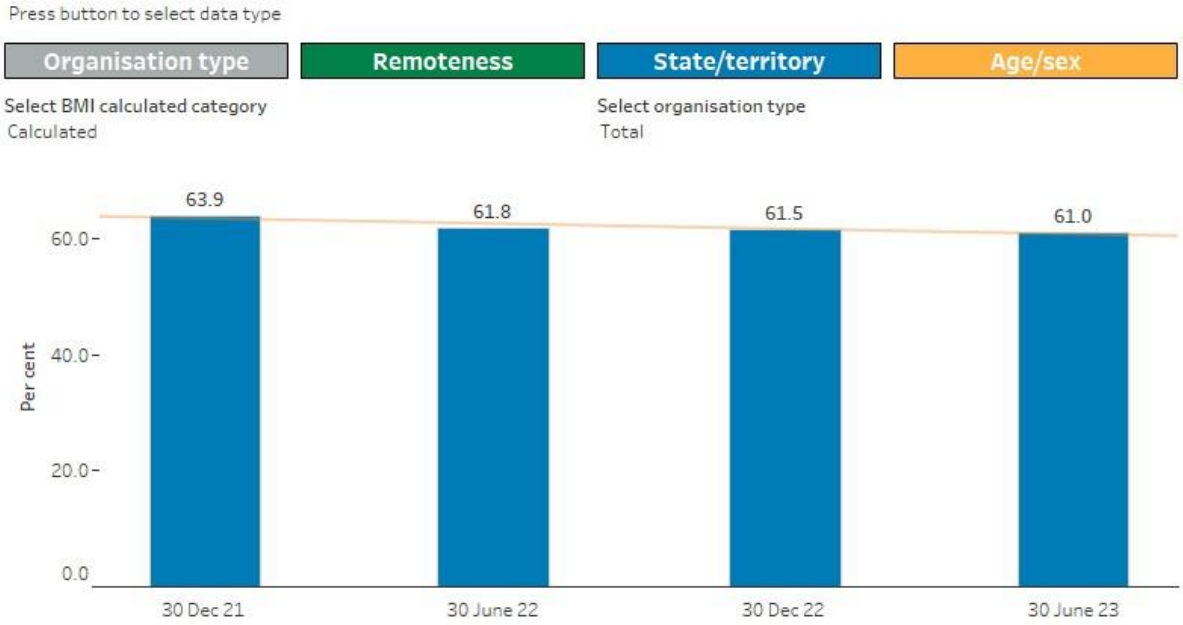
Why weight is important

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

Data from the Australian Bureau of Statistics' 2018–19 National Aboriginal and Torres Strait Islander Health Survey show that First Nations people aged 15 and over are less likely to be of normal weight than non-Indigenous Australians (AIHW 2023). The proportion of First Nations people who are of normal weight has decreased over time.

At June 2023, 61% (or around 152,000) of First Nations regular clients aged 18 and over had their BMI calculated, 39% (97,300) had not (Figure 1).

Figure 1: Whether Body Mass Index (BMI) was calculated by reporting period



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

Notes

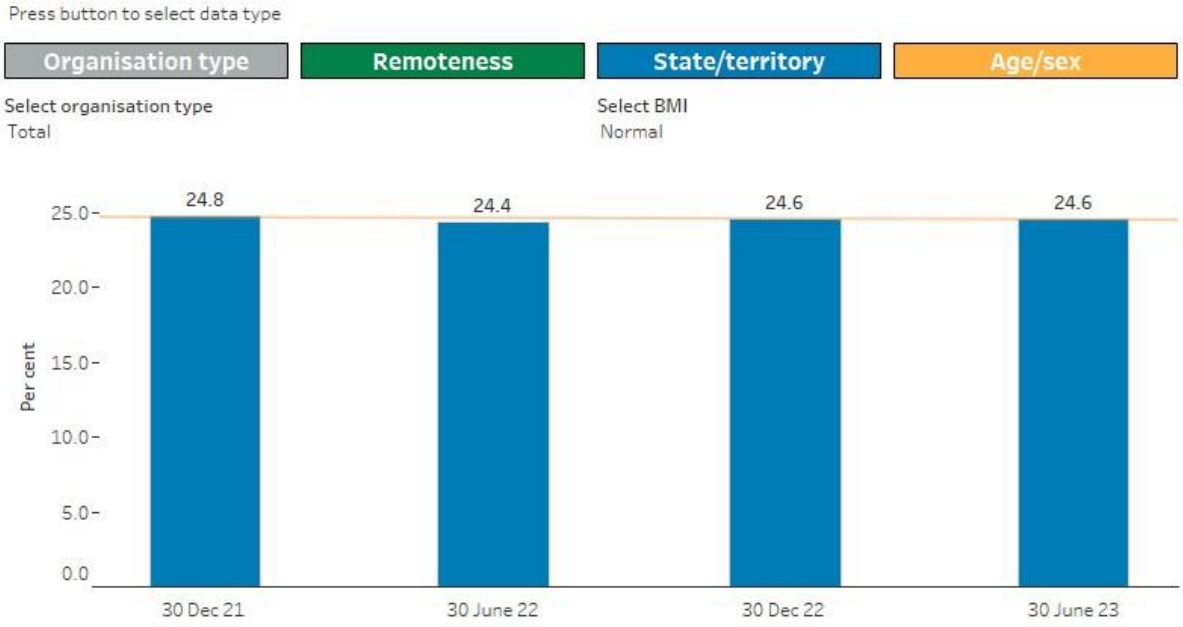
1. In December 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods for all categories, age groups or the total. For more information see Interpreting nKPI data.

2. For more information, including on interpreting changes over time, see Technical notes.

Of those with their BMI recorded:

- 25% (or around 37,300) were of normal weight
- 26% (or around 39,200) were overweight
- 45% (or around 67,800) were obese
- 5% (or around 7,600) were underweight (Figure 2).

Figure 2: Body Mass Index (BMI) result by reporting period



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

Notes

1. In December 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods for all categories, age groups or the total. For more information see Interpreting nKPI data.
2. Proportions are calculated using the denominator of First Nations regular clients with BMI recorded.
3. For more information, including on interpreting changes over time, see Technical notes.

For more information on BMI see Data.

Reference

AIHW (Australian Institute of Health and Welfare) (2023) *Aboriginal and Torres Strait Islander Health Performance Framework: overweight and obesity*, AIHW, Australian Government, accessed 11 December2023.

nKPI – chronic disease management indicators

Of the 9 chronic disease management measures presented in Table 1, 4 have improved, 2 show no (or limited) change and 3 have not improved over time.

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

Table 1: Trends for selected chronic disease management indicators[(a)]

Measure	Trend	Period
PI07: Chronic Disease Management Plan – type 2 diabetes[(b)]	×	December 2020 to June 2023
PI23: Blood pressure result recorded – type 2 diabetes	×	June 2017 to June 2023
PI24: Blood pressure result of ≤140/90mmHg – type 2 diabetes[(c)]	≈	June 2021 to June 2023
PI05: HbA1c result recorded (previous 6 months) – type 2 diabetes	×	June 2017 to June 2023
PI06: HbA1c result of ≤53 mmol/mol – type 2 diabetes	≈	June 2017 to June 2023
PI18: Kidney function test recorded (both eGFR and ACR) – type 2 diabetes[(b)]	√	June 2022 to June 2023
PI19: Kidney function test result of 'normal risk' – type 2 diabetes[(c)]	√	June 2022 to June 2023
PI18: Kidney function test recorded (both eGFR and ACR) – CVD[(c)]	√	June 2022 to June 2023
PI19: Kidney function test result of 'normal risk' – CVD[(c)]	√	June 2022 to June 2023

a. Trend is calculated as a linear trend of proportions in comparable periods between the June 2017 and June 2023 collection periods, including the December collection periods. Comparable periods may vary between indicators, for example, if there is a break in series. Where there has been a break in series, only the trend following the break is presented in Table 1. For data over time for all available periods see Data. For trends before and after a break in series see the visualisations on each indicator pages.

b. There have been changes to the specification of this indicator over time, however, data can be compared between periods with caution. For more information see Interpreting nKPI data.

c. There have been changes to the specification of this indicator over time. Data are not comparable over time for some components of this indicator. For more information see Interpreting nKPI data.

Notes

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

2. Some of the indicators in the national Key Performance Indicators (nKPI) collection have, or can be split into, more than one part.

3. Reporting to the nKPI collection for June 2020, December 2020 and June 2021 was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19.

4. For more information, including on interpreting changes over time, see Technical notes.

Source: nKPI data collection.

For more information on chronic disease management indicators see the page for each indicator and Data.

Chronic Disease Management Plan – type 2 diabetes (PI07)

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

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

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

There have been changes to the specification of this indicator over time. For more information see Interpreting nKPI data.

Why a Chronic Disease Management Plan is important

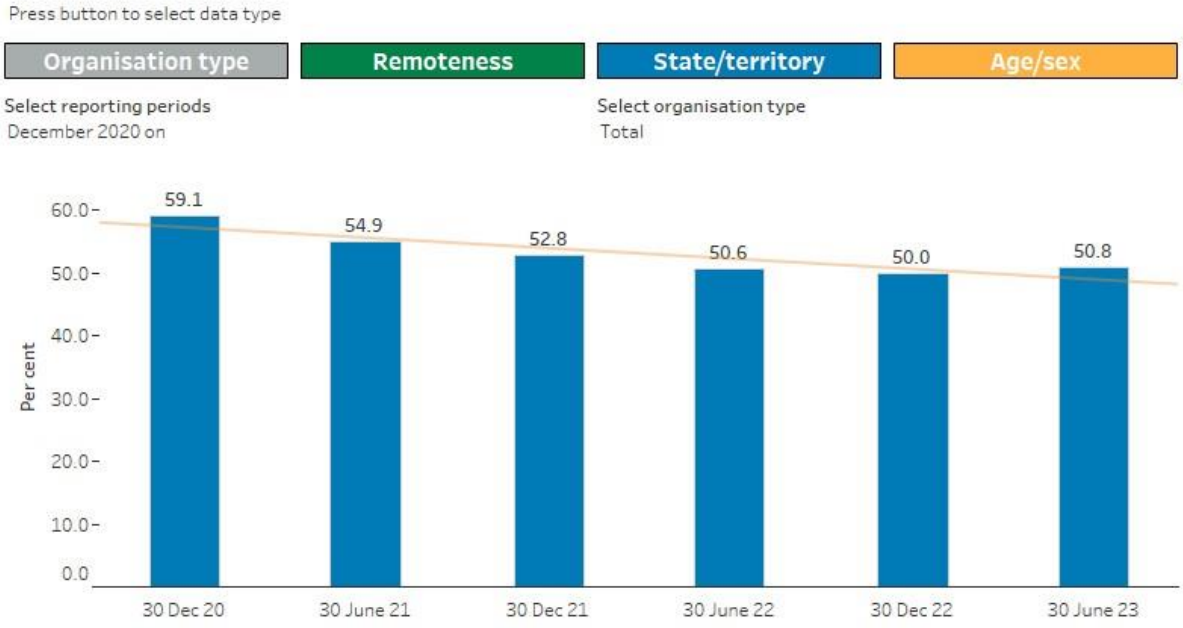
Much of the burden of disease among First Nations people is due to chronic disease.

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

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

At June 2023, 51% (or around 25,500) of First Nations regular clients with type 2 diabetes had a Chronic Disease Management Plan prepared within the previous 24 months (Figure 1).

Figure 1: Chronic Disease Management Plan – type 2 diabetes – by reporting period



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

Notes

1. In December 2020, specifications changed for this indicator and data from that point on cannot be compared with previous periods. For more information see Interpreting nKPI data.

2. For more information, including on interpreting changes over time, see Technical notes.

For more information on Chronic Disease Management Plans see Data.

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

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

- Blood pressure result recorded – type 2 diabetes (PI23): the proportion of First Nations regular clients with type 2 diabetes whose blood pressure result was recorded within the last 6 months.
- Blood pressure result – type 2 diabetes (PI24): the proportion of First Nations regular clients with type 2 diabetes whose blood pressure result recorded within the last 6 months was less than or equal to 140/90mmHg. There have been changes to the specification of this indicator over time. For more information see Interpreting nKPI data.

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

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

Why blood pressure result is important

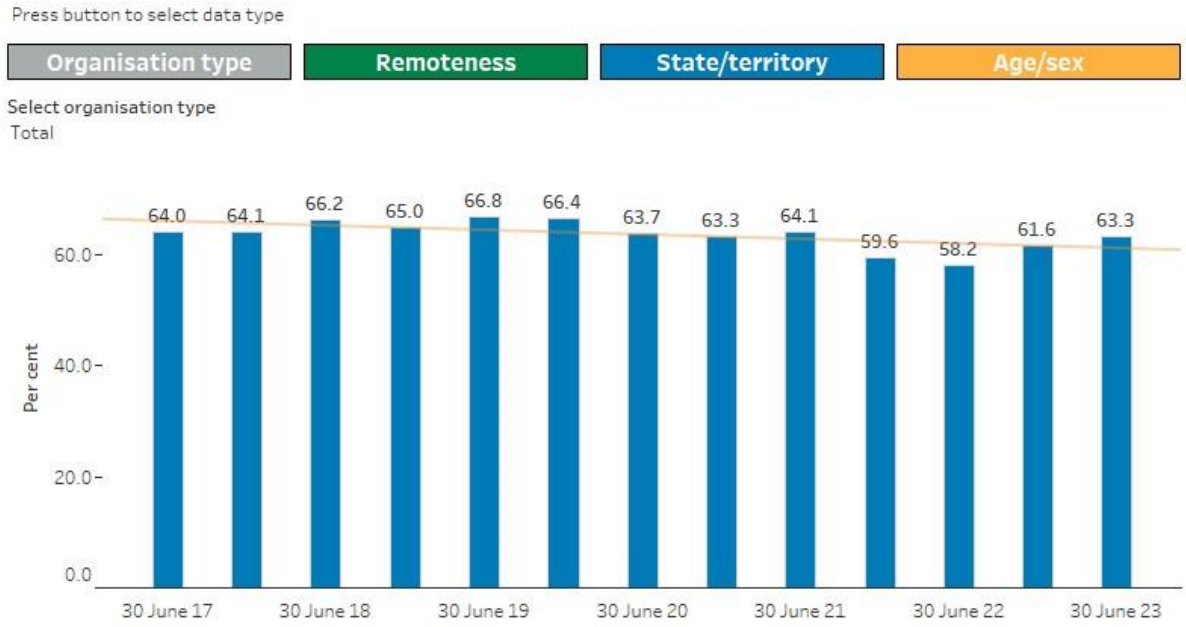
Blood pressure is the force exerted by the blood on the walls of the arteries and is written as systolic/diastolic (for example, 120/80 mmHg, stated as '120 over 80'). High blood pressure – also known as hypertension – is a risk factor for chronic conditions, including stroke, coronary heart disease,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

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

Blood pressure result recorded – type 2 diabetes (PI23)

At June 2023, 63% (or around 32,100) of First Nations regular clients with type 2 diabetes had their blood pressure result recorded within the last 6 months (Figure 1).

Figure 1: Blood pressure result recorded – type 2 diabetes – by reporting period



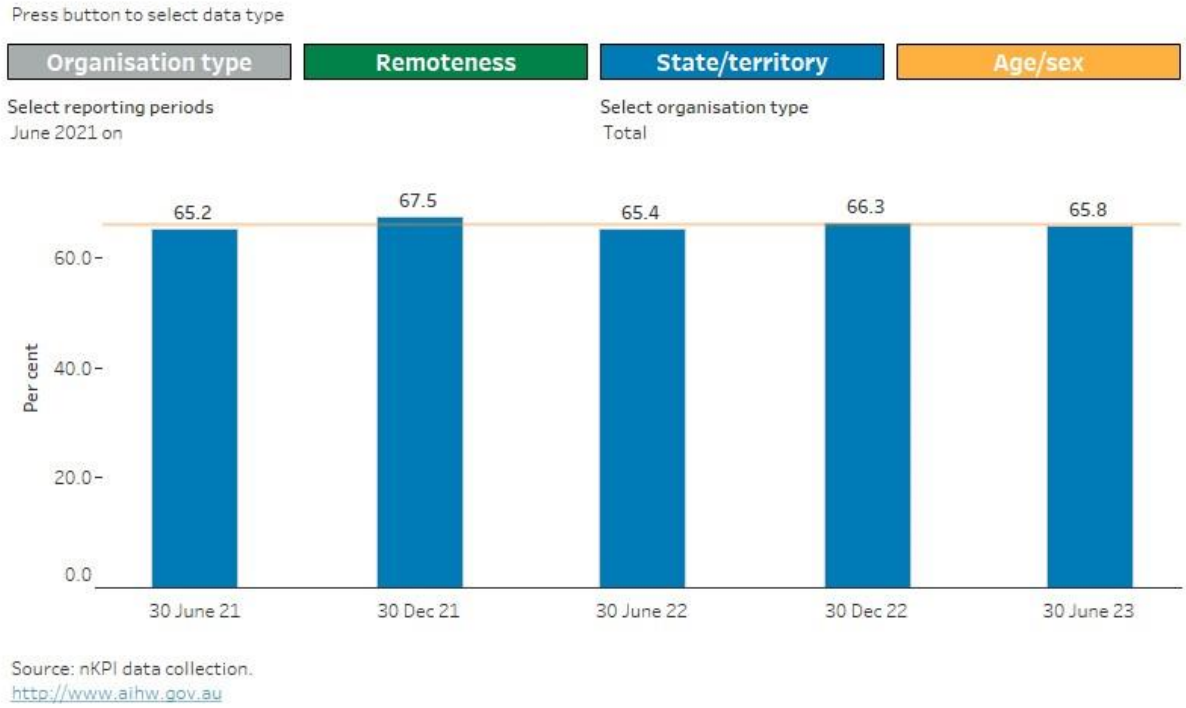
Source: nKPI data collection.
http://www.aihw.gov.au

Note: For more information, including on interpreting changes over time, see Technical notes.

Blood pressure result – type 2 diabetes (PI24)

At June 2023, 66% (or around 21,100) of First Nations regular clients with type 2 diabetes had a blood pressure result recorded within the last 6 months of less than or equal to 140/90mmHg (Figure 2).

Figure 2: Blood pressure result – type 2 diabetes – by reporting period



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

Notes

1. In June 2021, specifications changed for this indicator and data from that point on cannot be compared with previous periods. For more information see Interpreting nKPI data.

2. For more information, including on interpreting changes over time, see Technical notes.

For more information on blood pressure result see Data.

Reference

RACGP (The Royal Australian College of General Practitioners) (2020) *Management of type 2 diabetes: a handbook for general practice*, RACGP, accessed 1 November 2023.

HbA1c measurement – type 2 diabetes (PI05 and PI06)

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

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

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

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

Why HbA1c is important

The HbA1c (haemoglobin A1c or glycated haemoglobin) blood test gives an indication of whether blood glucose levels have been higher than normal over the preceding 6–8 weeks by looking at how much sugar (glucose) is bound in red blood cells. It is regarded as the gold standard for assessing glycaemic control.

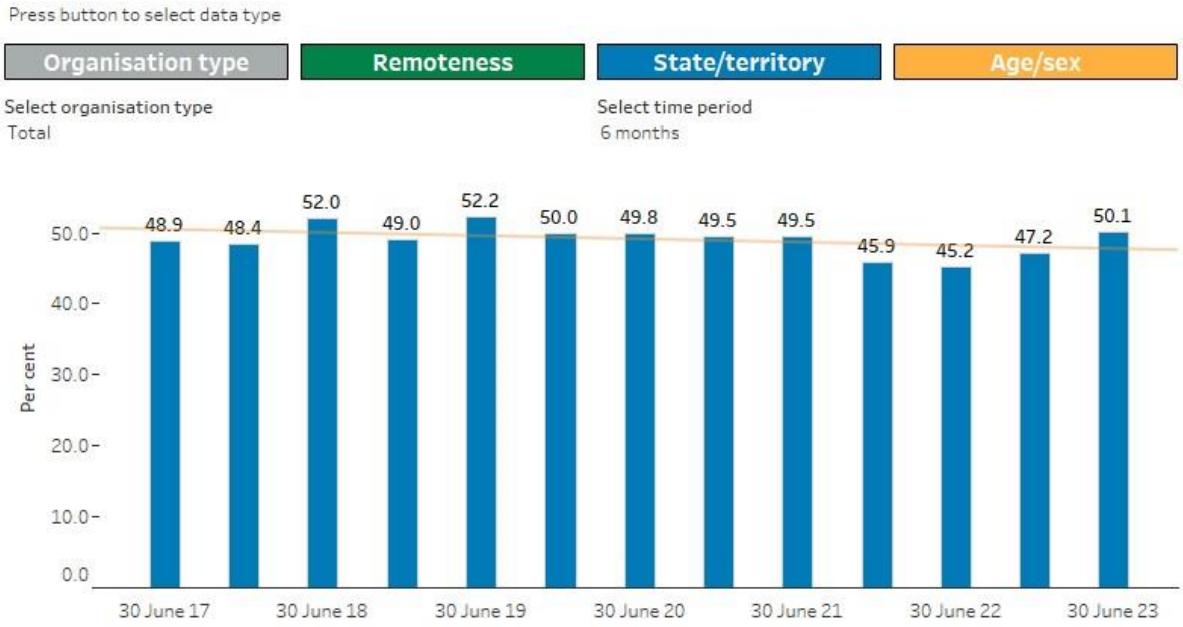
People who have diabetes need this test regularly to see if their levels are staying within range and whether they need to adjust their diabetes management. The general glycated haemoglobin (HbA1c) target in people with type 2 diabetes is ≤53 mmol/mol (≤7%) (RACGP 2020).

HbA1c result recorded – type 2 diabetes (PI05)

At June 2023, of First Nations regular clients with type 2 diabetes:

- 50% (or around 25,400) had an HbA1c measurement result recorded within the previous 6 months
- 66% (or around 33,200) had an HbA1c measurement result recorded within the previous 12 months (Figure 1).

Figure 1: HbA1c result recorded – type 2 diabetes – by reporting period and time period



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

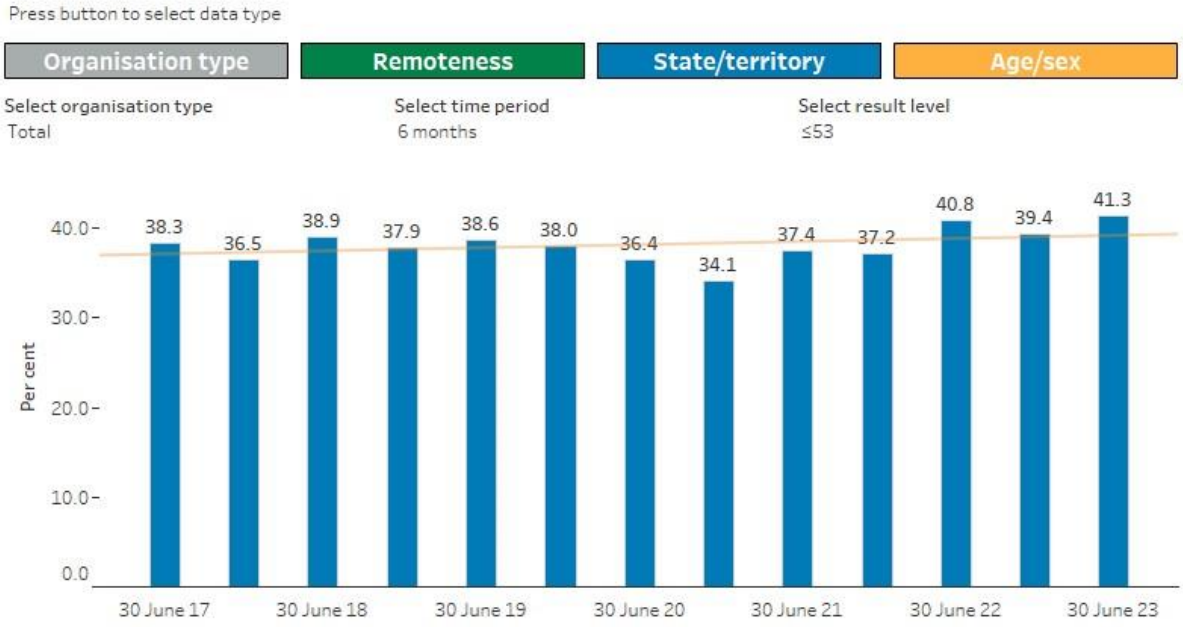
Note: For more information, including on interpreting changes over time, see Technical notes.

HbA1c result – type 2 diabetes (PI06)

At June 2023:

- 41% (or around 10,500) of First Nations regular clients with type 2 diabetes had an HbA1c measurement result of ≤53 mmol/mol recorded within the previous 6 months
- 42% (or around 13,800) had an HbA1c measurement result of ≤53 mmol/mol recorded within the previous 12 months (Figure 2).

Figure 2: HbA1c result – type 2 diabetes – by reporting period and time period



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

Note: For more information, including on interpreting changes over time, see Technical notes.

For more information on HbA1c results see Data.

Reference

RACGP (The Royal Australian College of General Practitioners) (2020) *Management of type 2 diabetes: a handbook for general practice*, RACGP, accessed 1 November 2023.

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

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

- Kidney function test type – type 2 diabetes and/or cardiovascular disease (CVD) (PI18): the proportion of First Nations regular clients aged 18 and over with type 2 diabetes and/or CVD who, within the previous 12 months, had:
  - both an estimated glomerular filtration rate (eGFR) AND an albumin/creatinine ratio (ACR) test result recorded
  - only an eGFR test result recorded
  - only an ACR test result recorded
  - neither an eGFR nor an ACR test result recorded.
- Kidney function test result (risk category) – type 2 diabetes and/or CVD (PI19): the proportion of First Nations regular clients aged 18 and over with type 2 diabetes and/or CVD who had both an eGFR and ACR test result recorded within the previous 12 months as either:
  - normal risk
  - low risk
  - moderate risk
  - high risk.

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

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

There have been changes to the specification of these indicators over time. For more information see Interpreting nKPI data.

Why testing kidney function is important

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

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

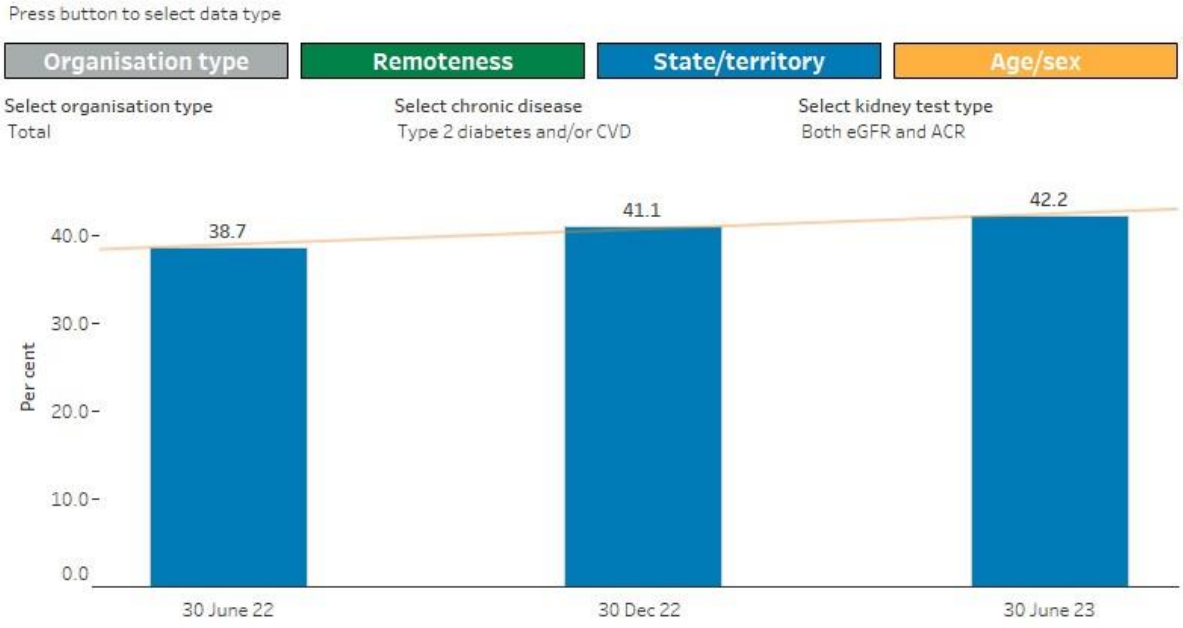
Data reported in the Aboriginal and Torres Strait Islander Health Performance Framework show that First Nations people are far more likely to develop, and to die from, chronic kidney disease than non-Indigenous Australians (AIHW 2023).

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

At June 2023, both an eGFR and an ACR test result was recorded within the previous 12 months for:

- 45% (or around 22,300) of First Nations regular clients aged 18 and over with type 2 diabetes
- 39% (or around 7,700) of First Nations regular clients aged 18 and over with CVD
- 42% (or around 24,800) of First Nations regular clients aged 18 and over with type 2 diabetes and/or CVD (Figure 1).

Figure 1: Kidney function test type – type 2 diabetes and/or CVD – by reporting period and kidney test type



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

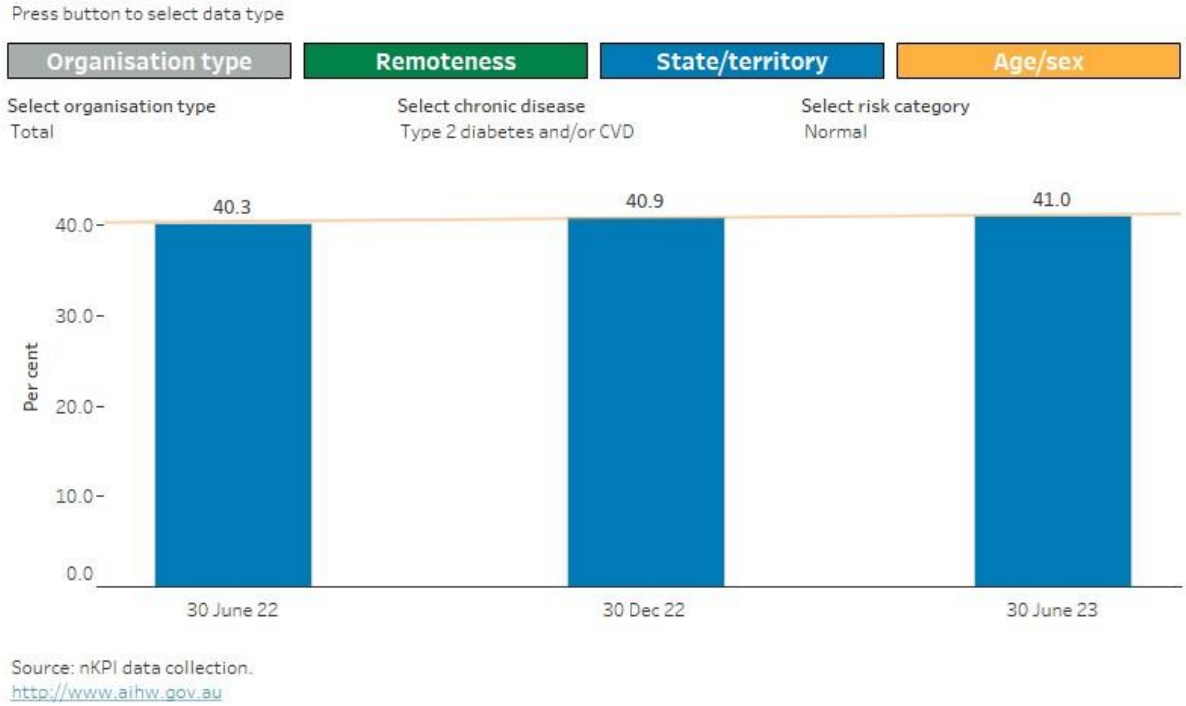
Note: For more information, including on interpreting changes over time, see Technical notes.

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

At June 2023, a risk category of 'normal' was recorded within the previous 12 months for:

- 39% (or around 8,500) of First Nations regular clients aged 18 and over with type 2 diabetes
- 41% (or around 3,100) of First Nations regular clients aged 18 and over with CVD
- 41% (or around 10,000) of First Nations regular clients aged 18 and over with type 2 diabetes and/or CVD (Figure 2).

Figure 2: Kidney function test result (risk category) – type 2 diabetes and/or CVD – by reporting period



Note: For more information, including on interpreting changes over time, see Technical notes.

For more information on kidney function test type see Data.

References

AIHW (Australian Institute of Health and Welfare) (2023) *Aboriginal and Torres Strait Islander Health Performance Framework: kidney disease*, AIHW, Australian Government, accessed 1 November 2023.

Kidney Health Australia (2020) *Chronic Kidney Disease (CKD) Management in Primary Care (4th edition)*, Kidney Health Australia, accessed 11 December 2023.

RACGP (The Royal Australian College of General Practitioners) (2020) *Management of type 2 diabetes: a handbook for general practice*, RACGP, accessed 1 November 2023.

Technical notes

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

Where to go for more information

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

- data tables accompanying this report – see Data
- nKPI and OSR data collection information – see the nKPI data collection guide and the Department of Health and Aged Care's Health Data Portal and OSR data collection information
- data quality statements for each collection – see Aboriginal and Torres Strait Islander specific primary health care key performance indicators (June 2023) and Online Services Report (OSR) for Aboriginal and Torres Strait Islander specific primary health care organisations (2022–23) and
- Department of Health and Aged Care's Health Data Portal.

In both collections, a client may attend more than one organisation. The extent to which this occurs is not known and is not adjusted for.

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

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

In this report, unless otherwise noted, data from the small number of organisations that received funding only to provide maternal and child health programs or services are included in nKPI data but are excluded from OSR data. These organisations should report only on funded activity and are primarily non-ACCHOs. For more information see Interpreting OSR data and Interpreting nKPI data.

Data collection and submission

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

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

Most CIS used by First Nations-specific primary health care organisations are able to extract, aggregate and upload the de-individualised data directly to the HDP through a direct-load process. Organisations with systems unable to complete the direct-load process can manually enter aggregate data directly into a web-based form through the HDP.

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

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

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

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

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

Comparisons over time

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

- While for the most part, it is the same organisations contributing to the collections, as a result of changes in funding, auspicing or reporting arrangements at the local level:
  - the organisations that are funded to provide services vary between periods
  - the funded organisations that are in-scope to report data vary between periods, for example, an organisation may be given an exemption from reporting for a specific period(s).

- Some organisations may be unable to report accurate data in particular periods or for particular data items (for example, because of changes in their CIS or record-keeping practices) and these data are excluded from national reporting. As such, the number of organisations submitting valid data, on the whole or for a particular data item, vary between periods.
- The impact of the COVID-19 pandemic, including associated changes in reporting requirements. For example, reporting for periods in 2019–20 and 2020–21 was made voluntary in acknowledgement of the additional pressures on organisations because of COVID-19 and there was an associated decrease in the number of organisations reporting in those periods. COVID-19 also affected the organisations reporting to the collections in a variety of other ways. For more information see Related material and Australia's Health 2022.

See also the Data Quality Statements for each collection in METEOR.

Estimated resident population (ERP)

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

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

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

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

Rounding

Numbers presented in tables and visualisations are unrounded.

The number of organisations presented in text are unrounded. All other numbers presented in text are rounded, according to the following rules:

- millions are rounded to one decimal place and written with a number and a word, for example, 10.2 million
- numbers over 100,000 and under a million are rounded to the nearest multiple of 1,000
- numbers between 1,000 and 100,000 are rounded to the nearest multiple of 100

- numbers between 500 and 999 are rounded to the nearest multiple of 10
- numbers between 100 and 499 are rounded to the nearest multiple of 5
- numbers between 0 and 99 are rounded to the nearest whole number.

Averages and proportions presented in text, tables and visualisations are rounded to one decimal place.

Interpreting OSR data

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

Where to go for more information

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

- data tables accompanying this report – see Data
- data quality statements for the OSR collection – see Online Services Report (OSR) for Aboriginal and Torres Strait Islander specific primary health care organisations (2022–23)
- Department of Health and Aged Care's Health Data Portal OSR data collection information.

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

Organisational participation and data exclusions

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

Table 1: Participation rate of OSR organisations

Collection period	In-scope to report data	Reported data	Participation rate (%)
2018–19	232	232	100.0
2019–20	235	215	91.5
2020–21	238	211	88.7
2021–22	234	230	98.3
2022–23	233	232	99.6

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

Table 2: Participation rate of OSR primary health care organisations

Collection period	In-scope to report data	Reported data	Participation rate (%)
2018–19	210	210	100.0
2019–20	215	196	91.2
2020–21	218	191	87.6
2021–22	215	211	98.1
2022–23	214	213	99.5

Note: Excludes maternal and child health organisations.

For the organisation that do report data, particular data items may be excluded from analysis if data quality issues have not been resolved. Common data quality queries received during data submission relate to:

- incomplete or inaccurate data (for example, workforce positions not reported or reported in terms of the number of people rather than full-time equivalent positions)
- data discrepancies between 2 or more questions (for example, the number of clients exceeding the number of episodes of care)
- large increases or decreases in data items compared with previous submissions.

Where significant data quality issues remain after follow-up with organisations, affected data are excluded from analyses. This varies by year and by data item (Tables 3 and 4).

Because OSR data items are generally reported by all organisations, a consistent number of organisations contribute to each result in each period unless there are data exclusions.

Table 3: OSR organisations with unresolved data quality issues

Collection period	Number of organisations with unresolved issues	Total number of organisations that reported data	Organisations with unresolved issues (%)	Data items excluded
2018–19	5	232	2.2	10
2019–20	2	215	0.9	3
2020–21	6	211	2.8	6

Collection period	Number of organisations with unresolved issues	Total number of organisations that reported data	Organisations with unresolved issues (%)	Data items excluded
2021–22	15	230	6.5	20
2022–23	2	230	0.9	2

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

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

Collection period	Number of organisations with unresolved issues	Total number of organisations that reported data	Organisations with unresolved issues (%)	Data items excluded
2018–19	4	210	1.9	5
2019–20	2	196	1.0	3
2020–21	6	191	3.1	6
2021–22	15	211	7.1	20
2022–23	2	213	0.9	2

Note: Excludes maternal and child health organisations.

Maternal and child health organisations

In this report, unless otherwise noted, data from the small number of organisations that received funding only to provide maternal and child health programs or services are excluded. This is because these organisations (referred to as maternal and child health organisations) are significantly different from other organisations reporting to the OSR collection, both in terms of what they are funded for and what they report.

Maternal and child health organisations should only report activity funded under the Indigenous Australians Health Programme (IAHP) but some report all activity and this varies by period. See also ‘Changes to the collection in 2018–19’.

Selected OSR data from maternal and child health organisations are provided in Data.

Changes to the collection in 2018–19

In 2018–19, the OSR collection underwent significant change to submission mechanism and content. In particular, in 2018–19 the collection:

- was moved into the Health Data Portal (previously submitted via OCHREStreams)
- was scaled back to include only 'core' items – items dropped include the substance use and social and emotional wellbeing modules, and the services provided and cultural safety items.

In addition, in collections prior to 2018–19, maternal and child health organisations:

- primarily answered different questions (in a separate module) to other organisations
- generally did not report data on number of clients, client contacts or episodes of care
- reported inconsistent workforce information, with some only reporting funded FTE while others reported more broadly.

Interpreting nKPI data

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

Where to go for more information

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

- data tables accompanying this report – see Data
- nKPI data collection information – see the nKPI data collection guide
- data quality statements for the nKPI collection – see Aboriginal and Torres Strait Islander specific primary health care key performance indicators (June 2023)
- Department of Health and Aged Care's Health Data Portal.

The national Key Performance Indicators (nKPI) collection is a set of process-of-care and health-status indicators organised under 3 domains – maternal and child health, preventative health and chronic disease management (Table 1a to Table 1c). Some indicators consist of more than one measure (for example, an indicator might be collected by different types of chronic disease).

Table 1a: Maternal and child health indicators, June 2023

Process-of-care indicators	Health-status indicators
PI13: First antenatal visit	PI02: Birthweight result
PI01: Birthweight recorded	PI11: Smoking during pregnancy
PI03: Health check – aged 0–14	

Table 1b: Preventative health indicators, June 2023

Process-of-care indicators	Health-status indicators
PI09: Smoking status recorded	PI10: Smoking status result
PI16: Alcohol consumption recorded	PI12: Body Mass Index (BMI)
PI03: Health check – aged 15 and over	PI21: CVD risk assessment result
PI20: CVD risk assessment recorded	

Process-of-care indicators	Health-status indicators
PI22: Cervical screening	
PI14: Immunisation against influenza	

Table 1c: Chronic disease management indicators, June 2023

Process-of-care indicators	Health-status indicators
PI07: Chronic Disease Management Plan – type 2 diabetes	PI24: Blood pressure result – type 2 diabetes
PI23: Blood pressure recorded – type 2 diabetes	PI06: HbA1c result – type 2 diabetes
PI05: HbA1c result recorded – type 2 diabetes	PI19: Kidney function test result (risk category) – type 2 diabetes and/or CVD
PI18: Kidney function test type – type 2 diabetes and/or CVD	

Data are collected twice a year, with census dates at 30 June and 31 December. The period of data covered varies by indicator. For example, for the 30 June 2023 census date, the data covers, depending on the indicator:

- 6 months up to the census date, that is, from, 1 January 2023 to 30 June 2023, or
- 12 months up to the census date, that is, from 1 July 2022 to 30 June 2023, or
- 24 months up to the census date, that is, from 1 July 2021 to 30 June 2023, or
- 5 years up to the census date, that is, from 1 July 2018 to 30 June 2023 (for cervical screening only).

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

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

Organisational participation and data exclusions

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

Table 2: Participation rate of nKPI organisations

Collection period	In-scope to report data	Reported data	Participation rate (%)
June 2017	228	228	100.0
December 2017	231	231	100.0
June 2018	236	233	98.7
December 2018	242	238	98.3
June 2019	240	234	97.5
December 2019	241	237	98.3
June 2020	236	220	93.2
December 2020	231	218	94.4
June 2021	232	215	92.7
December 2021	230	230	100.0
June 2022	230	230	100.0
December 2022	233	233	100.0
June 2023	233	233	100.0

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

Table 3: nKPI organisations with unresolved validation issues

Collection period	Number of organisations with unresolved issues	Total number of organisations that reported data	Organisations with unresolved issues (%)
June 2017	21	228	9.2
December 2017	25	231	10.8
June 2018	17	233	7.3
December 2018	2	238	0.8
June 2019	—	234	—
December 2019	—	237	—
June 2020	3	220	1.4
December 2020	6	218	2.8
June 2021	3	215	1.4
December 2021	17	230	7.4
June 2022	8	230	3.5
December 2022	6	233	2.6
June 2023	7	233	3.0

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

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

- Data from organisations using the MMEX CIS were excluded from data submitted in collections from June 2019 and earlier for indicators related to smoking and alcohol.
- PI13 (antenatal visits): data for some organisations using Communicare and Medical Director were affected by data extraction issues for June 2017, December 2017 and June 2018. This resulted in some categories being combined.

- PI20 (risk factors to enable a CVD risk assessment): MMEX results are excluded for June 2017.
- PI21 (CVD risk assessment result): data are only reportable from organisations with CIS which capture all data necessary to calculate a result (some CIS do not).
- PI22 (cervical screening): some data quality issues were identified with the initial June 2018 submission but these have been resolved for all other periods.
- PI18 and PI19 (kidney function test recorded and result) have had ongoing data quality issues since June 2017. Affected data were excluded.

Because of data exclusions, and because indicators may be applicable to different organisations (for example, maternal and child health organisations generally only report on maternal and child health indicators), the number of organisations contributing to results varies across indicators.

Changes to data extraction methods

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

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

Variations between CIS

There are variations between CIS and how each capture and extract results, in general and also between periods. For example:

- The PI09 smoking status recorded and PI10 smoking status result indicators specify that if a record does not have an assessment date assigned within the CIS, the record should be treated as current (that is, as having been updated within the previous 24 months). Whether the CIS capture all results or only those results updated within the previous 24 months varies between CIS. In particular, in June 2021, some CIS modified the inclusions for these indicators. The full impact of this has not been quantified but resulted in large decreases for some organisations between December 2020 and June 2021.
- In December 2021, the condition coding framework was introduced to align the codes used to define chronic diseases by the different CIS. Some CIS may have made changes to the condition codes for type 2 diabetes or CVD to bring their definition in line with the framework. This may have altered the number of clients included in PI05, PI06, PI07, PI18, PI19, PI20, PI21, PI23 and PI24.

Changes to indicators

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

Changes to indicators may impact interpretability of data over time (Table 4).

Table 4: Key changes to indicators over time and impact on time trends

Indicator	Changes	Impact on time trends
PI01 and PI02 (birthweight)	In June 2021, the definition for these indicators was adjusted to capture First Nations babies born in the previous 12 months who had more than one visit (previously included all First Nations babies born in the previous 12 months). In June 2021, multiple births were included in PI02 (previously these were only included in PI01).	Minimal
PI03 (health check)	In December 2020, the age range captured by this indicator was expanded to include all ages (previously did not include ages 5–24); disaggregation by sex for ages 0–4 was added; and included MBS items were expanded (from only MBS Item 715) to contain: in-	For ages 0–14: data from December 2020 on cannot be compared with previous period for ages 5–14 or the total; ages 0–4 can be compared with caution. For ages 15 and over: data from December 2020 on cannot be compared with previous periods for ages

Indicator	Changes	Impact on time trends
	person MBS items 715 and 228; and telehealth MBS items 92004, 92016, 92011 and 92023. In June 2023, included MBS items were updated to remove item numbers 92016 and 92023 which were no longer valid.	15–24 or the total; data for ages 25 and over can be compared with caution.
PI04 (childhood immunisation)	After December 2020, this indicator was retired.	Data last collected in December 2020.
PI07 (Chronic Disease Management Plan)	In December 2020, included MBS items were expanded (from only MBS Item 721) to contain: in-person MBS items 721 and 229; and telehealth MBS items 92024, 92068, 92055, and 92099. In June 2023, included MBS items were updated to remove item numbers 92068 and 92099 which were no longer valid.	Minimal
PI08 (Team Care Arrangement)	After June 2020, this indicator was retired.	Data last collected in June 2020.
PI09 and PI10 (smoking)	In June 2021, the age range captured by these indicators was expanded to include ages 11–14.	Data from June 2021 on cannot be compared with previous periods for the total. Data for ages 15 and over can be compared with caution. See also 'Variations between CIS'.
PI11 (smoking during pregnancy)	In June 2021, the definition of this indicator was adjusted to include only the latest smoking	Data from June 2021 on cannot be compared with previous periods for ages less than 20 or the

Indicator	Changes	Impact on time trends
	status recorded prior to the completion of the latest pregnancy (previously smoking status result was as recorded within the previous 12 months); and the lower age captured was expanded (age groupings changed to 'less than 20', '20–34' and '35 and older' from '15–19', '20–24', '25–34', and '35 and older').	total. Data for ages 20 and over can be compared with caution.
PI12 Body Mass Index (BMI)	In December 2021, the age range captured by this indicator was expanded to include ages 18–24 (previously ages 25 and over); and additional BMI categories were added for 'underweight (<18.50)', 'normal weight (18.50–24.99)', and 'not calculated' (previously overweight and obese only).	Data from December 2021 on for the total cannot be compared with previous periods. Data for overweight and obese categories for ages 25 and over can be compared with previous periods.
PI13 (first antenatal visit)	In June 2021, grouping of gestational age at first visit changed to 'before 11 weeks', '11–13 weeks', '14–19 weeks' and '20 weeks or later' 'did not have gestational age recorded', and 'did not attend an antenatal care visit' (previously 'less than 13 weeks', '13–less than 20 weeks', '20 weeks or later', 'no result recorded', and 'did not attend an antenatal care visit').	Data from June 2021 on for the total and some timing of visit categories cannot be compared with previous periods. Data on '20 weeks or later' can be compared. Data on whether or not there was antenatal care visit and whether or not gestational age was recorded at the first antenatal care visit can be compared with

Indicator	Changes	Impact on time trends
		caution back to December 2018.
PI14 (influenza immunisation)	In December 2020, the age range captured by this indicator was expanded to ages 6 months and over and age groups were added (previously ages 50 and over only with no further disaggregation by age).	Data from December 2020 on cannot be compared with previous periods.
PI15 (influenza immunisation – type 2 diabetes and/or COPD)	After June 2021, this indicator was retired.	Data last collected in June 2021.
PI17 (AUDIT-C)	After June 2022, this indicator was retired.	Data last collected in June 2022.
PI18 (kidney function test type)	In December 2021, the age range for this indicator was expanded to be for all ages (previously ages 15 and over), the test types recorded were revised, and the client group 'type 2 diabetes and/or CVD' was added. From June 2022, the age range for this indicator was changed to ages 18 and over.	Data from June 2022 on for the total cannot be compared with previous periods. Data for ages 25 and over can be compared.
PI19 (kidney function test result)	In December 2021 this indicator was not collected while modifications were made to its specifications. In June 2022, specifications for this indicator were adjusted to add the requirement for	Data from December 2021 cannot be compared with previous periods. Data from June 2022 on cannot be compared with previous periods.

Indicator	Changes	Impact on time trends
	both an eGFR and an ACR result to be recorded, add a client group category for 'type 2 diabetes and/or CVD', revise the age range to ages 18 and over (previously ages 15 and over), and revise the kidney function test result categories.	
PI22 (cervical screening)	In June 2018 to June 2020 – transitional changes were made to align with revised requirements under the National Cervical Screening Program (NCSP). The key changes were to include clients who had either a Papanicolaou smear (Pap test) conducted prior to 1 December 2017 or a human papillomavirus (HPV test) conducted from 1 December 2017; revise the age range to 20–74 to accommodate the former reporting age range (20–69) and the new age range (25–74). In December 2020 – the indicator was revised to collect only HPV tests conducted in the last 5 years where the test occurred on or after 1 December 2017.	Interpret with caution, noting minimal impact if intent is to look at meeting cervical screening requirements over time.
PI24 (blood pressure result)	In June 2021, the target blood pressure value was changed to 'less than or equal to 140/90mmHg'	Data from June 2021 on cannot be compared with previous periods.

Indicator	Changes	Impact on time trends
	(previously 'less than or equal to 130/80 mmHg').	

Maternal and child health organisations

A small number of organisations that received funding only to provide maternal and child health programs or services (referred to as maternal and child health organisations) are included in the nKPI data presented in this report. This is because, while their funding is provided only for specific programs or services within a broader organisation rather than to the broader organisation itself, the maternal and child health indicators included in the nKPI collection apply directly to the maternal and child health organisations and the aims of the programs or services they are funded to deliver are considered similar to the aims of maternal and child health care delivered within other reporting organisations.

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

Reference

AIHW (Australian Institute of Health and Welfare) (2018) *National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care: results for 2017*, National key performance indicators for Aboriginal and Torres Strait Islander primary health care series no. 5, Cat. no. IHW 200, AIHW, Australian Government, accessed 1 November 2023.

Glossary

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

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

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

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

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

- *Major cities* – collection districts (CDs) with an average ARIA index value between 0 and less than or equal to 0.2
- *Inner regional areas* – CDs with an average ARIA index value greater than 0.2 and less than or equal to 2.4
- *Outer regional areas* – CDs with an average ARIA index value greater than 2.4 and less than or equal to 5.92
- *Remote areas* – CDs with an average ARIA index value greater than 5.92 and less than or equal to 10.53
- *Very remote areas* – CDs with an average ARIA index value greater than 10.53.

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

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

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

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

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

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

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

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

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

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

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

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

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

First Nations people: People of Aboriginal or Torres Strait Islander descent who identify as an Aboriginal or Torres Strait Islander. The term 'Aboriginal and Torres Strait Islander' or 'Indigenous' may also be used in this report when referring to the name of an organisation or Program.

First Nations-specific primary health care organisations: Primary health care organisations that receive funding from the Department of Health and Aged Care to provide primary health care services mainly to First Nations people. The primary health care organisations include Aboriginal Community Controlled Health Organisations (ACCHOs), state and territory managed organisations, Primary Health Networks and other non-government organisations.

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

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

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

Indigenous status: Whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin.

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

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

mean: Average of a group of numbers.

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

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

non-Indigenous: A term used to describe people who have indicated that they are not of Aboriginal or Torres Strait Islander origin.

other Australians: People who indicated they are not of Aboriginal or Torres Strait Islander origin and those who did not state their Indigenous status.

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

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

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

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

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

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

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

Symbols

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

Notes

The latest available data for the Online Services Report (OSR) and the national Key Performance Indicators (nKPI) collections vary:

- The OSR collects contextual information once each financial year (1 July to 30 June) about reporting organisations, such as client numbers, client contacts, episodes of care, staffing levels and vacancies. The latest available data this report version are from the 2022–23 collection.
- The nKPI collects information twice a year (with census dates at 30 June and 31 December) on a set of process-of-care and health-status indicators (focusing on maternal and child health, preventative health, and chronic disease management) for First Nations people who are regular clients of a reporting organisation. The latest available data in this report version are from the June 2023 collection.

Latest update: 30 January 2024

Page updated	Details
All pages	All pages updated to include nKPI data up to June 2023 and OSR data up to 2022–23.

Data quality statement

- Aboriginal and Torres Strait Islander specific primary health care key performance indicators (June 2023) (aihw.gov.au)
- Online Services Report (OSR) for Aboriginal and Torres Strait Islander specific primary health care organisations, 2022–23; Quality Statement (aihw.gov.au).